

## **DRC-IHP Trip Report: Narcisse Embeke**

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October 2013

**Keywords:** Integrated Health Project; maternal, newborn, and child health; water, sanitation, and hygiene; family planning/reproductive health; malaria, tuberculosis, and nutrition

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## Integrated Health Project

in the Democratic Republic of Congo



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### **NARCISSE NAIA EMBEKE** **Trip Report**

#### **EXECUTIVE SUMMARY**

Narcisse Naia Embeke, Senior Technical Advisor (STA) for Child Health for the USAID-funded Integrated Health Project (IHP) in the Democratic Republic of the Congo (DRC), traveled to Washington, DC, to participate and represent IHP in the International Working Group on Diarrhea and Pneumonia. Ten countries were represented during the meeting, including Bangladesh, DRC, Ethiopia, India, Kenya, Niger, Nigeria, Pakistan, Tanzania, and Uganda. The meeting allowed for an exchange among organizations working in the area of child diarrhea and pneumonia in these countries. During the working group meeting, Dr. Embeke presented on IHP's work to reduce mortality and morbidity from diarrhea and pneumonia among children under 5, including challenges, IHP's approach, and next steps within the project and within the national DRC health strategy. Dr. Embeke also met with Management Sciences for Health (MSH) home office staff in Arlington to discuss possible child health abstract ideas, and ways to increase visibility of USAID/DRC and IHP's contribution to "A Promise Renewed" efforts.

Dr. Embeke also visited MSH's Cambridge, MA, office on October 10 and 11, 2013, during which time he met with IHP home office support staff to discuss child health communication strategies and Lives Saved Tool (LiST) activities. During a brownbag presentation, Dr. Embeke presented on the use of community care sites in DRC and the collaborative approach to improve care management of childhood diarrhea and pneumonia.

Following his participation in the working group and his meetings with MSH home office staff, Dr. Embeke recommends that the project collaborate with SIAPS, the World Health Organization and UNICEF in the efforts to make oral rehydration solution and zinc sulfate available over the counter. He also suggests that a coverage map with the organizations providing support to the fight against childhood illnesses be developed for the DRC.

## DRC-IHP Trip Report/N. Embeke/Washington DC and Cambridge MA/October 2013

<b>1. Domaine du Travail</b>	
Destinataire et client(s)/ Partenaire(s)	Washington, DC et Cambridge, MA Projet de Santé Intégré et USAID/RDC Diarrhea and pneumonia working group
Nom du consultant, rôle	Narcisse NAIA EMBEKE, STA Child Health PROSANI
Date of travel on Trip	7-11 Octobre 2013
Objectif de la mission/voyage	<ul style="list-style-type: none"><li>✓ Participer à un atelier international de groupe de travail de diarrhée et pneumonie à Washington DC.</li><li>✓ Partager l'expérience des i-CCM avec les collègues de MSH siège.</li></ul>
Objectifs / Activités / Livrables	<ul style="list-style-type: none"><li>✓ Evaluer et discuter des progrès réalisés dans le groupe de travail, les sous-groupes et les principaux partenaires Diarrhée et Pneumonie, des progrès réalisés en 2013.</li><li>✓ Discuter des progrès dans la mise en œuvre en RDC, Kenya et Niger.</li><li>✓ Identifier les prochaines étapes pour accélérer le progrès d'implémentation dans les pays.</li><li>✓ Partager avec les collègues MSH du siège l'expérience de la RDC sur la survie de l'enfant.</li></ul>
Background/Contexte	Un consortium comprenant Management Sciences for Health (MSH) et ses partenaires l'International Rescue Committee (IRC) et Overseas Strategic Consulting, Ltd. (OSC), intervient en République Démocratique de Congo (RDC), pour mettre en œuvre le Projet de Santé Intégré (PROSANI) financé par l'USAID pour une durée de 5 ans. Quarante zones de santé (ZS) sont couvertes par le projet dans 4 provinces à savoir : le Sud Kivu, le Katanga, le Kasai Oriental et le Kasai Occidental. Les composantes de PROSANI comprennent celles relatives aux soins de santé primaires notamment la santé de la mère, du nouveau-né et de l'enfant, la planification familiale, la nutrition, Eau, Hygiène et Assainissement (EHA), le VIH et SIDA, le paludisme, la tuberculose et les maladies tropicales négligées. Dans les zones cibles PROSANI couvre une population de 12 millions d'habitants dont 80 % vivent en milieu rural, en adoptant une approche centrée sur l'individu et la communauté. Pour ce faire, PROSANI apporte son appui technique et financier au Ministère de la Santé Publique (MSP) de la RDC.

## **2. Major Trip Accomplishments:**

### **DEROULEMENT DE LA MISSION**

#### **I. ATELIER GROUPE DE TRAVAIL DIARRHEA & PNEUMONIA**

Nous (moi et l'équipe MSH) avons participé du 7 au 8 Octobre 2013 à un atelier international de groupe de travail de Diarrhée et Pneumonie à Washington, DC. Cet atelier de groupe de travail a connu la participation des représentants de 10 pays (Bangladesh, RDC, Ethiopie, Inde, Kenya, Niger, Nigeria, Pakistan, Tanzanie, et Ouganda) qui ont la plus grande charge de mortalité des enfants de moins de 5 ans liée à la diarrhée et la pneumonie dans le monde. Les participants comprenaient également des partenaires comme USAID, Organisation Mondiale de la Santé (OMS), UNICEF, Abt Associates, Bill & Melinda Gates Foundation, Clinton Health Access Initiative (CHAI), Center for Infectious Disease Research in Zambia (CIDRZ), ELMA Philanthropies, Family Health International (FHI) 360, John Snow Inc. (JSI), McCann Health, Maternal and Child Health Integrated Program (MCHIP), Millennium Development Goals (MDG) Health Alliance, MSH, Speak Up Africa, Research Triangle Institute (RTI) International, Save the Children, Systems for

Improved Access to Pharmaceuticals and Services (SIAPS), et World Vision. Nous avons ensuite échangé avec les collègues du MSH siège en rapport avec la survie de l'enfant spécialement dans le domaine de prise en charge communautaire.

L'agenda de l'atelier sur les deux jours a prévu les sessions suivantes : la mise à jour sur la situation de diarrhée et pneumonie des pays ciblés par des principaux partenaires (Ethiopie, Tanzanie, Inde, Kenya et RDC) ; présentations et mises à jour des travaux sous-groupe : Amoxicilline, Demande Génération, M&E, Mobilisation de ressources, innovations dans la lutte contre la pneumonie, *Oral Rehydration Solution (ORS)/Zinc*, et autres domaines.

### **I.1 Aperçu général sur le groupe de travail diarrhée et pneumonie**

- Environ 80 million de dollars sont de nouveaux financements pour les 10 pays avec la plus grande charge de mortalité due à la pneumonie et diarrhée
- La plupart de ces pays sont encore à la phase de collecte des données de base et la phase initiale de la mise en œuvre
- *UN Commission on Life-Saving Commodities (UNCoLSC)* a mobilisé de 3 au 5 million de dollars pour les cinq pays avec la plus grande charge de diarrhée et pneumonie
- Comment soutenir les pays dans leur travail de lutte contre la pneumonie et de la diarrhée ?

### **I.2 Mise à jour de sous-groupe de travail**

#### ***Sous-groupe M&E pour les la lutte contre la diarrhée et pneumonie***

- Des drafts des documents sont produits :
  1. Les directives pour les indicateurs,
  2. Le suivi des Enquêtes Démographique et de Santé (EDS) et *Multiple Indicator Cluster Survey (MICS)*
- Les directives pour une série des nouveaux indicateurs :
  - Destinés à aider la collecte des données au niveau d'un pays
  - Aider dans les enquêtes qui doivent être effectuées à plusieurs niveaux : ménage, centre de santé.
- EDS 6 de RDC (le questionnaire global) est approuvé mais la liste des pays et le chronogramme n'est pas encore disponible

**Recommandation** : Partager les informations supplémentaires sur les indicateurs de la pneumonie et des lignes directrices avec CHAI.

### ***Sous-groupe Solution de Réhydratation Orale (SRO)/Zinc***

Déterminer les activités prioritaires. Les domaines d'intervention potentiels sont les suivants :

- Le Groupe de travail Diarrhée et pneumonie doit créer un lien avec UNCoLSC et vérifier si la 4ème recommandation sur le renforcement de la qualité qui précise que pour l'achat des SRO et zinc qu'il faut au moins trois fabricants de ces produits et la commercialisation doit être certifiée et les produits à prix abordable
- Améliorer l'accès aux produits : achat et fabrication de zinc de qualité

Fournir des conseils sur le statut réglementaire de SRO et zinc

### ***MSH : Prix des médicaments***

En collaboration avec l'OMS, publier la liste des fournisseurs et les prix des produits, les prix fournis à des fins d'appel d'offres. Le site pour le prix des médicaments, <http://erc.msh.org/priceguide>, est actif et le téléchargement en PDF avec des nombreuses rubriques d'utilisations : fixation de prix de référence, par exemple. La prochaine édition sera publiée en mars 2014.

**Recommandation** : Inclure plus de fabricants amoxicilline dispersible et les prix (un seul actuellement sur la liste). Les partenaires peuvent soumettre leurs besoins d'achat à MSH.

### ***Sous-groupe Amoxicilline***

Résultat 1 : Fournisseurs (Supply Division) de l'amoxicilline dispersible (AMX DT) de qualité

- Sur 10 fabricants qui sont entrés dans la dernière ERP, six ont passé à la deuxième étape (y compris les Inde, l'Autriche et le Chypre)
- En 2013, le SD et l'OMS ont publié une déclaration d'intérêt pour un Expert Review Panel (ERP) pour AMX
- Sept pays ont actuellement enregistré AMX DT et sept autres prévoient l'enregistrement en 2014
- Environ 20 pays ont commandé leur AMX DT via UNICEF
- Les pays ont la possibilité d'acheter les produits directement chez le fabricant ou par SD

La pharmacopée internationale définit la dispersion d'amoxicilline à moins de 3 minutes dans l'eau. Le groupe de travail a exprimé son inquiétude que trois minutes sont trop long ; ils ont suggéré de modifier la limite supérieure à 1 minute.

Résultat 2 : Plaidoyer (OMS)

- L'examen des coûts effectués et le gap de financement pour la prise en charge de diarrhée et pneumonie proposé par les pays seront analysés par un économiste en Novembre (document du gap en annexe 5).
- Les nouveau-nés ne sont pas officiellement couverts par les recommandations actuelles pour la prise en charge par l'amoxicilline dispersible. Pour la prise en charge des nouveau-nés (enfants de moins de 2 mois)

avec l'amoxicilline dispersible, l'OMS ne s'est pas encore prononcé et des études sont en cours pour cela.

- De nouvelles études africaines ont montré qu'AMX DT est aussi efficace pour la mortalité contre la pneumonie que la gentamycine IV chez les nouveau-nés ; la dose utilisée pour les moins de deux mois est de 75-100mg/kg/jour.
- A ce stade, aucune recommandation de l'OMS pour l'utilisation de l'amoxicilline pour la pneumonie.

Résultat 3 - diagnostics et pronostics (PATH) :

- La recherche qualitative et quantitative en Inde et au Kenya est terminée.

### **I.3 Mises à jour supplémentaires**

MSH a fait un résumé de l'enquête AMX DT en compilant les données de 19 pays. SIAPS, avec l'OMS, vont mettre sur pied un document en regard d'acquisition des 13 produits qui sauvent la vie des mères et des nouveaux nés. Les 13 commodités sont : Zinc 20mg cés sécables, SRO faible osmolarité, Amoxicilline cés dispersible 250mg, Chlorhexidine solution 7,1%, Dexaméthasone 4mg injectable, Ceftriaxone 1g injectable, Amoxicilline 1g injectable, Sulfate de Magnésium 500mg/10ml, Misoprostol 200 µg, Ocytocine 10UI, Levonorgestrel 750µg, Levonorgestrel, et les préservatifs féminins latex et lubrifiant.

### **I.4 Initiatives mondiales**

#### ***A Promise Renewed (APR)***

Le deuxième rapport annuel avec un nouveau taux de mortalité des enfants de moins de 5 ans était publié en septembre 2013. Des informations des pays de lancement disponible sur le site de web:

- Lancement d'APR en Ouganda au 11 ou 12 novembre 2013, y compris Global Newborn Action Plan (GNAP) et UNCoLSC
- Malawi va lancer APR en novembre 2013 aussi
- Namibie va lancer l'initiative au début de 2014
- Forum de haut niveau d'appel des partenaires le 21 octobre 2013. Ethiopie a présenté les progrès qu'elle a accomplis
- Les efforts doivent être poursuivis après le lancement (par exemple, le Kenya manque de suivi)

#### ***UNCoLSC***

Expansion substantielle en Afrique et Asie prévu au début de 2014.

### **I.5 Autres**

- Journée mondiale de la pneumonie est le 12 novembre (<http://worldpneumoniaday.org>). Voir en annexe le résumé de la journée célébrée par le PROSANI en RDC.

- Le sous-groupe de la mobilisation des ressources sous-groupe :
  - La session spéciale des donateurs s'est tenue le 25 septembre 2013 avec plus de 30 participants (experts mondiaux et bailleurs de fonds) pour discuter des lacunes de financement dans les 10 pays
  - Les nouvelles perspectives potentielles de suivi comprennent :
    - ✓ 1,15 milliard de dollars de nouveaux fonds pour les OMD 4 et 5 (USAID, l'UNICEF, la Banque mondiale, la Norvège)
    - ✓ Il est précisé que l'appui de l'UNICEF et l'USAID ne sont pas «nouveaux» fonds
    - ✓ GAVI présentera des propositions de pays à la prochaine réunion du comité d'examen indépendant

## **II. REUNIONS AVEC LES COLLEGUES DU SIEGE MSH ET PRESENTATION**

**II.1 Juan-Carlos Alegre** (directeur de gestion de résultats et l'apprentissage institutionnel): Il y a l'appel de soumission d'abstracts pour le 3ème symposium mondial sur les systèmes de recherche en santé qui aura lieu à Cape Town de 30 septembre au 3 octobre 2014. Le thème du colloque est : « La science et la pratique des systèmes de santé.» Les organisateurs du symposium mondial vont publier un supplément spécial au moment du colloque. Plus informations sur le symposium ici : <http://hsr2014.healthsystemsresearch.org/>. On a proposé un abstract à soumettre à ce symposium et envoyé à Juan- Carlos avant le 17 novembre 2013 mais nous n'avons pas pu soumettre à cause du délai court de soumission.

**II.2 Suzanne Diarra** (Conseillère Technique Senior de SIAPS) : On a discuté avec Suzanne Diarra concernant la démedicalisation du zinc et SRO et le guide de traitement de la pneumonie chez les enfants de moins de 5 ans selon les directives de l'OMS.

Action 1 : Travailler avec l'équipe SIAPS dans le processus d'obtenir une exemption pour démedicalisation SRO et le sulfate de zinc.

Résultat : En cours ; deux réunion tenu avec SIAPS et une réunion en vue avec plus des partenaires et la Ministère de la Sante Publique (MSP).

Action 2 : Partager avec le MSP le document de directives de l'OMS en rapport avec le traitement de la pneumonie chez les enfants de moins de 5 ans.

Résultat : Le document est partage et a servi au cours d'atelier de révision des directives de prise en charge de la pneumonie en RDC.

**II.3 Présentation** : *Brownbag Presentation* des activités de sites de soins communautaire en RDC reprenant les points suivant : qu'est-ce qu'un site de soins, les principaux résultats réalisés, les défis et les prochaines étapes suivantes.

**II.4 Elizabeth Walsh** (Directrice de Communication, *Center for Leadership and Management*): On a discuté les stratégies pour la visibilité, plaidoyer et communication pour *A Promise Renewed*. J'ai partagé les informations dans les 25 zones de santé rouges pour la visibilité de prise de photos avec les relais communautaires et travailler avec Landry a cet effet. Il s'agit de rendre beaucoup plus visible les activités que nous réalisons dans le cadre de *A Promise Renewed*. Nous sommes focalisés actuellement sur ce dossier. Il y a une journée porte ouverte prévue au mois de mars 2014. Nous n'avons pas encore des photos car les descentes de terrains étaient jusqu'à présent suspendus à cause de limitation budgétaire.

**II.5 Hubert Zirimwabagabo** (stagiaire) : J'ai travaillé avec Hubert dans la révision des cartes, pour les filles et les garçons, dans le cadre de concours sur *Records for Life* de Gates Foundation. On a travaillé sur les mises à jour des pages pour faciliter sa lecture. La carte révisée était soumise le 15 novembre 2013 mais notre conception n'a pas été choisie parmi les gagnants.

**II.6 Megan Rauscher** (Manager de Programme de SIAPS): J'ai fait le suivi avec Megan sur l'outil *Lives Saved Tool* (LiST). Spécifiquement, nous avons travaillé sur les mises à jour de logiciel *Spectrum* sur les nouvelles applications dans le calcul des vies sauvées. On a discuté aussi les mesures des enquêtes de démographiques et de santé <http://www.measuredhs.com/> et l'outil d'analyse LiST et les couvertures pour la RDC.

### 3. Next Steps:

- Elaborer la cartographie des partenaires de lutte contre la diarrhée connaître qui fait quoi, où, et quand.
- Responsabiliser le programme de lutte contre les maladies diarrhéiques avec l'appui des partenaires dont l'OMS, Unicef, MSH, SIAPS afin d'obtenir une exemption pour démedicalisation SRO et le sulfate de zinc.
- Travailler avec l'équipe SIAPS dans le processus d'obtenir une exemption pour démedicalisation de SRO et le sulfate de zinc.
- Partager avec le Ministère de la Santé Publique le flyer de directives de l'OMS en rapport avec le traitement de la pneumonie chez les enfants de moins de 5 ans.
- Proposer un abstract à soumettre au 3ème symposium mondial sur les systèmes de recherche en santé qui aura lieu à Cape Town et l'envoyer à Juan-Carlos Alegre avant le 17 Novembre 2013.

### 4. Contacts

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**5. Description des documents pertinents / Addenda:**

<b>Nom de fichier</b>	<b>La description de fichier</b>	<b>Localisation de fichier</b>
Annex 1_Working Group Brownbag Presentation_Oct 2013	Présentation pendant l'atelier de groupe de travail diarrhée et pneumonie	Attaché; eRoom
Annex 2_Cambridge i-CCM PowerPoint Presentation_Oct 2013	Présentation sur i-CCM pour la session <i>brownbag</i> au siège MSH	Attaché; eRoom
Annex 3_Notes from working group country updates	Les notes prise pendant l'atelier	Attaché; eRoom
Annex 4_Synthese_Journee Mondiale de la Pneumonie 2013	Synthèse des activités pendant la journée mondiale de la pneumonie	Attaché ; eRoom
Annex 5_MDG 4 Special Donor Session : Financing Diarrhea and Pneumonia Treatment Gaps	La situation de diarrhée et pneumonie dans chaque pays.	Attaché; eRoom

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## DRC Update on Diarrhea & Pneumonia Situation

October 7-8, 2013

Washington, DC

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- V. Key issues and questions for discussion
- VI. Next steps/upcoming priorities

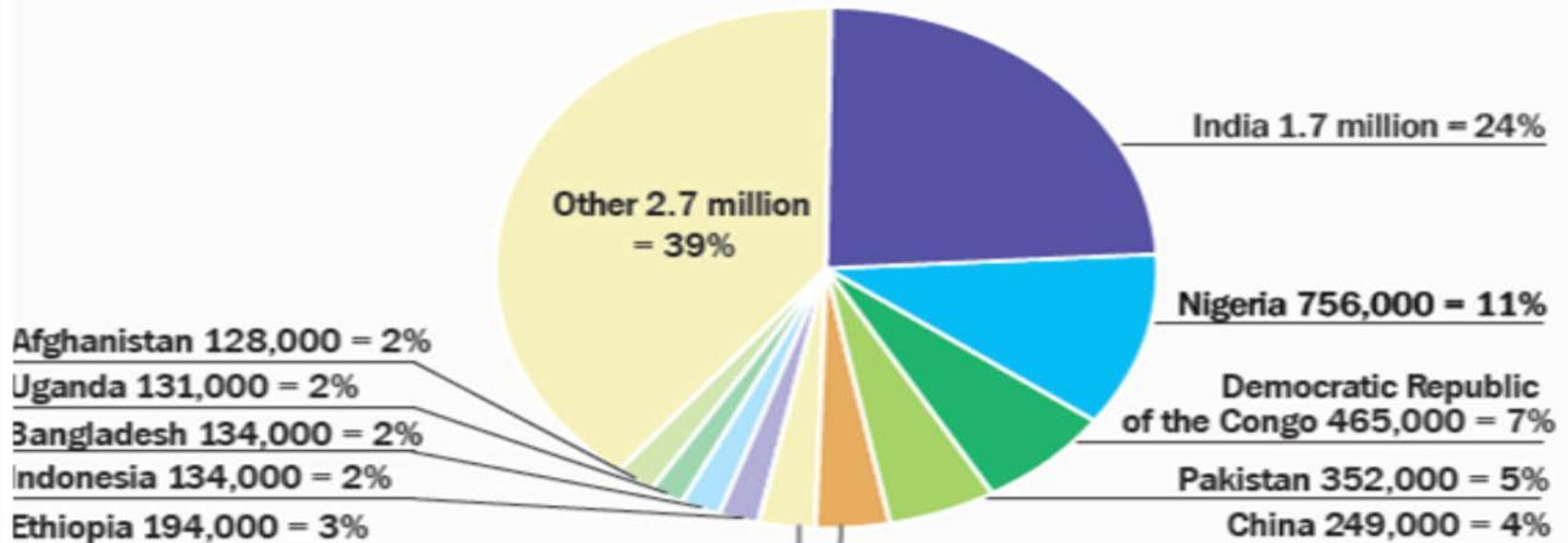
# BACKGROUND

# Current burden of diarrhea and pneumonia

## Half of all under-five deaths occur in just five countries

Number of under-five deaths by country (thousands and percentage share of global total)

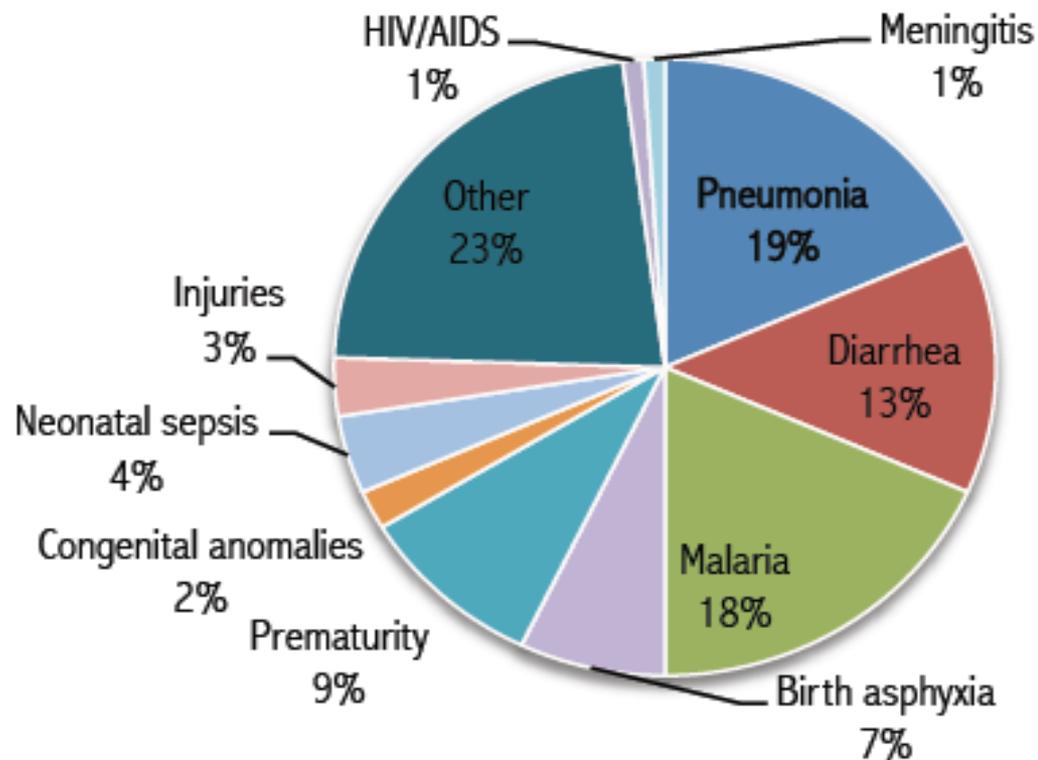
FIG.



Source: UNICEF. Committing to Child Survival: A Promise Renewed. Progress Report 2012

# Current burden of diarrhea pneumonia in DRC

Causes of under-five mortality in DRC



Source: Countdown 2015 : Maternal, Newborn and Child Survival: DRC. The 2012 Report

# Current burden of diarrhea and pneumonia in DRC

	Pneumonia	Diarrhea
Estimated number of cases annually	2,970,878	38,750,582
Prevalence	6%	27%
# deaths annually	70,380	46,920

## Sources:

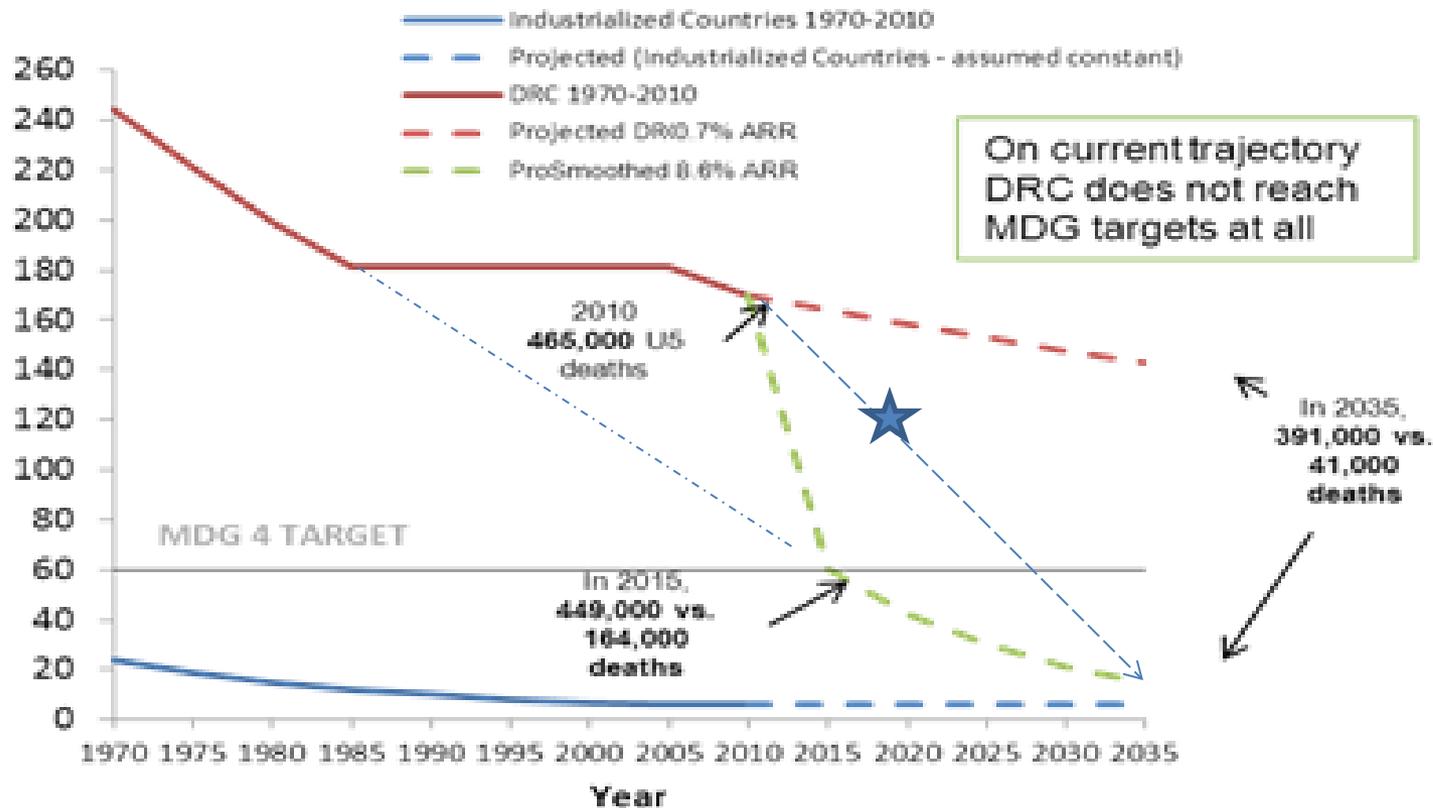
1. Christa L. Fischer Walker et al. Global burden of childhood pneumonia and diarrhoea: Childhood Pneumonia and Diarrhoea; The Lancet 2013
2. Multiple Indicators Cluster Survey 2010: RD Congo

# Current burden of diarrhea and pneumonia in DRC

U5MR

Deaths per thousand live birth

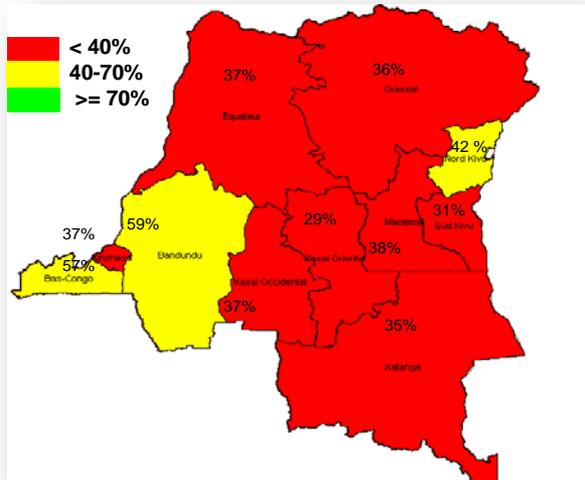
Under-Five Mortality Decline DRC 1970- 2035



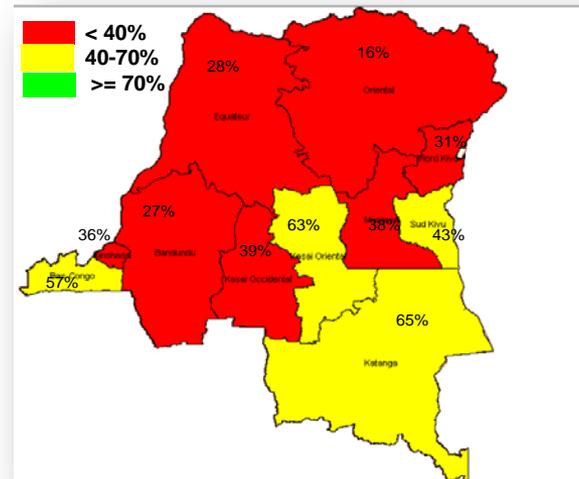
Source: A Promise Renewed: Action Framework. MOH DRC 2013

# Treatment coverage

ORS for Diarrhea treatment by province for under five  
DRC MICS 2010

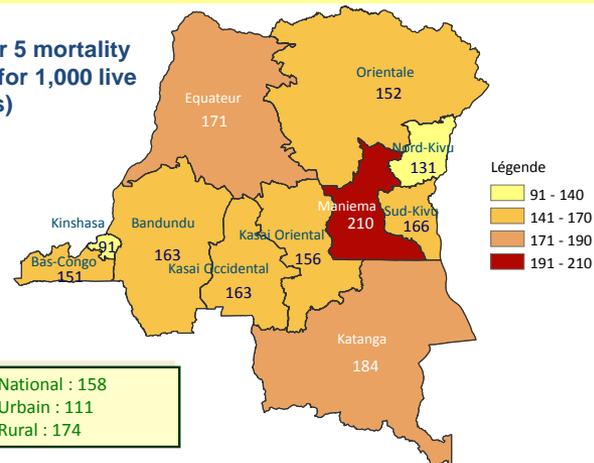


Antibiotics for pneumonia by province for Under five, DRC MICS 2010



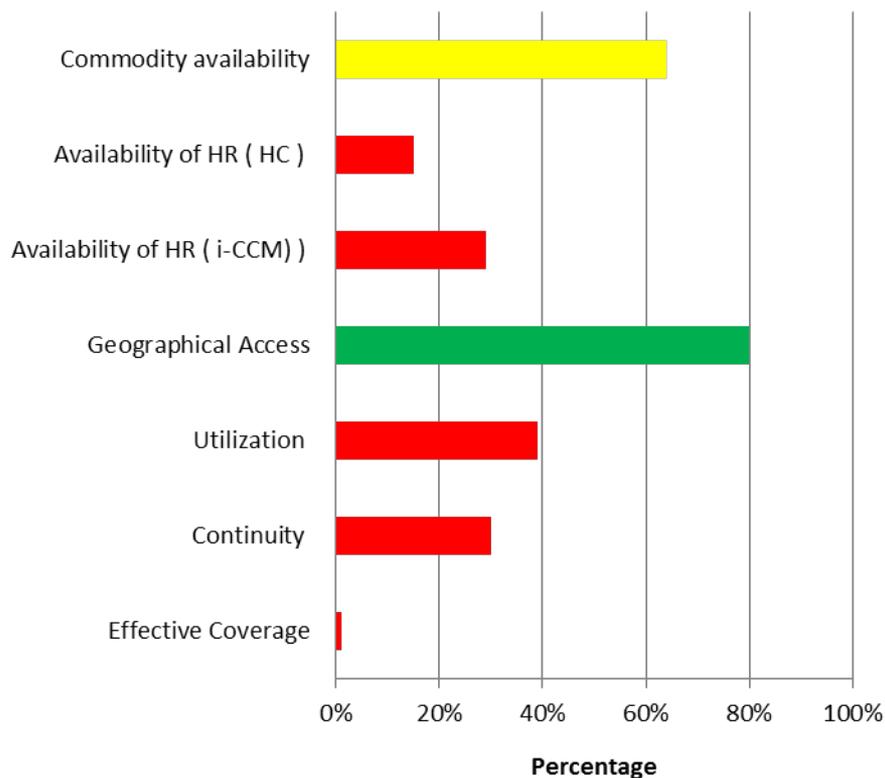
## Under 5 Mortality: level and disparity

Under 5 mortality rate (for 1,000 live births)

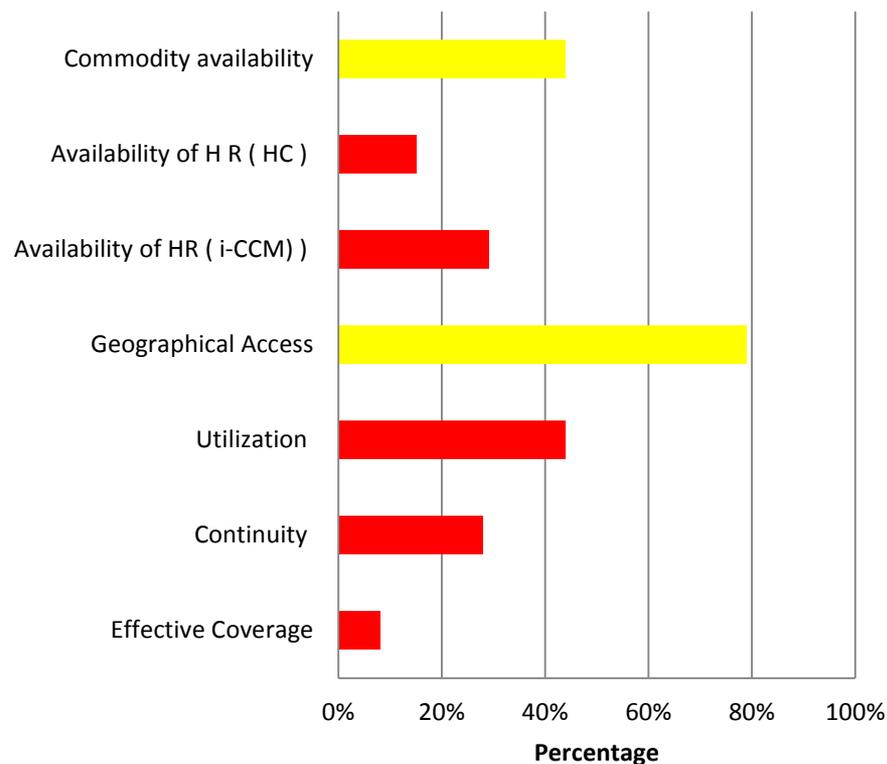


# Key barriers analysis to scale-up

## Diarrhea Treatment: LQAS in 10 health zones



## Pneumonia Treatment: LQAS in 10 health zones



Source: A Promise Renewed:Action Framework. MoH DRC 2013

# Key barriers to scale-up

1. Insufficient number of qualified health care personnel
2. Care providers misdiagnose pneumonia
3. Care providers incorrectly prescribe antibiotics
4. Care providers incorrectly evaluate the severity of cough and diarrhea
5. Distance to health facilities: 65% of the population live over 5 km away from a health facility
6. Stock outs of medicines
7. Financial inaccessibility

# UPDATE ON PLANNING

# Status of key milestones

Enabling element	Status
Essential Medicines Initiatives (EMI) National Plan	<ul style="list-style-type: none"> <li>• Secretary General of MoH recognizes the National Strategy of EMI</li> <li>• Budget for EMI strategy is included in the country UNCoLSC plan</li> </ul>
Policy change	<p>Diarrhea: Over-the-counter (OTC) status for zinc is in progress.</p> <p>Pneumonia: First line treatment policy was changed from cotrimoxazole to amoxicillin dispersible.</p>
Vaccination	New EPI vaccines introduced: Haemophilus influenzae b ( 2009); Pneumococcal Conjugate Vaccine ( PCV-13)
Partner Coordinating Mechanism	MNCH task force is chaired by the MoH (10 <sup>th</sup> Direction ), and is comprised of representatives from national programs, as well as other partners. The task force meets quarterly.

# Progress on resource mobilization

1. Health for Poorest Populations Project /UNICEF-MSH for diarrhea and pneumonia (4 Million USD for 1 year)
2. Integrated Health Project/MSH for diarrhea and pneumonia (\$4.1 Million USD for PY4)
3. Systems for Improved Access to Pharmaceuticals and Services/MSH i-CCM pharmaceutical interventions (750,000 USD to support APR)
4. Lundin Foundation (a mining company) funded Population Services International (PSI) for diarrhea prevention, treatment and ORS/zinc local manufacturer strengthening (1.5 Million USD)

# Progress on resource mobilization

5. Canadian International Development Agency (CIDA) through the World Health Organization for Rapid Access Expansion (RAcE) project for scaling up i-CCM (2 Million USD/year for 5 years)
6. UKAID for Accès aux Soins de Santé Primaires (ASSP Project)
7. Global Fund (10th round Malaria) through SANRU (Santé Rurale) for scaling up i-CCM (1 Million USD)
8. Save the Children through GlaxoSmithKline (GSK)

# Status of any related child survival strategies efforts

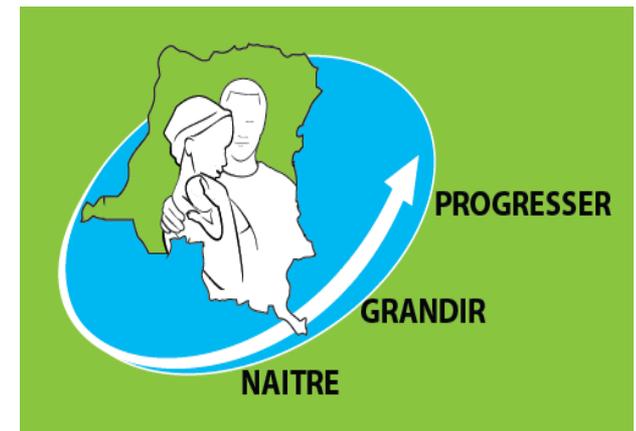
***A Promise Renewed (APR)***: Launched in DRC by the Ministry of Health on May 31, 2013

Objective: Save 430,000 lives of children under five and 7,900 mothers by 2015

The approach: “Safe Birth – Healthy Growth – Sustainable Progress”

Six strategies have been defined to implement the approach:

- Family kits, including vouchers
- Continuity of care
- Improvement of governance and management
- Promotion of healthy behaviors
- Strengthening human resources
- Community mobilization



# UPDATE ON IMPLEMENTATION PROGRESS

# Overview of program approach and strategy

## Essential Medicines Initiatives (EMI)

### 1. EMI Interventions

- ***Intervention 1:*** Integrate 3 national programs for child survival under the leadership of Directorate 5:
  - Programme National de Lutte contre le Paludisme (PNLP)
  - Programme National de Lutte contre les Infections Respiratoires Aigues (PNIRA)
  - Programme National de Lutte contre les Maladies Diarrhéiques (PNLMD)
- ***Intervention 2:*** Establish model health zones in the public sector

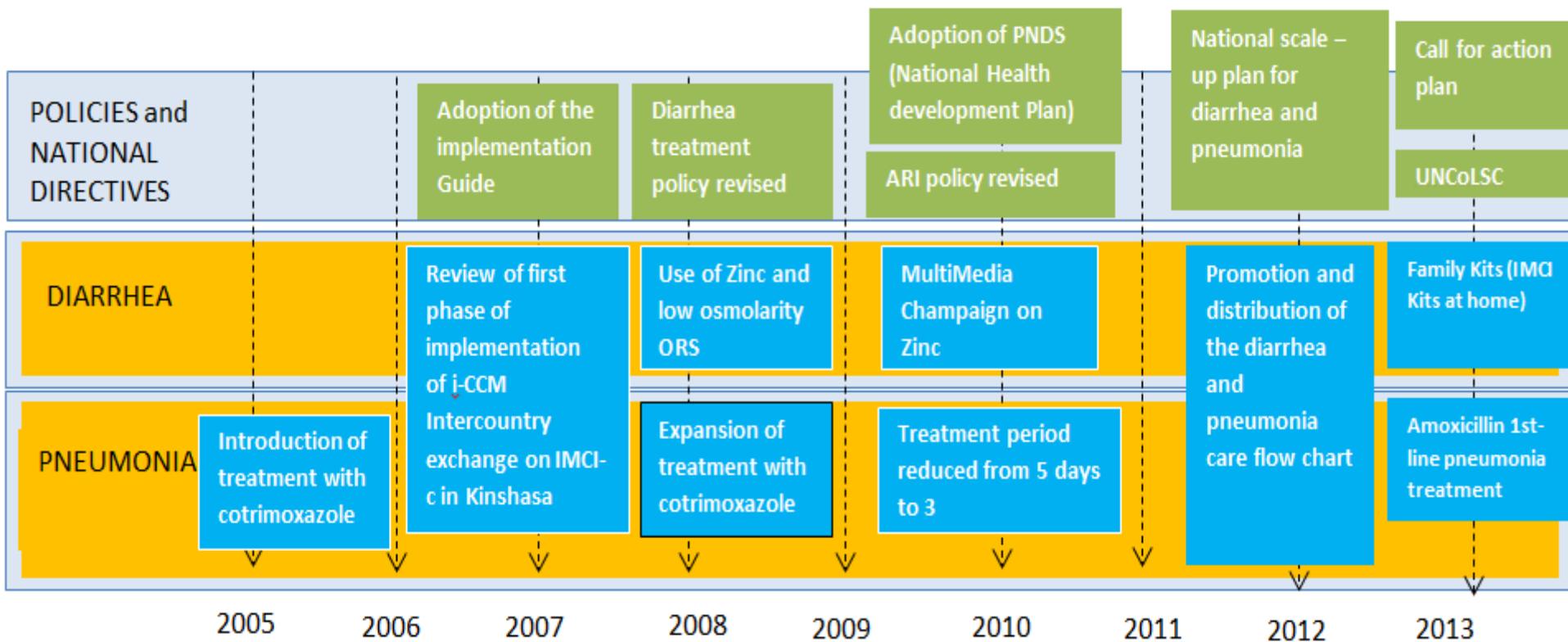
# Overview of program approach and strategy

- **Intervention 3:** Establish an accreditation program to regulate the private sector and improve quality of care provided.
- **Intervention 4:** Scale-up i-CCM.
- **Intervention 5:** Promote the local production and distribution of EMI drugs.
- **Intervention 6:** Obtain ORS/Zinc OTC status and universal coverage.
- **Intervention 7:** Intensive behavior change communication campaign

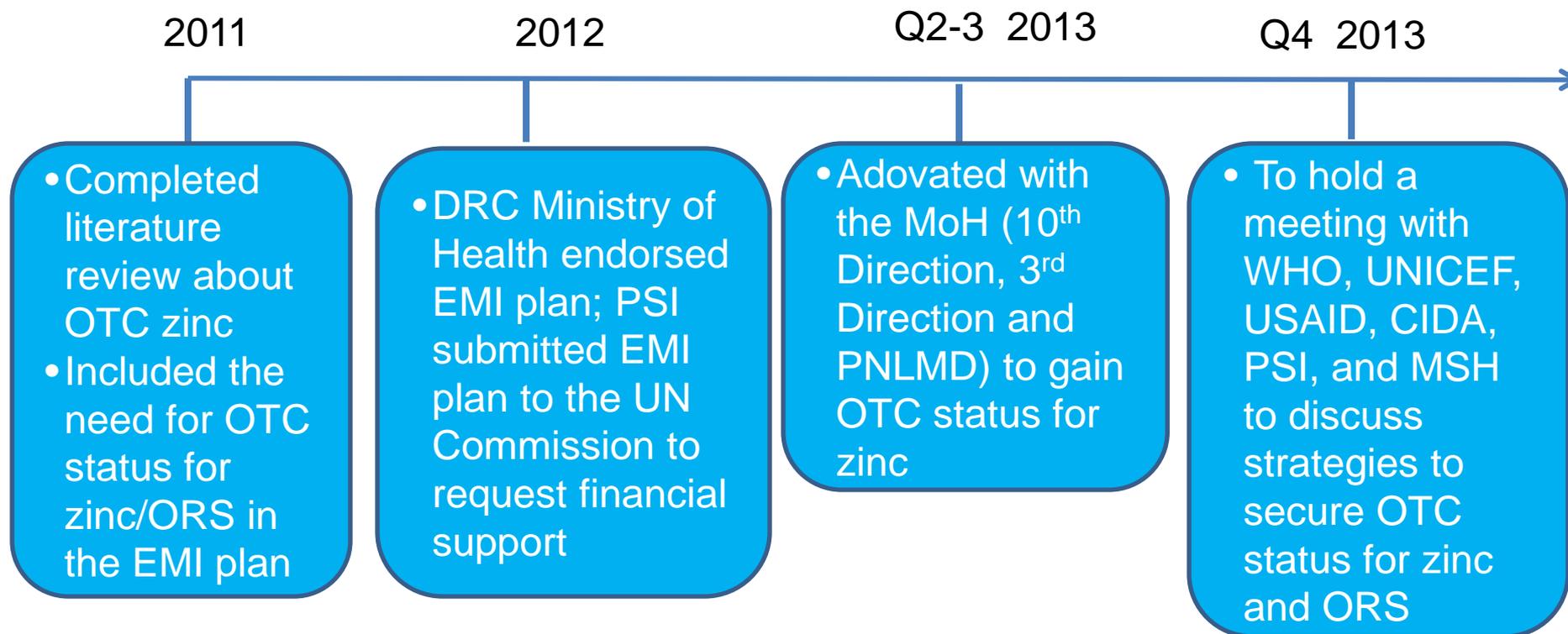
## 2. Estimated costs of EMI

- Revised budget for all EMI 7 interventions: 101.7 Million USD

# Status of key milestones: national policy changes for diarrhea and pneumonia



# Key milestones: of OTC Zinc Status



# Key accomplishments

- Finalized UNCoLSC country plan (August 2013)
- Introduced PCV -13 in all provinces (September 2013)
- Revised Pneumonia Case Management based on WHO guidelines (September 2013):
  - new classification
  - change in first line antibiotic therapy

# KEY LESSONS LEARNED

# Key lessons learned

1. Ensuring that all stakeholders, essentially at community level, are on board and promote aligned priorities can lead to project success.
2. Strong country leadership (at all levels) is required for successful treatment coverage.
3. NGOs and FBOs are highly efficient in rapid scale-up and quality i-CCM implementation.
4. Ongoing monitoring allows for key bottlenecks to be identified and addressed.

# KEY ISSUES AND QUESTIONS FOR DISCUSSION

# Key issues and questions for discussion

- Learn from other countries that have secured OTC status for zinc and ORS.
- The funding mechanism for EMI plan is still unclear.

# NEXT STEPS/UPCOMING PRIORITIES

# Next steps/upcoming priorities

1. Include amoxicillin dispersible in the National List of Essential Medicines.
2. Obtain OTC status for zinc.
3. Continue to track funding opportunities to fill the gap.

# Integrated Health Project

in the Democratic Republic of Congo

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# Projet de Santé Intégré en République Démocratique du Congo



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## Integrated Community Case Management in DRC

October 10, 2013

*Dr. Narcisse Embeke*  
*Child Health Senior Technical Advisor*



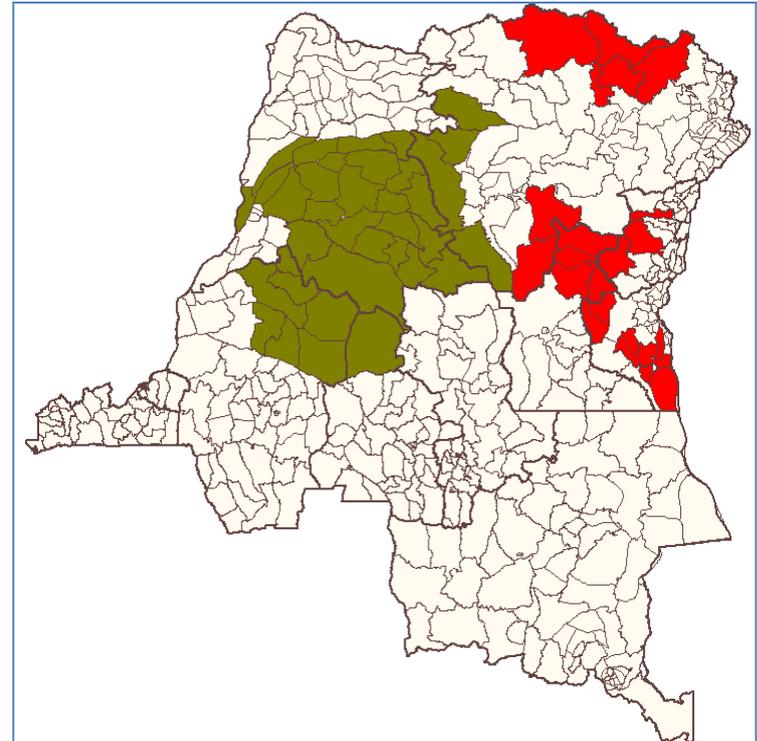
# Outline

- Background
- What is i-CCM?
- Key achievements
- Challenges
- Next steps

# IHP and DRC Overview

The Integrated Health Project supports 80 health zones, covering a population of 12,186,559. About 2,437,312 are children under the age of five.

- 70% of the total population live in rural areas.
- A large portion of the population does not have access to health services.
- 25% average rate of curative services in DRC, 38% in IHP-supported health zones.
- Community health workers fill many of the gaps in health services.



Many health zones are difficult to reach due to:

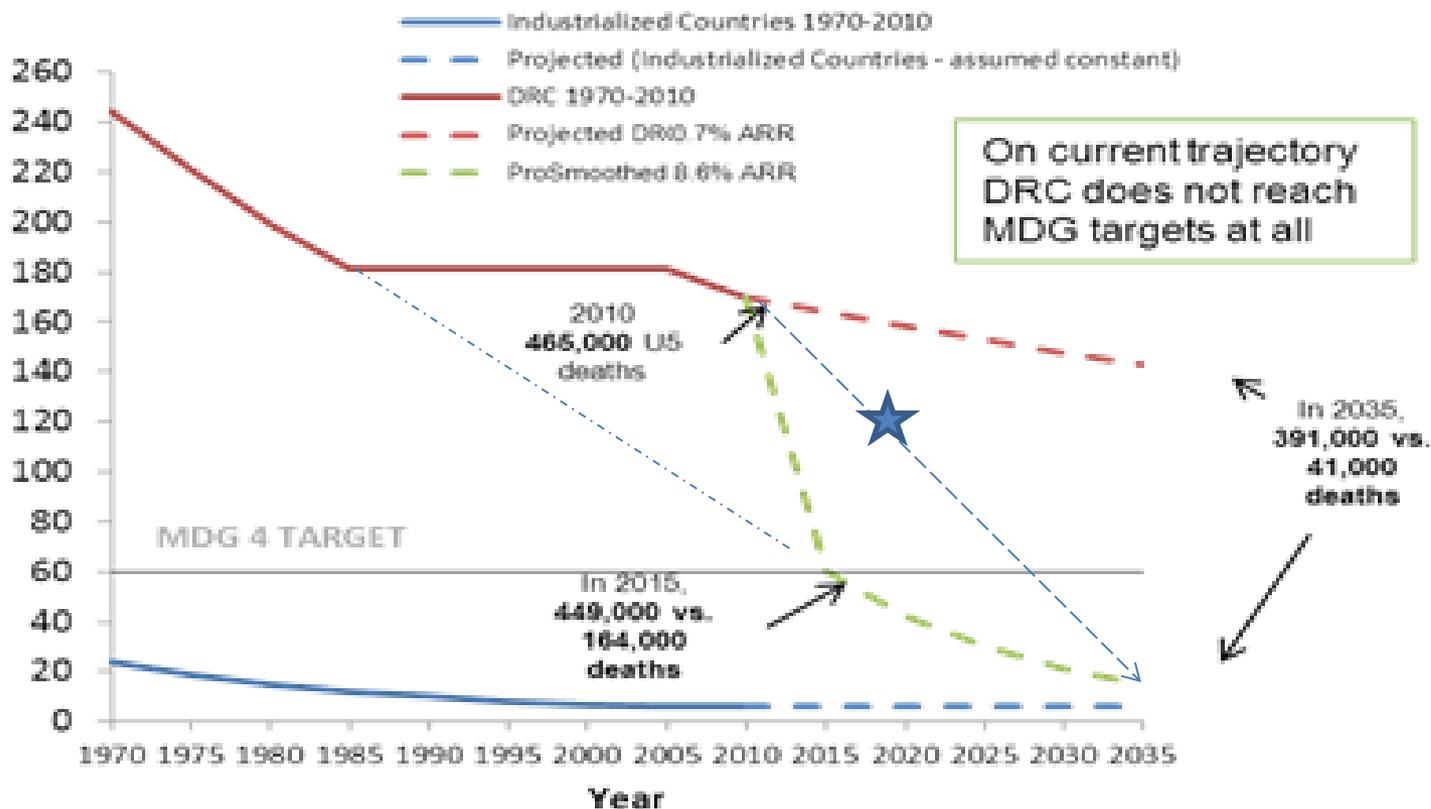
- : geographic inaccessibility
- : insecurity and armed conflict

# Background

## U5MR

Deaths per thousand live birth

### Under-Five Mortality Decline DRC 1970- 2035



Source: A Promise Renewed: Action Framework. MOH DRC 2013

# What is i-CCM?

## Integrated Community Case Management:

- i-CCM benefits villages or communities where access to health care is limited or difficult to obtain.
- A pair of trained and supervised community health workers (CHW) provides basic care for the community.
- In some cases, the CHWs provide care directly to children in their homes.
- CHWs provide care from their own homes using medical supplies and data management tools provided by IHP.



# Community Health Workers' Activities in Community Care Sites

## Preventive

- Encourage the community to seek health services
- Provide vaccination sites
- Provide family planning services



## Curative

- Case management for diarrhea, pneumonia, and malaria cases
- Refer and accompany community members to health centers, in serious cases



## Promotional

- Identify and refer malnutrition cases



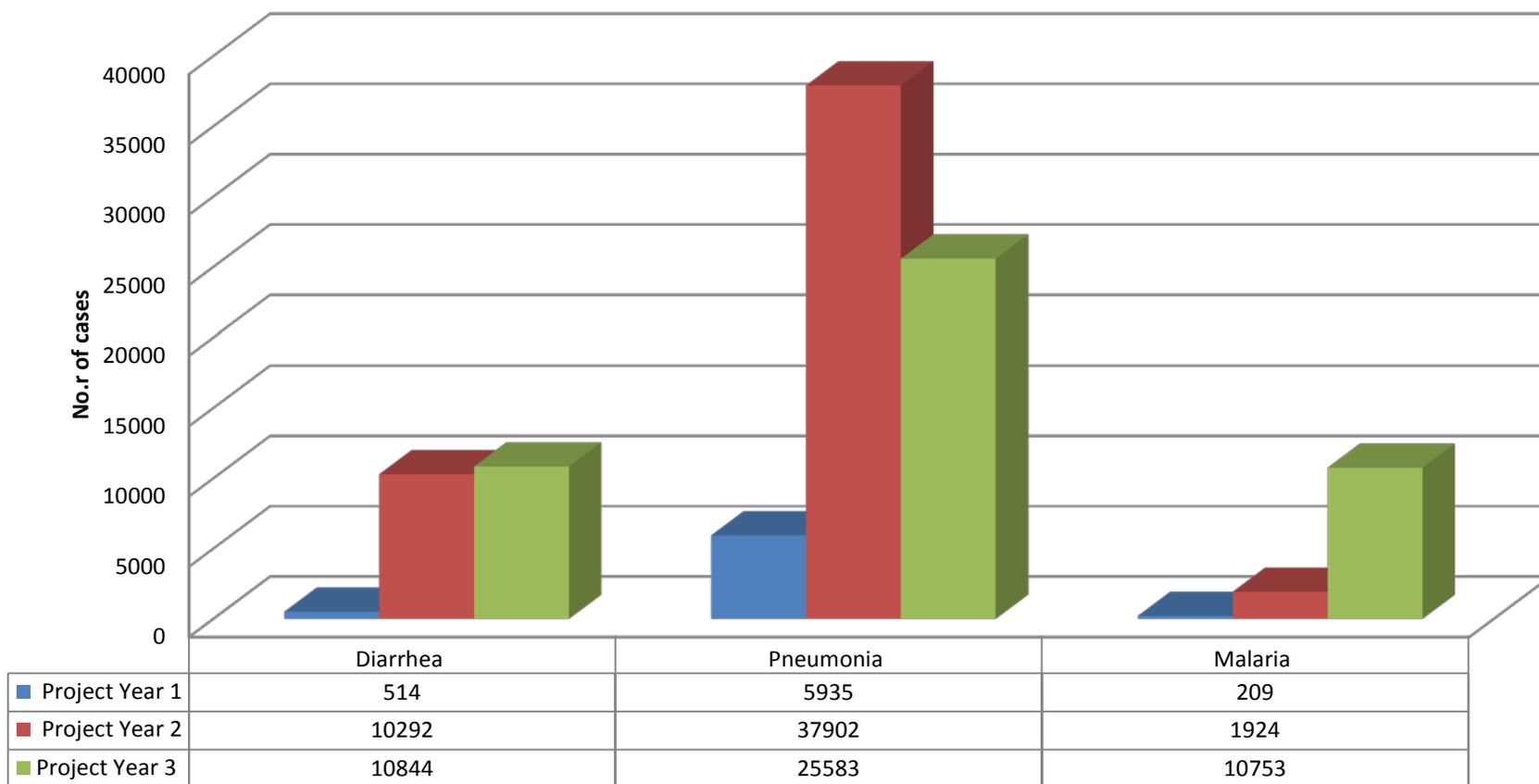
- Conduct home visits
- Conduct community sessions to promote health-seeking behaviors

# Demographics

Provinces	IHP Coordination office	No. of i-CCM sites	Population covered by i-CCM	No. of children under 5 covered by i-CCM
Sud Kivu	Bukavu	65	105,300	21,060
	Uvira	15	39,900	7,980
Katanga	Kamina	45	115,825	23,165
	Kolwezi	42	34,830	6,966
Kasaï Oriental	Mwene Ditu	62	65,455	13,091
	Tshumbe	51	77,800	15,560
	Kole	8	11,150	2,230
Kasaï Occidental	Luiza	38	90,835	18,167
<b>TOTAL</b>		<b>326</b>	<b>541,095</b>	<b>108,219</b>

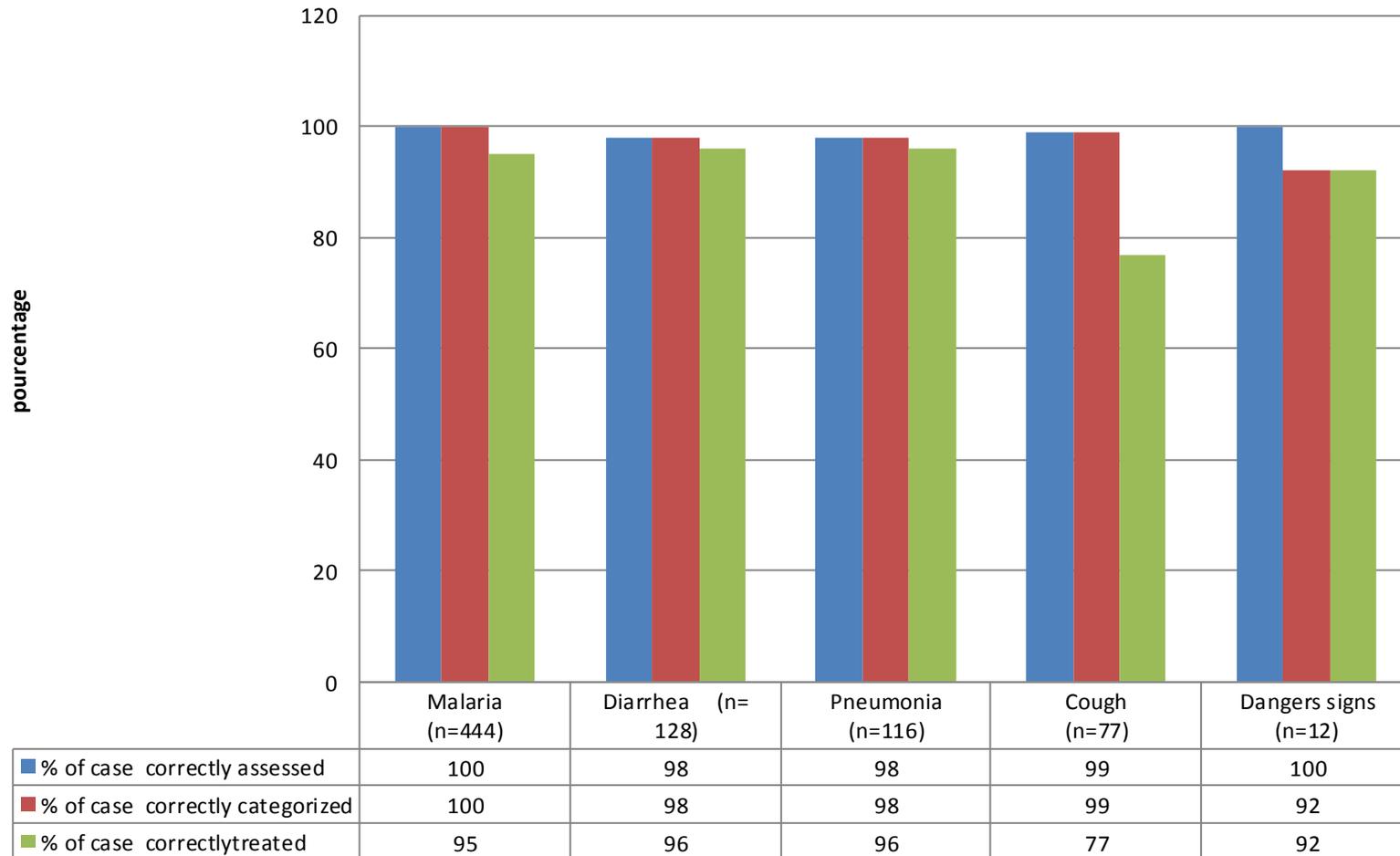
# Results

**Number of cases treated at community care sites between October 2010 and June 2013**



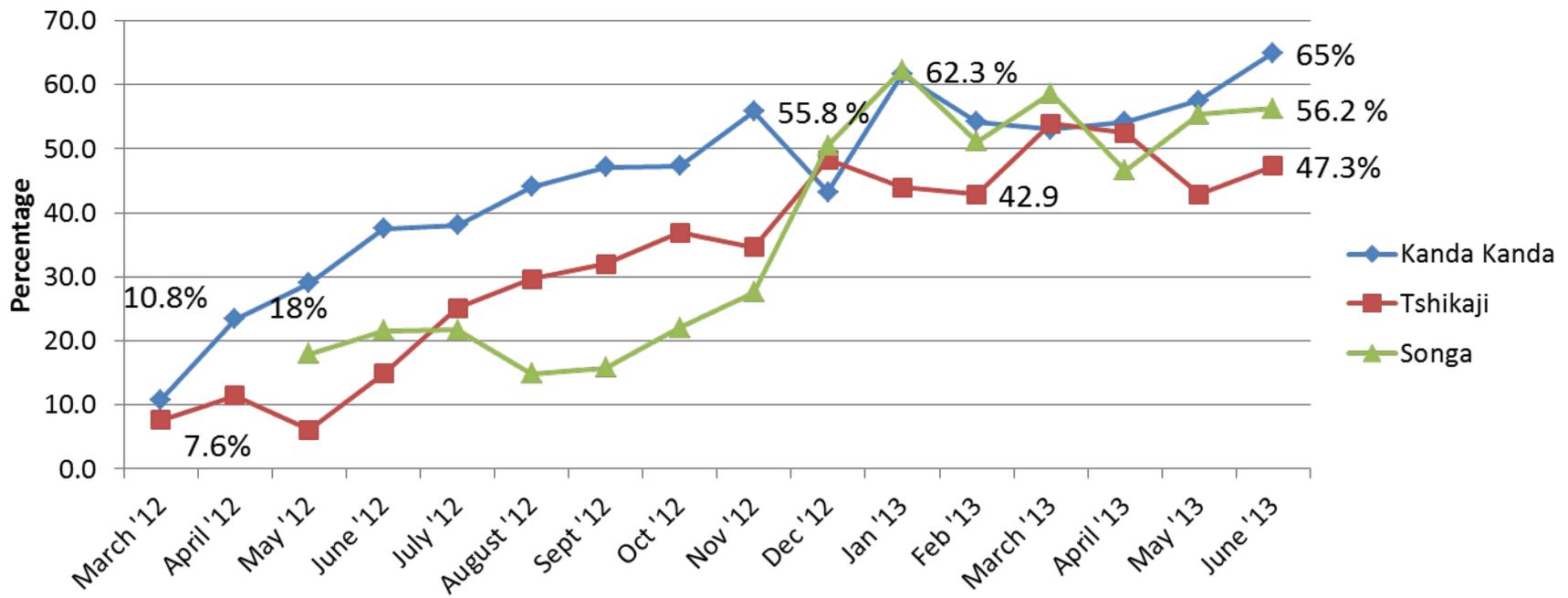
# Results

**Case management quality evaluation in Kanda Kanda Health Zone Q2Y3 IHP**



# Results: Collaborative Approach

**Progression of the rate of curative service use in community care sites in Kanda Kanda, Tshikaji, and Songa**



# Incentives and motivation for CHWs

- Supervision
- Post-training follow-up
- Bicycles to facilitate household visits
- Recognition from the community



# Justine's story



Justine during a home visit with a father and his son

# Challenges

- Low level of ownership of the community care site approach among provincial and district health administrations, as well as at the health zone level.
- Lack of integration of data collected at care sites into the national health records held by the health zones and the provinces.
- Frequent stock outs of medications and other supplies.
- Weak links between the health system and the community, particularly between the health zone and community care sites. Many care providers do not view community care sites as viable first-line health sites and often fail to restock them with supplies.

# Next steps

- Scale up the i-CCM sites.
- Regularly evaluate the data quality from care sites.
- Continue discussions with the Ministry of Health in order to integrate data from care sites into the national health information system.
- Share key achievements of community care sites, and lessons learned, with implementing partners and the Ministry of Health.

# Projet de Santé Intégré

en République Démocratique du Congo

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Annex 3 : Les notes prise pendant l'atelier

#	Pays	Résumé des échanges et Recommandations	Recommandations	Responsable
1	Ethiopie	<ul style="list-style-type: none"> <li>• Le Ministère de la santé est en train de travailler pour faire passer l'Amoxicilline dispersible comme médicament de la première ligne de lutte contre la pneumonie, ainsi le ministère élabore la cartographie des partenaires</li> <li>• Le document de plaidoyer qui a été soumis aux donateurs le 25 Septembre 2013, va être partagé avec les partenaires dans le pays.</li> <li>• Le financement actuel de l'UNICEF est utilisé pour accroître la demande, la gestion de la chaîne d'approvisionnement.</li> <li>• Le financement UNCoLSC sera livré avant la fin de cette année (4-5 millions de dollars)             <ul style="list-style-type: none"> <li>• Faire une nouvelle analyse de la situation en Éthiopie pour les interventions prioritaire : la Prise en Charge des Maladies de l'Enfance (PCIME) et la santé des enfants</li> </ul> </li> <li>• Amoxicilline dispersible est déjà utilisé au niveau du pays pour le sepsis</li> </ul>	<ul style="list-style-type: none"> <li>• Faire une nouvelle analyse de la situation en Éthiopie pour les interventions prioritaires, la PCIME et la santé des enfants</li> <li>• A quel niveau se trouve actuellement les statuts d' Over-the-counter (OTC) pour le zinc ?</li> <li>• Faire la mise à jour des mappings en ajoutant des nouveaux partenaires,</li> <li>• Discuter avec PFSA, Clinton Health Access Initiative (CHAI) et Program for Appropriate Technology in Health (PATH) pour prendre en compte la production locale de ORS et le zinc</li> </ul>	<p>(OMS et UNICEF)</p> <p>Alison</p>

#	Pays	Résumé des échanges et Recommandations	Recommandations	Responsable
2	Tanzanie	<ul style="list-style-type: none"> <li>• Amoxicilline dispersible est utilisé comme médicament de traitement de première ligne et est importé, deux fabricants internationaux (Allemagne et Chine) sont en attente d'approbation</li> <li>• L'amoxicilline de 250 mg est la présentation appropriée, et le dosage à 125mg doit être évité afin de créer de confusion chez les relais communautaires</li> <li>• L'UNICEF couvre 3 régions sur 26, couvrant six districts (petite partie des régions) pour la demande de soins et de stock- surveillance grâce à la technologie mobile et de sensibilisation à travers les adolescents</li> <li>• Les matériaux de McCann sont disponibles mais ne sont pas payés pour des spots radio etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Unicef va travailler avec C4D sur la mobilisation des ressources nationales et le recours aux soins</li> </ul>	
3	Nigeria	<ul style="list-style-type: none"> <li>• Fidson et Emzor n'ont pas encore commencé la fabrication dans leurs nouvelles installations et devrait commencer en Novembre</li> <li>• Olpham est un importateur et distributeur et dispose de co package pour 1,25 dollars</li> <li>• Swiss Pharma et Pharmotech sont nouveaux fabricants potentiels de zinc. Ils ont été inspectés et devront commencer la production en 2015</li> <li>• SD collaboration avec les fabricants nigériens - ont assisté à la conférence de l'offre à Copenhague (ex. Chi vise à avoir des prix compétitifs pour les co- packs)</li> <li>• 2 financements sont approuvés pour 20M USD. Gates va fournir pour la mise à échelle de traitement de diarrhée et pneumonie ; Kebbi, Benway pour l'offre et la</li> </ul>		

#	Pays	Résumé des échanges et Recommandations	Recommandations	Responsable
		<p>demande,</p> <ul style="list-style-type: none"> <li>• Tous les produits doivent satisfaire Good Manufacturing Practice (GMP) locale, et les normes de qualité</li> <li>• Travailler avec Unilever pour les campagnes de lavage des mains y compris la prise en charge de diarrhée : SRO et du zinc</li> <li>• Financement UNCoLSC 10 millions de dollars pour cette première année</li> <li>• Le coordinateur de pneumonie étant engagé</li> <li>• Une entreprise locale a enregistré pour produire des comprimés dispersibles amoxicilline</li> <li>• McCann intéressé pour le développement de matériaux sur l'amoxicilline</li> </ul>		
4	Uganda	<ul style="list-style-type: none"> <li>• Baisse de 85 % du coût des importations de zinc</li> <li>• Le statut OTC zinc est approuvé</li> <li>• 7000 ASC nouvellement formés en matière de création de la demande</li> <li>• DPCC travailler localement pour renforcer les stratégies PPT (prévenir, protéger et traiter)</li> <li>• C'est le seul pays d'Afrique subsaharienne avec un fabricant local (Medipharm) de l'amoxicilline dispersible- mais seulement il produit l'amoxicilline 125mg</li> <li>• MSH : STRIDES MNCH, SHORE, et le financement Gates pour les vendeurs de médicaments durables</li> <li>• Travailler avec des pharmaciens et des vendeurs de médicaments (les propriétaires et les assistants) sur le traitement de la diarrhée</li> <li>• Comment introduire avec succès des prix de détail</li> </ul>		

#	Pays	Résumé des échanges et Recommandations	Recommandations	Responsable
		<p>maximum (MRP) ?</p> <ul style="list-style-type: none"> <li>• Demandé des études d'autres pays</li> </ul>		
5	RDC	<ul style="list-style-type: none"> <li>• La bonne disponibilité des produits est adéquate, mais la faible capacité des ASC et les infirmiers dans la prise en charge fait défaut dans les 10 zones de santé les plus couverts par les partenaires (secteur privé et public)</li> <li>• Les sites de soins communautaires ont été mis en place et améliore l'accès géographique</li> <li>• La couverture effective est de 18% pour la pneumonie et 1% pour la diarrhée</li> <li>• Les obstacles pour la prise en charge sont: erreur de diagnostic de la pneumonie</li> <li>• Pas de fabricants locaux qui répondent aux spécifications / BPF de l'OMS</li> <li>• Tous les produits de santé sont importés - prend 8 mois être au pays entraînant des ruptures de stock -en plus de charges financières de l'importation</li> <li>• Amoxicilline dispersible est le traitement de première ligne, mais le zinc n'est pas encore OTC</li> </ul> <p>MNCH groupe de travail comprend tous les partenaires Différents projets partenaires sont en cours dont les kits familiaux.</p>	<ol style="list-style-type: none"> <li>1. Elaborer la cartographie des partenaires de lutte contre la diarrhée connaitre qui fait quoi, où, jusque quand.</li> <li>2. Responsabiliser le Programme de lutte contre les maladies diarrhéiques avec l'appui des partenaires l'OMS, Unicef, MSH, SIAPS afin d'obtenir une exemption pour démedicalisation SRO et le sulfate de zinc,</li> </ol>	
6	Niger	<ul style="list-style-type: none"> <li>• La mortalité des enfants de moins de 5 ans baisse de 6% par l'an - plus rapide que les prévisions des OMD 4,7%</li> </ul> <p>Les progrès dans certaines régions est beaucoup</p>	<ol style="list-style-type: none"> <li>a. Évaluer tous les ASC à l'échelle nationale afin de déterminer qui</li> </ol>	

#	Pays	Résumé des échanges et Recommandations	Recommandations	Responsable
		<p>moins que la moyenne nationale Un écart important subsiste entre les populations urbaines et rurales</p> <ul style="list-style-type: none"> <li>• La gratuité des soins pour les moins de 5 ans et les femmes enceintes</li> <li>• 2450 cases de santé existent. Chaque case de santé couvrent 3000 personnes - composé de 1 ASC et 1 technicien et ces agents sont payé par le gouvernement et les communautés locales</li> <li>• 37 % des gens se faire soigner et sont traitées au CdS</li> <li>• Les Services de soins de santé gratuits sont disponibles dans tous les centres de santé</li> <li>• Amoxicillin dispersible est le traitement de première ligne, mais pas sur la LME nationale</li> <li>• Statuts OTC pour le Zinc n'est pas obtenu. ∞ Discuter PCA avec PSI pour améliorer la communication et la mise en œuvre de la stratégie</li> <li>• UNICEF , PATH et ADF ( Agence française de développement ) soutien le ministère de Santé</li> <li>• Manque de coordination entre les partenaires dans le pays, en particulier avec les petites ONG</li> <li>• Les téléphones portables seront utilisés pour améliorer la communication et promouvoir le changement de comportement</li> </ul>	<p>offrent les services / identifier ceux qui ont des lacunes</p> <ul style="list-style-type: none"> <li>• Piloter une enquête auprès des ménages dans 1 district, pour compléter les données quantitatives.</li> </ul>	
6	Bangladesh	<ul style="list-style-type: none"> <li>• Le zinc et des SRO - de nombreux fabricants, une entreprise produit d'amoxicilline dispersible (UNICEF a certifié)</li> </ul>		

#	Pays	Résumé des échanges et Recommandations	Recommandations	Responsable
		<ul style="list-style-type: none"> <li>• Révision des plans sectoriels en cours pour commencer 2014-2015</li> <li>• Aucune directive écrite, utilisation demi-comprimé, comprimé dispersible est même sous forme de poudre ;</li> <li>• Des réunions trimestrielles et des présentations de pays devraient contribuer à ce large éventail de plans</li> </ul>		
7	Inde	<ul style="list-style-type: none"> <li>• Statut OTC pour zinc approuvé</li> <li>• Plaidoyer pour inclure les indicateurs de la pneumonie et la diarrhée au tableau de bord des indicateurs santé maternelle infanto-juvénile</li> <li>• FHI360 et Gates effectuent une enquête qualitative dans l'UP sur le comportement et traitement pour une suspicion de pneumonie chez les prestataires qualifiés (résultats par Avril 2014)</li> <li>• Gates et l'Université du Roi George de recherche qualitative sur la pneumonie</li> <li>• CHAI résultats de référence pour le zinc / ORS</li> <li>• Les agents de santé ont été " détournés" pour la santé maternelle au lieu de la santé infantile : traiter la diarrhée et la pneumonie</li> </ul>	<ul style="list-style-type: none"> <li>• UNICEF assurera le suivi avec Liliana à plaider pour l'inclusion d'indicateurs en Inde (et d'autres pays du tableau de bord de RMNCH)</li> <li>• Partager les résultats de recherche lors de la prochaine réunion</li> </ul>	
8	Pakistan	<ul style="list-style-type: none"> <li>• Lancement Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD) en Août au niveau national</li> <li>• Plaidoyer auprès des bailleurs de fonds sur la diarrhée et la pneumonie ? Il n'y a pas assez d'attention</li> </ul>		

#	Pays	Résumé des échanges et Recommandations	Recommandations	Responsable
		<ul style="list-style-type: none"> <li>• La gestion de Lady Health Workers a été décentralisée en raison de la capacité variable, certains ont été dissous complètement - doivent être relancés</li> <li>• UNICEF est engagé fortement dans le Pendjab et du Sind, sauf dans le Baloutchistan et Khyber Pakhtunkhwa</li> <li>• 75% de la diarrhée et la pneumonie soins sont traités dans le secteur privé</li> <li>• ATCO est un partenaire pour les SRO et du zinc et s'intéresse à AMX DT.</li> </ul>		
9	Kenya	<ul style="list-style-type: none"> <li>• La segmentation des interventions contre la diarrhée (par exemple 65% dans le secteur public)</li> <li>• Le déficit de financement est de 14 millions de dollars</li> <li>• CHAI a obtenu un financement mettre à l'échelle le traitement de la diarrhée et zinc, objectif est d'atteindre 65% d'ici 2015 ;</li> <li>• Collaborer avec l'Association pédiatrique Kenyane (KPA) :</li> <li>• Former initialement 1500 agents communautaires dans six mois</li> <li>• Intégrer de la prise en charge de la pneumonie dans la formation PCIME de gestion des produits de santé</li> <li>• Le Co -packs sont largement disponibles dans le secteur public et privé : 2 fabricants locaux de Co packages sont présents (non -GMP)</li> </ul>	Assurer le suivi de l'utilisation des fonds ACDI pour le développement des stratégies de lutte contre la pneumonie	UNICEF ET C4D

#	Pays	Résumé des échanges et Recommandations	Recommandations	Responsable
		<ul style="list-style-type: none"> <li>○ Dans la campagne multi média réalisée pour susciter la demande, la pneumonie n'est pas incluse en raison de ressources limitées</li> <li>○ Il y a utilisation de l'oxymètre dans les formations sanitaires pour le diagnostic et le traitement de la pneumonie,</li> <li>○ La formation en i-CCM se réalise en 5 jours et le paquet comprend la prise en charge de diarrhée avec (SRO et Zinc) et le paludisme (Tests Diagnostiques Rapides (TDR)). La pneumonie n'est pas prise en compte dans le paquet ;</li> </ul>		
10	Zambie	<ul style="list-style-type: none"> <li>• La majorité des soins pour la diarrhée et pneumonie sont réalisés dans le secteur public, l'analyse situationnelle montre un déficit de communication</li> <li>• Tout le zinc utilisé dans le secteur privé sont importé (approvisionnement à partir Shelys en Tanzanie)</li> <li>• Un projet pilote sur la recherche formative fait avec la LSHTM (London School) sur le changement de comportement,</li> <li>• Le lancement de GAPPD aura lieu à Mazabuka</li> </ul>	<ul style="list-style-type: none"> <li>• Aider les fabricants de zinc avec enregistrement PRA</li> </ul>	

## **Journée mondiale de la pneumonie a vecu!**

Le douzième jour du mois de Novembre de chaque année, le monde entier célèbre la journée de la pneumonie et en République Démocratique du Congo, le Ministère de la Santé a choisi la salle du Management Sciences for Health (MSH) comme de cadre à la commémoration de cette cinquième édition.

Pour cette édition, le Ministère de la Santé Publique à travers le Programme National de Lutte contre les Infections Respiratoire Aiguées (PNIRA) a organisé avec l'appui technique et financier de PROSANI une matinée scientifique des réflexions sur les mesures de lutte contre la pneumonie en RD Congo avec plusieurs sous thèmes du reste développés par les experts en la matière.

Au nombre des participants l'on compte l'Organisation Mondiale de la Santé (OMS), la Vision Mondiale, IMA World, des cliniciens des Cliniques Universitaires et des Hôpitaux Généraux de Référence de Kinshasa, de Kalembelembe et de Kintambo sans oublier des cadres des programmes et directions du Ministère de la Santé Publique.

Prenant la parole, le Directeur du PNIRA, **Dr J.F Ilunga** a fait savoir que tous les indicateurs relatifs à la pneumonie sont alarmants et de poursuivre que les participants devaient déterminer les goulots d'étranglement afin d'arrêter les actions concrètes car la pneumonie est une deuxième cause de la mortalité infantile en RDC avec treize nouveau-nés qui meurent chaque heure.

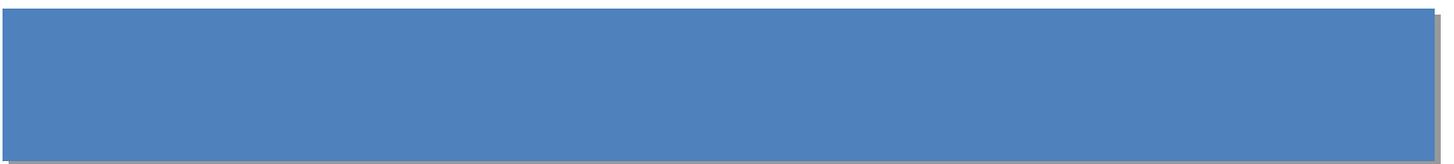
La pneumonie est responsable de 16 % de décès chez les enfants de moins de 5 ans. Il faut arrêter des stratégies idoines c'est-à-dire une réflexion pour l'action a dit **Dr Tutu Kalume**, Représentant le Secrétaire Général du Ministère de la Santé Publique, qui par la suite a remercié les partenaires pour leur accompagnement en termes d'appui technique et financier.

Il sied de rappeler que la journée mondiale a été créée en 2009 pour sensibiliser et promouvoir les interventions de protection, de prévention et de traitement de la pneumonie.

# MDG 4 Special Donor Session: Financing Diarrhea & Pneumonia Treatment Gaps

September 25th, 2013, New York





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## Annex

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Mining Compact for Child Health

## Reducing Childhood Deaths from Diarrhea & Pneumonia High Impact Opportunities in 10 Countries



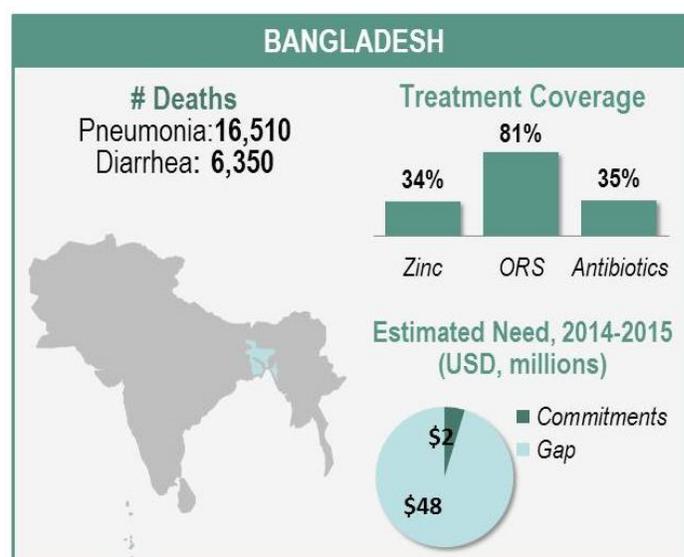
## Bangladesh: Reducing Childhood Deaths from Diarrhea & Pneumonia

Bridging the procurement gap for essential commodities

### MDG 4 in Bangladesh and Opportunity for Impact

Bangladesh is one of few low-income countries that have achieved the Millennium Development Goal (MDG 4) of reducing child deaths by two-thirds.<sup>1</sup> However, **nearly 23,000 children still die from diarrhea and pneumonia each year.**

An important factor of the country's success in achieving MDG 4 is its focus on diarrhea and on cost-effective solutions. Specifically, national efforts<sup>2</sup> have been implemented to scale-up the use of oral rehydration therapy (ORT) and zinc. As a result, Bangladesh has achieved **high rates of sustained use of treatment—81% for ORT (and 34% for both ORT and zinc).** Diarrhea now accounts for only 5% of child deaths in the country, a dramatic decrease from about 20% in 1993.



While the Bangladesh experience serves as an example for other high burden countries, it will be critical to sustain these improvements by further increasing the use of both zinc and ORT. Moreover, additional efforts are needed to decrease deaths from pneumonia, which can be largely prevented through treatment with amoxicillin. If national targets for scaling up diarrhea and pneumonia treatment are achieved in Bangladesh, **an estimated 6,400 lives of children can be saved in the next two years by 2015.**<sup>3</sup>

### What You Can Do

The Government of Bangladesh is expected to support the procurement of essential child commodities beginning in 2014-2015<sup>4</sup>; however, there is an immediate need to bridge the gap for public sector commodity procurement in the near-term. In particular, **US \$7.4 million** is needed to cover the cost of essential commodities, related equipment and overall program management. An additional **US \$42.9 million** will be required to support other key interventions to help achieve the full impact of the national program including trainings, procurement support, referrals, and communications for a total need of **US \$50 million**. It should be noted that a portion of this estimate will be covered by commitments secured to date from government and donors (US \$2 million).

ESTIMATED IMPLEMENTATION COSTS, 2014-2015 (USD)			
Cost Category	Year 1	Year 2	Total
Commodity procurement	\$ 3,570,000	\$ 3,780,000	\$ 7,350,000
Zinc dispersible tablets	\$ 1,610,000	\$ 1,720,000	\$ 3,330,000
Amoxicillin dispersible tablets	\$ 1,710,000	\$ 1,830,000	\$ 3,540,000
Salbutamol + nebulizer	\$ 250,000	\$ 230,000	\$ 480,000
Training	\$ 3,400,000	\$ 2,280,000	\$ 5,680,000
Procurement systems	\$ 160,000		\$ 160,000
Referral	\$ 300,000	\$ 11,670,000	\$ 11,970,000
Local level planning, monitoring, supervision	\$ 8,940,000	\$ 3,550,000	\$ 12,490,000
Communications	\$ 3,840,000	\$ 4,930,000	\$ 8,770,000
Coordination and management	\$ 1,800,000	\$ 2,000,000	\$ 3,800,000
<b>TOTAL</b>	<b>\$ 22,010,000</b>	<b>\$ 28,210,000</b>	<b>\$ 50,220,000</b>

<sup>1</sup> UNICEF. Committing to Child Survival: A Promise Renewed. Progress Report 2013. September 2013.

<sup>2</sup> Efforts include national scale-up of ORT in the 1970s and the Scaling Up of Zinc for Young Children Project or "SUZY", the first zinc scale-up effort in any country in 2004.

<sup>3</sup> Estimate calculated using the Lives Saved Tool, Johns Hopkins Bloomberg School of Public Health, March 2013. Note: the Lives Saved Tool does not reflect recent APR estimates from September 2013.

<sup>4</sup> Through its five-year health sector program (SWap)



The National Core Committee for Newborn Health will help to coordinate implementation of activities around diarrhea and pneumonia treatment across several stakeholder groups in the country.<sup>5</sup> Key partners working on diarrhea and pneumonia treatment scale-up efforts include: The Government of Bangladesh, UNICEF, icddr,b, WHO, Save the Children, Micronutrient Initiative, and BRAC, among others.

#### National Approach to Scaling Up Treatment for Diarrhea and Pneumonia

icddr,b is collaborating closely with the Government of Bangladesh, UNICEF, and other key stakeholders to implement the *National Scale-up Plan: Identifying Gaps and Challenges in Scaling up of Pneumonia and Diarrhoea Management in Bangladesh*, which was developed in early 2012. The plan aims to increase the coverage of zinc, ORS, and amoxicillin to 50% by 2016 and 80% by 2020 and outlines concrete areas for action.

Key interventions of the plan include:

- Improving the capacity of service providers and facilities for treatment of pneumonia and diarrhea
- Developing and implementing a procurement, planning and distribution system based on fully functioning, automated Logistic-MIS (L-MIS)
- Testing and implementing referral solutions for sick children
- Improving capacity for local level planning (LLP), quality assurance, supervision and monitoring
- Formulating and implementing an updated national communication strategy to improve home care and care-seeking
- Introducing dispersible amoxicillin in public sector facilities and ensuring regular and adequate supply of amoxicillin and zinc

The National Scale-up Plan is in line with recommendations of the UN Commission on Life-Saving Commodities for Women and Children, the Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea (GAPPD), A Promise Renewed, and the United Nations Secretary-General's Every Woman Every Child movement. Most recently, the Government of Bangladesh launched the Bangladesh Call for Child Survival for ending preventable child deaths by 2035 as part of the A Promise Renewed initiative, which further reflects the Government's unprecedented leadership around this high impact opportunity.

#### Contact Us

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<sup>5</sup> National Steering Committee for IMCI (Ministry level), National MNCH Forum (Directorate level), National Core Committee for Newborn Health (Ministry Level), National Working Team for Child Health.

## DRC: Reducing Childhood Deaths from Diarrhea & Pneumonia

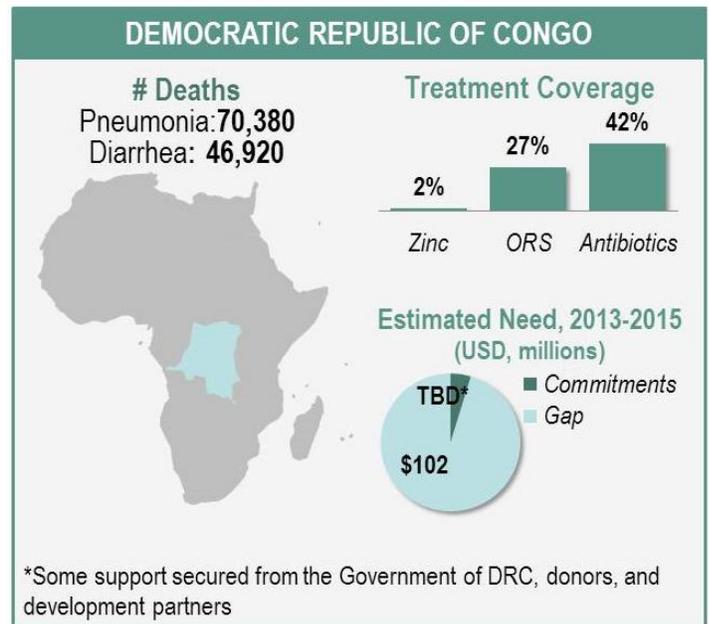
### Proposal for a large-scale integrated approach to treatment scale-up

#### MDG 4 in DRC and Opportunity for Impact

The Democratic Republic of Congo (DRC) has the third highest burden of under five deaths in the world. While the rate of child mortality has declined by 15% since 1990<sup>1</sup>, pneumonia and diarrhea remain the leading causes of death in the country. **Pneumonia and diarrhea are responsible for nearly 120,000 child deaths each year.**

Most of these deaths can be prevented with increased access to vaccines and medicines. Though DRC recently introduced the pneumonia vaccine in 9 of 11 provinces, it is not widely available.

Simple, highly-effective treatment already exists—zinc and oral rehydration solution (ORS) for diarrhea and amoxicillin for pneumonia. Yet only 42% of children with pneumonia receive antibiotics and 2% and 27% of children with diarrhea receive zinc and ORS, respectively.<sup>2</sup>



Only one third of the population obtains care from the official health system while most others are using traditional healers, prayer or self-medicating.<sup>3</sup> For both diarrhea and pneumonia, an estimated 40% of caregivers sought care for their children. Reasons for this are varied, but many people cannot afford care or transportation. Those that seek care at public health facilities often cannot access medicines due to stock-outs. Additionally, care-takers often misjudge the severity of cough or diarrhea, fail to appreciate the effectiveness of ORS for diarrhea and instead prefer antibiotics (e.g., injectable antibiotics) despite its ineffectiveness, or even blame cough and diarrhea on witchcraft.

By focusing on DRC's two leading causes of child mortality and scaling up access to appropriate treatment, there is an opportunity to rapidly accelerate the country's progress towards achieving the Millennium Development Goal (MDG 4) of reducing child deaths by two-thirds by 2015. If national treatment coverage targets were achieved, **there is potential to save 136,000 lives of children by 2015.**<sup>4</sup>

#### Proposed Approach for Large-Scale Implementation

Approximately 70% of the population of DRC lives in rural areas. Accessibility to health services and treatment is a challenge in these areas as only 35% of the population lives near a health facility.<sup>5</sup> To improve access to treatment beyond the facility level in these communities where the need is greatest, a large-scale program will be implemented to expand integrated Community Case Management (iCCM), a strategy to extend case management of basic childhood illnesses—including diarrhea and pneumonia—in line with the national strategy (see 'National Approach' below).

<sup>1</sup> UNICEF. Committing to Child Survival: A Promise Renewed. Progress Report 2013. September 2013.

<sup>2</sup> Democratic Republic of Congo, Ministry of planning: Multiple Indicator Cluster Survey (MICS)-2010; May 2011.

<sup>3</sup> Democratic Republic of Congo: Ministry of planning, National Institute of Statistics in Collaboration with UNICEF: Multiple Indicator Cluster Survey (MICS)-2010; May 2011.

<sup>4</sup> Estimate calculated using the Lives Saved Tool, Johns Hopkins Bloomberg School of Public Health, March 2013. Note: the Lives Saved Tool does not reflect recent APR estimates from September 2013.

<sup>5</sup> MCHIP, PSI, OMS, Save the Children pour République Démocratique du Congo Ministère de la Santé Publique. Prise en Charge Communautaire Intégrée des Maladies de l'Enfant: Documentation des Meilleures Pratiques et des Goulots d'Etranglement à la mise en œuvre du programme en RDC (2011).

The proposed program will be implemented in 1,500 remote sites in 45 health zones of the country through a phased rollout. In Year 1, this will include 35 health zones (Katanga, Kasai Occidental, and Sud Kivu provinces)<sup>6</sup> with the greatest incidence of disease but with the lowest treatment coverage rates. In Year 2, the program will focus on an additional 10 health zones (Equateur and Kinshasa provinces). These two phases will focus on increasing access to diarrhea and pneumonia treatment through community mobilization for improved care-seeking behavior, health promotion, referral of cases with danger signs, and appropriate recognition and case management of pneumonia and diarrhea by health providers in communities and at health facilities.

The program will aim to increase coverage of zinc and ORS for diarrhea to 70% and provision of amoxicillin for treatment of pneumonia to 70% in all 45 health zones. If these targets are achieved, the program will have potential to avert approximately 42,000 child deaths by 2015.

To achieve this target, the four program objectives include:

**Objective 1: Generating awareness and demand among caregivers:** Key opinion leaders ('relais promotionnels' or 'RPs' and relais institutional or 'RIs') such as pastors, school teachers, and opinion leaders will act as local community mobilizers to conduct behavior change communication activities for disseminating messages about awareness of and care-seeking behavior for diarrhea and pneumonia. These key influencers will help to create demand for services among caregivers. Mid and mass media will also be used to spread the message.

- Conduct trainings for RPs and RIs to educate them about diarrhea and pneumonia, and improve communication skills to tailor messages around local social and cultural beliefs underlying health behaviors
- Disseminate messages through local theater, radio, and mobile phone through text messages (SMS, mhealth); ongoing implementation of information, education, and communication (IEC) activities may potentially be supported by a small grants program for two local NGOs
- Organize special activities to disseminate messages to care-givers during Pneumonia Day (November), International Day of the African Child (June), and World Breastfeeding Week (August)

Potential implementing partners for this component include the Ministry of Health (MoH), Management Sciences for Health (MSH), C-Change, DRC-Competence, and WHO.

**Objective 2: Increasing provider awareness:** Two iCCM Community health Workers (CHWs) per site will provide iCCM services in their communities. The main activities for the iCCM CHW will include case management of simple illnesses, home visits, health promotion activities to prevent diarrhea and pneumonia, and community mobilization and reporting.

- Train iCCM CHW on appropriate prevention, diagnosis and treatment of pneumonia, diarrhea and malaria and how to obtain their first stock of essential commodities and all necessary supplies and devices for full iCCM implementation. Trainings will emphasize the importance of the pneumococcal vaccine for the prevention of pneumonia.
- Conduct regular supervision and, as necessary, re-training of topics and skills that need additional skill building for 'Relais de site de soins' (iCCM community health workers) at a central location
- 'Infirmiers titulaires' (nurses) from nearby facilities to conduct monthly supportive supervision visits. Local oversight and data analysis for sites located in catchment area to be provided by 'infirmiers titulaires' and a facility's 'équipe cadre de la zone de santé' (the health zone medical team)—which consists of a doctor, supervisory nurse, animateur communautaire, and rural development technician

Potential implementing partners for Objective 2 include the MoH and MSH.

**Objective 3: Ensuring availability of supply:** Ensuring the availability of key commodities for children at the community level is critical to the success of the program. In DRC, the pharmaceutical system is organized within the Système National d'Approvisionnement en Médicaments Essentiels (SNAME) and based on 'Centrales de Distribution Régionales

<sup>6</sup> MSH is already implementing the USAID-funded Integrated Health Project (IHP) in most health zones

des médicaments or 'CDRs' (regional medical stores) but of the 26 CDRs needed in the country there are currently only 15 CDRs. Furthermore, local drug manufacturers do not meet quality standards such as 'Good Manufacturing Practices' defined by WHO. As a result, these medicines are not widely available, especially in rural areas.

- Integrate all necessary commodities and devices into the current national system to help strengthen synergies with the MOH's pharmaceutical supply management expertise, the USAID-funded Systems for Improved Access to Pharmaceuticals and Services (SIAPS) project, and the CDRs
- Establish procedures for forecasting and strengthen the ordering system through the use of innovative technologies such as Commtrack through mobile phones, which is compatible with other electronic logistic management information systems (LMIS)
- Include medicines management in all continuing education and formative supervision of 'relais' (community health workers) as well as at the health facility level
- Establish quality improvement teams to monitor commodity availability at facility and community levels and set targets for improvement
- Promote rational use of medicines by providers and relais

Potential implementing partners include the MoH, MSH, WHO, UNICEF, Save the Children, and World Vision.

**Objective 4: Securing a conducive policy environment:** Less than 5% of the national budget is earmarked for health and the disbursement rate is approximately 70%. Furthermore, current budget allocations do not reflect health sector priorities<sup>7</sup>.

- Convene a meeting with all key stakeholders—national and provincial governments, Senate, and donors—to discuss the current situation of the health of Congolese children and advocate for increased funding to support scale-up of amoxicillin, zinc and ORS
- Support the revision and dissemination of the pneumonia guidelines and the adoption of dispersible amoxicillin in blister presentation for community level use. This will include registration support and revision of the Essential Medicines List

The monitoring and evaluation plan will include pre- and post-intervention measurement of project coverage and monthly reports of data and contextual factors. Data collection and compilation will take place in health facilities and health zones to inform decision making. Data will be transmitted to the provincial and national levels for surveillance and analysis. A quarterly control and verification system will allow corrective measures to take place in a timely manner. The project will use the following M&E strategies:

- Monthly supervision of RS by 'infirmiers titulaires'
- Monthly performance reviews of management by the sanitary district at the health zone and facility levels
- Monthly reporting of administration data
- Periodic surveys using Lot Quality Assessment Surveys (LQAS) to follow project implementation and validate administrative data
- Regular monitoring to identify and resolve bottlenecks, in collaboration with community leaders and health services, and develop a plan of action to put the project back on course

<sup>7</sup> République Démocratique du Congo, Ministère de la Santé Publique. Plan National de Développement Sanitaire, PNDS 2011-2015

## Budget

A total of approximately **US \$12.8 million** over the next three years is required to support implementation of the program (see below).

ESTIMATED IMPLEMENTATION COSTS, 2013-2015 (USD)				
Description	Year 1	Year 2	Year 3	Total
Objective 1. Generating awareness/demand among caregivers	\$ 530,229	\$ 681,004	\$ 304,933	\$ 1,516,166
Objective 2. Increasing provider awareness	\$ 1,250,550	\$ 1,387,800	\$ 627,300	\$ 3,265,650
Objective 3. Ensuring availability of product	\$ 1,042,824	\$ 905,336	\$ 383,014	\$ 2,331,174
Objective 4. Securing conducive policy environment	\$ 439,586	\$ 471,214	\$ 204,429	\$ 1,115,229
M&E Costs	\$ 261,055	\$ 275,628	\$ 121,574	\$ 658,258
Project management costs (personnel, travel, communication)	\$ 907,803	\$ 946,624	\$ 961,351	\$ 2,815,778
Sub-Total	<b>\$ 4,432,047</b>	<b>\$ 4,667,606</b>	<b>\$ 2,602,661</b>	<b>\$ 11,702,314</b>
General management costs	\$ 415,404	\$ 439,198	\$ 248,102	\$ 1,102,704
<b>Total costs</b>	<b>\$ 4,847,451</b>	<b>\$ 5,106,804</b>	<b>\$ 2,850,763</b>	<b>\$ 12,805,018</b>

MSH is well positioned to lead implementation of these efforts. MSH's work in child health in DRC began with the Basic Support for Institutionalizing Child Survival (BASICS) project more than a decade ago with a community-based model for treating and referring cases of pneumonia, diarrhea, malaria, and malnutrition. MSH is also implementing the USAID-funded Integrated Health Project (IHP), which increases the availability and use of high-impact services, products, and practices for a range of health issues including maternal, newborn, and child health, in most target health zones for the proposed program and will leverage these efforts to support implementation.

### The National Approach to Treatment Scale-up and Current Implementation Progress

DRC has made great strides in developing and implementing child-focused health strategies to accelerate progress toward achievement of MDG Goal 4. The *Scale-up Strategy for Essential Medicines for Child Survival: Diarrheal Disease, Malaria, and Pneumonia* was developed in 2012 as the guiding framework for implementation. The plan aims to increase treatment coverage of zinc, ORS, and amoxicillin to 30% by 2015 and outlines specific, concrete actions to be taken to improve access.

Key interventions of the plan to support scale-up include:

- Integrating the three national programs for child survival under the leadership of Directorate 5;
- Identifying or establishing "model" health zones in the public sector;
- Establishing an accreditation program to regulate the private sector and improving quality of care provided;
- Extending Community Health Care Site coverage under the authority of the HCs;
- Promoting the drug distribution system and local manufacturer of EMI drugs;
- De-medicalizing ORS/zinc and ensuring its universal coverage
- Launching a comprehensive behavior change communication campaign

The National Strategy is in line with recommendations of the UN Commission on Life-Saving Commodities for Women and Children, the Global Action Plan for Prevention and Control of Pneumonia and Diarrhea (GAPPD), A Promise Renewed, and the United Nations Secretary-General's Every Women Every Child movement.

As further examples of the Government of DRC's commitment to this high-impact opportunity of treatment scale-up, the country recently launched the *A Promise Renewed Acceleration Framework* in May 2013, which aims to reduce child mortality by 48% by 2015. The country has also submitted an implementation plan to follow the recommendations of the UN Commission on Life-Saving Commodities, which prioritizes amoxicillin, ORS and zinc for improved access and use.

The Ministry of Health has also classified the country's 516 health zones into three key categories—'priority', 'development' and 'demonstration' health zones—to identify and target regions requiring additional attention and

support.<sup>8</sup> It should be noted that implementation of 'l'Appel à l'action' (Call to Action) is particularly focused on the approach of the 'Kits familiaux' (family kits), by targeting health zones in development.

Current activities to reduce child mortality are coordinated by the MNCH Task Force, under the leadership of the 'Direction de la Famille' (Family Health Division) and other groups within the Ministry of Health. Diarrhea and pneumonia efforts in particular fall under the auspices of Integrated Management of Child Illness (PCIME).

Key partners working on diarrhea and pneumonia treatment scale-up in the country include: MSH, IRC, PSI, UNICEF, USAID, and WHO, among others.

### Contact

For more information on how you can contribute to the effort in DRC, please contact:

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<sup>8</sup> Cadre pour accélérer la réduction de la mortalité maternelle, néonatale et infantile; l'appel à l'action



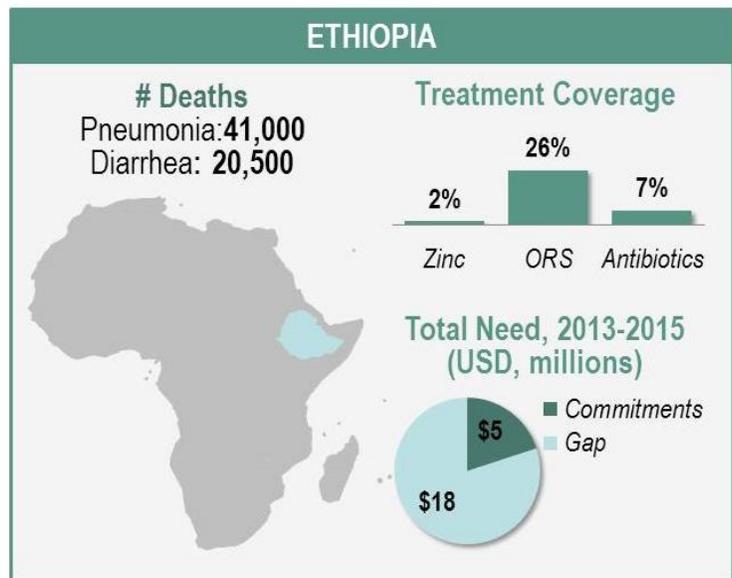
## Ethiopia: Reducing Childhood Deaths from Diarrhea & Pneumonia

### Proposal for a large-scale integrated approach to scale-up

#### MDG 4 in Ethiopia and Opportunity for Impact

Since 1990, Ethiopia has seen a remarkable reduction in under five deaths and is one of few countries that has achieved the Millennium Development Goal 4 (MDG 4) of reducing child deaths by two thirds.<sup>1</sup> However, pneumonia and diarrhea remain leading causes of death and are responsible for **more than 61,000 deaths each year**.

These deaths are largely preventable with access to simple, highly-effective, and affordable treatment, specifically oral rehydration solution (ORS) and zinc for diarrhea and amoxicillin for pneumonia. Yet, coverage of these treatments is unacceptably low—only 2% and 26% of children receive zinc and ORS, respectively,<sup>2</sup> and only 7% of children with pneumonia receive amoxicillin.<sup>3</sup>



In general, delayed treatment-seeking behavior and low utilization of health services are key bottlenecks to treating children under five through integrated delivery approaches, including integrated community case management (iCCM) and integrated management of neonatal and childhood illness (IMNCI). Only 27% of children with symptoms of acute respiratory infection and 32% of children with diarrhea were taken to a health care facility or trained health provider. While increased access to iCCM services at the community level has allowed more children to receive timely treatment, current utilization of these services in Ethiopia remains low, especially for children under two months. One study observed that a single health post had an average of 16 sick-child consultations per month, of which nearly all were children between the ages of two and 59 months; virtually no children under two months were seen.<sup>4</sup>

Improving access to treatment for diarrhea and pneumonia, as well as the management of community-based newborn sepsis, can help dramatically reduce under five deaths in Ethiopia. If national scale-up targets for zinc, ORS, and amoxicillin are achieved (see 'National Approach' below), **over 70,000 lives could be saved by 2015**.

#### Proposed Approach

To help catalyze the scale-up of pneumonia and diarrhea treatment in the country, a large-scale program is proposed to improve accessibility and availability of quality treatment and care, as well as enhance utilization of treatment services. The program will target children with diarrhea and pneumonia and newborns with sepsis living in four regions where the highest concentration of deaths occurs—Amhara, Oromia, SNNPR and Tigray—specifically in 450 woredas (districts). This will enable the country to cover nearly all woredas in these regions, building on existing efforts implemented by UNICEF in 200 districts. Overall, increasing the proportion of children receiving proper treatment for diarrhea (zinc from 0.2% to 75% and ORS from 26% to 89%), amoxicillin for pneumonia (from 7% to 40%), and antibiotics for neonatal sepsis cases (from 4% to 74%)<sup>5,6</sup> will avert more than 70,000 child deaths over the next three years.

<sup>1</sup> UNICEF: Committing to Child Survival: A Promised Renewed, Progress Report. September 2013.

<sup>2</sup> Call to Action: Preliminary Ethiopian Discussion. Addis Ababa Ethiopia. LiST, May 2012.

<sup>3</sup> All the statistics mentioned here is for 2010, before the implementation of iCCM, after 3 years of implementation, improvement is expected in the coverage of ORS, Zinc and antibiotics

<sup>4</sup> Miller NP, Amouzou A, Bryce J, Victora C, Hazel E, Black RE. Assessment of iCCM implementation strength and quality of care in Oromia, Ethiopia. Baltimore, USA and Addis Ababa, Ethiopia: Institute for International Programs, Johns Hopkins Bloomberg School of Public Health; 2013.

<sup>5</sup> Call to Action: Preliminary Ethiopian Discussion. Addis Ababa Ethiopia. LiST, May 2012.

To achieve this goal, the program will include four key objectives and activities:

**Objective 1: Generate awareness and demand among caregivers:** Innovative demand creation activities are imperative for improving and optimizing care seeking behaviors and thereby increasing utilization of iCCM and IMNCI treatment services for pneumonia and diarrhea. Equally important is sustaining long-term preventive behaviors to improve the health of Ethiopian children.

- Conduct regular mentoring, training, and refresher/review meetings for the community health extension workers (HEWs) and the Health Development Army (HDA) volunteers to increase their impact at the household level. Meeting topics will include: awareness of childhood danger signs, promotion of early health seeking behavior, appropriate treatment for diarrhea and pneumonia and adherence to proper treatment regimens, caring for the sick child, essential newborn care, and other protective and preventive key health interventions, including breastfeeding, immunization, use of insecticide treated bed nets, hand washing, and use of latrines
- Update and adopt the Family Health Guide (FHG) and develop radio spots and local video with messages around the appropriate pneumonia and diarrhea prevention and treatment to encourage behavior change communication (BCC) for households, HDAs, HEWs and primary health care unit staff
- Conduct refresher training, using the updated FHG, for the new and existing HEWs, as well as other Primary Health Care Unit (PHCU) staff. Enhance negotiation and communication skills to enable support the HDAs

**Objective 2: Improve provider skills:** Trained health professionals and HEWs need support to maintain and enhance their skills in assessing and managing childhood illness, including appropriate diagnosis and treatment of pneumonia, diarrhea, and newborn sepsis. A provider with a strong skill set is instrumental to ensuring that children receive proper quality care.<sup>7</sup> Health posts that received regular supervision on iCCM had a higher average number of satisfactory consultations<sup>8</sup>. Similarly, caseloads and consultations also increased after HEWs participated in performance review and clinical mentoring meetings.

- Conduct cascade training (a training of trainers or ToT structure) to reach health workers in public health centers and hospitals, as well as private clinics, with appropriate tools to utilize IMNCI case management of children with pneumonia, diarrhea, and newborn sepsis
- Woreda health office staff to conduct performance and clinical review meetings for health workers in both public and private sectors on case management of pneumonia and diarrhea
- Conduct cascade trainings led by the woreda health offices and PHCU staff to reach HEWs in the health posts with clear iCCM tools and understanding
- Convene regular performance and clinical review meetings for HEWs
- Adapt and produce training materials, performance review and clinical mentoring guides, visit checklists for health provider follow-up visits, and supportive supervision and mentoring guidelines based on new revisions for the assessment and treatment of pneumonia
- Conduct training for zonal health departments, woreda health offices, hospital and PHCU staff for start-up and regular follow-up, supportive supervision and mentoring visits to health posts, health centres, hospitals and private clinics

**Objective 3: Ensure availability of high-quality, affordable zinc, ORS, and amoxicillin.** It is critical that medicines for iCCM and IMNCI meet the particular needs of young children and their families. Proper treatment is strongly correlated with the availability of iCCM commodities, supplies, and job aids for health care workers<sup>9</sup>. Stock-outs of essential drugs

<sup>6</sup> Coverage targets for zinc, ORS, and amoxicillin from the Health sector development programme IV, 2010/11 – 2014/15. Federal Ministry of Health Ethiopia, October 2010

<sup>7</sup> Federal Ministry of Health: National Strategy for Child Survival in Ethiopia. July 2005. Addis Ababa, Ethiopia

<sup>8</sup> Miller NP, Amouzou A, Bryce J, Victora C, Hazel E, Black RE. Assessment of iCCM implementation strength and quality of care in Oromia, Ethiopia. Baltimore, USA and Addis Ababa, Ethiopia: Institute for International Programs, Johns Hopkins Bloomberg School of Public Health; 2013

<sup>9</sup> Miller NP, Amouzou A, Bryce J, Victora C, Hazel E, Black RE. Assessment of iCCM implementation strength and quality of care in Oromia, Ethiopia. Baltimore, USA and Addis Ababa, Ethiopia: Institute for International Programs, Johns Hopkins Bloomberg School of Public Health; 2013.

were found to be the primary bottleneck for iCCM implementation; a push system is still practiced in Ethiopia<sup>10</sup>. Coordinated efforts to consolidate systems and support supply chain management are also needed.

- Procure and distribute essential child health supplies and drugs, including ORS, zinc, and amoxicillin through the Pharmaceutical Fund and Supply Agency (PFSA)
- Orient and train PHCU staff and HEWs to improve the logistic management information system (LMIS) to initiate a pull system. Institute a system of bin cards at the health post level to ensure adequate and reliable supply
- Pursue co-packaging of zinc and ORS and initiate local production
- Collaborate with local pharmaceutical companies to increase local manufacturing, marketing, and distribution of quality and affordable child health essential medicines

**Objective 4: Create an environment for child health impact.** An enabling environment produces sound policy, promotes efficient and effective use of resources, and nurtures community participation in community case management (CCM)<sup>11</sup>. Existing policies may need to be modified or new policies may need to be implemented to improve the health care environment in Ethiopia. For example, a policy to identify amoxicillin as first line treatment and allow HEWs to administer amoxicillin at the community level could greatly improve proper pneumonia treatment.

- Pursue upstream level policy changes such as amoxicillin as first-line treatment for pneumonia and over the counter (OTC) status for zinc
- Test and document innovative preventive and diagnostic approaches for pneumonia and diarrhea
- Introduce innovative public-private partnerships for the prevention and treatment of pneumonia and diarrhea
- Support Federal Ministry of Health and Regional Health Bureaus on pneumonia and diarrhea routine health management information (HMIS) data to calculate and collect relevant iCCM and IMNCH impact indicators

Monitoring and evaluation will be critical to the success of this program. Baseline and end-line surveys, ongoing monitoring, and operational research will also be conducted to help identify and resolve implementation challenges and maximize impact.

## Budget

A total of **US \$13.5 million** is needed over the next three years to support implementation of the large-scale program in Ethiopia (see below).

ESTIMATED IMPLEMENTATION COSTS, 2013-2015 (USD)				
Description	Year 1	Year 2	Year 3	Total
Objective 1. Generating awareness/demand among caregivers	\$ 500,000	\$ 500,000	\$ 500,000	\$ 1,500,000
Objective 2. Improving provider skills	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000	\$ 6,000,000
Objective 3. Ensuring availability of product	\$ 1,500,000	\$ 1,500,000	\$ 1,500,000	\$ 4,500,000
Objective 4. Securing conducive policy environment	\$ 166,667	\$ 166,667	\$ 166,667	\$ 500,000
Project management costs (personnel, travel, communication)	\$ 166,667	\$ 166,667	\$ 166,667	\$ 500,000
<b>Sub-total</b>	\$ 4,333,334	\$ 4,333,334	\$ 4,333,334	\$ 13,000,000
<b>General management costs</b>	\$ 166,667	\$ 166,667	\$ 166,667	\$ 500,000
<b>TOTAL</b>	\$ 4,500,001	\$ 4,500,001	\$ 4,500,001	\$ 13,500,000

Objectives 1 and 2 will be implemented by selected partner organizations based on expertise and past experience in the focal regions and zones (see below for a list of potential partners). PATH is well positioned to lead implementation of activities under Objectives 3 and 4 in collaboration with the Federal Ministry of Health (FMoH), Regional Health Bureaus, UNICEF, PFSA and the Food Medicine Health Care Administration and Control Authority (FMHACA).

<sup>10</sup> According to follow-up visit, supportive supervision and performance review meeting aggregated data

<sup>11</sup> CORE Group, Save the Children, BASICS, MCHIP. Community Case Management Essentials: Treating Common Childhood Illnesses in the Community. A Guide for Program Managers. Washington, D.C.: CORE Group, Save the Children, BASICS and MCHIP; 2010.

### National Approach to Scaling Up Treatment for Diarrhea and Pneumonia

Improving child health is a key priority of the *Health Sector Development Plan (HSDP) IV*, the main overarching country plan under which child survival, including pneumonia and diarrhea treatment, fits. The plan aims to reduce the under-five mortality rate to 68 deaths per 1,000 live births<sup>12</sup> and also outlines several activities to achieve this goal, including the expansion of community services and facility-based IMNCI, strengthening the Health Extension Program (HEP), and implementing locally relevant and effective child health interventions<sup>13</sup>. The *HSDP IV* also enhances public private partnerships through collaboration with the private sector on the expansion of health infrastructure, local production of pharmaceuticals, provision of health services, training of health professionals, and mobilization of resources for the health sector. The *HSDP IV* specifies treatment coverage targets to be achieved by December 2015, with 89% and 75% of children with diarrhea receiving ORS and zinc, respectively; 40% of children with pneumonia receiving proper antibiotics; and 74% of neonatal sepsis cases treated with proper antibiotics.

PATH is working closely with the Government of Ethiopia and development partners to support these components of the *HSDP IV* and to facilitate increased access to treatment for diarrhea and pneumonia. Under the *HSDP IV*, The Child Health Team (part of the Maternal & Child Health Directorate, Federal Ministry of Health) serves as the main coordination body for supporting implementation of all child survival activities including diarrhea and pneumonia. Key implementing partners include: AMREF, Ethiopian Pediatric Association, IRC, JSI (L10K and SC4CCM), IFHP, Merlin, MSH, PMI, Save the Children, UNICEF, USAID, WHO, and others.<sup>14</sup>

The *HSDP IV* is in line with recommendations of the UN Commission on Life-Saving Commodities for Women and Children (UNCoLSC), the Global Action Plan for Prevention and Control of Pneumonia and Diarrhea (GAPPD), A Promise Renewed, and the United Nations Secretary-General's Every Women Every Child movement. As a further example of the Government of Ethiopia's commitment to this high-impact opportunity, Ethiopia's UNCoLSC country implementation plan specifically identifies zinc, ORS, and amoxicillin as priority commodities. In addition, under the stewardship of the Government of Ethiopia, more than 20 sub-Saharan African leaders took the unprecedented step of reaffirming their collective commitment to reduce under-five mortality rates to fewer than 20 deaths per 1,000 live births by 2035 by developing and implementing country-led roadmaps that integrate on-going efforts to accelerate reduction in child mortality<sup>15</sup>.

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<sup>12</sup> Health sector development programme IV, 2010/11 – 2014/15. Federal Ministry of Health Ethiopia, October 2010

<sup>13</sup> Health sector development programme IV, 2010/11 – 2014/15. Federal Ministry of Health Ethiopia, October 2010

<sup>14</sup> Key partners involved in iCCM and IMCI scale-up include AMREF, IFHP, IRC, JSI/L10K, Merlin, and Save the Children (funded by PMI, UNICEF, and USAID).

<sup>15</sup> UNICE: Committing to Child Survival: A Promised renewed, Progress Report. September 2013.

## India: Reducing Childhood Deaths from Diarrhea & Pneumonia

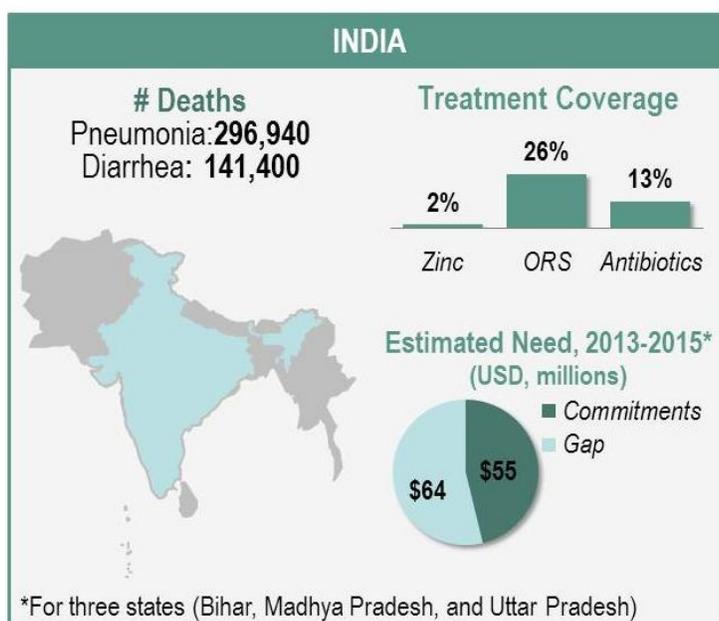
### Expanding rollout of treatment scale-up in Uttar Pradesh

#### MDG 4 in India and Opportunity for Impact

India has seen a 55% reduction in child mortality since 1990<sup>1</sup>, but **nearly 440,000 children in the country still die from diarrhea and pneumonia each year.**

The majority of these deaths can be averted through simple, effective, and affordable treatment—zinc and oral rehydration salts (ORS) for diarrhea and antibiotics for pneumonia. However, less than 2% of children are receiving the full recommended treatment for diarrhea and only 13% of children are receiving appropriate antibiotics.

By focusing on these leading causes of death and increasing access to treatment, **there is potential to save the lives of more than 545,000 children by 2015.**<sup>2</sup>



#### What You Can Do

Approximately 30% of all deaths from diarrhea and pneumonia in the country occur in one state—Uttar Pradesh. Despite the considerable need in Uttar Pradesh, current funding is only sufficient to cover treatment scale-up activities for diarrhea in a fraction of the total 75 districts in the state—31 districts are fully covered, but the **remaining 44 districts are only partially covered or not covered at all** (see map on next page).

As such, additional funding is needed to expand the reach of these activities—in the state of Uttar Pradesh and in other high burden states—in order to achieve full impact of the program. In an average district of Uttar Pradesh, approximately **US \$78,000 per district per year** is required to cover the costs of scale-up including generating provider demand (among both public and private providers) and conducting community-level activation to reach community leaders and mothers (see below).

ESTIMATED IMPLEMENTATION COSTS FOR UTTAR PRADESH, 2013-2015 (USD)			
Description	Cost per district (for 3 years)	# districts with gap*	Total Need
Training for public sector providers (e.g., ASHAs)	\$ 48,000	44	\$ 2,112,000
Detailing of private providers (e.g., RMPs)	\$ 66,000	44	\$ 2,904,000
Caregiver activation (women's meetings, school activation and engagement of self help groups)	\$ 45,000	44	\$ 1,980,000
Public and private provider collateral/POS materials	\$ 30,000	44	\$ 1,320,000
Training costs and logistics	\$ 15,000	44	\$ 660,000
Overall management	\$ 30,000	44	\$ 1,320,000
<b>TOTAL</b>	<b>\$ 234,000</b>		<b>\$ 10,296,000</b>

\*Actual gap may be smaller pending complete partner mapping

<sup>1</sup> UNICEF. Committing to Child Survival: A Promise Renewed. Progress Report. September 2013

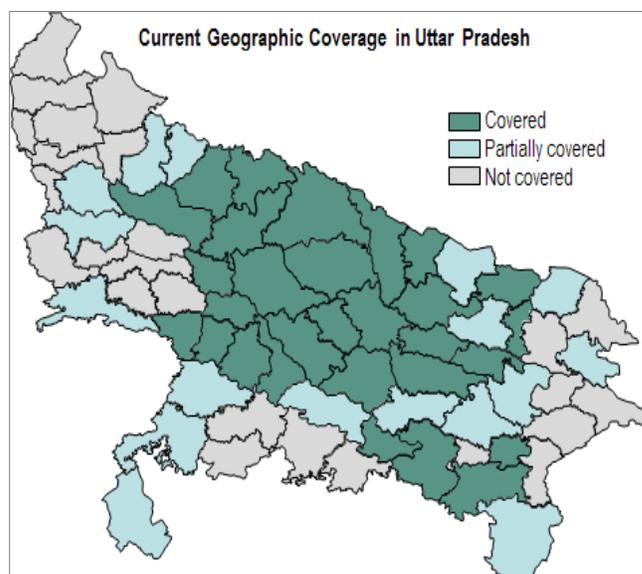
<sup>2</sup> Estimate calculated using the Lives Saved Tool, Johns Hopkins Bloomberg School of Public Health, March 2013. Note: the Lives Saved Tool does not reflect recent APR estimates from September 2013.

Current partners working in diarrhea treatment scale-up in Uttar Pradesh include: Abt Associates, CHAI, FHI360, Hindustan Latex Family Planning Promotion Trust (HLFPPT), Micronutrient Initiative, PATH, PSI, UNICEF, USAID, and World Health Partners (WHP).

### National Approach to Scaling Up Treatment for Diarrhea and Pneumonia

In early 2013, the Government of India launched the *Strategic Approach to Reproductive Maternal Newborn Child and Adolescent (RMNCH+A)*, which identifies zinc and ORS for the treatment of diarrhea and recommended antibiotics for pneumonia as key interventions for reducing child mortality. The Ministry of Health has also developed *Operational Guidelines for the Control of Childhood Diarrhoea through Scaling up Zinc and ORS* to guide state and district level implementation of treatment scale-up efforts.

CHAI and partners are working closely with the Government of India and key stakeholders to drive large-scale increases in the coverage of zinc, ORS and recommended antibiotics in high burden states of northern India. The Diarrhea Taskforce has also been established to help coordinate activities across various development partners.



Key activities include the following:

- Launch large-scale marketing campaign to generate demand for recommended treatments;
- Create supportive environment for zinc scale-up, including OTC status;
- Partner with pharmaceutical manufacturers to expand the distribution of ORS and zinc to rural markets;
- Improve practices of Rural Medical Practitioners (RMPs) through consistent communication; and
- Improve treatment skills and supplies of Accredited Social Health Activists (ASHAs)

The overall approach is in line with the UN Commission on Life-Saving Commodities for Women and Children, the Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea (GAPPD), A Promise Renewed, and the United Nations Secretary-General's Every Woman Every Child movement.

### Contact Us

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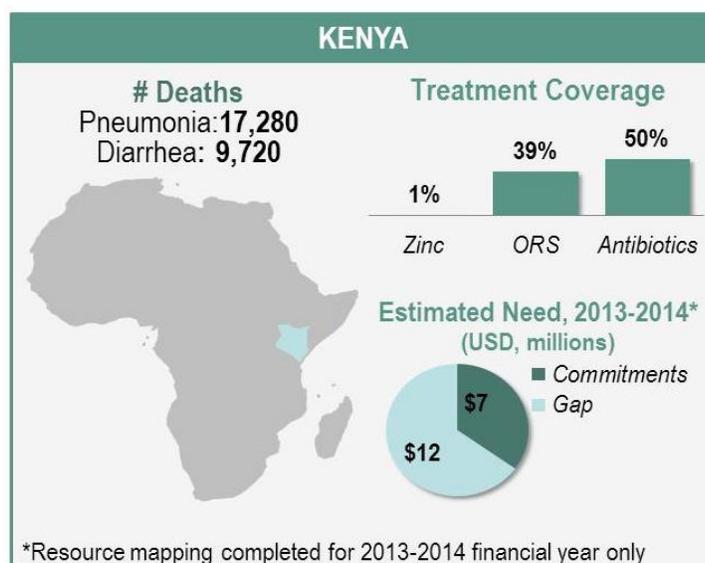
## Kenya: Reducing Childhood Deaths from Diarrhea & Pneumonia

### Scaling up access to treatment

#### MDG 4 in Kenya and Opportunity for Impact

Since 1990, child mortality in Kenya has declined by only 26%. This means the country will need to more than double its current rate of decline in deaths to achieve the Millennium Development Goal 4 of reducing child deaths by two-thirds by 2015.<sup>1</sup>

The introduction of new vaccines will help to reduce these deaths, but **nearly 30,000 children<sup>2</sup> still die from diarrhea and pneumonia each year** due to poor access to simple, effective and affordable treatment—oral rehydration solution (ORS) and zinc for diarrhea and recommended antibiotics for pneumonia. Only 1% and 39% of children, are receiving zinc and ORS, respectively, and 50% of children with pneumonia are receiving antibiotics.



If national targets for scaling up diarrhea and pneumonia treatment are achieved in Kenya, **an estimated 21,000 lives of children can potentially be saved by 2015.**<sup>3</sup>

#### What You Can Do

In Kenya, current funding is only sufficient to cover a partial set of interventions outlined in the national strategy for scaling up child essential medicines (see 'National Approach' below). As such, additional support is needed to achieve full impact of the program. In the 2013-2014 financial year an estimated **US \$14.2 million** is required to cover costs for case management, supply chain improvements, advocacy and communication, monitoring and evaluation and improved supply availability in the private sector. It should be noted that a portion (US \$2 million) of the total estimated need may potentially be filled through reallocation of existing commitments.

ESTIMATED IMPLEMENTATION COSTS, 2013/2014 FINANCIAL YEAR (USD)	
Description	Cost
<b>Objective 1: Case management</b>	<b>\$ 1,991,422</b>
Develop an operational research strategy	\$ 33,333
Improve skills of healthcare workers	\$ 1,958,089
<b>Objective 2: Commodities, equipment, logistics</b>	<b>\$ 3,333,241</b>
Strengthen quantification, forecasting, and procurement for child health commodities	\$ 3,002,278
Set up and operationalize an efficient commodity management system	\$ 238,796
Strengthen support systems	\$ 92,167
<b>Objective 3: Advocacy, communication, social mobilization</b>	<b>\$ 3,214,611</b>
Advocacy	\$ 172,356
Communication	\$ 3,042,256
<b>Objective 4: Monitoring &amp; evaluation</b>	<b>\$ 4,642,445</b>
Update and provide more data collection tools	\$ 4,636,889
Develop M&E framework	\$ 5,556
<b>Objective 5: Access through private sector channels</b>	<b>\$ 1,061,111</b>
Co-packaging of zinc/ORS, free sample distribution, communication materials	\$ 1,061,111
<b>TOTAL</b>	<b>\$ 14,242,829</b>

<sup>1</sup> UNICEF. Committing to Child Survival: A Promise Renewed. Progress Report. September 2013

<sup>2</sup> World Health Status Report, 2011

<sup>3</sup> Estimate calculated using the Lives Saved Tools, Johns Hopkins Bloomberg School of Public Health, March 2013. Note: the Lives Saved Tool does not reflect recent APR estimates from September 2013.

Current partners working in diarrhea and pneumonia treatment scale-up in Kenya include: the Government of Kenya, APHIA Plus, CHAI, Maternal and Child Health Integrated Program (MCHIP), Micronutrient Initiative, PSI, PATH, Strengthening Health Outcomes through the Private Sector (SHOPS), UNICEF, and WHO, among others.

### National Approach to Scaling Up Treatment for Diarrhea and Pneumonia

The Clinton Health Access Initiative (CHAI) is working in partnership with the Government of Kenya and other development partners to implement the *Scale Up Strategy for Essential Treatments in Children Under Five Years in Kenya*, which was endorsed by the Ministry of Public Health and Sanitation in 2012. The national strategy aims to ensure that 80% of children with diarrhea or pneumonia are receiving recommended treatment by 2015 and outlines concrete areas for action.

Key objectives include:

- **Case Management.** Expand access to Integrated Case Management of childhood illnesses in all levels of health care service delivery across public and private sectors
- **Commodities, Logistics and Equipment.** Increase availability and efficient use of essential commodities used in management of childhood illnesses
- **Advocacy, Communication and Social Mobilization.** Increase public awareness and generate demand for diarrhea and pneumonia management in children through advocacy, communication and social mobilization
- **Monitoring and Evaluation.** Strengthen the monitoring and evaluation of pneumonia and diarrhea disease management
- **Private Sector.** Strengthen access to appropriate diarrhea and pneumonia treatment through private sector channels

The Strategy directly supports recommendations of the UN Commission on Life-Saving Commodities for Women and Children, the Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea (GAPPD), A Promise Renewed, and the United Nations Secretary-General's Every Woman Every Child movement.

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## Niger: Reducing Childhood Deaths from Diarrhea & Pneumonia

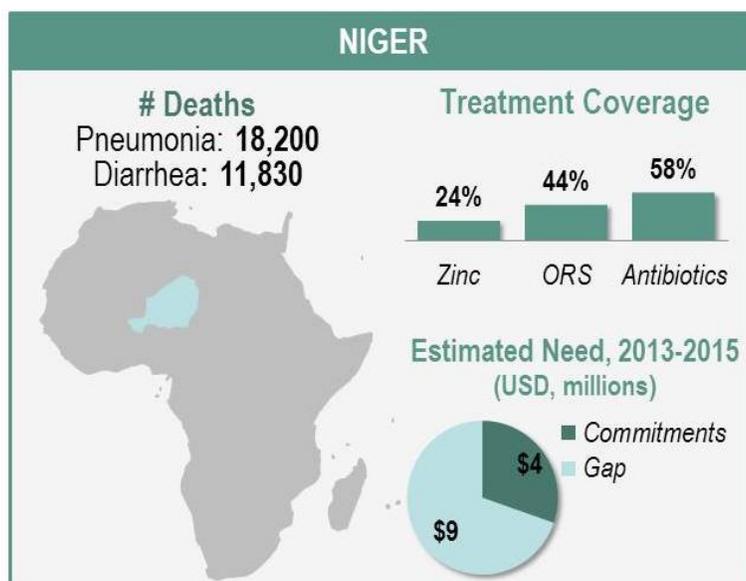
Scaling up treatment in 10 priority districts

### MDG 4 in Niger and Opportunity for Impact

In Niger, deaths among children under five has decreased by a striking 65% since 1990; yet, the current mortality rate of 114 per 1,000 births remains one of the highest in the world.<sup>1</sup>

Together, **pneumonia and diarrhea account for over 30,000 deaths each year** despite the availability of simple, cost-effective treatment—namely amoxicillin for pneumonia and zinc and oral rehydration solution (ORS) for diarrhea. Only 24% and 44% children with diarrhea receive zinc and ORS, respectively, while 58% receive appropriate antibiotics.<sup>2</sup>

If national targets are achieved, **there is potential to save over 27,000 children by 2015.**<sup>3</sup>



### What You Can Do

Progress has been made to secure funds for initial treatment scale-up efforts in the country, but more is needed to expand the reach of implementation (see 'National Approach'). Of **10 priority districts, current funding is sufficient to roll out selected activities in four districts while six districts are not covered at all** (see map on next page).<sup>4</sup>

In the four pilot districts, an additional average cost of **US \$237,667 per district per year** is required to cover gap filling activities (see Table 1). To allow the program to reach national scale, the key package of interventions (at **US \$267,222 per district per year**) will need to be rolled out in the remaining six priority districts (see Table 2). Overall, a total of **US \$9.2 million** is required to support full implementation in the 10 priority districts in Niger over the next three years.

Table 1. ESTIMATED COSTS FOR GAP-FILLING ACTIVITIES  
4 PILOT DISTRICTS, 2013-2015 (USD)

Description	Cost per district (3 years)	# districts with gap	Total
Innovation of mobile phone	\$ 125,000	4	\$ 500,000
Procurement of malaria RDTs	\$ 175,500	4	\$ 702,000
Child survival weeks	\$ 337,500	4	\$1,350,000
Monitoring of provider performance	\$ 75,000	4	\$ 300,000
<b>TOTAL</b>	<b>\$ 713,000</b>		<b>\$2,852,000</b>

Table 2. ESTIMATED COSTS FOR FULL IMPLEMENTATION  
6 DISTRICTS, 2013-2015 (USD)

Description	Cost per district (3 years)	# districts with gap	Total
Demand creation	\$ 366,667	6	\$ 2,200,000
Procurement and supply	\$ 275,000	6	\$ 1,650,000
Public-private partnerships	\$ 50,000	6	\$ 300,000
Service delivery	\$ 110,000	6	\$ 660,000
Country level project support & 7% recovery	\$ 499,780	10	\$ 1,499,340
<b>TOTAL</b>	<b>\$ 801,667</b>		<b>\$ 6,309,340</b>

<sup>1</sup> Committing to Child Survival: A Promise Renewed. Progress Report 2013

<sup>2</sup> Niger Demographic Health Survey, 2012

<sup>3</sup> Estimate calculated using the Lives Saved Tools, Johns Hopkins Bloomberg School of Public Health, March 2013. Note: the Lives Saved Tool does not reflect recent APR estimates from September 2013.

<sup>4</sup> Four pilot districts include: Madarounfa, Mayahi, Matameye and Mirriah. Six districts with no coverage include: Arlit, Bilma, Tchizerine, Dakoro, Guidam Roudji and Tanout

Current partners working in diarrhea and pneumonia treatment scale-up in Niger include PSI, UNICEF, and WHO among others.

### National Approach to Scaling Up Treatment for Diarrhea and Pneumonia

UNICEF is working closely with the Ministry of Health (MoH) and other key development partners in Niger to implement the *Essential Medicines Global Initiative Country Strategy*, which was developed and endorsed by the MoH in early 2012.

The plan, in concordance with the national health plan for child survival, aims to increase coverage of antibiotics, zinc and ORS to 90% by 2015 in the priority districts and outlines concrete actions for implementation.

Key interventions for addressing barriers to scale-up include:

- Improving the management of fever cases through differential diagnosis of malaria and pneumonia;
- Strengthening communication, follow-up and supply management through mobile phones;
- Creating demand and improve care-seeking through increase public awareness;
- Increasing availability of essential medicines through improved procurement and supply;
- Strengthening public-private partnerships;
- Expanding access to effective integrated case management at community and front-line health facility; and
- Monitoring and evaluation through qualitative and quantitative mid and year-end surveys.

The National Scale-up Plan is in line with the UN Commission on Life-Saving Commodities for Women and Children (UNCoLSC), the Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea (GAPPD), A Promise Renewed, and the United Nations Secretary-General's Every Woman Every Child movement.

### Contact Us

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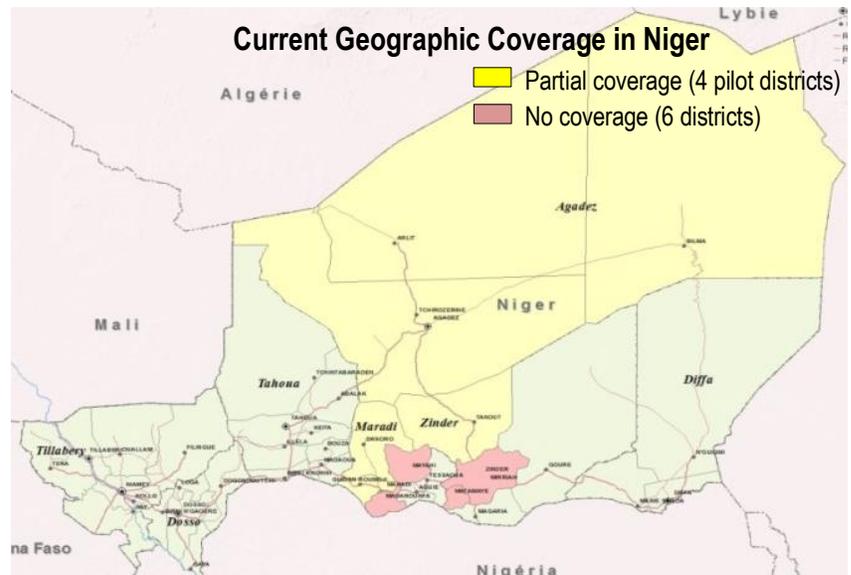
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## Nigeria: Reducing Childhood Deaths from Diarrhea & Pneumonia

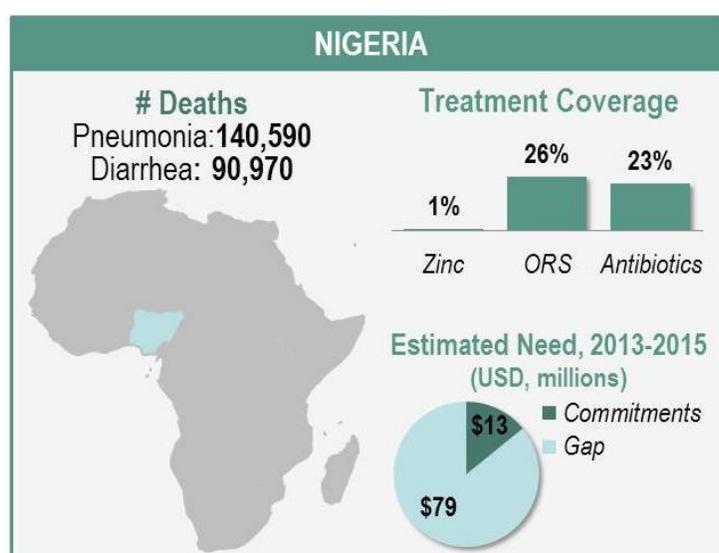
### Expanding rollout of treatment scale-up

#### MDG 4 in Nigeria and Opportunity for Impact

In the past two decades, child mortality in Nigeria has dropped by 42%.<sup>1</sup> Despite this progress, diarrhea and pneumonia still account for **over 230,000 child deaths each year**.

Simple, cost-effective treatments exist—zinc and oral rehydration solution (ORS) for diarrhea and amoxicillin for pneumonia—but coverage is currently low. Less than 1% of children in need are receiving both zinc and ORS and 23% are receiving antibiotics for pneumonia.

By rapidly scaling up access to zinc, ORS, and amoxicillin **there is potential to save 267,000 lives in the country by end of 2015**.<sup>2</sup>



#### What You Can Do

In Nigeria, initial progress has been made to fund treatment scale-up efforts but there are significant implementation gaps in high-burden states—while three states are fully covered, the remaining **34 states in the country are only partially covered or not covered at all** (see next page).

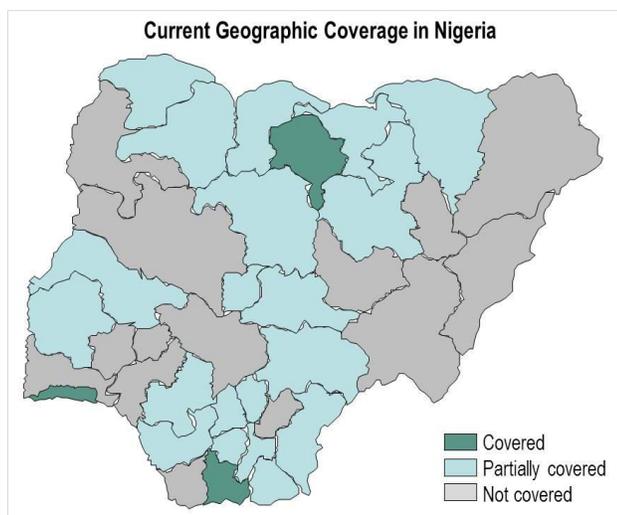
Additional funding is needed to expand the roll out of a comprehensive package of scale-up interventions. This includes three main interventions: rapidly influencing health providers to recommend appropriate treatment; increasing availability and affordability of high-quality supply; and generating demand among caregivers.

The average cost for implementation is **US \$900,000 per state per year** (see below). Resources are needed to support the full set of activities in certain states or one or more key intervention areas in a broader geographic scope. For example, **USD \$5 million** could support: 1) full implementation in two states or 2) activities targeting key influencers of health behavior in the community to drive demand and use of appropriate treatments in four states.

ESTIMATED IMPLEMENTATION COSTS, 2013-2015 (USD)			
Description	Cost per state (for 3 years)	# states with gap	Total Need
<b>Rapidly Influence Health Providers</b>	<b>\$ 348,334</b>		<b>\$ 8,518,341</b>
Clinical advisory outreach strategies to disseminate recommendations to lower-level health workers	\$ 126,667	34	\$ 4,306,668
Childhood illness management for PPMVs and community pharmacists	\$ 221,667	19	\$ 4,211,673
<b>Increase Availability and Affordability</b>	<b>\$ 950,000</b>		<b>\$ 27,075,000</b>
Public and private sector procurement and distribution	\$ 475,000	26	\$ 12,350,000
Expanding private sector sales and distribution systems	\$ 475,000	31	\$ 14,725,000
<b>Key Influencer Demand Generation</b>	<b>\$ 1,266,667</b>		<b>\$ 43,066,667</b>
Outreach through MNCH Weeks, Antenatal Clinics, and Immunization clinics	\$ 506,667	34	\$ 17,226,667
Reinforcing provider recommendations through CBOs and FBOs	\$ 760,000	34	\$ 25,840,000
<b>TOTAL</b>	<b>\$ 2,565,001</b>		<b>\$ 78,660,008</b>

<sup>1</sup> UNICEF. Committing to Child Survival: A Promise Renewed. Progress Report 2013. September 2013.

<sup>2</sup> Estimate calculated using the Lives Saved Tool, Johns Hopkins Bloomberg School of Public Health, March 2013. Note: the Lives Saved Tool does not reflect recent APR estimates from September 2013.



The *National Essential Medicines Coordinating Mechanism* can assist Development Partners in the selection of focus states and implementation to coordinate activities with existing, complementary partners. Current partners working on diarrhea and pneumonia treatment scale-up include: CHAI, Micronutrient Initiative, National Agency for Food and Drug Administration and Control (NAFDAC), Partnership for Transforming Health Systems Phase II (PATHS2), Pharmaceutical Manufacturers Group of the Manufacturers Association of Nigeria (PMGMAN), Society for Family Health (SFH), Strengthening Health Outcomes through the Private Sector (SHOPS), Subsidy Reinvestment & Empowerment Programme (SURE-P), USAID, Wellbeing Foundation Africa, WHO, United Nations Health 4+ (UNH4), and the National Malaria Control Program (NMCP).

### National Approach to Scaling Up Treatment for Diarrhea and Pneumonia

The Government of Nigeria and key stakeholders are working closely to implement the *National Essential Childhood Medicines Scale-up Plan*, which was endorsed by the Federal Ministry of Health of Nigeria in 2012. The plan aims to increase treatment coverage of zinc, ORS, and amoxicillin to 80% by 2015 and outlines specific, concrete actions to tackle these problems. Key interventions of the plan include:

- **Intervention 1:** Launching a national action campaign for child health
- **Intervention 2:** Leverage existing central supply chains to increase public-sector availability
- **Intervention 3:** Improve knowledge of primary health center staff to increase use of appropriate treatments
- **Intervention 4:** Support increased procurement of essential medicines at the state and local levels
- **Intervention 5:** Encourage production of affordable, high-quality ORS and zinc products
- **Intervention 6:** Identify and support actions to reduce the price of zinc and ORS
- **Intervention 7:** Continuous education of private retailers
- **Intervention 8:** Facilitate supplier marketing to boost retail sales

The plan is in line with the UN Commission on Life-Saving Commodities for Women and Children (co-led by President of Nigeria Goodluck Jonathan), the Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea (GAPPD), A Promise Renewed, and the United Nations Secretary-General's Every Woman Every Child movement.

As further examples of the Government's commitment to this high-impact opportunity, Nigeria's UN Commission country plan specifically identifies zinc, ORS, and amoxicillin as priority commodities. In addition, the Ministry of Health has set a goal of saving one million lives as part of the current administration's transformation agenda for the country, prioritizing childhood essential medicines as one of six key areas projected to have the greatest impact on lives saved.

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## Pakistan: Reducing Childhood Deaths from Diarrhea & Pneumonia

### Proposal for catalyzing treatment scale-up in two high-burden provinces

#### MDG 4 in Pakistan and Opportunity for Impact

Since 1990, the child mortality rate in Pakistan has declined by 38%. Yet, diarrhea and pneumonia, together, still account for **over 110,000 child deaths each year**.<sup>1</sup>

Low-cost and effective treatments already exist for both conditions—amoxicillin for pneumonia and oral rehydration solution (ORS) and zinc for diarrhea. However, only 3% and 41% of children with diarrhea receive zinc and ORS, respectively and 50% of children with suspected pneumonia receive appropriate antibiotics.<sup>2</sup>

Only 55% of children with suspected pneumonia are taken to a health facility for treatment and 50% of children with diarrhea seek care from an appropriate health provider.<sup>3</sup>

Key factors for low care-seeking and treatment include:

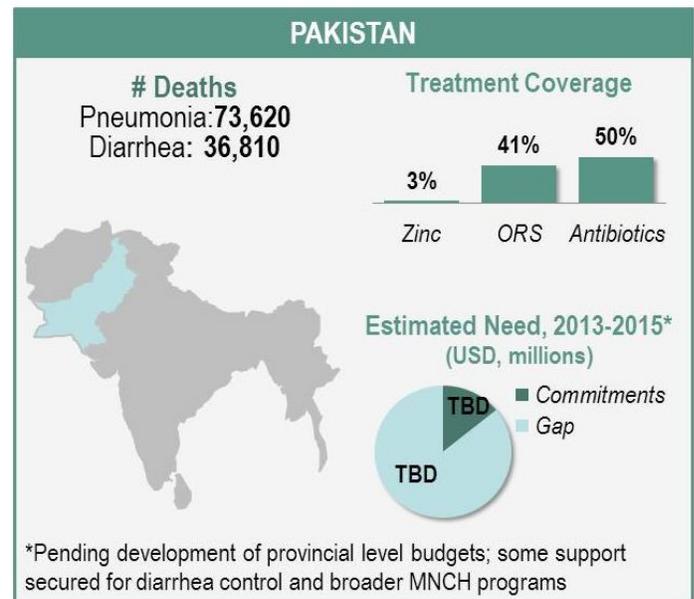
- Lack of knowledge about appropriate care seeking and treatment among caretakers;
- Limited capacity of female community health workers ('Lady Health Workers' or LHWs) to treat pneumonia;
- Inappropriate dispensing by and low knowledge of zinc among private and public sector providers; and
- Irregular or non-availability of medicines leading to underutilization of LHWs

In order to reach the Millennium Development Goal (MDG 4) of reducing child deaths by two-thirds by 2015, Pakistan will need to more than double its current rate of progress. Improving access to these cost-effective interventions will significantly accelerate the rate of decline of child deaths; if national scale-up targets are achieved (see 'National Approach' below), **more than 29,000 potential lives can be saved by 2015**.<sup>4</sup>

#### Program Approach for Large-Scale Implementation

Funding is needed to support a large-scale program to catalyze treatment scale-up efforts in the country (see 'National Approach' below). Specifically, the program will create awareness among caretakers and family members, build capacity among public and private sector providers, and increase availability and accessibility of recommended products.

The program will focus on two provinces of Pakistan—**Balochistan** and **Khyber Pakhtunkhwa (KPK)**—which account for nearly 90,000 child deaths annually and have the lowest rates of care-seeking and access to treatment. If treatment coverage targets are achieved (see right), the program will have potential to avert over 8,000 child deaths by 2015.



	Balochistan		KPK	
	Baseline	2015	Baseline	2015
Amoxicillin	24%	50%	44%	70%
ORS	35%	60%	24%	50%
Zinc	3%	30%	3%	30%

<sup>1</sup> UNICEF. Committing to Child Survival: A Promise Renewed. Progress Report 2013. September 2013.

<sup>2</sup> A Marketing Plus for Diarrheal Disease Control: Point-of-Use Water Disinfection and Zinc Treatment (POUZN) Project 2005-2010

<sup>3</sup> Pakistan Demographic and Health Survey 2012-13.

<sup>4</sup> Estimate calculated using the Lives Saved Tool, Johns Hopkins Bloomberg School of Public Health, March 2013. Note: the Lives Saved Tool does not reflect recent APR estimates from September 2013. If even more ambitious targets are achieved (80% coverage for zinc, ORS, and amoxicillin) there is potential to save nearly 70,000 lives by 2015.

The program will concentrate on four key intervention areas to scaling up pneumonia and diarrhea treatment:

**Objective 1: Create awareness among communities to adopt healthy behaviors and demand for effective diarrhea and pneumonia control:** A two-pronged approach—community level and large-scale mass media campaign—is required for creating awareness and generating demand for diarrhea and pneumonia treatments. Key messages will inform communities that LHWs are trained to treat diarrhea and pneumonia at the household level and are equipped with the medicines.

- Organize community level sensitization sessions in partnership with the LHW program targeting key opinion makers (e.g., religious leaders, teachers, locally elected representatives, health providers, local NGO representatives) to help disseminate messages to respective communities
- Organize district and provincial level advocacy meetings targeting key stakeholders (e.g., district authorities including health, water and sanitation departments, professional associations, elected representatives, NGO representatives) to create awareness among representatives and to act as pressure groups for increasing resources for pneumonia and diarrhea control
- Develop and disseminate messages and materials using mass media (print, electronic, social media), and popular dissemination channels among rural and peri-urban populations, like local cable television and FM radio stations
- Highlight pneumonia and diarrhea burden and treatments during events organized on World Pneumonia Day, Hand Washing Day, and World Water Day

**Objective 2: Improve access and quality of diarrhea and pneumonia case management:** LHWs, public sector peripheral facility-based health care providers and private practitioners are the first points of contact for households in rural and peri-urban areas. As such, there is an immediate need to strengthen the clinical skills of LHWs and also upgrade private practitioners' knowledge and skills to appropriately treat pneumonia and diarrhea.

- Support continuing education activities for public sector peripheral facility-based health care providers
- Facilitate revision of LHW curriculum and institutionalize continued education mechanism for LHWs
- Sensitize private sector health care providers on appropriate treatment for diarrhea and pneumonia through engaging professional associations. Conduct a biannual sub-district level continued education session on pneumonia and diarrhea.
- Upgrade IEC material for public and private sector health care providers to include the latest information on pneumonia and diarrhea prevention and treatment. Print and distribute materials for display and use during one on one counseling of caretakers

**Objective 3: Ensure availability of essential commodities for treatment of diarrhea and pneumonia:** Proper forecasting and budgeting in the public sector is necessary to ensure regular and adequate supply of ORS, zinc and amoxicillin. Engagement with local manufacturers will be critical to produce child friendly packaging and ensure accessibility to the rural and remote communities. The decentralization of the Federal Health Ministry has also led to a critical commodities gap for essential medicines for the 20,000 LHWs in the two provinces.

- Facilitate provincial and district level forecasting and budgeting for procurement of amoxicillin, ORS and zinc
- Work with local manufacturers to produce child-friendly formulations of amoxicillin, ORS and zinc (combined ORS and zinc packaging)
- Provide a one year supply of amoxicillin, ORS and zinc to community health workers in the two provinces
- Work with Departments of Health to improve logistics of information management systems

**Objective 4: Create an enabling environment for scale-up of diarrhea and pneumonia treatment:** A coordinated effort from all key partners and strong leadership from the Government is needed to achieve the program objectives. Building a stakeholder advocacy forum for smooth implementation and monitoring of the program is essential.

- Facilitate stakeholder coordination in the two provinces
- Support Departments of Health in both provinces to adapt the Global Action Plan on Pneumonia and Diarrhea
- Support resource mobilization for implementation of provincial essential medicines scale-up plans in KPK and Balochistan in partnership with UNICEF and other partners

## Budget

A total of **US \$12.5 million** over the next three years is required to support implementation of the large-scale program (see below).

ESTIMATED IMPLEMENTATION COSTS, 2013-2015 (USD)				
Description	Year 1	Year 2	Year 3	Total
Objective 1. Create awareness among communities	\$ 930,000	\$ 976,500	\$ 848,925	\$ 2,755,425
Objective 2. Improve access and quality of diarrhea and pneumonia case management	\$ 624,000	\$ 445,200	\$ 467,460	\$ 1,536,660
Objective 3. Ensure availability of essential commodities	\$ 4,412,000	\$ 117,600		\$ 4,529,600
Objective 4. Create enabling environment for scale-up	\$ 135,000	\$ 26,250	\$ 27,560	\$ 188,813
M&E Costs	\$ 180,100	\$ 156,555	\$ 134,395	\$ 471,050
Project management costs (personnel, travel, communication)	\$ 540,300	\$ 469,665	\$ 403,184	\$ 1,413,149
<b>Sub-Total (in USD \$)</b>	<b>\$ 6,821,400</b>	<b>\$ 2,191,770</b>	<b>\$ 1,881,527</b>	<b>\$ 10,894,697</b>
General management costs	\$ 1,023,210	\$ 328,766	\$ 282,229	\$ 1,634,205
<b>Total costs</b>	<b>\$ 7,844,610</b>	<b>\$ 2,520,536</b>	<b>\$ 2,163,756</b>	<b>\$ 12,528,902</b>

Save the Children (SC) is well positioned to lead implementation of this program. For the past two decades, SC has been working in child health in Pakistan. SC has implemented large-scale community case management programs for pneumonia and diarrhea in partnership with the Ministry of Health and has conducted ground breaking pneumonia research of global significance. SC's Every One campaign for newborn, child and maternal health advocacy will play a key role in highlighting the importance of pneumonia and diarrhea treatment and leverage funds for program implementation.

## National Approach to Scaling Up Treatment for Diarrhea and Pneumonia

SC and UNICEF are jointly working with the Government of Pakistan and other major stakeholders to support diarrhea and pneumonia treatment scale-up efforts. Due to decentralization of the Federal Ministry of Health in 2011, SC and UNICEF have been actively working with the provincial Departments of Health to develop and implement provincial-level scale-up plans for the country's four provinces—Punjab, Sindh, Balochistan and KPK—based on an initial national strategy developed in early 2012. The plans aim to drive large-scale increases in treatment coverage for zinc (to 30%), ORS (to 65%), and amoxicillin (to 70%) in the four provinces by 2015, including through the proposed program described above.

Proposed interventions of the provincial-level plans include:

- Improving drug management;
- Scaling up community programs;
- Partnering with the pharmaceutical industry;
- Conducting advocacy and demand generation;
- Building warehouse and logistics systems; and
- Educating general practitioner and chemists

The provincial plans are in line with recommendations of the UN Commission on Life-Saving Commodities for Women and Children, the Global Action Plan for Prevention and Control of Pneumonia and Diarrhea (GAPPD), A Promise Renewed, and the United Nations Secretary-General's Every Women Every Child movement. A national level launch of GAPPD was recently held, which will bring the importance of diarrhea and pneumonia treatment to the forefront.

SC and UNICEF have begun the process of establishing a coordination mechanism to harmonize implementation efforts across partners and align resources to maximize impact of individual efforts. Key stakeholders in the country working in diarrhea and pneumonia treatment scale-up include: Aga Khan University, JSI-Deliver, Pakistan Medical Association, Pakistan Pediatrics Association, Save the Children, UNICEF, and WHO, among others.

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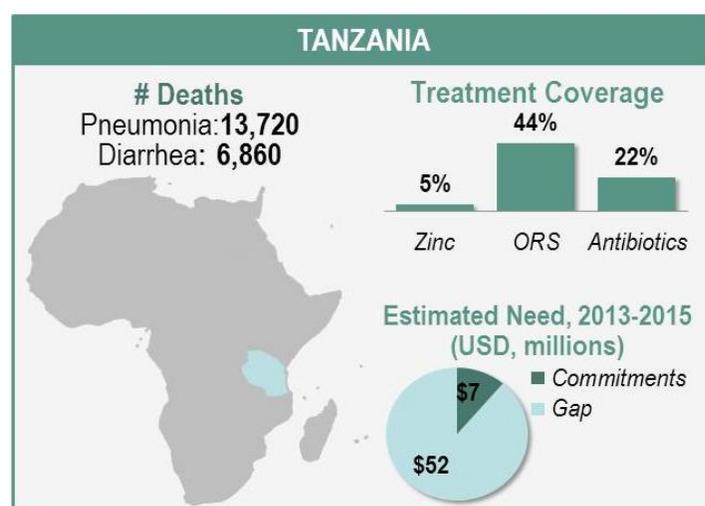
## Tanzania: Reducing Childhood Deaths from Diarrhea & Pneumonia

### Scaling up access to essential medicines

#### MDG 4 in Tanzania and Opportunity for Impact

Tanzania is one of few low-income countries that have successfully achieved the Millennium Development Goal (MDG 4) of reducing childhood deaths, with a 68% reduction in the number of deaths among children since 1990.<sup>1</sup> However, **nearly 21,000 children continue to die from diarrhea and pneumonia each year.**

These deaths are largely preventable with cost-effective treatment, specifically zinc and ORS for diarrhea and dispersible amoxicillin for pneumonia. But only 5% and 44% of children with diarrhea receive zinc and ORS, respectively, while only 22% of children with suspected pneumonia receive antibiotics.<sup>2</sup>



If national targets for scaling up diarrhea and pneumonia treatment are achieved in Tanzania, **an estimated 23,900 lives could be saved by 2015.**<sup>3</sup>

#### What You Can Do

While initial progress has been made to fund treatment-scale up in Tanzania, current funding is only sufficient to cover catalytic scale-up activities. To reach full potential of the national program, additional support is needed to cover costs of behavior change communication, provider training and detailing, strengthening private sector availability, monitoring and evaluation, and commodity procurement (e.g., bridge funding and free sample distribution pilots). Overall, approximately **US \$36.5 million** is required to cover total costs of scale-up over the next 3 years. The remaining gap of US \$15.5 million is currently being negotiated with the Government of Tanzania and other donors.

ESTIMATED IMPLEMENTATION COSTS, 2013-2015 (USD)				
Description	Year 1	Year 2	Year 3	Total
<b>Behavior change communication</b>	<b>\$ 1,386,355</b>	<b>\$ 4,814,850</b>	<b>\$ 1,671,450</b>	<b>\$ 7,872,655</b>
Rapid assessment to determine social behaviors	\$ 367,650	\$ 1,829,100		\$ 2,196,750
Demand generation campaigns	\$ 768,705	\$ 2,517,000	\$ 1,515,200	\$ 4,800,905
Training and follow-up of CHWs	\$ 250,000	\$ 468,750	\$ 156,250	\$ 875,000
<b>Provider training and detailing</b>	<b>\$ 1,505,436</b>	<b>\$ 3,668,704</b>	<b>\$ 2,985,153</b>	<b>\$ 8,159,293</b>
d-IMCI training and follow-up for in-service primary service providers	\$ 1,367,103	\$ 2,050,654	\$ 1,367,103	\$ 4,784,860
IMCI computerized training (ICATT) for pre-service providers	\$ 138,333			\$ 138,333
Needs assessment and roll-out of diarrhea treatment corners		\$ 1,618,050	\$ 1,618,050	\$ 3,236,100
<b>Strengthening product availability in private sector</b>	<b>\$ 336,000</b>	<b>\$ 1,543,500</b>	<b>\$ 1,118,250</b>	<b>\$ 2,997,750</b>
Strengthening ADDO network access to products at community level	\$ 336,000	\$ 1,543,500	\$ 1,118,250	\$ 2,997,750
<b>Monitoring and evaluation</b>	<b>\$ 250,000</b>	<b>\$ 300,000</b>	<b>\$ 400,000</b>	<b>\$ 1,191,485</b>
Quarterly supportive supervision	\$ 250,000	\$ 300,000	\$ 400,000	\$ 950,000
Vehicles for country coordination/supervision activities	\$ 241,485			\$ 241,485
<b>Commodity procurement</b>	<b>\$ 3,791,215</b>	<b>\$ 6,380,014</b>	<b>\$ 6,077,582</b>	<b>\$16,248,811</b>
Amoxicillin dispersible tablets	\$ 283,460	\$ 811,581	\$ 790,277	\$ 1,885,318
Zinc	\$ 2,491,254	\$ 3,326,559	\$ 3,631,111	\$ 9,448,924
Low osmolarity-ORS	\$ 666,501	\$ 1,270,624	\$ 1,332,444	\$ 3,269,569
Stock management	\$ 350,000	\$ 971,250	\$ 323,750	\$ 1,645,000
<b>TOTAL</b>	<b>\$ 7,510,491</b>	<b>\$16,707,068</b>	<b>\$12,252,435</b>	<b>\$36,469,994</b>

<sup>1</sup>UNICEF. Committing to Child Survival: A Promise Renewed. Progress Report 2013. September 2013.

<sup>2</sup>Tanzania Demographic Health Survey, 1991-1992

<sup>3</sup>Estimate calculated using the Lives Saved Tool, Johns Hopkins Bloomberg School of Public Health, March 2013. Note: the Lives Saved Tool does not reflect recent APR estimates from September 2013.

Implementation of activities will be coordinated through the Essential Medicines Initiative (EMI) Stakeholder group, led by the Tanzania Ministry of Health and Social Welfare (MOHSW). Key stakeholders working to support diarrhea and pneumonia treatment scale-up activities in the country include: WHO, USAID, UNICEF, PSI, UNFPA, MSH, CHAI, JSI, JHPIEGO, PATH, Tanzania Food and Drug Authority (TFDA), Pharmacy Council, Medical Stores Department (MSD), and Public Supplies Unit (PSU), among others.

### National Approach to Scaling Up Treatment for Diarrhea and Pneumonia

PSI is working closely with the MOHSW and other key development partners to implement the *Scale-up Strategy for Essential Medicines for Child Health*, which was developed and endorsed by the MOHSW in early 2012. The plan aims to increase coverage of zinc, ORS, and amoxicillin to 80% coverage by 2015 in four regions with high prevalence of pneumonia and diarrhea—Western Zone, Lake Zone, Southern Highland and Central Zone.

The community MNCH package outlines the following key interventions to support scale-up:

1. Expand TFDA registration to fast-track priority products list and register key drugs on the Essential Medicines List for Children (EMLc);
2. Roll-out diarrheal treatment corners and launch of pre-packaged ORS/zinc through public and private sector;
3. Adapt and scale-up proven m-Health monitoring systems;
4. Strengthen Accredited Drug Dispensing Outlet (ADDO) network access;
5. Build capacity for appropriate case management and incentives system to activate linkages (private and public); and
6. Conduct advocacy and demand generation activities to promote rational diarrhea and pneumonia diagnosis and treatment

The Strategy is in line with recommendations of the UN Commission on Life-Saving Commodities for Women and Children (UNCoLSC), the Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea (GAPPD), A Promise Renewed, and the United Nations Secretary-General's Every Woman Every Child movement. For example, Tanzania's UNCoLSC country implementation plan specifically identifies zinc/ORS and dispersible amoxicillin as priority commodities, further demonstrating the Government of Tanzania's commitment to this high impact opportunity.

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## Uganda: Reducing Childhood Deaths from Diarrhea & Pneumonia

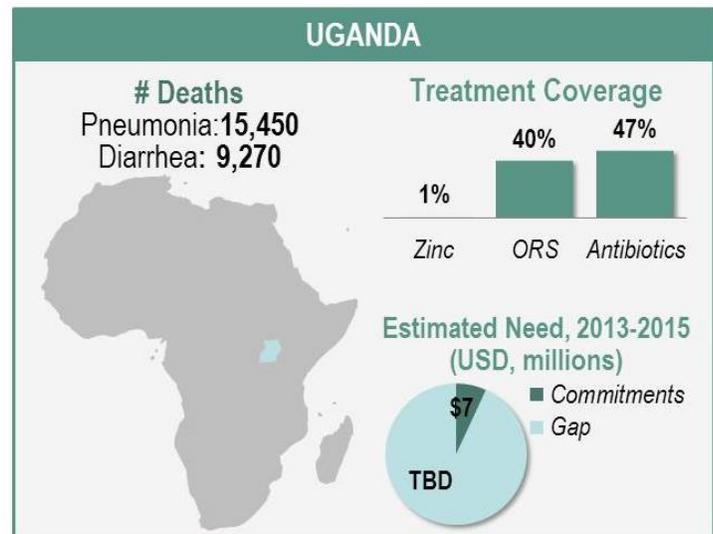
### Update on financing for priority interventions for treatment scale-up

#### MDG 4 in Uganda

Since 1990, child mortality in Uganda has declined significantly by 61%<sup>47</sup>; yet, **nearly 25,000 children in Uganda still die each year from pneumonia and diarrhea.**<sup>48</sup>

Simple, cost-effective treatments exist—oral rehydration salts and zinc for diarrhea and amoxicillin for pneumonia. But less than 1% of children receive the full recommended treatment for diarrhea and 47% receive antibiotics.

Achieving significant increases in coverage of these appropriate treatments has potential **to save nearly 29,000 children lives in Uganda by 2015.**<sup>49</sup>



#### Funding and Progress to Date

In Uganda, initial progress has been made to scale up treatment for diarrhea. Specifically, zinc has been classified as over-the-counter (OTC) status, which will enable widespread uptake in the private retail sector. On the supply side, a total of five zinc and six ORS products are now registered in Uganda, compared to one and three, respectively, a year ago; this increase in high-quality supply is facilitating improved pricing – including an 80% decrease in the import price of zinc. Additionally, a co-packaged zinc and ORS product has been introduced in public health facilities and updated diarrhea and pneumonia trainings have been rolled out among public and private providers nationally.

Building on this progress, the Ministry of Health recently submitted a country plan for funding from the *UN Commission on Life-Saving Commodities for Women and Children* for priority activities over the next three years to drive increased use and access to zinc, ORS, and amoxicillin, among other essential commodities. Key priorities in this plan include:

#### Zinc/ORS

- Increasing the availability and use of ORS and zinc in public facilities
- Expanding distribution and improving pricing in the private supply chain
- Accelerating the introduction of low-cost, optimal products

#### Amoxicillin

- Providing diagnostic breathing counters for public health centers and village health teams (VHTs)
- Conducting formative study on packaging for amoxicillin at facility and community levels
- Updating the Standard Clinical Treatment Guideline to include amoxicillin as 1<sup>st</sup>-line treatment for pneumonia and the Essential Medicines List to include amoxicillin use by VHTs
- Engaging local pharmaceutical manufacturers to produce quality assured dispersible amoxicillin
- Reducing the price of amoxicillin dispersible formulation at the retail level

<sup>47</sup> UNICEF. *Committing to Child Survival: A Promise Renewed. Progress Report.* September 2013

<sup>48</sup> Liu, Li, et al, for the Child Health Epidemiology Reference Group of WHO and UNICEF. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000. *The Lancet*, Early Online Publication, 11 May 2012.

<sup>49</sup> Estimate calculated using the Lives Saved Tool, Johns Hopkins Bloomberg School of Public Health, March 2013

**Cross-cutting**

- Developing a behavior change communication strategy to increase demand for recommended treatment
- Incorporating iCCM commodities into the national supply chain
- Educating public and private providers about diarrhea and pneumonia management and the recommended treatment
- Evaluating iCCM effectiveness
- Training public providers on using the IMCI curriculum and distributing job aids for public health workers
- Developing a mobile phone platform to support provider supply, stocking and dispensing practices

Availability of funds from the RMNCH Trust Fund to support priority activities in Year 1 will be determined in the 3<sup>rd</sup> quarter of 2013. Additional support for Years 2 and 3 will be determined pending this feedback.

The *Diarrhea and Pneumonia Coordinating Committee (DPCC)* is assisting with overall coordination of implementation activities across development agencies. Current partners supporting the Ministry of Health in diarrhea and pneumonia treatment scale-up in the country include: Clinton Health Access Initiative (CHAI), Malaria Consortium, PACE, Strengthening Health Outcomes through the Private Sector (SHOPS), Uganda Health Marketing Group (UHMG), and UNICEF among others.

**Scaling Up Treatment for Diarrhea and Pneumonia in Uganda**

In addition to its country plan for the UN Commission on Life-Saving Commodities for Women and Children, the Ministry of Health and DPCC partners is also revising the *Diarrhea and Pneumonia Protect Prevent Treatment (PPT) Strategy* to align with the new Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea (GAPPD), which was launched in early 2013. The plan aims to drive significant increases in treatment coverage of zinc, ORS, and amoxicillin and outline specific, concrete actions to drive an integrated, all-encompassing, and cross-disease approach:

- **Protect** children by providing a healthy environment where they are at low risk from infection;
- **Prevent** children from becoming ill with pneumonia and diarrhea by immunizing them against predicted pathogens; and
- **Treat** those with disease using WHO-recommended case management practices

**Contact Us**

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# Transforming Diarrhea and Pneumonia Treatment

## A cost-effective opportunity to reduce child mortality

### The opportunity

The global health community has made great progress toward improving the health of children in developing countries. Thanks to investments from national governments, bilateral programs, multilateral organizations, foundations, and the private sector, child deaths have dropped by 70 percent worldwide in the last 50 years - a remarkable accomplishment largely due to high-impact solutions like effective treatments, new and low-cost vaccines, and improved health services.

But more investment is needed with fewer than three years left to reduce child mortality and meet Millennium Development Goal 4. Over 2 million children under 5 years still die each year from diarrhea and pneumonia despite the availability of simple and affordable treatments. More than 60 percent of these deaths occur in just ten countries: **Bangladesh, Democratic Republic of Congo, Ethiopia, India, Kenya, Niger, Nigeria, Pakistan, Tanzania, and Uganda.**

Donors can have significant impact by investing in programs that ensure greater access to treatments for child pneumonia and diarrhea in these high-burden countries.

### We know what works

The treatments for diarrhea and pneumonia are highly effective, low-cost measures that have been proven to save children's lives. **Oral rehydration solution (ORS)** and **zinc**, together, can prevent more than 90 percent of deaths from diarrhea.<sup>1</sup> **Amoxicillin**, with appropriate case management, can reduce deaths from pneumonia by 36 percent to 42 percent. Each treatment course costs less than 50 cents per child.

**No child should die when simple solutions are available**

<sup>1</sup> ORS prevents deadly dehydration from diarrhea and can avert 93 percent of deaths from diarrhea. Zinc shortens the episode of diarrhea and reduces death rates by 23 percent.



PATH/Heng Chivoan

### The Working Group

The Diarrhea and Pneumonia Working Group is a global coordinating body focused on accelerating access to these treatments. Together, the members of the Working Group (see back page) aim to achieve between 60 percent and 80 percent diarrhea and pneumonia treatment coverage by:

- Ensuring wide availability of **high-quality, affordable** treatments in both the public and private sectors.
- Securing a conducive and supportive **policy and regulatory** environment for treatment.
- Ensuring **harmonization of efforts** across partners to maximize impact of individual investments.
- Generating **demand** for ORS, zinc, and amoxicillin, and **teaching** caregivers when/where to seek treatment.
- Improving **knowledge and skills** of health providers to promote and deliver **appropriate treatment** and care.

The Working Group provides technical assistance, resource mobilization, and monitoring and evaluation support to organizations and governments working in the ten countries.

**The time is right**

Global and national leaders have demonstrated unprecedented leadership around this high-impact opportunity. The ten countries have developed national scale-up plans for children’s essential medicines, which specify national coverage targets and concrete areas for action during the next three years. These plans directly support recommendations of the United Nations [Commission](#) on Life-Saving Commodities for Women and Children, the Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea ([GAPPD](#)), [A Promise Renewed](#), and the United Nations Secretary-General’s [Every Woman, Every Child](#) movement.

**Why invest?**

- Without sustained and increased investment, we risk **losing our progress** on improving the health of children in developing countries toward reducing preventable deaths from diarrhea and pneumonia.
- Implementation of the national scale-up plans in ten countries has potential to **save 1 million lives<sup>2</sup>** by 2015 if 80% coverage is achieved.
- Sustained investment in child health is needed to establish a cycle of **health and prosperity**.
- As child health improves, so do **local economies** and ultimately international commerce and trade.

**Contact us**

For more on how you can contribute to this global effort, please contact the United Nations Children’s Fund (Mark Young at [myoung@unicef.org](mailto:myoung@unicef.org)) or Clinton Health Access Initiative (Nancy Goh at [ngoh@clintonhealthaccess.org](mailto:ngoh@clintonhealthaccess.org)).



Amoxicillin is recommended by the World Health Organization for treatment of childhood pneumonia.



Oral rehydration salts and zinc are recommended by the World Health Organization for treatment of childhood diarrhea.

<sup>2</sup> Estimates calculated using the Lives Saved Tool, Johns Hopkins Bloomberg School of Public Health, March 2013.



## TREATMENT OF CHILDHOOD PNEUMONIA AT THE COMMUNITY LEVEL WITH AMOXICILLIN DISPERSIBLE TABLETS

Pneumonia is one of the leading causes of death in children in the developing world, killing about 1.2 million children under five per year.<sup>1</sup> The number of children with pneumonia symptoms who receive medical care is extremely low,<sup>2</sup> and as a result, they are not properly treated with antibiotics. A child receiving antibiotic treatment within the first 24 hours of displaying bacterial pneumonia symptoms can be saved. Many countries are currently attempting to increase access to appropriate treatment through community-based initiatives such as community case management<sup>3</sup>—and appropriately so, because studies show that by increasing the coverage of integrated interventions to 90%, we can, by 2025, reduce the number of global under-five pneumonia deaths by 67%.<sup>4</sup> In response to these high but preventable infant and child mortality rates, the child survival community has declared an unambiguous commitment to rapidly scaling up efforts to increase access to antibiotic treatment for pneumonia.

**The World Health Organization (WHO) has established dispersible amoxicillin as the newly recommended first-line treatment for pneumonia in children under the age of five.** Details can be found in the *WHO Recommendations for Management of Common Childhood Conditions*.<sup>5</sup>

Oral amoxicillin is preferred over co-trimoxazole as first-line treatment because it is effective against both nonsevere and severe pneumonia in low-HIV settings and because of increased resistance to co-trimoxazole and lower efficacy of co-trimoxazole than amoxicillin. In high-HIV settings, amoxicillin is also preferred because oral co-trimoxazole is recommended for *Pneumocystis pneumonia* prophylaxis.



Although 500 mg amoxicillin capsules and tablets are widely available, this strength is not suitable to treat pneumonia in younger age groups (lower weight bands), and capsules cannot be split.

Traditionally, amoxicillin powder for oral suspension has been the dosage form of choice for children under the age of five years. However, dispensing complications are associated with this formulation, which makes it unsuitable for some settings; for example, it requires clean water and a measuring device for mixing, and another marked measuring device for administering the medicine. Additionally, the mixed suspension has a short shelf life of a few days after reconstitution and so cannot be prepared in advance.

Amoxicillin dispersible tablets are equivalent to the oral suspension powder, but each dose is pressed into a tablet that quickly disperses in a small amount of water (5–10 mL) or breast milk at the time of use. Furthermore, older children and adults can swallow dispersible tablets just as they do other, non-dispersible tablets.

**Community case management of pneumonia by community health workers (CHWs) presents unique supply chain considerations—**

- Often long distances are traveled to resupply points.
- Products are transported on bicycle, foot, or donkeys, presenting temperature and space challenges.

- Storage space is limited, and products are exposed to sunlight, heat, and rain during transport and community use.
- The repackaging environment is unclean.

### Amoxicillin dispersible tablets in blisters meet the special needs of CHWs.

Dispersible tablets—

- are child- and supply chain-friendly
- come in appropriate strengths and pack sizes to meet the needs of CHWs, caregivers, and children
- are packaged for easy dispensing and inventory management—a course of treatment is one or multiple blister strips
- do not have to be split to get the correct dosage
- are packaged with information and pictures for caregivers to remember instructions for administration

Dispersible tablets are also more cost-effective.

Suspensions—even the dry powder for oral suspension—are bulkier and therefore costlier to ship and more challenging to distribute. In addition, the price of treating an 11-month-old child with amoxicillin oral suspension ranges from US\$0.44 to US\$1.60,<sup>6</sup>

whereas the cost of treatment with amoxicillin dispersible tablets ranges from US\$0.23-0.44 for 2-11 months to US\$0.46 to 0.63\$ for 12-59 months.<sup>7</sup> The dosing specifications for amoxicillin dispersible tablets used at community level are summarized below.

They are described in detail in *WHO's Integrated Management of Childhood Illness: Caring for Newborns and Children in the*

*Community Handbook* and in the new CHW training package from UNICEF and WHO.

**With simple dosing and clear, easy instructions on prescribing and administration, the most effective and practical treatment is oral amoxicillin dispersible tablets.**

Age	Pneumonia*	Severe pneumonia with danger signs
Under 2 months	Give 1 × 250mg amoxicillin tablet immediately, and refer urgently to a health facility	
2–11 months	1 × 250mg amoxicillin tablet twice a day for 5 <sup>8</sup> days	Give 1 × 250mg amoxicillin tablet immediately, and refer urgently to a health facility
12–59 months	2 × 250mg amoxicillin tablets twice a day for 5 days	Give 2 × 250mg amoxicillin tablets immediately, and refer urgently to a health facility

\*Fast breathing classification based on assessment of respiratory rate (RR): RR > 50/min (2-11 mo.); RR > 40/min (12-59 mo.)

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<sup>1</sup> WHO. GAPPD: ending preventable child deaths from pneumonia and diarrhoea by 2025.

[http://www.who.int/woman\\_child\\_accountability/news/gappd\\_2013/en/index.html](http://www.who.int/woman_child_accountability/news/gappd_2013/en/index.html)

<sup>2</sup> UNICEF. 2012. *Pneumonia and Diarrhoea: Tackling the Deadliest Diseases for the World's Poorest Children*. New York: UNICEF.

[http://www.unicef.org/media/files/UNICEF\\_P\\_D\\_complete\\_0604.pdf](http://www.unicef.org/media/files/UNICEF_P_D_complete_0604.pdf) pp. 24–38.

<sup>3</sup> WHO/ UNICEF Joint Statement: Integrated Community Case Management (iCCM). 2012.

[http://www.who.int/maternal\\_child\\_adolescent/documents/statement\\_child\\_services\\_access\\_whounicef.pdf](http://www.who.int/maternal_child_adolescent/documents/statement_child_services_access_whounicef.pdf)

<sup>4</sup> Child Health Epidemiology Reference Group (CHERG). Case Management on Childhood Pneumonia Mortality.

<http://cherp.org/projects/List-summaries/pneumonia-management.html>

<sup>5</sup> WHO. 2012. *Recommendations for Management of Common Childhood Conditions: Evidence for technical update of pocket book recommendations: newborn conditions, dysentery, pneumonia, oxygen use and delivery, common causes of fever, severe acute malnutrition and supportive care*. Geneva; WHO.

[http://www.who.int/maternal\\_child\\_adolescent/documents/management\\_childhood\\_conditions/en/](http://www.who.int/maternal_child_adolescent/documents/management_childhood_conditions/en/), pp. 15–16.

<sup>6</sup> Using prices from the Management Sciences for Health, *International Drug Price Indicator Guide 2011*.

<http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=DMP&language=English>.

<sup>7</sup> Using prices from UNICEF Supply Division catalogue (consulted August 2013) Lower prices being for 100 tablets packs and higher prices for blisters

<sup>8</sup> Three days in a low-HIV setting.

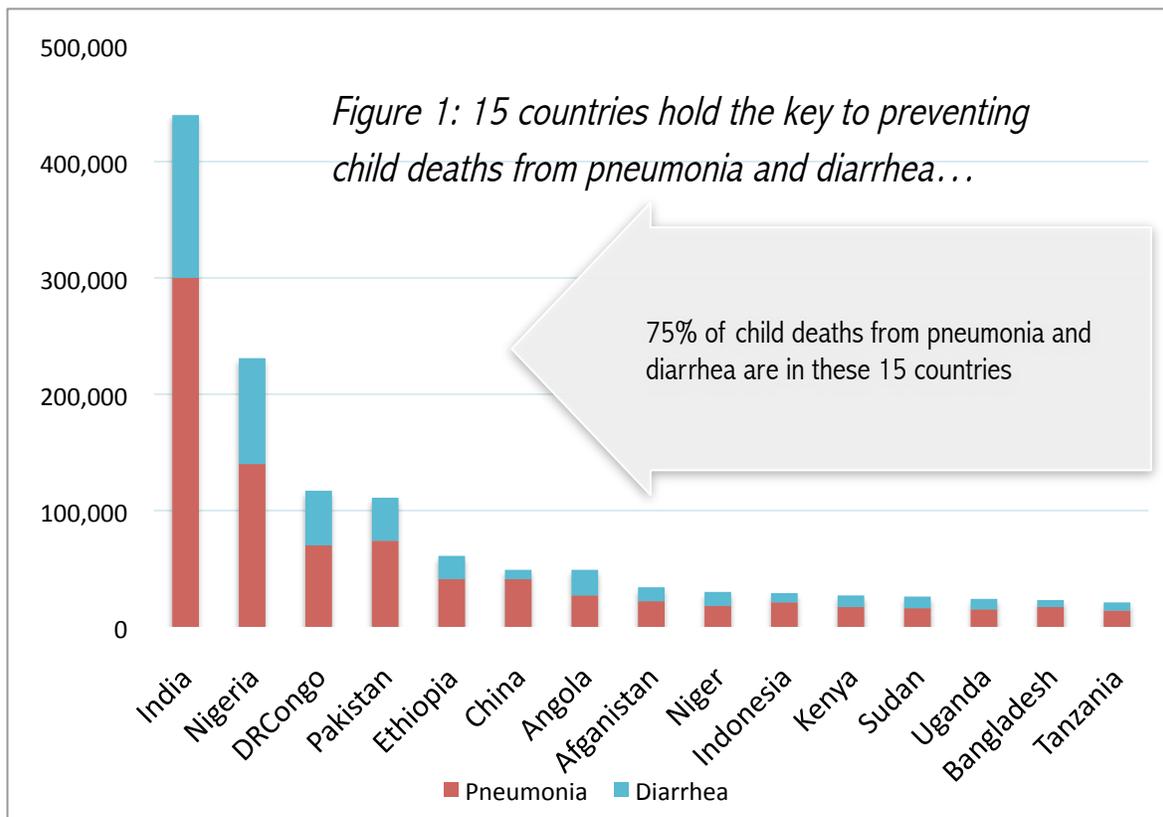
# MINING COMPACT FOR CHILD HEALTH

## *Mobilizing the World's Leading Mining Companies for Child Survival*

September 2013

### CHALLENGE

In 2012, 6.6 million children did not reach their 5 birthdays. The majority died in just 15 countries with India and Nigeria accounting for more than one third of all deaths. Tragically 1.7 million (26%) child deaths are caused by pneumonia and diarrhea, which are entirely preventable and treatable at low cost (Figure 1). For diarrhea, oral rehydration salts (ORS) and zinc treatment could avert over 90% of deaths at a cost of less than 50 cents per treatment, and antibiotics could avert over 40% of pneumonia deaths for a similar cost. ORS prevents diarrhea-induced death from dehydration and zinc treatment lessens the severity and duration of diarrhea and provides protection against future infections that cause diarrhea and pneumonia. Zinc is such a precious commodity for child health that eradicating zinc deficiency alone could prevent the deaths of 400,000 children. But despite the lifesaving potential of zinc, ORS and antibiotics, most children never receive these treatments (Table 1). Demand for ORS is low and almost non-existent for zinc as the relationship between zinc and child health is not well understood by consumers or health providers in most countries. This has created a market trap limiting supply and distribution of both zinc and ORS. Low recognition of the symptoms of childhood pneumonia is inhibiting care seeking and antibiotics. If demand is unlocked, billions of episodes of diarrhea would require treatment with zinc and ORS every year and millions of episodes of pneumonia would require antibiotics, triggering a supply-side response that could prevent more than a million child deaths each year.



## OPPORTUNITY

Successfully preventing these 1 million child deaths would accelerate the achievement of Millennium Development Goal 4 (MDG4). To achieve MDG4 we need to prevent the deaths of an estimated 4 million children under 5 in the 900 days left to December 31<sup>st</sup> 2015. Urgent action to scale up coverage of pneumonia and diarrhea treatments could contribute significantly to the prevention of those child deaths and mining companies are well positioned to champion the use of these treatments in the countries where child deaths are concentrated. The wide geographic reach of many of the major mining companies means that they already operate in many of the countries with the highest burdens of child mortality and have a direct interest in investing in the health of local communities. Further, as mining companies extract zinc - the commodity that has such a strong and positive impact on child health - they are natural champions for child health. Good work is already underway with *Zinc Saves Kids*, an initiative by the International Zinc Association (IZA) and UNICEF, and the *Zinc Alliance for Child Health*, a partnership between Teck Resources, the Micronutrient Initiative, the Canadian International Development Agency (CIDA) and UNICEF.

*“Zinc is one of the greatest untapped resources for child survival and growth, with preventive zinc supplements among the three interventions with the largest potential effect on mortality in children younger than 5 years and zinc treatment able to reduce diarrhea deaths by 23%.”*

*-MDG Health Alliance*

Table 1	Under 5 deaths (pneumonia & diarrhea)	ORS coverage	Zinc coverage	Antibiotic coverage
India	440,000	26%	0.3%	13%
Nigeria	231,000	26%	1%	23%
DRC	117,000	26%	2%	42%
Pakistan	111,000	41%	0%	50%
Ethiopia	61,000	26%	0%	7%
China	49,000	No data	No data	No data
Angola	49,000	40%	No data	No data
Afghanistan	34,000	30%	No data	No data
Niger	30,000	18%	No data	No data
Indonesia	29,000	35%	No data	No data
Kenya	27,000	39%	1%	50%
Sudan	26,000	22%	No data	66%
Uganda	24,000	40%	1%	47%
Bangladesh	23,000	77%	23%	22%
Tanzania	21,000	44%	5%	No data

A majority of sick children do not receive proper treatment for pneumonia and diarrhea.

## MINING COMPACT FOR CHILD HEALTH

The *Mining Compact for Child Health* seeks to build on these successful initiatives by inviting the world's leading mining companies to join forces with governments, non-government organizations, industry associations and civil society to stimulate the growth and development of sustainable markets for quality, affordable, child-friendly zinc, ORS and antibiotics in the countries with the greatest numbers of under 5 child deaths.

Based on country plans developed by governments in close coordination with leading global child health organizations, a number of key activities have been identified to successfully achieve the goal of a long-term, sustainable and significant reduction in childhood deaths from pneumonia and diarrhea.

To become a partner in the *Mining Compact for Child Health*, companies are asked to commit to, and support, one or more of the following five multi-stakeholder lead activities in the countries with the highest numbers of child deaths:

1. Work with development partners and other stakeholders to support country-led efforts to develop local markets for quality, affordable, child-friendly formulations of zinc, ORS and the WHO recommended antibiotic for the treatment of childhood pneumonia – amoxicillin dispersible tablets
2. Support efforts to dramatically increase family use and health provider recommendation of zinc and ORS to treat childhood diarrhea, amoxicillin dispersible tablets to treat pneumonia, and zinc supplements and fortified zinc products (e.g. staple foods) to improve children's nutritional status and resistance to infection
3. Finance public education campaigns about the benefits of zinc for child health and ORS and zinc as treatments for diarrhea to increase demand for zinc/ORS among consumers and healthcare providers and campaigns raising awareness about the danger signs of childhood pneumonia and the importance of seeking care from a qualified health provider quickly
4. Leverage existing company distribution channels, networks and workplace programs, where appropriate, to increase access to zinc, ORS and amoxicillin for children, particularly in rural and remote areas
5. Advocate to governments and other stakeholders for greater access to quality, affordable, child-friendly zinc, ORS and amoxicillin products for children

*There has never been a more important time to act. With less than 850 days to achieve Millennium Development Goal 4 accelerated action on the leading causes of child death in the countries where most deaths are concentrated is now critical.*

The **Mining Compact for Child Health** is part of a global push to end child pneumonia and diarrhea deaths and is consistent with the recommendations of the:

- [Integrated Global Action Plan for Pneumonia and Diarrhea](#)
- [Declaration on Scaling Up Treatment of Diarrhea and Pneumonia](#)
- [UN Commission on Life-Saving Commodities for Women and Children](#)
- [A Promise Renewed: Child Survival Call to Action](#)

Members of the Mining Compact become part of the United Nations Secretary-General's [Every Woman, Every Child](#) movement and their work is highlighted during United Nations General Assembly week and at other times throughout the year.

## SECRETARIAT

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Data sources: [Committing to Child Survival: A Promise Renewed](#) Progress Report, UNICEF 2013, [Pneumonia and Diarrhea. Tackling the Deadliest Diseases for the World's Poorest Children](#), UNICEF 2012

