SEA-CHD-6
Distribution: General

First Meeting of the South-East Asia Region Expert Group on Child Health and Development

A Report
WHO/SEARO, New Delhi, India, 20–22 August 2008

WHO Project: ICP DDE 003

World Health Organization
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1. Background and introduction

The Regional Director, WHO South-East Asia Region, Dr Samlee Plianbangchang, established a South-East-Asia Region Expert Group on Child Health and Development with the following terms of reference:

(1) To advise the Regional Director on priority technical areas of work and regional strategic directions related to neonatal and child health and development in the South-East Asia (SEA) Region for inclusion in the proposed South-East Asia Regional Strategy for Child Health and Development;

(2) To provide technical advice on improving the delivery of effective neonatal and child health interventions at high coverage through public health systems in South-East Asia, with emphasis on quality;

(3) To suggest mechanisms for addressing information gaps and country-based actions to monitor and evaluate the effectiveness of child health initiatives;

(4) To give technical advice on setting regional priorities for research in neonatal and child health and development to generate evidence that has policy and programme implications; and

(5) To provide guidance on initiatives that will increase the demand for effective child health interventions and ensure equity in the provision of services through public health systems in countries of the SEA Region.

The rules of business of the Expert Group are provided in Annex 1 and the list of members and Secretariat are at Annex 2.

2. Objectives

The first meeting of the Expert Group was organized in the Regional Office during 20-22 August 2008. The objectives of the meeting were to:

(1) Initiate the development of a South-East Asia Regional Strategy for Child Health and Development;

(2) Apprise the Expert Group about the proposed SEA Regional Office initiative: Integrated Control of Diarrhoea and Respiratory Infections Programme; and

(3) Seek guidance from the Expert Group about the agenda and organization of the forthcoming High-Level Consultation to Accelerate Progress towards Achieving Maternal and Child Health Millennium Development Goals (MDGs 4 and 5) in South-East Asia, to be held at Ahmedabad, India, from 14-17 October 2008.

3. Inaugural session

The meeting was opened by Dr Myint Htwe, Director, Programme Management, WHO Regional Office for South-East Asia, who stated that WHO was an organization of Member States wherein the Regional Office and country offices should be considered as the Secretariat of the Organization. WHO has had a long tradition of working through individuals, experts, consultants and WHO collaborating centres. It also promoted regional professional networking and activities, namely South-East Asia Public Health Educational Institutions Network (SEAPHEIN), South-East Asia Nursing and Midwifery Educational Institutions Network (SEANMEIN), South-East Asia Regional Medical Institutes Network (SEARMIN) and so on. Dr Myint Htwe stated that the deliberations and recommendations of the Expert Group would be important for developing the regional action plan for maternal and child health in the context of the Millennium Development Goals. He urged the Group to suggest evidence-based, context-specific actionable and measurable recommendations and reiterated the need for adopting the health system approach and strengthening health information systems. He also stressed the need for operational research to find solutions to problems that were unique to the SEA Region. In this context, he stated the need to learn ways to address demand-side factors and strengthen delivery of services through the primary health care approach by utilizing community-based workers as well as defining the role of the private sector in child health.

Dr Myint Htwe stated that the recommendations of the Expert Group would be forwarded to the Regional Director for his consideration. These recommendations would provide guidance to the Regional Office on its work in the area of child health and development in the coming years.

4. Proceedings

In his introductory remarks, the Chairperson of the Expert Group, Dr M.K. Bhan, urged the group to think out of the box and come up with a blueprint for action that is practical and takes into cognizance the ground realities of the SEA Region. He stated that Member States were currently faced with a difficult situation as they receive conflicting advice from diverse sources and sometimes even from different departments of WHO. He emphasized the need for more innovations to scale up interventions, with due emphasis on quality, and for addressing the demand-side factors. Measuring the impact of services and reprogramming according to emerging trends is another area of focus, he stated. Finally, he suggested that the regional strategy should provide guidance on stewardship and policy options to Member States for their child health and development programmes.

5. Draft South-East Asia regional strategy for child health and development

There was agreement that the document should be called "Improving Child Health and Development in South-East Asia Region: A Strategic Framework for Action".

It was also agreed that the draft Strategic Framework should be accompanied by a technical document containing the evidence base for the strategy.

The Expert Group recommended that the Regional Office produce an additional document of recent and ongoing successful child health and development experiences of the SEA Region and beyond, to provide guidance to Member States for scaling up child health interventions.

The strategy will focus on child survival, health and development of children under five years. However, the health concerns of older children in the age group of 6-10 years also need to be addressed. This age group is often neglected by conventional child health and adolescent health programmes.

The draft strategy developed by the Regional Office was reviewed thoroughly by the Expert Group. There was broad agreement on the contents; however, the Group suggested a revised framework for presenting the contents and recommended additional emphasis on linkages with other programmes, namely Nutrional Health and Development (NHD), Expanded Programme on Immunization (EPI), HIV/AIDS and Making Pregnancy Safer (MPS). They also suggested stronger emphasis on partnerships with the private sector, non-governmental organizations (NGOs) and local governments in planning, implementation and monitoring. It was agreed that the strategy, in addition to child survival, will advocate for child health and development in a comprehensive manner.

The revised framework proposed by the Expert Group is given below:

(1) Introduction

- (a) Rationale for accelerated action.
- (b) Purpose and scope of the document.

(2) Situational analysis and justification

- (a) Levels of mortality/ill-health and progress.
- (b) Intervention coverage.
- (c) Health system challenges that need to be addressed:
  - (i) Policy;
  - (ii) Implementation at scale with quality; and
  - (iii) Monitoring and evaluation.

(3) Regional Strategy

- (a) Objectives.
- (b) Guiding principles.
- (c) Strategic approaches.
- (d) Essential package of services - technical policy.

(e) Strategies for implementation at scale with quality:

(1) Policy

(i) Stewardship and governance;

(ii) Process for policy formulation and review;

(iii) Policy principles; and

(iv) Areas where policy are needed.

(2) Implementation

(i) Stewardship and governance.

(ii) Careful programme design and planning.

(iii) Human resources and management.

(iv) Sustainable financing.

(v) Effective communication strategies.

(vi) Effective community-based action.

(vii) Referral systems.

(viii) Guidelines for countries on the implementation process.

(3) Monitoring and evaluation

(i) Monitoring framework.

(ii) Monitoring systems and indicators.

(iii) Assessment of quality.

(iv) Supportive supervision.

(v) Process for regular programme review.

(4) Research

(a) Appropriate policy.

(b) Research funding and capacity.

(c) Research gaps and priority setting.

(5) Implications of the strategy and expected roles and responsibilities

(a) Member States.

(b) WHO and other partners.

(6) Conclusion

It was agreed that the aforementioned framework could undergo minor changes with the finalization of the strategy.

The Expert Group further suggested that:

- The Regional Office should endeavour to make this a joint WHO-UNICEF strategy.
- The Regional Office should make all efforts to get the strategy endorsed by a high-level regional statutory authority like the Regional Committee.

6. Technical issues

Guidance was sought from the Group on certain technical issues that were part of the literature published recently. These are:

(1) Home-based newborn care;

(2) Vitamin A prophylaxis in the neonatal period;

(3) Routine chlorhexadine application on umbilical stump of newborn babies; and

(4) Pre-conceptual folic acid for women;

Specific guidance was also sought on the issue of making public health recommendations on the basis of recently published studies on these subjects. The guidance of the Expert Group is summarized below:

6.1 Home-based newborn care

- Early initiation of and exclusive breastfeeding, maintenance of warmth, hygienic cord care, early detection of danger signs and care-

seeking, management of local infections, and extra care of low-birth-weight (LBW) babies should be recommended as a package for home-based newborn care.

- Introduce the concept of postnatal visits by community-based health workers for home-based neonatal care in the neonatal period (at least on day 1 soon after birth and on day 3; also on day 7, if possible).
- Sick newborns identified during home visits will need urgent treatment. Local infections and some feeding problems can be treated at home. Newborns with severe sickness should be referred to the nearest health facilities for inpatient care.
- There should be guidelines for situations where referral of a sick neonate is not possible. Evidence from some countries in the SEA Region and beyond suggests that community health workers are able to recognize severe illnesses and administer treatment. Based on local policies and situations, well-supported and supervised community health workers may be empowered to identify and manage/treat sick neonates in domiciliary settings.

6.2 Folic acid in pre-conception period

- There is overwhelming evidence on the efficacy of folic acid in preventing neuro-developmental defects. However, there is no effectiveness experience as yet. Effectiveness trials should be encouraged as part of the research agenda.

6.3 Chlorhexadine for umbilical sepsis

- So far, there is only one study that supports this treatment. It would be premature to make it a global recommendation at this stage.

6.4 Vitamin A

- There is insufficient evidence at this point in time to recommend prophylactic Vitamin A for neonates.

7. Integrated Control Programme for Acute Diarrhoea and Respiratory Infections (ICDR)

Dr Madhu Prasad Ghimrie made a presentation on the proposal of the Regional Office on "Integrated Control Programme for Acute Diarrhoeal and Respiratory Infections (ICDR)". The Expert Group welcomed the need to highlight the scaling-up initiatives for diarrhoeal diseases and acute respiratory infections (ARI) control in children. They, however, opined that this should not be promoted as yet another vertical initiative and suggested that the Regional Office think through the guidance to countries about the implementation modalities of ICDR. A short concept note on ICDR has been provided in Annex 3.

8. High-level Consultation to Accelerate Progress towards Achieving Maternal and Child Health MDGs 4 and 5 in South-East Asia

The objectives and tentative programme of the High-Level Consultation to Accelerate Progress towards Achieving Maternal and Child Health Millennium Development Goals (MDGs 4 and 5) in South-East Asia held in Ahmedabad, India, from 14-17 October 2008 were presented to the Expert Group and their guidance sought. The Group expressed its appreciation to the Regional Office for organizing this event. It recommended that presenters from participating countries should be identified at an early date and provided clear guidance about their presentations much in advance. They suggested an additional topic on "Multisectoral Collaboration" in the programme. These recommendations have been noted and will be further discussed by the Regional Office Task Force on Health MDGs. Accordingly; the programme of the High-Level Consultation will be revised.

9. Making an investment case for MNCH in Asia and the Pacific

A short discussion on "Making an Investment Case for Maternal and Child Health (MNCH) in Asia and the Pacific" was organized for the information of the Expert Group.

Dr Dini Latief and Dr Samira Aboubaker made short interventions to inform the Expert Group about the "Investment Case". This is an initiative jointly prepared by WHO, UNICEF, UNFPA, The World Bank, Asian Development Bank (ADB), Gates Foundation, AusAid, Canadian International Development Agency (CIDA), JICA, DfID, USAID and Partnership for Maternal, Newborn and Child Health. The Investment Case, which is still under development, presents an investment strategy that combines the best available science and economics and is based on evidence about what works in practice. It demonstrates that the lives of women and their children can be saved – and MDGs 4 and 5 achieved – for less than an extra dollar per person each year.

10. Recommendations and next steps

The Expert Group agreed on the next steps to be taken along with the timeframes. It recommended that the Strategic Framework should be finalized by the end of 2008 and presented to Member States for discussion/endorsement in the first quarter of 2009. It also suggested that the Regional Office should work towards endorsement of the strategy by the Regional Committee, if possible, in 2009 itself. The following timeline was agreed to:

- A draft strategy entitled "Improving Child Health and Development in the South-East Asia Region: A Strategic Framework for Action" to be revised and circulated to the Expert Group by 30 September 2008. All members of the Expert Group will provide the Regional Office at least one short write-up on "experiences"/"best-practices" with suitable references, by 1 September 2008. These will be used as illustrations in the strategic framework and/or other proposed accompanying documents.
- The Expert Group and partners will review these and give their comments to the Regional Office by 31 October 2008.
- The Regional Office will finalize the draft by 30 November 2008.
- The final draft will be presented to Member States in the first quarter of 2009 for their review and endorsement.
- The Regional Office will work towards the Regional Committee adopting a resolution endorsing the strategy in 2009.

11. Next meeting of the SEA Region Expert Group on Child Health and Development

Dr Gado Tshering kindly offered to host the next meeting of the Expert Group in Bhutan, preferably in the first quarter of 2009. The exact dates will be decided in consultation with members and the Regional Office Senior Management.

Annex 1

Background, purpose, terms of reference and tenure

1. Background and purpose

The Child Health and Development Unit proposes to establish a South-East Asia Region (SEAR) Expert Group on Child Health and Development to provide guidance for our collaborative work with Member States to promote Child Health and Development in the Region on a regular basis.

One of the main purposes of the Expert Group will be to provide guidance for advocacy to Member States to identify practical, evidence-based actions to accelerate and/or sustain progress towards meeting the national and sub-national Millennium Development Goal related to child survival. The Expert Group will also help provide guidance for exploring alternative health delivery channels to increase coverage with effective interventions adopting the primary health care approach.

The immediate objective that the Regional Office plans to achieve through guidance provided by the Group is the development of a regional strategy for accelerated action for achievement and sustaining the MDG 4 by Member States at national and sub-national levels.

2. Terms of reference

The proposed Terms of Reference for the Expert Group are:

(1) To advise the Regional Director on priority technical areas of work and regional strategic directions related to neonatal and child health and development in the South-East Asia Region for inclusion in the proposed South-East Asia Regional Strategy for Child Health and Development.

(2) To provide technical advice about improving delivery of effective neonatal and child health interventions at high coverage through public health systems in South-East Asia, with emphasis on quality.

(3) To suggest mechanisms for addressing information gaps and country-based actions to monitor and evaluate the effectiveness of child health initiatives.

(4) To give technical advice on setting regional priorities for research in neonatal and child health and development to generate evidence that has policy and programme implications.

(5) To provide guidance about initiatives that will increase demand for effective child health interventions and to ensure equity in the provision of services through public health systems in countries of the SEA Region.

3. Membership and tenure

While considering the membership of the Expert Group, the following issues have been taken into consideration:

(1) The total number of members of the Expert Group should not exceed 15 persons.

(2) Ensure representation from as many member countries as possible.

(3) The members of the Expert Group would be from either of the following fields:

- maternal, neonatal, child health, nursing, midwifery, and community health areas;
- national programme managers;
- persons of eminence from academia in the field of MCH; and
- focal persons/experts from WHO/CCs.

4. Term of expert group

The duration of any member occupying the chair and/or being a member of the Expert Group will not be for more than two consecutive years. Thereafter, to maintain continuity, cessation of membership will be done in a staggered manner. It will be ensured that the total tenure of any member does not exceed three years.

The Expert Group will meet once in an year.

It is proposed to organize the first meeting of the Expert Group in the Regional Office to enable interaction of the Senior Management of the Regional Office and technical units with the Expert Group. Thereafter, meetings may be organized in any of the Member States.

We may organize future meetings in collaboration with our WHO-CCs.

In addition to the annual meeting of the Expert Group, an urgent meeting may also be called to address any pressing issues.

Annex 2

List of participants

Dr M.K. Bhan
Secretary to the Government of India
Department of Biotechnology
Ministry of Science and Technology
Block-2, 7th Floor CGO Complex
Lodhi Road, New Delhi 110003
Tel: 91-11-24362950,
Fax: 91-11-24360747
Email: mkbhan@dbt.nic.in

Dr Gado Tshering
Secretary
Ministry of Health
Royal Government of Bhutan
Thimphu, Bhutan
Tel: 975-2-326627
Fax: 975-2-324649
Email: drgado_03@hotmail.com

Dr Shams El Arifeen
Senior Scientist and Head
Child Health Unit
Public Health Sciences Division
International Centre for Diarrhoeal Diseases Research,
Bangladesh (ICDDR,B)
Mohakhali
Dhaka 1212, Bangladesh
Tel: 880-2-881-0115
Fax: 880-2-881-6050
Email: shams@icddrb.org

Dr Dharma S. Manandhar
President and Executive Director
Mother and Infant Research Activities in Nepal, and
Head, Department of Paediatrics
Kathmandu Medical Colleege
755 Prasuti Marg, Thapathali
Kathmandu, Nepal
Tel: 977-1-4266208
Fax: 977-1-4278522/4265174
Email: dsm@healthnet.org.np or
dharamasm@yahoo.com

Dr Vinod K. Paul
Head, Department of Paediatrics and
Director, WHO Collaborating Center for Training and Research in Newborn Care
Department of Paediatrics
All India Institute of Medical Sciences
Ansari Nagar
New Delhi 110029, India
Tel: 91-11-26594372
Fax: 91-11-265988663
Email: vinodpaul@neonatalhealth.com or
vinodkpaul@hotmail.com

Dr Veena Jirapaet
Professor of Paediatric Nursing
Faculty of Nursing,
Chulalongkorn University
Pathumwan District
Bangkok 10330, Thailand
Tel: (M) 66-8-66126046 (O) 66-2-2189822
Fax: 66-2-4182560
Email: j_veena@hotmail.com or
jveena@chula.ac.th

Dr Budi Utomo
Faculty of Public Health
University of Indonesia
FKMUI Building, G-211 Kampus UI, Depok
West Java, Indonesia
Tel: 62-21-7270154, 62-811 960263
Fax: 62-21-727 0153
Email: butomo49@yahoo.co.id

Prof Sanath Lamabadusuriya
Senior Professor of Paediatrics
Faculty of Medicine
University of Colombo
Colombo, Sri Lanka
Res: 38A, Nawala Road,
Nuegoda, Sri Lanka
Tel: 0094-11-2695300(O); (M) 777-886119
Fax: 009411 5378767
Email: sanathp.lama@gmail.com or
drsplama@sltnet.lk

Prof Kyu Kyu Khin
Professor/Head
Department of Paediatrics
University of Medicine (2)
Yangon, Myanmar
Tel: 951-699863
Email: judythwin@optusnet.com.au

Dr Kirana Pritasari
Directorate of Child Health
Ministry of Health
Republic of Indonesia
Jl HR Rasuna Said Blok X5 Kav 4-9
Floor 7th Block C
Jakarta 12950, Indonesia
Tel: 62-21-5273422
Fax: 62-21-5214891
Email: kirana_id@yahoo.com

Dr Vijay Kumar
1 Babar Road
New Delhi 110001, India
Tel: 91-172-2567770 (M) 9810088321
Email: kumarv40@gmail.com

Dr Sultana Khanum
Advisor
Royal Society of Tropical Medicine and Hygiene (RSTMH) for South-East Asia
International Public Health Consultant
65 DOHS (old)
Masjid Road, Banani
Dhaka 1206, Bangladesh
Tel: 880-2-8712393, (M) +8801731514658
Fax: 880-2-8827642
Email: shona2008@yahoo.com or
shonakhan@doctors.org.uk

WHO Secretariat

Dr Samira Aboubaker
Coordinator
Country Implementation and Support (CIS)
Child and Adolescent Health CAHH/HQ
Geneva, Switzerland
Email: aboubakers@who.int

Dr Dini Latief
Director
Department of Family and Community Health
FCH, WHO/SEARO
New Delhi
Tel: 91-11-23309320
Fax: 91-11-23378510
Email: lateifd@searo.who.int

Dr Ardi Kaptiningsih
Regional Adviser
Reproductive Health and Research
RHR, WHO/SEARO
New Delhi
Tel: 91-11-23309319
Fax: 91-11-23378510
Email: kaptiningsiha@searo.who.int

Dr Kunal Bagchi
Regional Adviser
Nutrition Health and Development
NHD, WHO/SEARO
New Delhi
Tel: 91-11-23309313
Fax: 91-11-23378510
Email: bagchik@searo.who.int

Dr Sudhansh Malhotra
Regional Adviser
Child Health and Development
CHD, WHO/SEARO
New Delhi
Tel: 91-11-23309317
Fax: 91-11-23378510
Email: malhotras@searo.who.int

Mr N. Mitroo
Senior Administrative Secretary
Child Health and Development
WHO/SEARO
New Delhi
Tel: 91-11-23309316
Fax: 91-11-23378510
Email: mitroon@searo.who.int

Annex 3

Integrated Control Programme for Acute Diarrhoea and Respiratory Infections (ICDR)

1. Background and rationale

Acute respiratory infections (ARI) and diarrhoea are the two leading causes of mortality in children worldwide, including in the South-East Asia (SEA) Region of WHO.[1] Both are communicable diseases and also cause high morbidity across all age groups. Non-tubercular respiratory infections lead the causes of mortality across all age groups. Outbreaks of cholera or shigellosis are still very common and cause deaths in children and adults alike. The impact on nutrition by recurrent episodes of diarhhoea can be considerable in all age groups thus putting the affected population at more risk from other serious infectious and non-infectious diseases. The poor, with inadequate access to proper nutrition, essential health services, safe water and sanitation facility and, above all, with deficient knowledge and awareness, suffer and succumb to these diseases.

Disease burden

Globally, onethird of primary health care attendance by >5 years age group, which includes the adult population, is for respiratory symptoms; with non-tubercular respiratory infections accounting for the majority.[2] In developing countries with high mortality, namely Bangladesh, DPR Korea, India, Myanmar and Nepal from the SEA Region, non-tubercular respiratory infections account for 10% or more of total deaths across all age groups, leading all other causes of death.[3] Across the 0-5 year age group, ARI and

[1] Bryce, J., C. Boschi-Pinto, K. Shibuya K and R.E. Black. 'WHO estimates of the causes of death in children', *The Lancet*, 2005; 365:1147-1152

[2] WHO/HTM/TB/2004.333.Geneva. Respiratory care in primary care services- a survey in 9 countries.

[3] World Health Organization. Department of Measurement and Health Information. Estimated total deaths by cause and WHO Member State. 2004.

diarrhoeal diseases together are responsible for almost 48% of the estimated 3.07 million deaths annually. With 408000 annual deaths from pneumonia in the under-5 population, India tops the list of 15 countries with the highest estimated number of deaths from this condition.[4] Worldwide among the elderly, the annual incidence of community acquired pneumonia is estimated at 25-44/1000 population with mortality rates as high as 30%.[5] No concrete estimates are available for the SEA Region, but are likely to be high. Emerging and re-emerging acute respiratory infections such as SARS and Avian Influenza in the region are also presenting serious public health threats with their potential to cause a pandemic.

Current estimates of morbidity from acute diarrhoea worldwide in under-5 children suggest 1.4 billion episodes of diarrhoea per year, 3 episodes per child per year, and annual 123 million clinic visits and 9 million hospitalizations,[6, 7] with loss of 62 million DALYs.[8] This average masks the real morbidity rates of up to 10-12 episodes a year among children in some of the developing countries. Out of a little less than 2 million deaths worldwide in this age group, 552,000 deaths are estimated to occur in the SEA Region from acute diarrhoea. Little data is available on the diarrhoeal disease burden, diarrhoea morbidity and its contribution to mortality in the adult population.

Status of ARI/ADD control programme and challenges

Over the years, dedicated programmes for the control of diarrhoeal diseases and respiratory infections, which have a tangible impact on under-5 mortality rate (U-5MR), paved the way for facility based Integrated Management of Childhood Illnesses (IMCI). However, in many member

[4] Rudan I, C. Boschi-Pinto, Z. Biloglav, K. Mulholland and H. Campbell. 'Epidemiology and etiology of childhood pneumonia', *Bull World Health Organ,* 2008; 86: 408-16.

[5] J. Janssens and K. Krause. 'Pneumonia in the very old', *The Lancet Infect Dis*, 2004: 4: 112–24

[6] M. Kosek, C. Bern, and R. Guerrant. 'The Global Burden of Diarrheal Disease, As Estimated from Studies Published Between 1992 and 2000', *Bulletin of the World Health Organization* , 2003 ; 81: 197-204.

[7] A. Levine and K.A. Santucci. 2008. Ed. D. Marby, http://www.emedicine.com/emerg/TOPIC380.HTM

[8] C.J. Murray and A.D. Lopez. 'Global mortality, disability, and the contribution of risk factors: Global Burden of Disease Study'. *Lancet*, 1997; 349(9063):1436-42.

countries in the SEA Region, coverage and performance is yet to be optimal. Even in Nepal, where the IMCI strategy is said to be the most productive, the *percentage of children under five with suspected pneumonia who received antibiotics in 2005-2006, was only 25%.*[9] The reasons are diverse, including inadequate political commitment, resource, fragmented implementation and weak linkage between community and health facility components, and most importantly, the lack of visibility.[10] Capacity and motivation of health care personnel are also lacking. Multi-sectoral participation for implementation along the health continuum has also not been well explored yet.

Way forward

Experience has demonstrated the usefulness of combining case management and preventive interventions with advocacy, training, research and M&E components. More importantly, promotion of community participation in planning and delivery of services strengthens primary health care elements and their uptake. In recent years, new developments that include effective home management of severe but uncomplicated pneumonias with high dose oral amoxicillin,[11] use of low-osmolarity oral rehydrating salt solutions and zinc to treat acute watery diarrhoea, zinc supplements to reduce the incidence of diarrhoeal diseases and pneumonia, etc. have emerged as effective tools for case management and prevention. Hand washing alone can reduce the incidence of ARI and diarrhoeal diseases by 30 to 50%.[12,13] Effective behaviour change to promote such simple methods of personal hygiene is therefore one of the

[9] UNICEF-Progress for Children 2007: A World Fit for Children Statistical Review. Under-five mortality. Pneumonia.

[10] Wardlaw, T., P. Salama, E.W. Johansson and Mason E. 'Comment. Pneumonia: the leading killer of children'. *The Lancet*, 2006; 368 (9541): 1048-1050. Published Online September 18, 2006. DOI:10.1016/S0140-6736(06)69334-3

[11] Hazir, T., M. Fox LeAnne, Y.B. Nisar, et al. for the New Outpatient Short-Course Home Oral Therapy for Severe Pneumonia (NO-SHOTS) Study Group. 'Ambulatory short-course high-dose oral amoxicillin for treatment of severe pneumonia in children: A randomised equivalency trial', *The Lancet,* 2008; 371:49-56. DOI:10.1016/S0140-6736(08)60071-9

[12] Luby, S.P., M. Agboatwalla, D.R. Feikin, et al. 'Effect of handwashing on child health: A randomized control trial', *The Lancet*, 2005; 366 (9481): 225-233.

[13] Ejemot, R.I., J.E. Ehiri, M.M. Meremikwu and J.A. Critchley. 'Hand washing for preventing diarrhoea', *Cochrane Database of Systematic Reviews,* 2008, Issue 1. Art. No.: CD004265. DOI: 10.1002/14651858.CD004265.pub2

key components of the ARI/diarrhoea control programme. Improvements in other physical environmental, sociocultural factors, namely water quality at the point-of-use, in-door air quality, household-level animal management, etc., together with multi-sectoral collaborations at the community and administrative levels and introduction of safe and cost-effective newer vaccines for cholera, rotavirus disease, haemophilus influenzae type b, and pneumococcal and influenza infections are also extremely important.

Hence, control of acute diarrhoeal and respiratory infections essentially based on lessons from the past, and newer scientific developments and innovative strategies is high priority of the Regional Office to bring about positive health impact in Member States. The programme is conceptualized and planned as Integrated Control of Diarrhoea and Respiratory Infections (ICDR) Programme, underscoring a combination of facility and community-based paradigm shift. An outline of the integrated model is given at the end of this Annex.

Relevance to the Millennium Development Goals (MDGs) and health systems strengthening

The ICDR programme is expected directly and indirectly to contribute to the MDGs by contributing to the reduction of burden of communicable diseases (MDG 6). Reducing child mortality through the programme is to contribute to achieving MDG 4. Reducing disease burden in the community will also indirectly contribute to poverty reduction (MDG 1). The ICDR programme envisages strengthening of health care service delivery at the community level towards improving access to prompt diagnosis and treatment, and referral system.

Potential opportunities for donors/funding agencies

The ICDR programme aims at bringing about a sizeable reduction in disease burden and mortality, thereby contributing to the achievement of MDGs. The programme is designed to strengthen health systems, especially at the community level and first-level health care, thereby helping to improve health care service delivery where it is most needed. Additionally, the poorest of the poor are the most affected and at risk, hence the generally low-cost interventions would provide for a relatively high return, thereby addressing inequities in the health sector. The donors/funders

therefore have an important opportunity to contribute to the desired health goals and outcomes as well as overall development.

2. Design and implementation of the programme

Goal

To improve health status in the SEA Region by reducing morbidity and mortality related to acute diarrhoeal and respiratory infections through integrated control.

Targets

- Reduction of the annual incidence and case fatality rate of severe acute respiratory infections in children, such as pneumonia, by half the current level by the year 2015.
- Reduction of the annual morbidity and case fatality rates for acute diarrhoea in children to half the current rate by the year 2015.
- Reduction of the annual incidence and case fatality rates of pneumonia in adult population to three-fourths of the current level by the year 2015.
- Reduction of the annual incidence and case fatality rates of acute diarrhoeal diseases in adult population to half of the current level by the year 2015.

Objectives

- Strengthening the prevention of diarrhoea and respiratory infections.
- Provision of quality care along the continuum from the institution to the community and home.
- Disease surveillance for planning and response.
- Mobilization of national and international support for this endeavour.

Strategies

- Advocacy for building support and establishing/strengthening partnerships.
- Establishing effective disease surveillance systems.
- Strengthening early diagnosis and complete case management.
- Improving the effectiveness of programme management and M&E.
- Improving the capacity of programme implementers.
- Enhancing knowledge, awareness and responsive behaviour in the affected communities.
- Undertaking operations research.

Activities

- To conceptualize and devise a strategic framework through consensus for integrated control of acute diarrhoea and respiratory infections in member countries to ensure timely planning and implementation of curative and preventive components.
- To provide technical assistance to member countries in implementation of the strategic framework.
- To support generation of evidence through surveillance and research, including on disease burden.
- To intensify advocacy at multiple levels (political, administrative, media).
- To assist in capacity development, communication and social mobilization activities.
- To assist member countries in establishing a sound monitoring and evaluation system for result-based performance and desired impact.

3. Estimated Programme Budget

The total fund requirement for Integrated Control of Acute Diarrhoeal and Respiratory Diseases in the South-East Asia Region is estimated as $11.53 million over a period of four years.

No	Items	US$/per year (000)
1.	Human resources: professional staff, technical advisors, support staff	1200
2.	Travel	350
3.	Workshops, consultative meetings	350
4.	Publication and dissemination: Advocacy and communication materials; training materials, documents, reports, etc	400
5.	Miscellaneous – communication, stationery, administrative support	250
6.	Overheads (13%)	332
7.	Total per year	2882
Total for FOUR years		**11 528**

4. Programme monitoring, evaluation and results dissemination

This project is expected to: (i) assess the progress made in control of acute diarrhoea and respiratory infections; (ii) provide strategic directions to member countries; (iii) facilitate accelerated planning and actions for the ICDR programme.

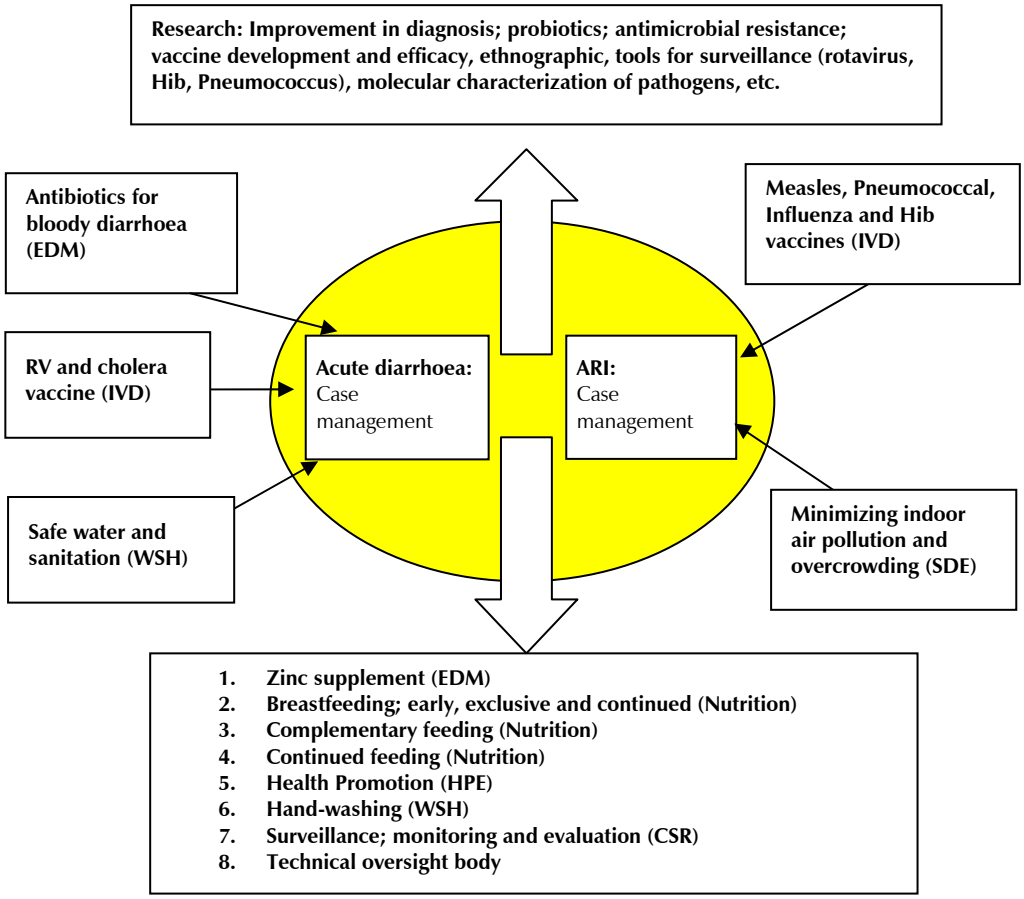
The indicators for monitoring and evaluating processes, outcomes and outputs will be streamlined prior to commencement of project along with the means of verification and frequency of monitoring. In addition, targets and timelines will be fixed. Reports (related to situation analysis, gap analysis, disease burden, synthesis of consultation/training, updates, etc.) and materials (for advocacy and communication) will be submitted to the

Donor/Funding Agency. These will be shared with the country programme as well as other stakeholders, as appropriate. The guidelines, modules, advocacy and communication materials, press releases, etc. will be published and posted on SEA Regional Office website and printed/published for wider dissemination.

5. WHO Regional Office capacity

The WHO Regional Office for the South-East Asia Region has all the relevant departments and technical units to provide leadership and guidance for health sector improvement in the Region. The Department of Communicable Diseases and Surveillance (CDS) that has been providing strategic directions to Member States of the SEA Region in preventing and controlling all known and emerging/re-emerging infectious diseases will lead the ICDR programme. The Regional Office has already established an internal Working Group for this programme and, in addition, has created a Regional Technical Advisory Group (RTAG) consisting of international experts and programme managers in the field of diarrhoeal and respiratory diseases. Within the CDS, a team is being constituted for the programme for close collaboration with WHO country offices and country programmes. In addition, various partners and stakeholders including TDR, World Bank, Institute for One World Health, Organization for Innovation, Implementation and Impact (O3i) will be involved in the overall planning, implementation and oversight.

Outline of an integrated approach for Integrated Control of Acute Diarrhoea and Respiratory Infections (ICDR)



Annex 4

Investment case for maternal, newborn and child health in Asia and the Pacific

Why MNCH?

- Central to social and economic development.
- Strong economic returns to individuals, family, and economy (MOF)..
- Known, affordable solutions allow politically visible measurable results in a few years
- Solutions strengthen the overall health system.

Why Asia and the Pacific?

- High rates.
- High numbers.
- Asia accounts for 41% deaths under five, half maternal deaths, almost 60% neonatal deaths.

Problem statement: the five "I"s that are common to this Region

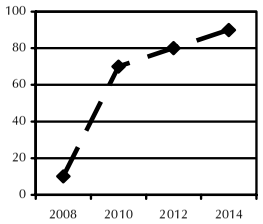
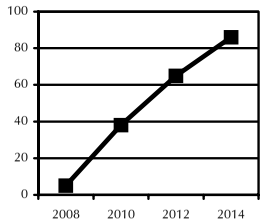
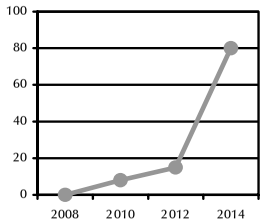
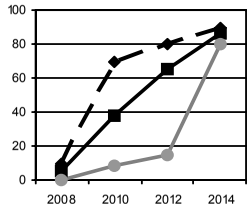
- Inadequate expenditure.
- Inefficient expenditure.
- Inequitable expenditure, especially because of out-of-pocket payments.
- Incentives do not connect expenditure to good outcomes.
- Incomplete implementation and expenditure of key programmes.
  - These problems vary across countries.
  - These problems are unlikely to get fixed without change, and in many cases extra expenditure.

Invest in what? And what does it "buy"?

- Build on existing base.
- Identify the "next best buys" to use additional budgets to unblock bottlenecks to high and equitable coverage of essential MNCH services.
  - Whether short-term, medium-term, whether short-term or long-term; whether demand-side or supply-side; whether public or private or both.
- Real life example: in a low income situation with high mortality, an additional investment of $1.50 per person per year is likely to buy a 20% reduction in MNCH mortality in a few years.
- Know what you buy AND know what is needed to achieve a target AND know where to get the biggest impact for the next dollar you spend.

Possibilities for engagement

- Communicate with non-health financial decision-makers. Investment case because of good economic returns.
- Help Government identify "best buys" and how to link budgets to performance and outcomes.
- Support as requested: technical assistance; examples from the Region; mobilize donor expenditure.

Modelling characteristics	Strategy A		Strategy B		Strategy C	Strategy A+B+C
Scale-up rate from current coverage levels	Rapid progress 		Linear progress 		Exponential progress 	
Service delivery focus	Demand for minimum package of Community and outreach services	Demand for First level clinical care	Supply of Expanded Package of Community and outreach services	Supply of First level clinical care; demand for and quality of referral care	Supply of and demand for Referral care	Supply and demand of expanded community and outreach services + first level and referral clinical care
Intervention packages	Exclusive Breastfeeding, (EBF), Immunization (EPI), Oral Rehydration (ORT), hand-washing, Family Planning (FP) and antenatal care (ANC)	Skilled Birth Attendance (SBA), Facility Based Integrated Management of Newborn and Child Illness(F-IMNCI)	Complementary and therapeutic feeding Zn supplementation New vaccines Community based C-IMNCI	Skilled Birth Attendance (SBA), Facility Based Integrated Management of Newborn and Child Illness(F-IMNCI)	Emergency Obstetric and Neonatal Care (EmnOC) and C-sections, Anti retrovirals (ART), Prevention of Mother to Child Transmission of HIV PMTCT); Water & sanitation (WASH)	EBF, EPI, ORT, FP, ANC, SBA, F-IMNCI,Comp+Ther Feeding, Zinc, New vaccines, C-IMCI, EmOC, ART, PMTCT, WASH
Type 1: **2010 MDG** results + costs	**MDG 4: 20%** **MDG 5: 20%** **MDG 1: 20%**	**$ 1.5**	**MDG 4: 10%** **MDG 5: 25%** **MDG 6: 5%**	**$ 2.5**	**MDG 4: 5% $ 1.5** **MDG 5: 5%** **MDG 6: 15 %**	**MDG 4: 20% $ 4.5** **MDG 5: 30%** **MDG 1, 6, 7 20%**

Type 1**: 2012** MDG results + costs	**MDG4: 22%** **MDG5: 20%** **MDG 1: 20%**	**$ 2**	**MDG4: 18%** **MDG5: 35%** **MDG 6: 10%**	**$ 3.3**	**MDG4: 10% $ 2** **MDG5: 20%** **MDG 6: 20%**	**MDG4: 25% $ 5.5** **MDG5: 40%** **MDG 1,6,7 20%**
Type 1: **2015** MDG results + costs	**MDG 4: 25%** **MDG5: 25%** **MDG 1: 20%**	**$ 2.5**	**MDG 4: 25%** **MDG5: 50%** **MDG 6: 25%**	**$ 4**	**MDG 4: 20% $ 4** **MDG5: 50%** **MDG6: 40%**	**MDG 4: 50% $ 10** **MDG5: 70%** **MDG 1,6,7: 50%**
Type 2: national MDG results + costs						
Type 2: rural MDG results + costs						
Type 2: hard to reach areas: MDG results + costs						
Type 3: disadvantaged groups: MDG Results + costs						

Member States of the WHO South-East Asia (SEA) Region are committed to achieve the Millennium Development Goals that include the goal of reducing under-five child mortality by twothirds of the level in 1990 by the year 2015. In spite of impressive declines in under-five mortality rates in the past two decades; the SEA Region still accounts for about 3 million of the global 10 million deaths of children under the age of five years annually. A South-East Asia Regional Expert Group on Child Health and Development has been established to provide guidance to the WHO South-East Asia Regional Office and Member States in the Region to strengthen child health initiatives. The Expert Group will also provide guidance in developing a regional strategy for child health and development; provide technical advice on effectively improving delivery of neonatal and child health interventions; suggest mechanisms for addressing information gaps; suggest priorities for research; and provide guidance for improving demand for child health services.

This publication is an account of the deliberations of the First Meeting of the South-East Asia Regional Expert Group on Child Health and Development.

World Health Organization
Regional Office for South-East Asia

World Health House
Indraprastha Estate,
Mahatma Gandhi Marg,
New Delhi-110002, India

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