Child and Adolescent Health and Development

Progress Report **2006–2007**

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HIGHLIGHTS

Child and Adolescent Health and Development

Progress Report **2006–2007**

Message from the Director

I am pleased to present some of the highlights of the work during 2006–2007 of the World Health Organization in the area of Child and Adolescent Health and Development.

The greatest preventable risks faced by newborn babies and children under five in low-income countries are low birth weight, newborn illness, childhood diseases and malnutrition. For adolescents aged ten to 19 years, some of the main health risks are HIV and too-early pregnancy, as well as substance use and mental health problems.

Focusing on these major challenges, we are engaged in research, supporting the use of that research for policy change and programme implementation, and monitoring the results of evidence-based approaches in countries.

Taking a public health perspective, we aim both to strengthen health systems and to empower communities and families. Our goal is to protect and improve the health and well-being of children and adolescents, contributing to the achievement of the Millennium Development Goals (MDGs).

To date, we have supported 30 countries to develop national child survival strategies that are the basis for uniting all stakeholders to work towards a common goal and purpose.

In 2006–2007 we celebrated the tenth anniversary of the Integrated Management of Childhood Illness (IMCI) strategy. Now introduced in more than 100 countries around the world, IMCI is still relevant and still addresses the major killers.

Having analysed the results of the latest research, and recognizing the need to accelerate policy change and programme implementation for the high risk newborn period, we expanded IMCI to cover the management of illness and care of infants from the first day of life. In order to address the need for training on the treatment and care of children with HIV, we developed a complementary course for care of children with HIV within IMCI and also for care of children with HIV and AIDS in referral facilities.

As appropriate feeding is central to child well-being, we finalized a five-day course to provide health workers with skills for counselling mothers on breastfeeding, complementary feeding, and feeding when the mother is infected with HIV. This integrated training has already been introduced in 30 countries.

CAH has one of the largest research programmes in WHO. In 2006–2007, we have supported research and updated recommendations on giving children iron supplements in malaria-endemic areas, and on the safety and efficacy of zinc supplements for young children.

To prevent illness and death in the first week of life, we are carrying out research on post natal visits in the home by community health workers (CHW) who introduce key prevention and care messages and actions to the mother. We are also developing CHW training materials for the community management of illness in newborns and older children, and the promotion of key practices to maintain health.

In 2006–2007 landmark progress was made in the area of early childhood development with the publication of a Lancet series which brought to the world's attention the huge loss of potential from malnutrition in early childhood. Similarly, the Joint Statement on the community-based management of severe acute malnutrition which we published with UNICEF, the World Food Programme and the UN System Standing Committee on Nutrition, makes treating severe malnutrition in the community possible, giving the prospect of better development for millions of children.

In the field of adolescent health, in 2006-2007 we marked the tenth anniversary of the call made by WHO, UNFPA and UNICEF for Action for Adolescent Health.

In the 1980s and 90s WHO played a key role in putting adolescent health and development on the public health agenda. Looking back, it is extraordinary that so little attention had previously been paid to this group, who represent an estimated one fifth of the world's population.

Times have changed. Governments, UN organizations and NGOs are now more and more aware of the reasons why they should be concerned about what happens during adolescence: for the present, for the future, for this generation and the next. From the HIV pandemic to the non-communicable diseases that confront governments around the world, what happens during adolescence is key to responding effectively to the problems that they face.

In 2006-2007 we have focused our efforts on strengthening the response of the health sector to adolescent health, and specifically the stewardship role of ministries of health in four key areas:

- gathering and using strategic information;
- developing supportive, evidence-informed policies;
- scaling up the provision of health services and commodities; and
- strengthening action in other sectors and civil society.

In 2006–2007, we generated evidence for programmatic action, developed and tested methods and tools to support those actions, built capacity for their implementation, and supported and documented results in countries. Using HIV and reproductive health as entry points, we supported ten 'focus' countries to strengthen their health sector's response to adolescents' needs in these and other areas. We have worked in ways that not only resonate with ministries of health and other partners in the health sector, but that also build on the organizational priorities set by WHO's Director-General: particular attention to Africa; a focus on health issues that affect young women; and efforts to strengthen the system that provides the services that adolescents need to improve their health and development.

We recognize that partnerships are essential to moving forward in this challenging area. We work closely with other departments within WHO, with UN agencies (especially UNICEF, UNFPA, and the World Bank), with key development partners including bilaterals, NGOs and professional associations, as well as many collaborating centres. WHO is hosting the Partnership for Maternal, Newborn and Child Health and we are an active member working together with them to meet MDGs four and five.

We are heading into a new biennium which will present new challenges. 2008–2009 will be the first two years of WHO's new Medium-Term Strategic Plan. Over the past two years we have succeeded in turning global attention to the need for much greater focus on achieving MDGs 4, 5 and 6 and the need to strengthen health systems. We must now sustain that pressure and deliver on key promises to improve the health and development of the world's children and adolescents.

Dr Elizabeth Mason
Director, WHO Department of Child and Adolescent Health and Development

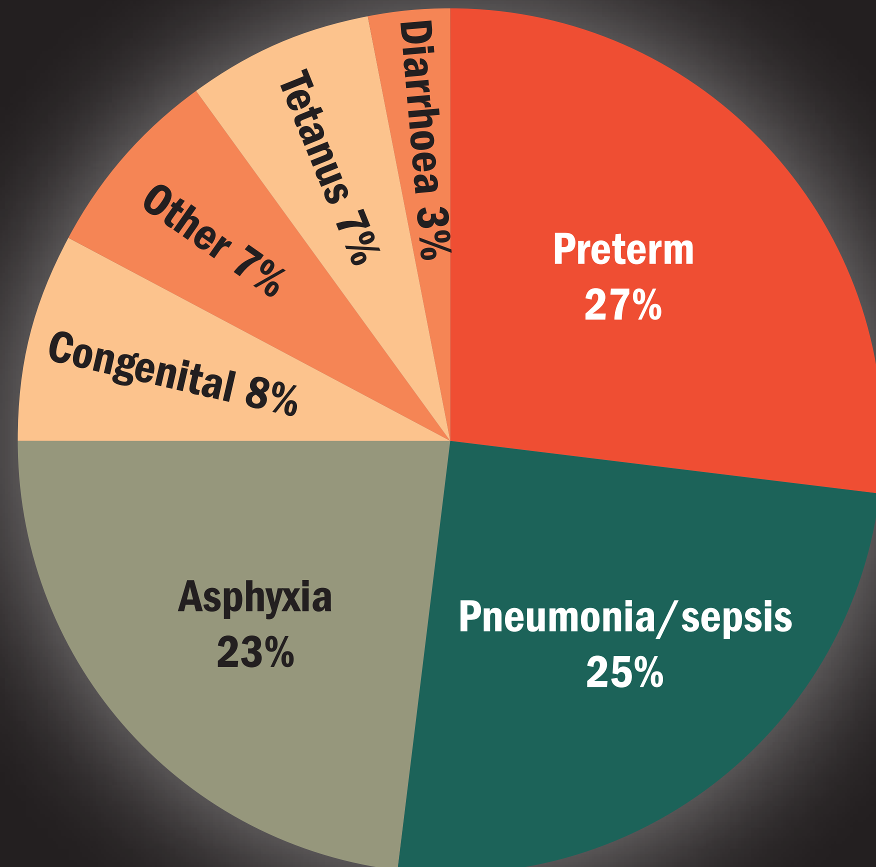
OVERVIEW

Causes of newborn deaths ■ Newborn guidelines ■ Newborns in IMCI ■ Breastfeeding ■ HIV and infant feeding ■ Infant feeding indicators

NEWBORNS

The first few days and weeks of life are among the most critical for child survival. Every year, an estimated 4 million children die during the first month of life. Almost all of these deaths (98%) occur in developing countries. Most neonatal deaths are due to pre-term birth, asphyxia and infections such as sepsis, tetanus and pneumonia. In 2006–2007, to support efforts by countries and regions to reduce newborn deaths, we worked to build capacity for the planning and delivery of improved newborn care services in health facilities and communities, to provide tools and guidance for extending population coverage, and to evaluate the impact of all those actions.

Causes of **newborn deaths**



Source: WHO World Health Statistics 2007.

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Newborn **Guidelines**

We are now engaged in research to make sure that the guidelines for newborn care not only are effective, but also that they are being implemented well and reach all newborns. One important approach is for community health workers to make home visits during the first week of life. We are designing training courses to help community health workers to acquire the necessary knowledge and skills and use them in home visits in the early days of life to achieve the greatest benefit to the health of newborns.

Newborns in **IMCI**

The Integrated Management of Childhood Illness (IMCI) strategy is being continually improved and extended – not just to more countries and communities, but also to cover more specific needs. Based on a study that covered close to 9 000 young infants in six countries, we have identified a small set of clinical signs that selects newborns with severe illness requiring hospitalization. These have been used in improving the IMCI guidelines for clinical assessment of children aged 0–2 months.

UNICEF/HQ04-0174 Roger LeMoyne.jpg

NEWBORNS

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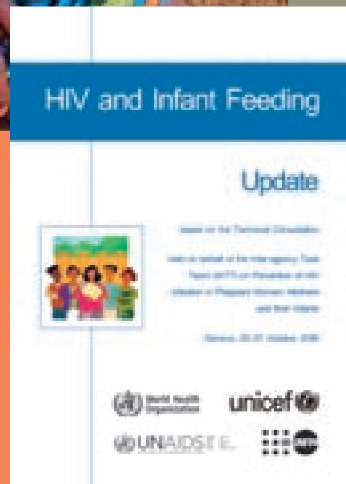
BREASTFEEDING

Over the past two years, we have gained new evidence for the health advantages of breast-feeding and making recommendations for its practice. We can say with full confidence that breastfeeding reduces child mortality and has health benefits that extend into adulthood. Exclusive breastfeeding for the first six months of life is the recommended way of feeding infants, followed by continued breastfeeding with appropriate complementary foods for up to two years or beyond. To support more mothers and infants around the world to practise exclusive breastfeeding, we have created a five-day course for lay health workers, along with all the necessary training materials and guidelines on how to counsel mothers about the feeding of infants and young children. We have also produced a guide for programme managers on how to plan and implement national programmes for infant and young child feeding.

HIV and Infant Feeding



Should a mother breastfeed if she is infected with HIV? We have reviewed the results of research and found that exclusive breastfeeding during the first six months of life carries a lower risk of HIV transmission than "mixed" feeding. Stopping breastfeeding early can lead to other health-risks for the child, unless an acceptable, feasible, affordable, sustainable and safe alternative is available. To ensure widespread awareness and use of this information, we have worked with partners to develop a "Consensus Statement" on HIV and infant feeding, and technical guidance has been updated to reflect the best available evidence.

Infant Feeding Indicators

In 2006–2007 we continued work with partners to develop simple, valid and reliable population-level indicators to assess infant and young child feeding practices. We hosted a consensus meeting in November 2007 which resulted in a document entitled "Indicators for assessing infant and young child feeding practices". It presents eight core and seven optional indicators for assessing feeding practices in children aged 0-24 months.

WHO/Harry Anenden

Core indicators

1. **Early initiation of breastfeeding**
2. **Exclusive breastfeeding under six months**
3. **Continued breastfeeding at one year**
4. **Introduction of solid, semi-solid or soft foods**
5. **Minimum dietary diversity**
6. **Minimum meal frequency**
7. **Minimum acceptable diet**
8. **Consumption of iron-rich or iron-fortified foods**

Optional indicators

9. **Children ever breastfed**
10. **Continued breastfeeding at two years**
11. **Age-appropriate breastfeeding**
12. **Predominant breastfeeding under six months**
13. **Duration of breastfeeding**
14. **Bottle feeding**
15. **Milk feeding frequency for non-breastfed children**

Worldwide, the major killers of children under five are neonatal causes of death, pneumonia, diarrhoea, malaria, measles and HIV. Hospitals are overburdened by the numbers of children with severe illness, and many children never reach a local clinic, much less a district hospital. In 2006–2007, we researched and developed new ways of reaching young children by improving care in clinics and hospitals, as well as extending health services into the community, to reduce further the burden of mortality from these threats.

OVERVIEW

MDG 4: How are we doing? ■ IMCI coverage and evaluation ■ Country Profiles ■ Pocket Book of Hospital Care for Children ■ Bringing health to communities ■ New approaches to training health workers ■ New Treatment for Severe Malnutrition at Community Level ■ Paediatric HIV ■ Pneumonia ■ ORS+Zinc ■ Child Development ■ Child and Adolescent Rights ■ Regional Story: Eastern Mediterranean Region

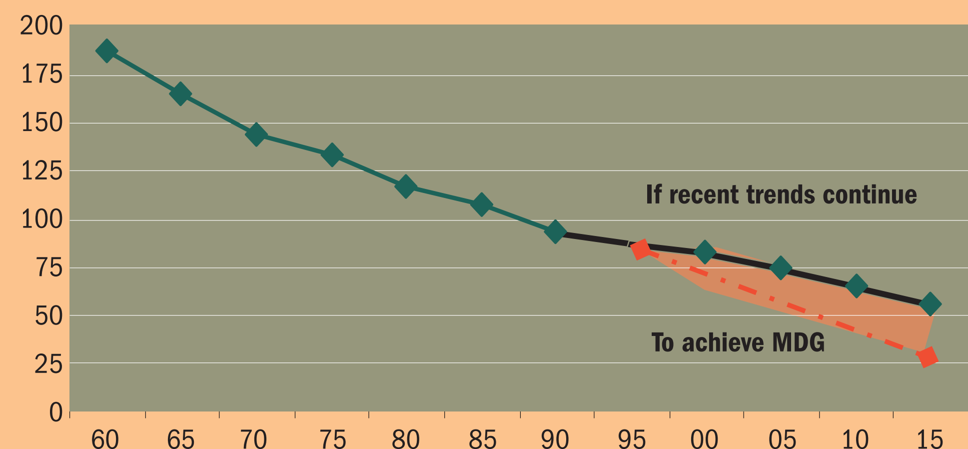
CHILDREN

Millennium Development Goal 4
How are we doing?

Tracking global progress towards MDG4 – to reduce by two thirds the mortality rate of children under five years old by 2015 from the 1990 rate – reveals that 16 of the 68 highest-mortality rate countries are on track to meet the goal: Bangladesh, Bolivia, Brazil, China, Egypt, Eritrea, Guatemala, Haiti, Indonesia, Lao People's Democratic Republic, Mexico, Morocco, Nepal, Peru, the Philippines and Turkmenistan; 26 countries are making some progress but they need to accelerate; and 12 have made no progress: Botswana, Cameroon, the Central African Republic, Chad, the Congo, Equatorial Guinea, Kenya, Lesotho, South Africa, Swaziland, Zambia and Zimbabwe.

Goal 4 **Reduce Child Mortality**

Target: To reduce by two-thirds, between 1990 and 2015, the under-five mortality rate



Source: Under-five mortality rates from the Inter-Agency Child Mortality Estimation – WHO, UNICEF, World Bank, UNDP, and independent experts

IMCI coverage and evaluation

Since 1996, we have supported the implementation of the Integrated Management of Childhood Illness (IMCI) strategy. To date, IMCI has been introduced in more than 100 countries around the world. In many countries, including 19 in the African Region, geographic coverage of IMCI has been expanded to cover more than 50% of all districts.

In 2006–2007 the Department continued work on the multi-country evaluation (MCE) to measure the impact, cost and effectiveness of IMCI. Information on key indicators such as child mortality, child nutritional status, and family behaviours was gathered in Brazil, Peru, Uganda and the United Republic of Tanzania, and activities are ongoing in Bangladesh. The results of the MCE so far indicate that:

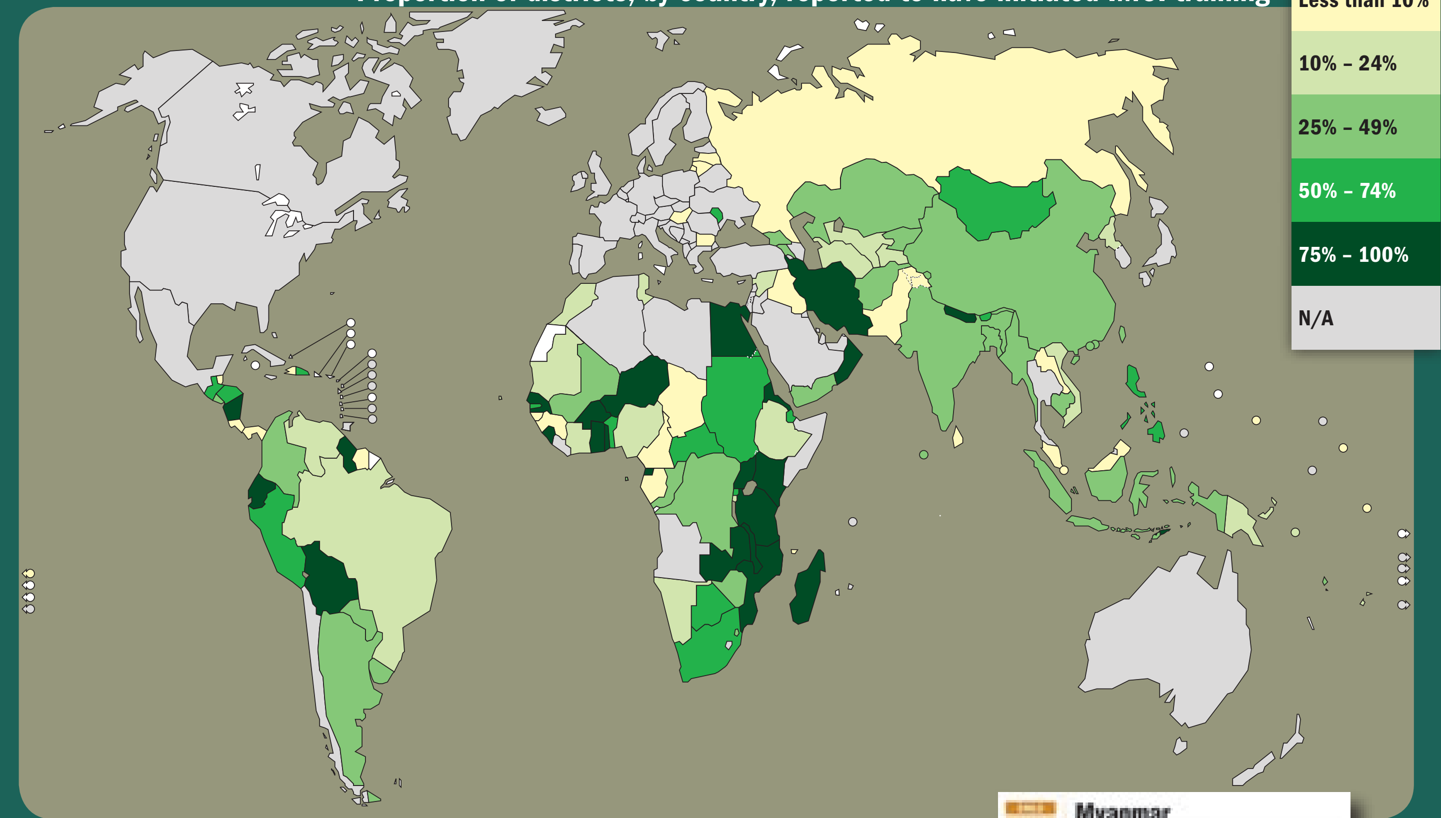
- IMCI improves health worker performance and quality of care;
- IMCI can reduce under five mortality and improve nutritional status, if implemented well;
- IMCI is worth the investment, as it costs up to six times less per child correctly managed than current care.

Implications of the findings are that:

- child survival programmes require more attention to activities that improve family and community behaviour;
- the implementation of child survival interventions needs to be complemented by activities that strengthen system support;
- a significant reduction in under five mortality will not be attained unless large scale intervention coverage is achieved.

Estimated coverage of IMCI training, as of December 2007

Proportion of districts, by country, reported to have initiated IMCI training



Country Profiles

To support the development of evidence-based policies and strategies for child health in countries, we have developed a number of "country profiles". These profiles present key epidemiological information to help countries determine the best package of interventions and strategies for delivery, based on their specific needs and circumstances. Profiles for countries, including Bangladesh, India, Indonesia, Myanmar and Nepal were made available on our website in 2007, and many more will be published in 2008.

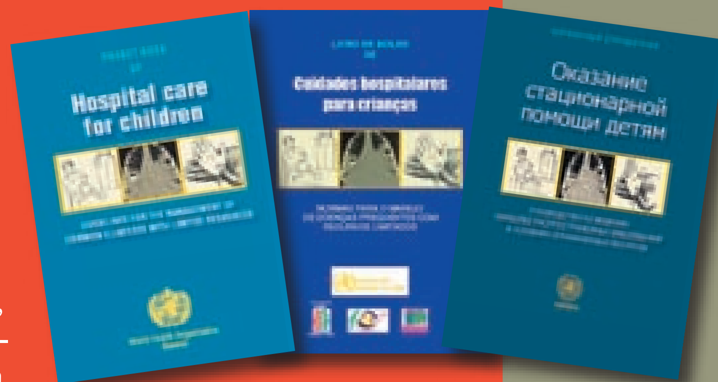
www.who.int/child_adolescent_health/data/country_profiles

CHILDREN

Pocket Book of **Hospital Care for Children**

UNICEF/HQ06-2052/Pablo Bartholomew

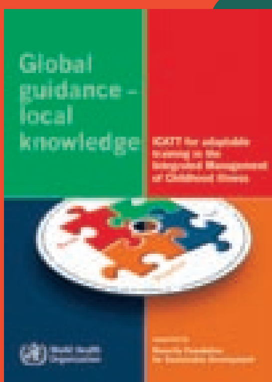
This pocket-sized manual for senior health workers caring for young children in hospitals in developing countries was a great success when first launched in 2005. In 2006–2007 the pocket book was translated into several additional languages, including Armenian, French, Chinese, Portuguese, Russian and Turkish, and continues to be in high demand around the world. It presents up-to-date treatment recommendations for both inpatient and outpatient care in small hospitals where basic laboratory facilities and essential drugs and inexpensive medicines are available. It focuses on management of the major causes of death and illness in young children, such as pneumonia, diarrhoea, severe malnutrition, malaria, meningitis, measles and HIV infection. It also covers neonatal problems and surgical conditions of children which can be managed in small hospitals.



BRINGING HEALTH TO COMMUNITIES

To bring essential child survival interventions into more homes and communities, we are developing state-of-the-art materials to provide community health workers with basic care-giving skills for the management of childhood illness, better care for newborns, and to promote key family practices to prevent illness and promote wellness. The package of training materials is designed to be delivered at a designated "health house" where parents and other care-givers can seek care for a sick child, and through home visits, targeting newborns in particular. The modules on the management of childhood illness have been developed as a first priority, to meet the urgent demands of countries and partners to expand access to care for child diarrhoea, malaria, and pneumonia.

New approaches to training health workers

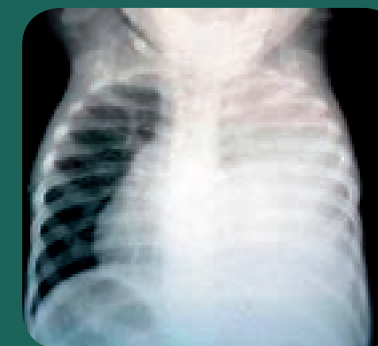


To develop the capacity of more health workers to prevent and treat sick children, we have developed new approaches for delivering training on the Integrated Management of Childhood Illness (IMCI). In 2006–2007 we worked with the Novartis Foundation for Sustainable Development to develop a computerized tool for adapting the IMCI guidelines for distance learning or classroom training of health workers in both pre-service and in-service settings. We have also continued working with countries to introduce IMCI into the curriculum of medical and nursing schools.

New **Treatment for Severe Malnutrition** at Community Level

Malnutrition contributes to more than half of all childhood deaths globally. However, a recently developed home-based treatment for severe acute malnutrition is giving hundreds of thousands of malnourished children a new chance at a healthy life. Ready-to-use Therapeutic Food (RUTF) – based on peanut butter mixed with dried skimmed milk and vitamins and minerals – has revolutionized treatment of severe malnutrition. It is safe to use at home, can be consumed directly by the child and provides sufficient nutrient intake for complete recovery. Local production of RUTF paste is already under way in several countries including the Congo, Ethiopia, Malawi and Niger. In 2007 WHO, UNICEF, the World Food Programme and the UN System Standing Committee on Nutrition adopted a Joint Statement on the community-based management for severe malnutrition. WHO and UNICEF have since worked together to develop a field manual for the community-based management of severe malnutrition, and the IMCI guidelines have been revised to take account of the new home-based treatment.

PNEUMONIA



Pneumonia is the largest single cause of death in children under five. In 2006–2007 we led the initiative to develop a Global Action Plan for Pneumonia (GAPP). In March 2007 consensus was reached on a comprehensive approach to prevent and control child pneumonia which includes key strategies of nutrition, reduction of indoor air pollution, immunization, and better case management. In 2008 the GAPP will continue with work to facilitate the promotion and implementation of these interventions at country level, in the context of child survival strategies to achieve MDG4.

In addition, in 2006–2007 we supported two key studies – one in Pakistan, the other in Bangladesh, Egypt, Ghana and Viet Nam – to examine whether severe pneumonia can be safely treated at home. The Pakistan study demonstrated the safety and efficacy of treating children aged 3-59 months with severe pneumonia with oral antibiotics outside of a hospital setting. Findings indicate that treatment guidelines for severe pneumonia should be reviewed in 2008. However, it should be noted that this treatment strategy will not be appropriate in high HIV prevalence settings, nor in cases of very severe pneumonia.

Paediatric **HIV**

AVECC/H. Vincent

Without treatment, more than half of all HIV-infected children die before their second birthday. If HIV infection is identified early and the child gains access to quality treatment and care, as well as support for their family, they have a much greater chance at survival and better quality of life. Staff from headquarters and the Regional Office for Africa have worked together in 2006–2007 to develop an adaptation of the IMCI guidelines for use in settings with a high prevalence of HIV/AIDS. We also developed a training course to build health worker capacity for managing children and infants infected with or exposed to HIV, which is already being used in 13 African countries.

CHILDREN

WHO/Carlos Gaggero

ORS+Zinc

Diarrhoeal diseases are a leading cause of sickness and death among children in developing countries. We have built an evidence base that shows that treating children with diarrhoea with low-osmolarity Oral Rehydration Salts (ORS) and zinc supplements is safe, cost-effective and saves lives. Low-osmolarity ORS shortens the duration of diarrhoea and reduces the need for hospital-based intravenous fluids. Zinc supplements reduce the severity and duration of the episode. We have developed guidelines and tools to support implementation, monitoring and evaluation of the combined ORS+zinc treatment strategy. We are now looking at the feasibility of incorporating zinc into routine treatment through studies in India, Mali and Pakistan. We have developed guidance for manufacturers on the production of low-osmolarity ORS and, together with partners, transferred technology to Bangladesh, India and Pakistan for the production of zinc tablets.

Child Development

Each year over 200 million children fail to reach their full potential in cognitive development because of poverty, poor health and nutrition, and lack of early stimulation. In 2007 The Lancet published a series on "Child development in developing countries" which was co-authored by staff from the Department. The series shed light on new information demonstrating the urgent

CHILD AND ADOLESCENT RIGHTS

To facilitate the integration of a "rights-based perspective" into the planning and implementation of policies, interventions and programmes for child and adolescent health, we have developed a training course. The course strengthens understanding and knowledge of child rights and the United Nations Convention on the Rights of the Child (CRC). Participants from WHO and counterparts in countries learn about the relationship between needs, obligations and rights, and about how the CRC can be used for policy development, as well as planning, programming and managing programmes for child and adolescent health. During 2006–2007, we conducted multi-country trainings in the African and Western Pacific Regions, as well as two countries in the Region of the Americas: Honduras and Nicaragua. As a result, in 2006 and 2007, the African, Americas and Western Pacific Regions all provided support to the CRC reporting process, including through the review of selected state party reports.

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Regional Story

Eastern Mediterranean Region

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