Towards a Grand Convergence for Child Survival and Health

A strategic review of options for the future building on lessons learnt from IMNCI

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Table of Contents

Abbreviations and acronyms

ASHA	Accredited social health activist
BIVA	Bioelectrical impedance vector analysis
BMGF	Bill & Melinda Gates Foundation
CBD	Community-based distributor
CBNC	Community-based newborn care
CHW	Community health worker
C-IMCI	Community IMCI
DHIS2	District Health Information Systems 2
DHS	Demographic and Health Survey
ENAP	Every Newborn Action Plan
EPI	Expanded Programme on Immunization
EQUIST	Equitable strategies to save lives
ETAT	Emergency triage assessment and treatments
EWEC	Every Woman Every Child
GAPPD	Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea
GAVI	Global Vaccine Alliance
GFATM	Global Fund for the fight against AIDS, TB and Malaria
GFF	Global Financing Facility
GIS	Geographic information system
GKI	Global key informant
GPS	Global positioning system
HBB	Helping babies breathe
HMIS	Health management information system
ICATT	IMCI computerized adaptation and training tool
iCCM	integrated community case management
IMCI	Integrated management of childhood illness
IMNCI	Integrated management of newborn and childhood illness
IMPAC	Integrated management of pregnancy and child birth
LiST	Lives saved tool
LMIC	Low- and middle-income countries
MBB	Marginal budgeting for bottlenecks
MDG	Millennium development goal
MoH	Ministry of health
MNCH	Maternal, newborn and child health
NGO	Non-governmental organization
OSCE	Objective structured clinical examination
PHC	Primary health care
PIP	Performance improvement plan
PLA	Participatory learning and action
QoC	Quality of care
RCT	Randomized controlled trial
REC	Registre Electronique de Consultation
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
SCT	Social cognitive theory
SDG	Sustainable development goal
SMS	Short message service
TB	Tuberculosis
UNICEF	United Nations Children's Fund
WASH	Water, sanitation and hygiene
WHO	World Health Organization

Executive Summary

1. Over the past quarter century, child mortality has more than halved, dropping from 91 to 43 deaths per 1000 live births between 1990 and 2015. Yet in 2015 an estimated 5.9 million children still died before reaching their fifth birthday, most from conditions that are readily preventable or treatable with proven, cost-effective interventions. Given the stakes we, the global child health community, must do far better to assist countries to deliver the best possible strategies to help each child survive and thrive.

2. In 1995, WHO and UNICEF developed Integrated Management of Childhood Illness (IMCI) as a premier strategy to promote health and provide preventive and curative services for children under five in countries with greater than 40 deaths per 1000 live births. In 2003 care for newborns under one week of age was added and the strategy was renamed as IMNCI in many countries.[1] Over 100 countries have adopted IMNCI and implemented to varying degrees its three components: 1) improving health worker skills, 2) strengthening health systems and 3) improving family and community practices.

3. Twenty years later a stock-taking is warranted. Interest and funding for IMNCI have waned, implementation has proved problematic and coverage at scale was rarely achieved. With attention focused on specific child health areas such as immunization and communicable diseases, a holistic view of child health has arguably been lost inside the continuum of reproductive, maternal, newborn, child and adolescent health (RMNCAH). Nevertheless, IMNCI ushered in a transformation in how we view effective child health services. We now must build on lessons learnt to redesign the strategy, incorporating the latest evidence-based interventions and most effective delivery mechanisms, and integrating the rich repository of tools and resources that have become available since IMNCI was launched. We must also re-position IMNCI under the Sustainable Development Goals (SDGs) and the U.N. Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).[2] Our Review aims to maximize the potential of IMNCI to end preventable newborn and child mortality and help children thrive wherever they live, by supporting a seamless continuum of high-quality care spanning the home, community and health facility.

4. All countries have committed to reducing under-five mortality to 25 or less and newborn mortality to 12 or less per 1000 live births by 2030. These targets are ambitious yet achievable, provided there is political will, adequate investment and concerted action. To achieve a "Grand Convergence for child survival and health within a generation", we must strengthen health systems, build capabilities to meet children's health needs, and work towards universal health coverage. We have the knowledge, resources and opportunities to invest. What is required now is renewed energy to capture attention and mobilize action, maximizing funding from domestic, bilateral and multilateral sources including the Global Financing Facility (GFF).

5. The present Strategic Review brought together an independent expert advisory group with study group members at WHO and UNICEF to review past lessons and propose an agenda to stimulate momentum for improving care for children. The Review draws its conclusions from 34 unique sources of data, 32 of which were specifically commissioned. The data set represents contributions from over 90 countries and hundreds of experts in child health and related areas, and considers findings from a comprehensive review of the published and unpublished literature as well as in-depth case studies of implementation. Study group members used data to answer pre-defined questions and extracted key messages at

[1] We use the term IMNCI for consistency throughout this report, recognizing that newborn care was added at a later date.
[2] Hereafter referred to as the "Global Strategy".

participatory workshops; preliminary recommendations were then refined by a small group of high-level stakeholders representing global, regional and country levels. The findings of our review will be shared widely.

IMNCI implementation twenty years on

6. IMNCI was developed to increase coverage of evidence-based, high-impact interventions, taking an integrated approach to promotion, prevention and treatment and focusing on the top killers of children under five. IMNCI also represented a set of core values, by promoting a holistic, child-centred approach to childhood illness that sought to address basic human rights to health and health care. As such, IMNCI attempted to address the tension between selective and comprehensive approaches to primary health care and related questions around rights and programme expediency.

7. There has been near universal adoption of the IMNCI strategy by target countries, with widespread reported implementation of facility-based activities. Since 2010 there has been increasing implementation of integrated community case management (iCCM), building on WHO/UNICEF guidance and training materials. A 2016 Cochrane review found that IMNCI was associated with a 15% reduction in child mortality when activities were implemented in health facilities and communities. Other data have shown positive effects on health worker practices and quality of care. Improvements in care-seeking and household practices have been more rarely documented, as investment in community and home-based interventions has lagged. IMNCI's distillation of case management of the major killers of children under five years of age into a clinical algorithm and guidelines was highly appreciated by service providers and policy-makers for its simplicity and comprehensiveness, and it transformed how care for children is perceived at global and country levels.

8. However, IMNCI implementation suffered from a number of setbacks, with uneven implementation between and within countries, and insufficient attention to improvements in health systems and family and community practices. Countries and donors failed to agree on sustainable funding, and fragmentation of support by global partners led to a loss of IMNCI's built-in synergy around its three components. The fact that tools to support the health system and community components became available slowly and had variable uptake did not help countries build coherent programmes from the start. The emerging global attention to newborn mortality also contributed to a shift of focus in countries, with insufficient clarity on the complementary roles of maternal and child health units in addressing newborn health.

9. After IMCI was launched, WHO and UNICEF did not provide sufficient, sustained, focused global leadership, and too little attention was paid to programme monitoring, targets and operational research. Only countries with strong government leadership and political commitment were able to engage in the unified, country-led planning necessary to support scaling up. IMNCI was better implemented when: a) the health system context was favourable, b) a systematic approach to planning and implementation was used and c) political commitment allowed for institutionalization. The absence of an explicit emphasis on equity, community engagement and linkages to other sectors (for example education or water and sanitation (WASH)) were blind spots that limited IMNCI's contribution to reducing child mortality.

Looking forward: options for countries

10. Past experiences make clear that government ownership and government-led planning and implementation are required to scale up interventions and services – but that these depend on strong country leaders and disciplined partners. Child health stakeholders must work to mobilize political support in the context of a renewed focus on primary health care. Country actors and partners must reach convergence around an integrated, funded plan that aligns

maternal, newborn and child health programming under a common national vision, with specific national targets and monitoring to assess progress.

11. The highest-achieving countries in the era of the Millennium Development Goals (MDGs) were those that implemented tailored responses to the main bottlenecks to providing care for children. Countries must work with support from global partners to define strategies adapted to their epidemiological and health systems contexts, reviewing points of service and building on systems strengths. Examples include engaging the private sector to improve quality of care in countries with high rates of care-seeking in this sector, or adopting iCCM in contexts with low access to facilities and an existing cadre of CHWs. Integrated case management and delivery of interventions combining prevention and treatment remains the recommended approach for reasons of quality, effectiveness, efficiency and child rights.

12. District teams are the *sine qua non* of operational planning and implementation, and their efforts will be essential to improving quality of care. As such, IMNCI is a key element of both primary health care and universal health coverage. Resources for district teams must be mobilized including through advocacy at subnational level, alongside efforts to avoid rapid staff turnover and build up child health teams. Much greater attention must be paid to operational detail at district level, with improved data central to decision-making. Demonstration districts within countries can serve as laboratories to determine what works best, creating a learning system among district teams through which successful approaches can be generalized. Simultaneous monitoring can allow countries to quickly adjust course; active district child health committees comprising users, leaders and professionals can provide independent review.

13. Countries should explicitly prioritize reaching poor, under-served populations by using equity and mapping analyses to target service provision, and ensure free services for children at the point of care. Strategies to support households' capacity to produce health must be integrated into efforts to create a continuum of care for children at household, community and facility levels. To promote care-seeking and healthy practices, especially for newborns, countries should scale up evidence-based strategies for community engagement such as women's groups, accredited social health activists, home visits and health committees, linking these to ongoing monitoring to provide accountability for results.