On 22 March 2015, survivors of polio who are members of the Kano State Polio Victims Trust Association sit on tricycles specially designed for people with disabilities, in Kano State, Nigeria. In addition to making the tricycles, the members have been instrumental in educating local communities about the importance of vaccinating children against polio, including by going door to door and showing parents the very real consequences of the disease. Nigeria is one of just three countries worldwide where polio remains endemic.
Neonatal deaths account for 45 per cent of all under-five deaths, making the first 28 days of life – the neonatal period – the most vulnerable time for a child’s survival. Yet, in 2012, one in three babies – an estimated 44 million – entered the world without the help of a skilled health care provider, putting them at even greater risk during this most vulnerable time.
1 Situational analysis/context

Despite advances, the toll of under-five deaths is staggering. Between 1990 and the end of 2015, a total of 236 million children will have died. About 16,000 children under 5 die every day – 11 children lost every minute. Although the progress achieved so far is great, it is insufficient to meet the goals to which the world has committed for child health and survival. Sub-Saharan Africa continues to shoulder the greatest burden, where one in 12 children dies before age 5, while in high-income countries, the ratio is one in every 147 children.

In many countries, lack of capacity in national health systems hinders progress. Lack of trained health workers; weak supply chains and persistent bottlenecks that prevent the reliable supply of life-saving commodities; gaps in resources that hinder implementation of adopted policies; and insufficient capacity at the national and/or sub-national level for management, monitoring and strengthening of the health system persist in many countries. For example, between 1990 and 2014, the global proportion of women delivering their babies with skilled attendance rose only slightly, from 59 per cent to 71 percent. This means that in 2014 about 36 million births in low- and middle-income countries occurred with no skilled attendant present.

The attention of global health sector programming and funding is shifting towards these systemic bottlenecks – away from disease-specific initiatives and towards sustainable investments that build government capacity, encourage domestic finance and promote strong, equitable health systems. For example, these principles are reflected in the updated Global Strategy for Women’s, Children’s and Adolescents’ Health, under the umbrella of the United Nations Secretary-General’s Every Woman Every Child initiative.

The economic case for investing in child health is well established. Better child health has immediate benefits, such as lower treatment costs and fewer missed schooldays. It is also associated with lower fertility rates. In the longer term, these benefits transform into a more productive labour force: children survive into adulthood with better cognitive skills and more schooling which increases their economic output – and innovation. Moreover, longer life expectancy coupled with higher wages leads to greater savings, which then fuels greater investments in productive activities and a virtuous circle of growth. A 2014 *Lancet* study estimates that increasing health expenditure in 74 high income countries by $5 per person through 2035 could yield up to nine times that value in economic benefits.¹

2 Problem statement

Although child deaths from leading infectious diseases have declined significantly, pneumonia, diarrhoea and malaria are still the top three killers of children, and millions of children still lack access to quality care; vaccines to protect them against killers like polio, measles and tetanus; and affordable life-saving commodities, such as oral rehydration salts for diarrhoea treatment or insecticide-treated mosquito nets to prevent malaria. This is why, for example, in 2013, pneumonia, diarrhoea and malaria caused roughly one third of all under-five deaths.

Neonatal deaths account for 45 per cent of all under-five deaths, making the first 28 days of life – the neonatal period – the most vulnerable time for a child’s survival. Yet, in 2012, one in three babies – an estimated 44 million – entered the world without the help of a skilled health care provider, putting them at even greater risk during this most vulnerable time. These preventable newborn deaths, like under-five deaths, are concentrated in the world’s poorest countries. Together, low-income and lower-middle-income countries account for 85 per cent of all neonatal deaths, even though they are home to only 62 per cent of the world’s newborns. By contrast, only 2 per cent of neonatal deaths occur in high-income countries and 13 per cent in upper-middle-income countries. Substantial disparities remain in all regions, and there is much to be done to

realize the right of every child to survival, health and development.

Children and families in fragile and emergency settings are particularly vulnerable, whether they are subject to protracted conflict or struck by an unexpected disaster. For example, the Ebola crisis eroded hard-won progress towards the Millennium Development Goals in the three most affected countries, where basic child health services and facilities for safe childbirth were severely weakened or interrupted as health systems strained to manage the emergency response. Significant investments are required to support national capacities to build strong health systems that deliver, monitor and evaluate quality, equitable health care and services for children.

3 Proposed solutions

There are proven solutions that save lives. For example, when governments commit to supporting every pregnant woman in receiving at least four visits with a skilled health care professional, it is the first step towards the quality antenatal care that reduces maternal and child mortality and sets the stage for a healthy future. Globally, since preterm birth complications and complications during labour and delivery (intrapartum-related complications) account for nearly 60 per cent of neonatal deaths, investments in maternal care, specifically labour and delivery care and other high-impact interventions focused on the 24 hours around the time of birth, hold the greatest potential for preventing many of these deaths. After birth, a package of postnatal interventions, including keeping the baby warm, early initiation of breastfeeding, first polio vaccination and postnatal checks for baby and mother, can save even more lives. More details on how these simple, affordable and evidence-based interventions can prevent the death of most newborns and their mothers are outlined in the Every Newborn Action Plan.

After the neonatal period, children need different kinds of health interventions and quality care to survive and thrive. Proven preventive and treatment measures, including increased coverage and utilization of low-cost commodities like oral rehydration salts, zinc and amoxicillin can reduce morbidity rates caused by pneumonia and diarrhoea deaths. Increased access to and uptake of new vaccines can help protect children from these common child illnesses. Evidence also shows that community health workers are able to provide very high-quality treatment services, and because they are close to home, community health workers reach children early, before a treatable condition progresses to more severe illness and possibly death. Yet, too often, community health workers lack appropriate training, support and supplies, or are too few compared to the number of households for which they are responsible. The poorest and most marginalized children are the least likely to have access to these necessary interventions and services, all of which are included in the Global Action Plan for Pneumonia and Diarrhoea to eliminate preventable child deaths. In addition, the regular use of insecticide-treated mosquito nets is one of the most effective ways to prevent malaria transmission and reduce malaria deaths among children. Diagnostic testing and increased access to appropriate therapy are necessary to help children sick with malaria get well soon.

Immunization reaches more than 80 per cent of the world’s children, protects the lives of millions of mothers and newborns every year and remains a critical solution for reducing child mortality. Innovative partnerships between the public and private sectors are making immunizations increasingly affordable and available, with impressive results against killer diseases like polio, measles, pneumonia, diarrhoea and tetanus. Despite this progress, there is still much to be done to reach the last 20 per cent of children who still do not have access to immunization.

In every country, a resilient health system is the vehicle that delivers solutions like these to children and families. To function sustainably and equitably, health systems need the right mix of human resources, government leadership, accountability and community ownership. When taken up together, these approaches can save millions of lives.

Creating demand for quality health services and the uptake of safe, healthy and caring practices is also central to achieving sustainable health outcomes. Community outreach and engaging women, men and children of all ages help to break down the barriers that prevent individuals and families from seeking care. For example, by understanding the needs of the community, the health services are better able meet them.
The end result of UNICEF engagement should be reductions in health disparities, improved resilience in the context of outbreaks and emergencies and overall improvements in population health. UNICEF’s approach integrates programming in technical areas, including child health, health in humanitarian action, immunization, maternal and newborn health, and polio. The impact in terms of improved health outcomes is multiplied and sustained when children are also well nourished, educated, have access to clean water and sanitation facilities and live in a safe, protective environment that stimulates them from an early age to develop and reach their full potential.

UNICEF’s role

UNICEF is mandated by the United Nations General Assembly to advocate for the protection of the rights of every child, everywhere, to help meet children’s basic needs and to expand their opportunities to reach their full potential. With our partners, including governments, civil society and the private sector, UNICEF is bolstering action to increase quality and coverage of solutions like the ones described above in order to end preventable deaths, reduce illness and enhance health outcomes for women and children.

As detailed in the 2014 Annual Results Report for Health, UNICEF was able to demonstrate progress toward meeting global goals for reducing child mortality with concrete results. A new global health strategy (2015) helps drive the organization both to strengthen areas of comparative advantage and to further develop areas where enhanced engagement will support equity in health outcomes for children in all the diverse country contexts in which UNICEF works.

UNICEF’s comparative advantage in health is defined by several factors:

Delivering services for mothers and children: UNICEF provides services in fragile/emergency contexts, supports programmes in low-capacity contexts, builds management capacity in governments and procures and delivers supplies. With partners, UNICEF goes the last mile to reach women and children who still lack access to life-saving interventions, some of whom live in the most dangerous and hardest-to-reach parts of the world.

Empowering communities: UNICEF has experience supporting families, communities and local government in taking the concrete actions required to strengthen health systems and create demand for health services and healthy behaviours, so that every woman and every child can demand, access and utilize quality health services. The range of work includes engaging communities for social and behaviour change, generating demand, strengthening accountability, supporting programme delivery and building resilience.

Influencing government policies: UNICEF has experience in linking global experience and community-level realities in order to shape favourable policies for child health. UNICEF uses an integrated approach to child survival and development that places the focus on strengthening health systems, building capacity and integrating services. This includes supporting evidence-based policymaking and budgeting, promoting scale-up of effective interventions and innovations as well as sharing knowledge and promoting South-South exchange. In the 2014–2017 Strategic Plan, UNICEF’s child-centred focus brings together six
technical health programme areas: child health (pneumonia, diarrhoea and malaria); health in humanitarian action; strengthening health systems; immunization; maternal and newborn health; and polio, in line with the global shift in the health sector described above.

Advocate for every child’s right to health: On behalf of children, UNICEF advocates for policies and resources that enable continued progress towards the vision of a world where no child dies from a preventable cause and all children reach their full potential health and well-being. To enhance the evidence base for this advocacy, UNICEF supports evidence generation, conducts detailed situation analyses at the country level and works to expand the resources available at the country level.

The end result of UNICEF engagement should be reductions in health disparities, improved resilience in the context of outbreaks and emergencies and overall improvements in population health. As described above and shown below, UNICEF’s approach integrates programming in technical areas, including child health, health in humanitarian action, immunization, maternal and newborn health, and polio. The impact in terms of improved health outcomes is multiplied and sustained when children are also well nourished, educated, have access to clean water and sanitation facilities and live in a safe, protective environment that stimulates them from an early age to develop and reach their full potential.

The importance of this approach has been reinforced by the Ebola emergency in West Africa, which has been, to many, a stark example of how weak health systems can fail to prevent and control disease outbreaks, thus magnifying existing disparities and eroding overall population health. Availability of data that is fit for purpose, reliable, timely and able to be disaggregated enough to allow substantive equity analysis is a key determinant of country capacity for the monitoring and evaluation and responsive actions necessary for sharpening plans, enhancing programmes and strengthening health systems.

At the global level, UNICEF advocacy and engagement in partnerships aims to drive policy change and action in countries, supporting progress that is already underway. UNICEF plays a leadership role in many global maternal and child health partnerships, including the following: H4+, a collaboration between UNICEF, the United Nations Population Fund, World Health Organization (WHO), the World Bank and UN Women; the International Health Partnership; the
Reproductive, Maternal, Newborn and Child Health Trust Fund and its associated steering committee; A Promise Renewed; the Partnership for Maternal, Newborn & Child Health, based at WHO; GAVI Alliance; the Vaccine Alliance; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Global Polio Eradication Initiative; the Secretary-General’s strategy, Every Woman Every Child; Countdown to 2015; Maternal and Neonatal Tetanus Elimination Initiative; and the Measles & Rubella Initiative. UNICEF also played an influential role in the development of Every Woman Every Child, the new United Nations Global Strategy for Women’s, Children’s and Adolescents’ Health, and its accompanying operational framework; and the design of the World Bank’s new Global Financing Facility for Reproductive, Maternal, Newborn, Child and Adolescent Health, and is deeply engaged in technical partnerships focused on ending preventable child deaths, which include the Diarrhoea and Pneumonia Working Group (co-chair with the Clinton Health Access Initiative) of the Community Case Management Task Force, the Roll Back Malaria Partnership and the Every Mother Every Newborn initiative. Indeed, for more than 65 years, UNICEF has been building the relationships and the technical expertise needed to support countries in implementing practical solutions for health. UNICEF has been convening government leaders, celebrities, community activists, religious leaders, doctors, volunteer health workers, families as well as children themselves to commit to saving lives and promoting children’s health.

On 23 March 2015, a volunteer community mobilizer speaks to women and their children about best nutrition practices, at the centre for the community-based management of acute malnutrition (CMAM) in the district hospital in the Local Government Area of Bichi, Kano State, Nigeria. Members of a network of mobilizers conduct the educational sessions at CMAM centres and in communities – and help ensure that malnourished children are reached with oral polio vaccines and other routine immunizations. UNICEF supports the mobilizers by providing them with training and supplies. Nigeria is one of just three countries worldwide where polio remains endemic.
**Areas of focus and expected results**

For UNICEF, the focus in the health sector is on supporting improved and equitable use of high-impact maternal, newborn and child health interventions and promotion of healthy behaviours. UNICEF aims to contribute to the following expected results in the 132 UNICEF target countries with health programmes:

- In 54 countries, 100 per cent of facilities providing basic emergency obstetric and newborn care are operational on a 24/7 basis (baseline: 37 countries in 2014);

- In 120 countries, a policy on focused antenatal care has been developed, adopted and implemented (baseline: 99 countries in 2014);

- In 80 countries, a policy for home visits of newborns is developed and/or revised and adopted and in use (baseline: 68 countries in 2014);

- One hundred and thirty-two countries have no stock-outs lasting more than one month at the national level for oral rehydration salts (baseline: 117 countries in 2013);

- In 10 malaria-endemic countries, the target number of health workers in UNICEF-supported programmes are trained to use rapid diagnostic tests for malaria in children (baseline: five countries in 2014);

- Fifty-three malaria-endemic countries have no stockouts lasting more than one month at the national level of all artemisinin-based combination therapies for malaria treatment (baseline: 48 countries in 2014);

- Forty countries reach the target number of community health workers trained to implement integrated community case management (baseline: 22 countries in 2013);

- In 100 countries, a policy for community health workers to provide antibiotics for pneumonia is in place (baseline: 66 countries in 2013);

- In 100 countries, relevant essential commodities are registered and 80 countries have guidelines for use of these commodities in facilities and communities (baseline: 45 countries in 2014);

- In 47 polio-affected countries, less than 1 per cent of children under 5 are missing polio vaccination due to refusal (baseline: 20 countries in 2014);

- No polio-priority country cancels, postpones or reduces in size planned supplemental implementation activities due to gaps in vaccine supply (baseline: two countries in 2014);

- One hundred and twenty-two countries have no stock-outs lasting more than one month at the national level of vaccine containing DTP (diphtheria, pertussis and tetanus) (baseline: 141 countries in 2014);

- Note: Similar target and baseline for measles vaccines in development.

- Forty countries monitor barriers and bottlenecks related to child survival in at least 80 per cent of districts prioritized for district health system strengthening (baseline: nine countries in 2013);

- Seventy-five countries develop costed implementation plans for maternal, newborn and child health care (baseline: 52 countries in 2013);

- Forty countries have mainstreamed risk reduction/resilience, inclusive of climate change, into national health strategies and plans (baseline: 27 countries in 2013);

- Forty countries that are cholera-endemic or at risk for cholera have comprehensive multi-sectoral cholera preparedness plans (baseline: 26 countries in 2014);

- Ninety-five per cent of children aged 6–59 months (or aged 6 months to 15 years in affected areas) who are identified by UNICEF in humanitarian situations are vaccinated against measles (baseline: 70 per cent of children in 2013);

- One hundred per cent of families identified by UNICEF in humanitarian situations within malaria-endemic areas receive two insecticide-treated nets (baseline: 30 per cent of families in 2013);

- Fifty countries have plans with a budget allocated to reduce pregnancy among adolescent girls (aged 15–19 years) (baseline: 30 countries);

- Forty-two countries produce an analysis of sex-differentiated infant and child mortality estimates (baseline: 42 countries in 2014);
UNICEF aims to contribute to the following results among others in the 132 target countries with health programmes:

- Forty-eight countries develop, budget and implement a maternal, newborn and child health communication plan (baseline: 16 countries in 2013);

- Fifty-nine countries monitor and produce a scorecard on reproductive, maternal, newborn and child health (baseline: 44 countries in 2014);

- UNICEF generates 45 peer-reviewed journal or research publications on maternal, newborn, child or adolescent health per year (baseline: 40 publications in 2014).

Evidence generation, cross-cutting programming and advocacy:

Progress in health also requires investment in robust evidence and data as well as support to the national systems that collect data, including through household surveys. Improved data on adolescent health and better evidence on cross-cutting issues such as disability, gender and social or ethnic origin are particularly urgent needs. Progress toward health outcomes relies also on UNICEF’s work on Communication for Development (C4D) and advocacy, such as efforts to strengthen community dialogue, catalyse child participation and community decision making or to increase the overall focus on children in national budgeting.

6. Key assumptions, risks and mitigation measures

A few fundamental assumptions underpin UNICEF’s work. These are outlined below.

- Health remains a priority at both global and national levels. The risk is that other sectors attract attention away from health or new research reveals that the increased investments in health have not resulted in improvements in health status. To mitigate these risks, UNICEF builds evidence showing the connection between investing in health and changes in health status, and the social benefits derived from improvements in health, and advocates for the benefits of investments in health.

- Opposition to immunization remains localized. The risk is that broader coalitions opposed to immunization, in particular against polio, undo success achieved or that misleading research reveals a connection between a vaccine and a health problem, thereby undermining public confidence in immunizations. To mitigate this risk, UNICEF invests in building vaccine confidence in caregivers, communities and leaders at all levels and responds rapidly to misinformation about vaccines.
• No significant new global threats to child health emerge. The present risk is that a new pathogen might emerge and rapidly spread. UNICEF’s work to strengthen health systems and to build the resilience of communities, families and children mitigates this risk.

• Human resources for health are adequate to deliver health services. Every year, multiple humanitarian crises in rapid succession threaten to overstretch UNICEF’s capacity to respond. To mitigate this risk, UNICEF develops the capacity of health workers at all levels, including through training and technical assistance, and supports policy shifts to enable lower cadres of health workers to play more important roles.
Overall funding gap for health (in US$):

- Resource requirements (2014–2017, as per SP)
- Estimated funded (Jan 2014 – Aug 2015)
- Estimated funding gap (Sept 2015 – Dec 2017)

Details of funding gap by programme area, 2015–2017 (in US$):

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<th>Programme Area</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Total</th>
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Background and additional information

On 1 October 2014, Katiki Zondani, 13 months, has her mid-upper arm circumference measurements taken by a health worker at the Ngabu Clinic, Chikwawa district, Malawi. “The major causes of malnutrition in the district are food security, disease and education. Sometimes people just don’t know how to feed themselves or their families properly,” says John Mugawa, district nutrition coordinator. It was at the growth and monitoring clinic that the health worker picked up that Katiki was severely malnourished. She was admitted to hospital immediately. Her mother Maria was encouraged to test for HIV. Her results came back positive and so did Katiki’s. They are now both on antiretrovirals, and Katiki’s diet is supplemented with plumpy nut (a peanut-based paste for treatment of severe acute malnutrition).


The latest health-related working papers and briefs are available online at <www.unicef.org/health/index_working_papers.html>.

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