



## African Leadership for Child Survival



Federal Democratic Republic of Ethiopia  
Ministry of Health



Keep the Promise—Invest in A Child  
Addis Ababa, Ethiopia  
16-18 January 2013

## Meeting Report

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## **Background**

Since 1990, the number of child deaths in sub-Saharan Africa has dropped by 39 percent. Many African countries are within reach of the 2015 Millennium Development Goal to reduce the under-five mortality rate by two-thirds. Yet even with the availability of proven, inexpensive, high-impact interventions for maternal, newborn, and child health, their adoption is slow and high rates of childhood illness and death persist in a number of countries. In sub-Saharan Africa 1 in 8 children die before they reach their fifth birthday.

For the first time in history, the necessary knowledge and technologies exist to reach the world's most marginalized children with life-saving interventions. Declines in child and maternal mortality can be accelerated, enabling more countries to achieve Millennium Development Goals (MDGs) 4 and 5 by 2015 and sustaining the momentum well into the future. In an effort to catalyze this needed global action for child survival, the Governments of Ethiopia, India, and the United States together with UNICEF convened the 'Child Survival Call to Action' in Washington, D.C. in June 2012. Under the banner of 'Committing to Child Survival: A Promise Renewed', more than 160 governments signed a pledge to renew their commitment to child survival, to eliminate all preventable child mortality in two decades.

To maintain this momentum, the Government of Ethiopia, and former Minister of Health Tedros Adhanom, convened the 'African Leadership for Child Survival—A Promise Renewed' Meeting January 16-18, 2013, in Addis Ababa. Ministers of Health and experts from across Africa came together with peers and global experts to ensure child survival is at the forefront of the social development agendas across the continent and renew the focus of African leaders to galvanize their own country's efforts and sustain the gains made over the last two decades.

### **What is the Child Survival Call to Action?**

On June 14-15, 2012, over 80 countries represented by governments and a multitude of partners from the private sector, civil society, and faith-based organizations gathered at the Child Survival *Call to Action* – a high-level forum convened by the governments of Ethiopia, India and the United States, in collaboration with UNICEF. The *Call to Action* challenged the world to reduce child mortality to 20 or fewer child deaths per 1,000 live births in every country by 2035. Reaching this historic target will save an additional 45 million children's lives by 2035.

Over two days, through new pledges and expanded partnerships, leaders from across the spectrum set the course for a sustained, global effort to end preventable child deaths. Several new partnerships were announced and expanded at the Call to Action. Announcements included: engaging religious leaders across diverse faiths to be effective drivers of behavior change; uniting with private sector to help mothers during labor, delivery, and the first 24 hours postpartum; providing small grant awards to developing country researchers; and aligning technical and financial resources to scale up use of oral rehydration salts (ORS) and zinc for diarrhea.

In addition, the Democratic Republic of Congo, Ethiopia, India, Nigeria, and Pakistan made the following commitments to increasing child survival in their respective countries:

- **DEMOCRATIC REPUBLIC OF CONGO (DRC)** pledged to increase the health budget in the national budget. In addition, the DRC committed to monitor and evaluate all activities by strengthening the supervision at the base and run a better coordination process of all activities with stakeholders at any level. The Government of DRC and the Eastern Congo Initiative (ECI) announced its support of a new Advisory Council on Child Survival, which will convene multiple stakeholders who are committed to developing strategies for reducing child mortality in Congo.
- **ETHIOPIA** declared child survival a powerful indicator of a country's overall development. Ethiopia expects to exceed MDG 4 targets by 2015 and, with accelerated efforts and strategic shifts, believes it can reduce under-five mortality to 30 per 1,000 live births by the year 2025. Six months from now, Ethiopia proposed hosting a follow-up session with African Health Ministers around the upcoming AU Summit. And together with UNICEF, Ethiopia would also like to host the 2nd year follow-up from the Call to Action in Addis Ababa, in 2014.
- **INDIA** is committed to preparing future iterations of a global roadmap to end preventable child deaths. The Government of India has committed to give an urgent priority to convergence of Health and Child Care Services under the universal health coverage. Minister Azad personally pledged to advocate for child survival at all fora, including the upcoming BRICS conference at New Delhi in Nov. 2012. In order to expand the scope and coverage of immunization, particularly in high focus areas, year 2012 has been declared as the "Year of Intensification of Routine Immunization" by Government of India.
- **NIGERIA** made a commitment to its people—and a commitment to its children—to reduce substantially the under-five mortality rate. Through its Subsidy Reinvestment and Empowerment (SURE-P) Program, Nigeria expects to provide approximately \$500 million over four years in additional funding to support thousands of frontline health workers, improve primary healthcare services in more than 3000 rural health facilities – ultimately reaching up to 1.2 million mostly poor rural pregnant women and their children with essential health services.
- **PAKISTAN** committed to a partnership with donors and the private sector to track progress toward reducing under- five child deaths, and to developing a Score Card that will be used to track progress at the federal and provincial level. The United Kingdom Department for International Development, the Australian Agency for International Development, and USAID are working together with the Government of Pakistan to prevent approximately 195,000 under five child deaths over three years through an investment of \$485 million.

## **Call to Action Goals**

The Child Survival Call to Action has three main goals:

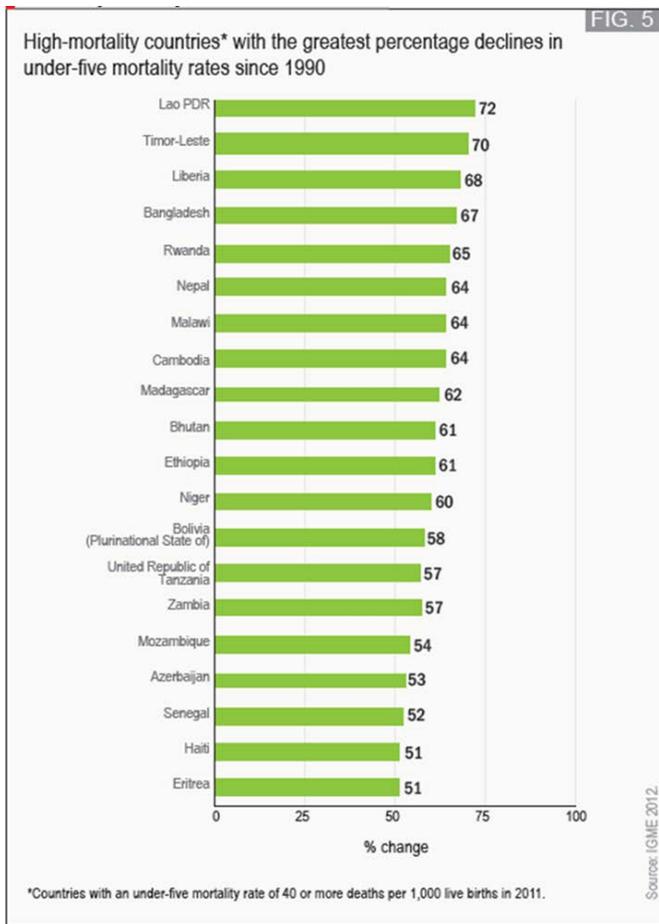
1. Mobilize political leadership to end preventable child deaths;
2. Achieve consensus on a global roadmap highlighting innovative and proven strategies to accelerate reductions in child mortality; and
3. Drive sustained collective action and mutual accountability.

## **Child Mortality in sub-Saharan Africa**

Sub-Saharan Africa has the highest risk of death in the first month of life and is among the regions showing the least progress. However, sub-Saharan Africa has seen a decline in its under-five mortality rate, with the annual rate of reduction doubling from 1.5 to 3.1 percent between 1990–2000 and 2000–2011. This region accounts for 38 percent of global neonatal deaths, and has the highest newborn death rate, globally (34 deaths per 1,000 live births in 2011). Neonatal deaths account for about one-third of under-five deaths globally (1.1 million newborns die in the first month of life). Sub-Saharan Africa has reduced under-five mortality by 39 percent between 1990 and 2011.

If current trends persist, 1 in 3 children in the world will be born in sub-Saharan Africa, and its under-five population will grow rapidly. The highest rates of child mortality are still in the region—where 1 in 9 children dies before age five, more than 16 times the average for developed regions (1 in 152). The under-five mortality rate in Africa declined from 163 in 1990 to 100 per 1,000 live births in 2011. These rates of decline are still insufficient to achieve Millennium Development Goal 4 by 2015.

Liberia, Rwanda, Malawi, and Madagascar are among the top 10 countries with the greatest percentage decline in their under-five mortality rates from 1990-2011. The under-five mortality rates decreased in these countries by 68 percent, 65 percent, 64 percent, and 62 percent, respectively.



Source: Committing to Child Survival: A Promise Renewed Progress Report 2012: <http://apromiserenewed.org>

### Key Statistics on Causes of Death and Modes of Prevention

Neonatal complications, diarrhea, pneumonia, and malaria account for most deaths among children under five years of age in Africa. In 2010, 15 percent of newborn deaths in Africa can be attributed to infections related to the delivery process. Diarrhea causes about 11 percent of under-five deaths worldwide with nine-tenths of these deaths occurring in Sub-Saharan Africa. Use of Oral Rehydration Salts (ORS), one of the three key interventions for diarrhea, has increased from 24 percent of children in sub-Saharan Africa receiving ORS in 2000 to 30 percent in 2011.

In 2011, Malaria accounted for a loss of nearly 500,000 lives of children under-five in the world with almost all of the deaths occurring in sub-Saharan Africa (Child Health Epidemiology Reference Group, 2011). In 2000, only 2 percent of children under-five in Africa slept under Insecticide Treated Nets (ITNs), this number increased dramatically to 38 percent in 2010. Tanzania, Niger, and Mali have increased ITN use to over 60 percent.

In sub-Saharan Africa, care-seeking for pneumonia has improved from 36 percent in 2000 to 46 percent in 2010 for rural areas, and from 49 percent to 52 percent in urban areas.

165 million children under 5 are stunted (low height for age) in their growth due to poor nutrition during the first 1,000 days of life. Stunting rates in sub-Saharan Africa have decreased from 47 percent in 1990 to 40 percent in 2011, yet the prevalence is still high.

Exclusive breastfeeding is a critical part of improving child survival and development. Sub-Saharan Africa has seen increases from 21 percent in 1995 to 33 percent of infants under six months who are exclusively breastfed in 2010.

Maternal mortality is also a risk factor for neonatal and infant mortality. The largest threat of maternal mortality occurs during labor, birth, and the 24 hours following birth. Many of the interventions known to save the lives of women and their newborns depend upon the presence of a Skilled Birth Attendant (SBA). In Africa, 48 percent of births in 2011 were attended by skilled health personnel.

Millions of children die from diseases that can be prevented through vaccines. In 2011, African immunization coverage was estimated at 77 percent. The World Health Organization (WHO) estimates that 20 percent of under-five deaths—approximately two million deaths annually—could be prevented with existing vaccines.

In 2010, 6 percent of under-five deaths in sub-Saharan Africa were associated with HIV. In some countries the rate is much higher, 28 percent in South Africa and 23 percent in Swaziland. In 2011, Swaziland, Botswana, and South Africa all achieved over 90 percent coverage of the most effective medicines for Preventing Mother-to-Child Transmission (PMTCT).

### **Organization of the Meeting**

The African Leadership for Child Survival Call to Action meeting was held for three days in Addis Ababa, Ethiopia, from January 16-18, 2013. The focus of the meeting was on:

- Scientific evidence for high impact interventions that can accelerate progress shared;
- Progress in achieving national Millennium Development Goals for child survival reviewed;
- Approaches (best practices) for scaling up high impact interventions for newborn and child health reviewed; and
- Galvanizing momentum for country led national Child Survival Action Plans.

A full plenary session featuring key African leaders and representatives from international donors opened the meeting. Six panel presentations were held during the meeting which included international experts in newborn, child and maternal health, as well as leading African researchers who shared their country's experience in addressing bottlenecks to scaling up child survival. Topics included: community-based management of newborn sepsis; integrated Community Case Management of

childhood illnesses; strategies for reducing stunting; and increasing skilled birth attendance. A copy of the meeting agenda can be found in Annex One and a list of participants is located in Annex Two.

Country representatives formed small working groups on the final day and developed preliminary country action plans for reducing child mortality in their countries, which were shared with the plenary. Ministers and Deputy Ministers of Health present on the third day of the meeting gave comments and remarks, and closing remarks were made by the hosts of the meeting, including the Government of Ethiopia, USAID, and UNICEF.

### **Summary of Day One**

Day One featured an opening plenary in the morning, a morning panel session on community-based newborn care, a lunch time presentation on reaching child immunization targets in Africa, and an afternoon panel session titled “Overcoming Bottlenecks to Implementation and Scaling Up to Complement Facility Level Care”. The evening of Day One also featured a reception at the Sheraton Hotel with brief public remarks by host representatives.

The opening plenary featured remarks by the Honorable Ministers of Foreign Affairs and Health from Ethiopia, H.E. Teodros Adhanom and H.E. Kesetebirhan Admasu; Commissioner for Economic Affairs, Africa Union Commission, H.E. Maxwell Mkwezalamba; Deputy Assistant Administrator, Bureau of Global Health, USAID/Washington, Wade Warren; the Head of Health, UNICEF, Mickey Chopra; and video messages from USAID Administrator Rajiv Shah, UNICEF Executive Director Anthony Lake, and UNICEF Goodwill Ambassador Leo Messi. An introductory video about the Child Survival Call to Action Conference in Washington in June 2012 was played and described the ensuing resolve of 169 global leaders, CSOs, FBOs etc who pledged to end preventable child deaths by 2035. Available transcripts of remarks are contained in Annex Three.

Key highlights from the opening plenary included:

1. One of every four babies born is born in Africa. Half of these babies are born at home. It is often the poorest mothers who give birth at home where they are alone and without assistance should complications occur.
2. Half of all child deaths occur in Africa. A total of 6.9 million children died globally in 2011 and about half of these deaths are newborn deaths due mainly to preterm delivery, birth complications and newborn infections. Approximately 1.1 million children die during labor. Additionally, 201,000 mothers die from birth complications. Other leading causes of child death include pneumonia, diarrhea and malaria with malnutrition underlying more than a third of these deaths. WHO estimates that 22 million child globally do not complete a full course of basic vaccines.
3. Despite these dismal figures, Africa is making progress in addressing child health issues and child mortality is decreasing. However, in most African countries the progress is not fast enough to ensure that they will meet the MDG targets. This decline is especially slow for neonatal mortality.

4. There are interventions which we know can impact child health, but these need to be more widely applied within the lower incomes countries. Malawi and Niger are both positive examples demonstrating how - even within lower income countries - when these known child health interventions are successfully implemented child mortality and morbidity can be addressed.
5. It is clear all of the countries attending this meeting are making a sincere commitment to tackle this important issue and to meet the MDGs.

In the morning, the first panel presentation covered the topic of community-based newborn care. The panel featured a presentation from Joy Lawn, Save the Children/Saving Newborn Lives, then a presentation of country case-studies from Kenya (Peter Gisore) and Ethiopia COMBINE (Abeba Bekele, SNL/SCT Ethiopia). These were followed by a life story from Health Extension Worker Belaynesh Mulugeta, Hidakaliti Health Post, Dale Woreda, Sidama Zone SNNPR in Ethiopia.

Part of this panel session also included a facilitated panel discussion with Joy Lawn, Peter Gisore, Abeba Bekele, Mary Taylor, Senior Program Officer, Gates Foundation and Samira Abubaker, WHO/Geneva.

According to these presenters, the delivery of services must take place where the majority of the population resides. To this end, community health workers/health extension workers (CHWs/HEWs) can serve as a platform for implementing integrated community case management (iCCM). The Ethiopia example of HEWs show the impact a strong community based program can have:

1. CHWs must become a professionalized cadre to ensure career progression. This necessitates getting payment for their services.
2. Successful CHW programs are closely linked to facilities.

At lunch time, Jean-Marie Okwo-Bele, Head of Immunizations, WHO/Geneva gave a presentation on immunization. Entitled "Reaching the Final 20 Percent", Dr. Okwo-Bele discussed achieving 100 percent coverage of all three doses of the diphtheria-tetanus-pertussis (DPT) vaccination, necessary for children before they reach 12 months of age. Strengthening routine immunization services is crucial to achieving MDG 4.

The second panel was titled "Overcoming Bottlenecks to Implementation and Scaling Up to Complement Facility Level Care", and featured Robert Black, Chair, Department of International Health, Johns Hopkins Mailman School of Public Health, a presentation of country case-studies from Ethiopia (Mehret Hiluf, Director, Agrarian Health Promotion and Disease Prevention Directorate, MOH) on national scaling up of iCCM in Ethiopia, and a life story from a Health Extension Worker (HEW) Nigist Abebe, Dongore Furda Health Post, Boset Woreda, East Shoa Zone, Oromia. Finally, Asma Yaroh, Reproductive Health Executive Director, MOH, Niger, gave a presentation on community-based child health programs and child mortality reduction.

According to these speakers, addressing child mortality and morbidity requires:

1. increasing the focus on the first month of a child's life;

2. linking access to quality and ensuring the services including immunization reach underserved communities wherever they are;
3. focusing on behavior change and not just biomedical interventions as was very well documented by the Health Extension Workers of Ethiopia's HEP;
4. eliminating user fees on lifesaving commodities for women and children;
5. taking a health systems approach through which issues such as human resources, supervision, commodities, and use of data to monitor and measure progress and ensure accountability are adequately addressed with the use of scorecards;
6. increasing political commitment and ownership and ensuring community engagement

In the evening, a welcome Reception was held at the Sheraton Hotel for all participants and invited guests. Host organization representatives, including Dr. Peter Salama, UNICEF Representative to Ethiopia, Ambassador Donald Booth, U.S. Ambassador to Ethiopia, and H.E. Kesetebirhan Admasu, Minister FMOH, Ethiopia gave short welcoming remarks.

### **Summary of Day Two**

Day two began with summary of Day one and introduction to Day two. The third panel of the meeting, "Reducing Stunting to Increase Child Survival", featured experts in the area of nutrition, stunting, and child survival. Bjorn Ljungqvist, REACH Coordinator, UN World Food Program gave a global overview and presented scientific evidence on stunting during the first 1000 days of life. Also included in the panel was a presentation of country case-studies from Rwanda by Odette Kamazi and Zambia by Elywn Chomba. Finally, this panel featured a facilitated panel discussion with country experiences on scaling up strategies for reducing stunting from Tanzania (Olivia Yambi), Rwanda (Odette Kamazi) and Zambia (Elywn Chomba).

Highlighted findings from this panel include:

1. There has been rapid socioeconomic development in many countries in the past decade, but stunting has not diminished (especially in sub-Saharan Africa).
2. There are three key determinants for stunting: food security, access to health services, and care of the child.
3. Chronic malnutrition is associated with:
  - a. increase in infections;
  - b. mental retardation, school delay;
  - c. reduction of the income level of the country;
  - d. adult (heart) disease; and
  - e. low birth weight.
4. Stunting takes place in the first years of life (impact on the brains of children), particularly during the first 1000 days, but also before conception.
5. Malnutrition is not related to genetics, but is instead an environmental issue.
6. In monitoring the success of nutrition programs, it is important to follow 3 indicators:
  - a. The frequency of feeding an infant;

- b. The diversification of food given to an infant; and
  - c. The presence of dairy products in the diet.
- 7. Eating habits, as well as hygiene and sanitation, are also factors affecting the growth of children. In addition, the importance of mother's nutritional support, taking account of food insecurity and accountability.
- 8. The elements of success of the experiences of Ethiopia, Rwanda, Zambia and Tanzania where the prevalence of stunted growth exceeds 40 percent are:
  - a. A strong commitment and a policy and strategic framework, with a multisectoral approach
  - b. The setting up of structures at all levels, training, standardization of services
  - c. The involvement of the communities and the motivation of community health workers
  - d. A strong monitoring and evaluation system
  - e. BCC activities (exclusive breastfeeding, supplementary feeding, early marriage, etc.)
  - f. The partnership

A key take-out message from this panel is that to reduce stunting in children, it is not the level of funding which is important, but what is being done and how (coverage and adequacy of services).

The fourth panel, "Evidence on Population Level Change in Addressing Behavioural and Social Determinants of Child Survival", featured a global overview of scientific evidence with special focus on Africa context by Michelle Kaufman, Monitoring and Evaluation Specialist, Centre for Communication Programs at John Hopkins Bloomberg School of Public Health. This presentation was followed by three country case studies, including

"The case of SBC for Malaria Prevention & Treatment in Tanzania", Martin Alilio, SBC Specialist, USAID; "Partnerships in Social & Behaviour Change for Child Survival", Yonas Dare, Program Department Head, Ethiopia Inter-Faith Forum for Development Action, (EIFFDA), and "Delivering Social and Behaviour Change Communication at Scale" by Rocio Berzal, Communication for Development Specialist, UNICEF, Niger.

Several approaches were presented, including community-based approaches, mass media, communication technology (SMS), social marketing approaches, and holistic and integrated approaches.

The panel presenters reinforced the concepts behind communication for social change. These include:

1. empowering communities and individuals;
2. ensures the quality of the interventions;
3. facilitates the adoption of new policies and interventions;
4. reinforces awareness and changes in perception; and
5. reduces the barriers to use and avoid missed opportunities.

To advance implementation of communication for social change, countries should consider some key points:

1. the importance of measuring impact in a standardized way and the importance of monitoring and evaluation of programs;

2. the use of the data for evidence-based planning and messages;
3. the need for more evidence about the effect of long-term behavior change;
4. policies and the involvement of the community for sustainability;
5. partnerships and coordination; involving those outside the health care system (religious organizations, women's organizations, schools, private sector) for greater impact; and
6. Documentation and modeling for diffusion.

Panel five presenter, Tigest Ketsela, Director of Health Promotion Cluster, WHO Regional Office for Africa discussed how to increase skilled birth attendance for decreasing maternal and newborn mortality and integration for child survival. In her global overview, she raised the following points:

- Maternal mortality has seen a 50 percent reduction over a period of 20 years (from 800 to 400/100,000), but there is a significant disparity between the countries. In Africa, only two countries achieved the MDG 5, and nine have made no progress. The causes of maternal mortality are known and high-impact interventions exist which include qualified assistance at childbirth. Skilled birth attendance is defined as the existence of qualified personnel involved at delivery, as well as a supportive environment for providing skilled care (e.g., policy, equipment, supervision). The trend shows that MDG 5 will not be achieved if we do not increase our efforts.
- Neonatal mortality is 30 percent of the total mortality among children under five, and the causes are known and avoidable. There is a direct correlation between skilled attendance at childbirth and maternal mortality, as well as between maternal mortality and neonatal mortality.
- Interventions that can save the lives of mothers and newborn children are implemented at coverage levels below 50 percent.
- There needs to be a functional system at any time to ensure adequate management and medical intervention for unpredictable and urgent complications.
- In addition good coverage skilled birth attendance is not enough; quality and equity of services need improvement.

The “Three Delays” are the factors contributing to maternal and neonatal mortality, including decision-making at the household level, challenges related to geographic and financial access to services, and challenges faced in getting care within the facility, including the lack of qualified staff (including deployment, distribution, maintenance, etc.), inadequate management structures, policies, and regulations.

Progress in improving maternal mortality rates is possible (countries such as Thailand, Malaysia, and Sri Lanka serve as examples). However, government commitment and sustainable efforts are needed to reduce maternal mortalities. It is also important to know where and how to invest together, in order to ensure a coordinated and integrated approach. Countries are considering various opportunities to do so:

- UN Global Strategy for Women’s and Children’s Health
- The 13 life-saving commodities for women (Every Woman Every Child Campaign)

- Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA)
- Elimination of mother to child transmission of HIV
- Harmonization for Health in Africa
- Multilateral and bilateral donor agencies and foundations

Concrete actions to save the lives of mothers and newborns take place through the commitment to universal access to care, monitoring of progress and resources, and through operational research.

Tigest Ketsela from the WHO Regional Office for Africa then gave a short introduction to “Addressing the Challenge of Women’s Health in Africa”, a report of WHO’s Commission on Women’s Health in the African Region. This report has been published and was officially launched at the meeting and distributed to participants. In the report, the expert Commission argues that women’s health is the foundation for social and economic development in Africa. Thus women’s health has huge implications for the region’s development. The report defines six priority actions for improving women’s health in the region.

A brief documentary film about subject of women’s health in Africa and the report was viewed during the meeting. Afterwards, the report was officially presented to the meeting participants.

The sixth and final panel of Day two covered cross-cutting themes in child survival. Angela Spilsbury, Senior Health Adviser, DFID, gave a presentation on “The golden opportunity: integrating family planning programs to reduce maternal and newborn mortality”. In addition, Charles Mwansambo (Malawi) gave a presentation on the Malawi experience and challenges and opportunities in PMTCT to reduce newborn mortality.

This panel addressed cross-cutting themes regarding family planning and prevention of mother to child transmission of HIV, including:

1. The role of family planning in neonatal and maternal mortality reduction:
  - The child mortality rate decreases by 50 percent if birth intervals are two years or greater
  - Women who use FP have higher socio-economic status because they are more productive
  - \$1 investment in FP yields \$4 in productivity
2. The London Family Planning Summit in July 2012 served to reaffirm international donor commitments (including the private sector) for access to family planning.
3. Implementation of Option B+ in Malawi demonstrated a net increase in the number of HIV+ women and children that survive.

A final cross-cutting theme considered during this panel was “Linking African Leadership for Child Survival to Global Initiatives”, presented and discussed by Mickey Chopra, UNICEF, and Samira Abubaker, WHO.

The panelists called for countries to do the following:

- Implement evidence-based programming, based on analysis of bottlenecks and identification of milestones
- Strengthen accountability within the health and welfare sector
- Mobilize all sectors and actors (e.g., a high-level meeting) to support child survival at country level.

Countries may have access to initiatives that have specific resources:

1. The UN Commission on Life-Saving Commodities for Women and Children
2. Countdown to 2015, Lives Saved Tool (LiST; Global Partnership for a Malaria-free World). Useful documents for completing reviews and analyses. There is also a possibility of technical support for national Countdown exercises.
3. Renew the Promise Campaign (UNICEF)
4. UNICEF's Global Action Against Pneumonia and Diarrhea
5. Global Strategy for Women's and Children's Health and the Commission on Information and Accountability for Women's and Children's Health

Panel members stressed that countries are signatories to these different initiatives, and it is important to support the implementation of the commitments in a coordinated manner.

### **Summary of Day Three**

Day three began with a summary of Day two and introduction to Day three. Day three focused on the development of country action plans, and opened with a short panel discussion on maintaining national momentum. Peter Berman, Economist, Harvard School of Public Health, gave a presentation entitled "Developing a Balanced Workplan". According to this presentation, two essential elements of a workplan to achieve child survival goals are: (1) the right interventions that can prevent avoidable mortality and their effective integration; and (2) a health system that can pay for and deliver these services to those who need them in a sustainable way. It is important to focus on both of these elements at the same time, as well as focusing on important determinants which are outside of the system, such as girls education. It is also important to learn and adapt successes from other countries, such as Ethiopia's national scorecard for monitoring progress in maternal and child health.

Tewodros Bekele, Director General, Urban HPDPD then gave a presentation on Ethiopia's process in developing national scorecards and a national action plan for child survival. Two objectives of Ethiopia's MNCH scorecard are to: (1) enhance accountability and drive action to improve performance for MNCH; and (2) easily track and compare performance across regions for key indicators (eg, skilled birth attendance and measles vaccination coverage). The scorecard is designed to fit into the existing performance management process. Ethiopia's national action plan, or Roadmap for Child Survival, contains strategies that include nearly all of the universally-known interventions to reduce mortality among children under five years. Ethiopia seeks to scale up each of the high impact interventions to 90 percent coverage by 2020 and 95 percent by 2025. They hope that through the successful

implementation of the Roadmap, they will reduce their under-five mortality rate to 30/1,000 live births by 2025.

Instructions were then given to country delegates for developing plans in a brief country action planning process held during the remainder of the morning. Country teams were assigned into groups, and these groups met to discuss and develop national action plans. Representatives from each of the country teams were then invited to present their ideas and plans to the plenary.

In closing, each of the Ministers and Deputy Ministers present on Day three were invited to speak for a few minutes and give their remarks and comments on child survival and maternal and child health in their respective countries. H.E. Félix Kabange Numbi, Minister of Health, Democratic Republic of Congo gave a presentation on the DRC experience. In addition, the following Ministers and Deputy Ministers gave remarks:

H.E. Dr. Carlos Masseca, Deputy Minister of Health, Angola

H.E. Mme Moinafouraha AHMED, Minister of Health, Solidarity, Social Cohesion and Gender Promotion, Comoros

H.E. Naman Keita, Minister of Health, Guinea

H.E. Lucia Nthabiseng Makoe, Deputy Minister of Health, Lesotho

H.E. Halima Daudi, Deputy Minister of Health, Malawi

H.E. Nazira Vali Abelula Deputy Minister of Health, Mozambique

H.E. Ali Addallahi Warsame, Minister of Health Puntland Somalia

H.E. Yatta Lori Lungor, Deputy Minister for Health South Sudan

H.E. Douglas Tendai Mombeshora, Deputy Minister for Health and Child Welfare, Zimbabwe

H.E. Bahar Idriss, Minister of Health, Sudan

A Meeting Consensus Statement was drafted and circulated for review during the meeting. The final statement was given by H.E. Richard Nchabi Kamwi, Minister of Health, Namibia. This statement is contained in this meeting report on page 14. Closing remarks were given by Dennis Weller, USAID/Ethiopia Mission Director, Peter Salama, UNICEF Representative to Ethiopia, and H.E. Kesetebirhan Admasu, Minister of Health, Ethiopia. Copies of these final remarks can be viewed in Annex Four.

## **African Leadership for Child Survival—A Promise Renewed Meeting Consensus Statement, 18 January 2013**

We the African Countries that have signed the pledge of Committing to Child Survival, A Promise Renewed met in Addis Ababa between 16 and 18 January 2013, as the first continental follow up to consolidate our efforts to accelerate progress in newborn, child and maternal health.

The African continent shares a significant global burden of newborn, child and maternal mortality. Most of these deaths are preventable. Thirty per cent of African countries are on track to achieve MDG 4, and some African countries have already reduced U5MR to below 20/1,000 live births. However, many countries have to intensify their efforts to meet this important goal.

To accelerate progress we need targeted and effective implementation of high impact interventions. Dramatic reductions in preventable child deaths can be achieved through concerted action in five critical areas, outlined in the Global Roadmap:

1. Geography: Increase efforts in the areas where the most deaths occur, prioritizing budgets and committing to action plans to end preventable child deaths.
2. High Burden Populations: Focus country health systems on scaling-up access for underserved populations, to include rural and low income groups.
3. High Impact Solutions: Focus on the primary causes of child death.
4. Gender Equality: Invest beyond health programs to include educating girls and boys, empowering women and men, and inclusive economic growth.
5. Mutual Accountability and Financing: Unify around a shared goal and common metrics.

We are committed to develop and implement country-led roadmaps that integrate on-going efforts to accelerate progress to end preventable deaths among children under five years of age by 2035, and reduce U5MR to below 20/1,000 live births in all African nations.

## **ANNEXES**

## **ANNEX ONE – Meeting Agenda**



COMMITTING TO CHILD SURVIVAL  
**A PROMISE RENEWED**



Federal Democratic Republic of Ethiopia  
Ministry of Health

# African Leadership for Child Survival

Keep the Promise—Invest in A Child

Program

Addis Ababa, Ethiopia

16-18 January 2013



**H.E. Dr. Tedros Adhanom, Minister of Foreign Affairs, Ethiopia**

Dr. Tedros graduated with a Bachelor's degree in Biology from Asmara University in 1986. He received a Master's degree in immunology of infectious diseases from University of London in 1992. In 2000, he received his PhD in Community Health from University of Nottingham, UK. He received the young investigator award from the American Society of Tropical Medicine and Hygiene (1999) and a young researcher award from Ethiopian Public Health Association (2003).

Dr. Tedros was appointed Minister of Foreign Affairs in November 2012. Dr. Tedros has served in various expert and leadership positions at the federal level and in regions since 1986 and published several articles. He was deputy Minister of health before becoming the minister in October 2005 after the national election.

Ethiopia has developed a very ambitious five year Health Sector Development Program, and he is very optimistic that the set targets could be achieved and calls for all partners to enhance their support. He is the only new member of the TPLF executive council who was not member of the guerrilla war waged against the Derg regime.

In March 2011 Dr. Tedros received the Jimmy and Rosalynn Carter Humanitarian Award in recognition for his outstanding leadership in the rapidly evolving field of global health and his involvement in enhancing Ethiopia's active engagement in major international forums.



**H.E. Dr. Kesetebirhan Admassu, Minister of Health, Ethiopia**

Dr. Kesetebirhan Admasu was appointed Minister of Health in November 2012. Prior to his appointment as State Minister for Health Programs at the Federal Democratic Republic of Ethiopia in October 2010, he served as Director General of Health Promotion and Disease Prevention General Directorate in the Ministry. In his capacity as DG, Dr Kesetebirhan has overseen the health sector reform and led the implementation of the country's flagship program, the health extension program. He is a champion of innovation, task-shifting and implementation at scale. In his tenure as DG, he has led the roll out of integrated community case management of childhood illnesses and insertion of single-rod implant through the health extension platform.

Dr Kesetebirhan has dedicated his entire career to public service and scientific research focused on major public health problems in Ethiopia. A Medical Doctor by training with Masters in Public Health, Dr Kesetebirhan has served in a number of clinical and public health positions. He has worked as public private partnership team leader, CEO of a tertiary hospital and DG before assuming his current ministerial portfolio.



**Wade Warren, Deputy Assistant Administrator, USAID**

Wade Warren is a Deputy Assistant Administrator in the Bureau for Global Health at the U.S. Agency for International Development (USAID). He has responsibility for strategic planning, budgeting, procurement, human resources, project design, monitoring and evaluation, and communications. The Global Health Bureau is USAID's second largest bureau in terms of personnel, and health programming constitutes one third of the Agency's total budgetary resources.

Prior to this assignment, Mr. Warren was the Acting Chief Operating Officer of the State Department's Office of the Director of U.S. Foreign Assistance, where he had overall responsibility for strategic planning, budgeting, program planning, and performance reporting for \$32 billion annually in foreign assistance. Mr. Warren also worked for thirteen years for USAID's Bureau for Africa, serving in Zimbabwe, Botswana, and Washington, D.C. In Washington, he served as the Director of the Africa Bureau's Office of Development Planning and as the Bureau's Acting Deputy Assistant Administrator. He was responsible for the Bureau's policy, budgeting, programming, and operational processes, with particular emphasis on strategic frameworks for USAID's 23 bilateral and three regional missions in Africa.

Mr. Warren received his undergraduate degree in history from Georgetown University's School of Foreign Service in 1981 and his graduate degree in international business from the Thunderbird School of Global Management in 1990. Throughout the 1980s, he worked as an analyst in the U.S. House of Representatives, and from 1991 to 1994, he served as Chief Financial Officer of the U.S. Telecommunications Training Institute, a non-profit organization that provides policy and technical training to communications professionals from the developing world.



**Rajiv Shah, Administrator, USAID**

Dr. Rajiv Shah serves as the 16th Administrator of USAID and leads the efforts of more than 8,000 professionals in 80 missions around the world.

Since being sworn in on Dec. 31, 2009, Shah managed the U.S. Government's response to the devastating 2010 earthquake in Port-au-Prince, Haiti; co-chaired the State Department's first review of American diplomacy and development operations; and now spearheads President Barack Obama's Feed the Future food security initiative. He is also leading "USAID Forward", an extensive set of reforms to USAID's business model focusing on seven key areas, including procurement, science & technology, and monitoring & evaluation.

Before becoming USAID's Administrator, Shah served as undersecretary for research, education and economics, and as chief scientist at the U.S. Department of Agriculture. At USDA, he launched the National Institute of Food and Agriculture, which significantly elevated the status and funding of agricultural research. Prior to joining the Obama administration, Shah served for seven years with the Bill & Melinda Gates Foundation, including as director of agricultural development in the Global Development Program, and as director of strategic opportunities.

Shah earned his medical degree from the University of Pennsylvania Medical School and his master's in health economics from the Wharton School of Business. He attended the London School of Economics and is a graduate of the University of Michigan.



**Mickey Chopra, Chief of Health/ Associate Director, Programs, UNICEF**

Dr. Mickey Chopra took up his post as Chief of Health and Associate Director of Programmes at UNICEF's New York Headquarters in August 2009, leading the agency's work on maternal, newborn and child health, immunization, paediatric HIV/AIDS, and health systems strengthening, policy and research. Prior to his appointment to UNICEF, Dr. Chopra was the director of the Health Systems Research Group of the South Africa Medical Research Council.

A British national, Dr. Chopra is qualified as a medical doctor with an additional degree in medical sociology from the University of Southampton in England. After completing his internship, he went to work as a district medical officer in the rural health district of Hlabisa, South Africa. He had a particular focus on child health and nutrition programs and received his Diploma in Child Health during this time.

After receiving his Masters in Public Health (Primary Health in Developing Countries) at the London School of Hygiene and Tropical Medicine in 1997, he joined the nascent School of Public Health at the University of the Western Cape in South Africa. In 2008, he earned his PhD from Faculty of Medicine, University of Uppsala in Sweden.



**Anthony Lake, Executive Director, UNICEF**

On 1 May 2010, Anthony Lake became the sixth Executive Director of the United Nations Children's Fund, bringing to the position more than 45 years of public service.

During his career, Anthony Lake has worked with leaders and policy makers across the world. In 2007-2008, he served as a senior foreign policy adviser to the presidential campaign of Barack Obama, a role he also performed during the Clinton presidential campaign of 1991-1992. He has managed a full range of foreign policy, national security, humanitarian and development issues at the most senior levels: as National Security Advisor (1993-1997) under President Bill Clinton, and as Director of Policy Planning in President Carter's administration (1977-1981). He joined the US State Department in 1962 as a Foreign Service Officer.

Upon leaving the government, he served as the United States President's Special Envoy, first in Ethiopia and Eritrea, and later in Haiti, from 1998 to 2000. His efforts, for which he received the 2000 Samuel Nelson Drew Award, contributed to the achievement of the Algiers Agreement that ended the war between Ethiopia and Eritrea. He also played a leading role in shaping policies that led to peace in Bosnia and Herzegovina, and Northern Ireland.

His experience in international development began in the 1970s, as Director of International Voluntary Services, leading the work of this 'private Peace Corps'. In that same decade, he also served on the boards of Save the Children (1975-1977) and the Overseas Development Council. Over the past 10 years, Anthony Lake has been an International Adviser to the International Committee of the Red Cross (2000-2003) and Chair of the Marshall Legacy Institute, which works in conflict-affected countries to remove landmines and assist survivors, and advance children's rights.

Anthony Lake's ties with UNICEF are long-standing, dating back to 1993, when he worked with UNICEF's third Executive Director, James P. Grant, on the organization's presentation of its flagship publication, 'The State of the World's Children', at the White House. From 1998 to 2007 he served on the Board of the US Fund for UNICEF, with a term as Chair from 2004 to 2007, after which he was appointed a permanent honorary member.

Immediately prior to his appointment with UNICEF, Anthony Lake served as Distinguished Professor in the Practice of Diplomacy at the Edmund A. Walsh School of Foreign Service at Georgetown University. He has been a member of the Board of Trustees at Mount Holyoke College and a member of the Advisory Council of the Princeton Institute for International and Regional Studies, and has served on the Governance Board of the Center for the Study of Democracy at St. Mary's College of Maryland.

He obtained a B.A. degree from Harvard in 1961, read international economics at Trinity College, Cambridge, and went on to receive his Ph.D. from the Woodrow Wilson School of Public and International Affairs at Princeton University in 1974.

# Wednesday, 16 January, 2013

8:30-9:00	Gather
9:00-10:15	Opening Plenary
9:00-9:15	H.E. Dr. Tedros Adhanom, Minister of Foreign Affairs, Ethiopia
9:15-9:30	H.E. Dr. Kesetebirhan Admassu, Minister of Health, Ethiopia
9:30-9:40	H.E. Dr. Maxwell Mkwezalamba, Commissioner for Economic Affairs, AU Commission
9:40-9:50	Wade Warren Deputy Assistant Administrator, Bureau of Global Health USAID Rajiv
9:50-9:55	Shah, Administrator, USAID (video)
9:55-10:05	Mickey Chopra, Chief of Health/Associate Director, Programs, UNICEF Anthony
10:05-10:10	Lake, Executive Director, UNICEF (video)
10:10-10:15	Leo Messi, Goodwill Ambassador, UNICEF (video)
10:25-10:50	Tea Break: video clips and country gallery
10:50-12:50	Block One: Community-based Newborn Care
10:50-11:20	International expert, global overview and scientific evidence: Joy Lawn, Save the Children/Saving Newborn Lives
11:20-11:50	Presentation of country case-studies from Kenya (Peter Gisore) and Ethiopia COMBINE (Abeba Bekele, SNL/SCT Ethiopia), life story from Health Extension Worker Belaynesh Mulugeta - Hida- kaliti Health Post, Dale Woreda, Sidama Zone, SNNPR
11:50-12:50	Facilitated panel discussion with Joy Lawn, Peter Gisore, Abeba Bekele, Mary Taylor, Bill and Melinda Gates Foundation, and Samira Abubaker, WHO/Geneva  <i>Lead Discussant: Mickey Chopra</i>
12:50-14:15	Lunch
13:30-14:00	Jean-Marie Okwo-Bele, Head Of Immunizations, WHO/Geneva: "Reaching the Final 20 Percent" or Integration of EPI with pneumonia and diarrhea within iCCM
14:30-16:30	Block Two: iCCM: Overcoming Bottlenecks to Implementation and Scaling Up to Complement Facility Level Care
14:30-15:00	International expert, global overview and scientific evidence: Robert Black, Chair, Department of International Health, Johns Hopkins Mailman School of Public Health
15:00-15:30	Presentation of country case-studies from Ethiopia (Mehret Hiluf), national scaling up of iCCM in Ethiopia and a life story from a Health Extension Worker, Nigist Abebe - Dongore Furda Health Post, Boset Woreda, East Shoa Zone, Orominya  Niger: Asma Yaroh, MoH Niger community based child health program and child mortality reduction
15:30-16:00	Audience Q&A with presenters
18:30	Welcome Reception: Sheraton Hotel
19:00-19:10	Dr. Peter Salama, UNICEF Representative to Ethiopia Ambassador
19:10-19:20	Donald Booth, U.S. Ambassador to Ethiopia H.E. Dr. Kesetebirhan
19:20-19:30	Admasu, Minister of Health, Ethiopia

# Thursday, 17 January, 2013

9:00-9:15	Summary of Day One and Outline of Day Two Agenda (Nigeria)
9:15-11:15	Block Three: Reducing Stunting to Increase Child Survival
9:15-9:45	International expert, global overview and scientific evidence: Bjorn Ljungqvist, UN World Food Program
9:45-10:15	Presentation of country case-studies: Rwanda (Odette Kamazi) and Zambia (Elwyn Chomba) Facilitated panel
10:15-11:15	discussion with Tanzania (Olivia Yambi), Rwanda (Odette Kamazi), and Zambia (Elwyn Chomba)  <i>Lead Discussant: Bjorn Ljungqvist</i>
11:15 -11:30	Tea Break: video clips and country gallery
11:30-13:00	Block Four: Evidence on Behavior Change in Addressing Child Survival
11:30-12:00	International expert, global overview and scientific evidence: Michelle Kaufman, Johns Hopkins University, Center for Communications Programs
12:00-12:30	Country Case Studies: <input type="checkbox"/> The case of SBC for Malaria Prevention & Treatment in Tanzania: Martin Alilio, USAID <input type="checkbox"/> Partnerships in Social & Behaviour Change for Child Survival: Yonas Dare, Ethiopia Inter-Faith Forum for Development Action <input type="checkbox"/> Delivering Social and Behaviour Change Communication at Scale: Rocio Berzal, UNICEF, Ni-ger
12:40-13:00	Plenary Engagement - General responses and moderated questions  <i>Lead Discussant: Kerida McDonald</i>
13:00-14:00	Lunch
13:30-14:00	Group Photo
14:00-15:00	Block Five: Increasing Skilled Birth Attendance for Decreasing Maternal and Newborn Mortality – Integration for Child Survival
14:00-14:30	International expert, global overview and scientific evidence: Tigest Ketsela, WHO Regional Office for Africa
14:30-14:55	Women's Health
14:30-14:35	Tigest Ketsela, WHO Regional Office for Africa, short introduction to “Addressing the Challenge of Women's Health in Africa”
14:35-14:50	Documentary clip about report
14:50-14:55	Presentation of the report to Minister of Health: “Addressing the Challenge of Women's Health in Africa”  <i>Lead Discussant: Tedla W. Giorgis</i>
15:00-16:15	Cross-cutting themes in child survival
15:00-15:30	Panel: Angela Spilsbury, Senior Health Adviser, DFID - The Golden Opportunity and integrating family planning programs to reduce maternal and newborn mortality, and <b>Charles Mwansambo (Malawi)</b> - The Malawi experience and challenges and opportunities in PMTCT to reduce newborn mortality
15:30-15:50	Q&A from audience on skilled birth attendance, family planning/continuum of care and women's health, and PMTCT
15:50-16:15	Linking African Leadership for Child Survival to Global Initiatives Panel: Mickey Chopra, UNICEF, and Samira Abubaker, WHO
16:15-16:30	Tea Break: video clips and country gallery

# Friday, 18 January, 2013

9:00-9:15	Summary of Day Two and Outline of Day Three Agenda (Senegal)
9:15-11:20	Maintaining National Momentum: Country Action Plans
9:15-9:30	Peter Berman, Economist, Harvard School of Public Health: Setting a vision for Child Survival
9:30-9:45	Tewodros Bekele, Urban HPDPD: Ethiopia's process: scorecards, national action plan; instructions to country delegates for developing next steps in country action planning process
10:30-10:45	Tea Break
10:45-11:30	Country teams/group work
11:30-12:00	Report-outs from country teams
12:10-13:00	Lunch
13:00-13:10	Return to main hall – video clip on Democratic Republic of Congo
13:10-13:25	H.E. Felix Kabange Numbi Mukwampa, Minister of Health, Democratic Republic of Congo – Sharing the DRC experience
13:25-14:25	Closing remarks
13:25-14:00	Brief remarks from each Minister/Vice-Minister of Health
14:00-14:10	H.E. Richard Nchabi Kamwi, Minister of Health, Namibia - Final Meeting Consensus Document
14:10-14:15	Dennis Weller, USAID/Ethiopia Mission Director
14:15-14:20	Peter Salama, UNICEF Representative to Ethiopia
14:20-14:25	H.E. Dr. Kesetebirhan Admasu, Minister of Health, Ethiopia
14:25	Close of Program and Departure

## **ANNEX TWO – List of Participants**

## Participant List

No.	Name	Organization/Title/Country
1	H.E. Dr. Carlos Masseca	Deputy Minister of Health, Angola
2	Dr. Higildo Jamba Rodrigues	MOH, Angola
3	Dr. Helga Freitas	MOH, Angola
4	Dr. Jose Roberto Santos	MOH, Angola
5	Mr. Hildo Carreiro	Angolan Embassy, Ethiopia
6	Mr. Ahmed Mohamed AHMED	MOH Head of Nutrition, Comoros
7	SAID ALI MBAE	Comoros UNICEF Health Specialist
8	Mme Moinafouraha AHMED	Minister of Health, Solidarity, Social Cohesion and Gender Promotion, Comoros
9	Dr. Felix Kabange Numbi Mukwampa	Minister of Health, Democratic Republic of Congo
10	Dr. Felix Kitenge wa Momat	Adviser to the management of medical facilities and new projects, DRC
11	Dr. Thomas Kataba	Expert in Management Studies and Schedules, DRC
12	Mande Mande wa Dove	Secretary to the Minister of Public Health, DRC
13	TOKO ALPHONSE LHAY	Health Specialist, UNDP DRC
14	Dr Salah Banoita Tourab	General Secretary, Djibouti
15	Dr. SABER ALI AHMED	Head Doctor of Arnaud Community Health's Center, Djibouti
16	Dr. Naman Keita	Minister of Health, Guinea
17	Dr. Helal Antoinette	MOH Guinea
18	Dr. Annah Wamae	Head of Family Health Department at the MoPHS, Kenya
19	HON. DR. LUCIA NTHABISENG MAKOA	Deputy Minister of Health Lesotho
20	MRS. MATHEBANE MARY RAMATABOEE	Child Survival Officer, Lesotho
21	Honourable Halima Daudi	Deputy Minister of Health, Malawi
22	Mr Norman Lufesi	ARI Programme manager, Malawi
23	Dr Charles Mwansambo	PS Health, MOH Malawi
24	Ruth Madison	USAID Malawi
25	Mrs Fanny Kachale	Director (RHU) Malawi

26	Mr Humphrey's Nsona	IMCI Coordinator Malawi
27	Dr. Madina Sangare	Sr. Reproductive Health Advisor, USAID/Mali Health Team
28	Dr. DIARRA Houleymata N'Diaye	Country Director of HKI, Mali
29	Mr. Boureima Allaye Toure	Head of the Malian Civil Society Coalition, Mali
30	Ms. Abebech Assefa	CIDA Mali
31	Nazira Vali Abelula	Deputy Minister of Health, Mozambique
32	Dr Richard Nchabi Kamwi	Minister of Health, Namibia
33	Selma H.D Auala	Deputy Director: Primary Health Care, MOH Namibia
34	Dr Myo-zin Nyunt	Chief Health and Nutrition, UNICEF Namibia
35	Ms Wezi Tjaronda	PA to the Minister, Namibia
36	Dr. Naftal Hamata	Special Adviser to the Minister, Namibia
37	Ms. Nambata Angula	USAID Namibia
38	Dr. Khaled Bensaid	Chief of Health, UNICEF Niger
39	Dr. Asma Yaroh	Reproductive Health Executive Director MoH Niger
40	Abimbola Williams	Senior Maternal & Newborn Manager, Save the Children Nigeria
41	Ado Jimada Gana Muhammad	Executive Director, National Primary Health Care Development Agency, Nigeria
42	Adetokunbo Olushola Oshin	Deputy Project Director, SURE-P-MCH, NPHCDA, Nigeria
43	Nnenna Ihebuzor	Director, Community Health Services, Nigeria
44	Bocar Mamadou Daff	HIV/AIDS Program, Senegal
45	Ramatoulaye Dioume	Senior Technical Adviser, USAID Senegal
46	Aissatou Diop	HIV /AIDS Program Senegal
47	Mariam SYLLA DIENE	Health Specialist Senegal
48	H. E. Dr. Ali Addallahi Warsame	Minister of Health Puntland, Somalia
49	HE. Dr. Yatta Lori Lungor	Deputy Minister for Health, South Sudan
50	Dr. John Choi Tibo Akeg	Director General for Pediatrics, Malakal hospital, South Sudan
51	H.E. Bahar Idriss	Minister of Health, Sudan
52	Talal Elfadil	Director of Primary Health Care, Sudan
53	Dr. Elwyn Chomba	Ministry Community Development Mother and Child Health, Zambia
54	Dr Douglas Tendai Mombeshora	Deputy Minister for Health and Child Welfare, Zimbabwe

55	Dr Bernard Madzima	Director Family Health, Zimbabwe
56	Dr Assaye Kassie	UNICEF Zimbabwe
57	Dr. Tedla W. Giorgis	MOH Ethiopia
58	Dr. Elizabeth Joy Lawn	Director Global Evidence and Policy, Saving Newborn Lives/Save the Children
59	Dr. Peter Gisore	Professor
60	Dr. Abeba Bekele	Save the Children
61	Belaynesh Mulugeta	HEW Ethiopia
62	Mary Taylor	Gates Foundation
63	Dr. Samira Aboubaker	Policy, Planning and Programmes Maternal, Newborn, Child and Adolescent Health and Development (MCA), World Health Organization
64	Dr. Sirak Hailu	WHO Ethiopia
65	Dr. Jean-Marie OKWO-BELE	Director, Immunization, Vaccines and Biologicals, World Health Organization
66	Dr. Robert Black	JHU
67	Dr. Mehret Hiluf	Ethiopia
68	Nigist Abebe	HEW Ethiopia
69	Mr. Bjorn Ljungqvist	World Food Program
70	Odette Uwera Kamanzi	President of Rwanda's Nutritionists Society
71	Ms. Olivia Yambi	Tanzania
72	Dr. Michelle Kaufman	Research and Evaluation officer
73	Martin Alilio	USAID
74	Yonas Dare	EIFFDA
75	Rocio Berzal	UNICEF Niger
76	Koona Keapoletswe	Director PMTCT Botswana
77	Dr. Tigest Ketsela MENGESTU	Director, Health Promotion Cluster, AFRO WHO
78	Fidele Ngabo	Director Maternal and Child Health, MOH Rwanda
79	Angela Spilsbury	DFID
80	Peter Berman	Harvard
81	Dr. Tewodros Bekele	Director General, Urban HPDPD
82	Melanie Renshaw	ALMA
83	Dr. Tedros Adhanom	Minister MoFA Ethiopia
84	Dr. Kesetebirhan Admasu	Minister MOH Ethiopia
85	H.E. Dr. Maxwell Mkwezalamba	Commissioner for Economic Affairs, African Union Commission

86	Gordon Wade Warren	Deputy Assistant Administrator Global Health
87	Dr. Mickey Chopra	Head of Health, UNICEF
88	Dennis Weller	USAID Ethiopia Mission Director
89	Dr. Kebede Worku	Ethiopia State Minister of Health
90	Janis Timberlake	Deputy Director Program Services and Country Program Officer
91	Rochika Chaudhry	GHI Senior Country Advisor
92	Dr. Ferew Lemma	MOH Ethiopia
93	Troy A. Jacobs	Senior Medical Advisor, Child Health & Pediatric HIV/AIDS, USAID
94	Dr. Neghist Tesfaye	UNICEF Ethiopia
95	Dr. Amir Aman Hagose	Director FMOH, Ethiopia
96	Meseret Yetube	Director FMOH, Ethiopia
97	Sintayehu Abebe	Director FMOH, Ethiopia
98	Petros Kidanu	Director FMOH, Ethiopia
99	Dr. Mulualem Gessesa	Neonatologist – Yekatit 12 Hospital, Ethiopia
100	Prof. Bogale Worku	Ethiopia Pediatric Society - Executive Director Pediatrician
101	Abiy Seifu	MCHIP Ethiopia
102	Dr. Khaled Bessaoud	WHO
103	Assefa Ayde	FMOH, Ethiopia
104	Hana Desalegn	FMOH, Ethiopia
105	Mohammed Reshid	FMOH, Ethiopia
106	Atsede Birhane	Minister's Secretary, FMOH, Ethiopia
107	Tadele Shonde	FMOH, Ethiopia
108	Berhanu Asfaw	FMOH, Ethiopia
109	Dr. Phaniel Habimana	UN Regional Adviser, Child and Adolescent Health
110	Dr Teshome Desta Woldehanna	Focal Person for Child and Adolescent Health
111	Dr Pierre M'Pele-Kilebou	WHO Representative Ethiopia
112	Dr. Fiona Braka	WHO Ethiopia EPI
113	Dr. Sirak Hailu	WHO Ethiopia CAH
114	Ms. Marianna Maculan	WHO Ethiopia Partnership focal person
115	Mr. Abraham Gebregiorgis	WHO Ethiopia Policy Advisor
116	Nikolay Esipenko	First Secretary from the Embassy of Russian Federation
117	Cynthia Kamikazi	GAVI Alliance, Rwanda

118	Kate Wembley	Save the Children, Ethiopia
119	Birkety Mengistu	Save the Children, Ethiopia
120	Joy Phumpaphi	Executive Secretary, ALMA
121	Beza Seyoum Alemu, Ph.D	USG - Postdoctoral Fellow NIH/NIAID/LMIV
122	Dr. Negussu Mekonnen	Country Representative, MSH-Ethiopia
123	Mr. Haile Wubneh	D/Chief of Party, ENHAT CS, MSH-Ethiopia
124	Dr. Senait Fisseha, JD OBGYN	University of Michigan
125	Dr. Teshome Gebre Kanno	Regional Rep for Africa, Taskforce for Global Health
126	Dr. Francois Marie Lahaye-	French Embassy
127	Anne Nolan	AusAid
128	Rebecca Yohannes	AusAid
129	Frew Tekabe	World Bank
130	Dr. Namana NV Gandham	World Bank
131	Mohamed Ali Kamil	World Bank
132	Meiraf Tadese	World Bank
133	Rahel Belete	CHAI
134	Luelseged Ahmed	CHAI
135	Marius Jong	Netherlands
136	Dr. Warren Naamara	UNAIDS
137	Rahel Getta	UNAIDS
138	Dr. Christine Sadia	UNAIDS
139	Jane Alaii	Consultant
140	Megan Kays	PSI
141	Bongiwe Ndondo	Soul City Institute
142	Adrian Chikumbe	Ministry of Health
143	Victoria Sande	MaiKhande
144	Linje Manyozo	
145	Thom Ofem	JHU

146	Rafael Obregon	Communication for Development
147	Patricia Portela Souza	Communication for Development
148	Joah Jahn	Public Health & Policy
149	Mario Bravo	Communication for Development
150	Candace Gebre	Rapporteur
151	Betemariam Alemu	Behaviour & Social Change
152	Samson Hailegiorgis	Public Health Consultant
153	Ato Jihad Keno	Director
156	Negussie Teffera	Executive Director
157	Dr. Sudhakar Morankar	Professor of Medical Anthropology
158	Mr. Lakew Abebe	Assis. Professor, Health Education and Behavioral Sciences
159	Chalachew Wassie	Social Psychology, Head College of Social Sciences and Languages
160	Asnakew Tagele	Currently PhD student of Educational Psychology in the Department of Psychology
161	Biniyam Bogale	Medical Sociology
162	Sheri-Nouane Duncan-Jones	USAID
163	Nicole Scheigg	USAID/LPA
164	Nena Terrell	USAID
165	Karen Ottoni	USAID
166	Niko Welch	USAID
167	Eshete Yilma	USAID
168	Katy Handley	USAID
169	Carmela Green-Abate	PEPFAR, USAID
170	Elise Jensen	HAPN Office Chief
171	Robert Sauers	Communications Specialist
172	Mary Harvey	Nutrition Officer
173	Yirga Ambaw	Public Health Specialist
174	Tom Kenyon	USAID
175	Nwando Diallo	USAID
176	Yared Kebede Haile	Infectious Disease Advisor
177	Samuel Hailemariam	HSS Specialist
178	Bethmariam Alemu	SBCC Specialist
179	Yoseph Woldegebriel	PMTCT Specialist

180	Zewditu Kebede Tessema	Reproductive Health Advisor
181	Luwei Pearson	UNICEF
182	Peter Salama	UNICEF
183	Kerida McDonald	UNICEF
184	Alexandra (Sacha) Westerbeek	UNICEF
185	Wossen Mulalu	UNICEF
186	Mulugeta Feleke	UNICEF
187	Joan Jahn	UNICEF
188	Seblewengel Hailu	UNICEF
189	Guy Clarysse	UNICEF
190	Guido Borghese	UNICEF
191	Atakilt Berhe	UNICEF
192	Sarah Konopka	ASH Project, MSH
193	Gwendolyn Morgan	ASH Project, APHRC
194	Bruk Mengesha	MSH Ethiopia
195	Abiy Andargachew	MSH Ethiopia
196	Suzzane McQueen	ASH Project, MSH
197	Edna Jonas	ASH Project, MSH
198	Djalene Tesfaye	MSH Ethiopia

## **ANNEX THREE – Keynote Remarks and Presentations**

**Welcoming Speech**  
**By**  
**Dr. Tedros Adhanom Ghebreyesus**  
**Minister of Foreign Affairs**

*‘African Leadership for Child Survival—A Promise Renewed’*  
*January 16, 2013*

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Dear Honorable Chairperson of the African Union Commission

Distinguished Ministers

Colleagues, stakeholders and friends

And welcome to the ‘African Leadership for Child Survival—A Promise Renewed’ three days conference.

I’m confident you’ll find your stay in Ethiopia hospitable and productive.

It was back in June of 2012, that the Government of Ethiopia accepted to co-host the Washington summit of ‘A Call to Action for Child Survival, a promise kept’, with the Government of India, the United States and UNICEF. The main objective of the summit was to propose to the leaders of all countries of the world a renewal of their commitment to child survival and to the elimination of all preventable deaths within two decades.

It was a great accomplishment that, shortly after the June summit, 169 countries signed a pledge committing to develop and implement actionable plans.

Together we stood up and declared that All Children must have a future that is bright and full of hope! Because, our boys and girls deserve nothing less than our full and dedicated efforts to this end!

What is even more impressive, in our continent of Africa, 47 out of 54 countries signed the call for action pledge and with determination to achieve 100% of the targeted goals.

**And, this is a great achievement!**

The African continent has made tremendous stride in advancing health status and health care in the past decades. However, progress has been uneven. Countries affected by conflict and chronic emergencies face additional challenges; and in some cases delays to Millennium Development Goals (MDG) achievement.

I can assure you of Ethiopia’s commitment to the provision of the necessary leadership to significantly decrease maternal and infant mortalities. Through determined efforts — an investment in financial and human resources, as well as progressive policies and unique community mobilization effort—Ethiopia has and will continue to expand our health care system to reach under-served communities, especially women, children, and young people in rural areas.

The Government of Ethiopia’s unwavering commitment towards achieving the country’s Millennium Development Goal will also be reflected in the increased rate in child survival.

As we look beyond 2015, the effort and resources that we have invested to the Millennium Development Goals must be continued. We need new vision, new targets and new frontier to concur. Our global and national achievements have collectively been remarkable, however perhaps uneven within our own boundaries. We have to cognizant that we still face pockets of child mortality higher than the national average and MDG targets. Therefore, beyond 2015, we should consider and develop strategies to ensure equity for children's survival.

Eliminating preventable deaths among children shouldn't only be a dream, but a duty and a reality to aspire for, carried out with full conviction.

**And, this, I believe, is achievable!**

I, therefore, call upon all the countries to honor your pledge with a firm local commitment, national plans and budgets, but most importantly with action.

I also call upon all development partners to support country led initiatives to end preventable deaths among women, newborns and children.

Let's join hands to make Africa a continent a place fit for children not only to survive but to also thrive, hence becoming members of a productive society.

I wish you a pleasant stay in Addis Ababa, and a successful conference with meaningful outcomes.

**Thank You!**

**Remarks by the Hon. Minister Dr. Kesetebirhan Admasu**  
**Minister of Health, Federal Democratic Republic of Ethiopia at the**  
**'African Leadership for Child Survival-A Promise Renewed' Meeting**

Addis Ababa, 16 January 2013

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*Your Excellency Dr. Dlamini Zuma, Chairperson of AU Commission, Honourable Ministers, Excellencies, Distinguished Guests and Speakers, Ladies and Gentlemen:*

On behalf of the Government of Ethiopia and all at the Ministry of Health let me express my warmest welcome to all of you.

It is a great honor for Ethiopia and the Ministry of Health to be hosting this special event. As we approach closer to the conclusion of our commitment to the MDGs we look ahead to our pledge beyond 2015. Now is a pivotal period for countries across the continent of Africa and indeed, to our partners and allies in the field of child survival.

Many who have come to participate in this momentous conference have come from far and wide to honor our invitation. Your presence is highly appreciated. I would also like to express my heart-felt appreciation to all those involved in organizing this landmark event. Thank you for all your concerted efforts to ensure the participation of many critical stakeholders and notable persons.

*Honourable Ministers of Health* - allow me to take also take this opportunity to thank you all personally for taking time out from your busy schedule to be with us here today, for your outstanding commitment on child survival in particular, and more broadly, to the improvement of the health and well being living conditions of communities throughout Africa. We applaud your Governments – for their enduring contributions and clear leadership in the area of child health in general and reverting child mortality in particular.

My message today is three-pronged: First, I want to say a few words about the significance of our presence in the 'African Leadership for Child Survival: A promise Renewed' meeting here today. Second, I want to share with you the progress Ethiopia has made on Child Survival. And finally, I will speak briefly about the importance and need of renewed commitment by leaders of the health sector in Africa beyond 2015 and towards the reduction of child mortality to below 20 by 2035.

*Excellencies, Ladies & Gentlemen* -

This Conference is a follow on the Child Survival Call to Action summit that we co-hosted back in June 2012 in Washington with the United States Government and the Government of India, with an invaluable support from UNICEF. This event led to the signing of a pledge by 169 countries globally and 46 of countries in Africa committing to taking action for child survival. What brings us here today is to reaffirm the renewal of the pledges that have been made and to get the attention of our African leader's focused on child survival and the elimination of preventable child deaths.

We in Africa have made tremendous strides in advancing health care and improving the health status in the past decades. As we look beyond 2015, the effort and resources that we have invested in MDGs will need to be intensified. While we need to celebrate our accomplishments, we also need new vision, new

targets and new frontiers to conquer. Yes, our global and national achievements have collectively been remarkable, however uneven within our own boundaries. Beyond 2015, we should consider and develop new strategies to ensure the inclusion of more innovative and proven interventions in an equitable manner for children's survival. We should target the hardest to reach areas regardless of the difficulties to render services. Integration of proven initiatives with the existing local processes, systems and practices requires a thoughtful country specific strategies and approaches. In Africa, there are countries in the category of upper middle income, as well as in the category of least developed countries. Hence, the course of action should be guided by the local conditions and culture, and should enable us develop the capacity, systems and structures required to deliver up our commitments.

At this conference, in the next few days, we are going to hear case studies and success stories to demonstrate how various countries reduced child mortality, malnutrition and improved maternal, newborn and child health. While many countries have great stories to tell on their successful practices, unfortunately, in a short period of 3 days, we could only be able to listen to only a few.

It is undeniable that the momentum has been building despite the challenges we are facing, and it is this heightened momentum and the strong evidence ~~show~~ of commitment by African leaders on child survival that could make all the difference in ensuring the mobilization of all resources to reinvigorating our collective fight against child mortality.

Our Child Survival progress chart shows us that we are making encouraging progress despite set-backs and considerable challenges. I believe, that the incredible global momentum we have seen on Child Survival over the last few years alone inspires renewed optimism. In Ethiopia, we are stepping up our efforts and have taken actions setting even more ambitious child health/ survival targets for the coming years and opening up our strategies to accommodate innovative and scientifically proven high impact interventions **at full scale**.

*Excellencies, Ladies and Gentlemen,*

In Ethiopia, similar to all developing countries, we now know well that there is simply no alternative but to increase and harmonize investments in an integrated health systems approach to expanding child health services. We strongly believe that the key components which enabled us to significantly reduce child mortality over the past years is mainly a result of our sustained and massive investment in building strong, well-functioning and accessible health delivery systems. And thanks to the steadfast commitment of our government and the support of a wide range of partners we have registered steady progress in strengthening our health system, resulting in improved access and quality of child health services. I want to emphasize that every thing we hope to achieve in the future still hinges on further building up of a strong well-functioning country health systems.

On increasing access to services - we are rapidly expanding access to basic health services – both through major government-led efforts to rapidly increase the number of well-equipped health facilities throughout the country and through our country-wide Health Extension Program - which has trained and deployed over 34,000 Health Extension Workers in communities across the country.

Our Health Extension Workers are locally recruited young women, high school graduates with an additional year of intensive training in the delivery of a package of key health promotion and disease prevention interventions. As women, they are more accessible to and trusted by local women and especially mothers who are the primary beneficiaries of their services. Health Extension Workers have been actively reaching out to women and their children at the community level, teaching them about

family planning, closely following up on pregnant mothers and those with newborns and young children and educating families about healthy living.

We have been strengthening our health workforce at every level, focusing in particular on mid-level health professionals and areas where we can save lives – that is, by using task shifting and pragmatic training strategies. We are also revamping our health information system, establishing an effective health commodities supply and logistics system, and have introduced a sustainable health financing mechanisms through health insurance scheme tailored to our country needs.

*Ladies and gentlemen –*

I strongly believe that if there is one sure indicator that will tell us if we are on the right track - it will be the health and well-being of our children. We simply cannot claim to have a strong nation if we do not reach our children with basic health services. We cannot improve child survival without establishing a strong health system. These two objectives cannot be separated.

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We have recently developed our child survival roadmap. Our objective is scale up all the effective interventions known (MNCH, nutrition, family planning), and the non-health interventions, such as secondary girls education by 2025. This road map will allow us to avert about 300,000 under 5 deaths a year and eliminate preventable deaths by 2035.

We are conducting a VISIONING exercise for our district health system based on the experience of some middle income countries. We analyzed skilled human resources for health posts, health centers and hospitals, health care financing, private sector and civil society involvement. In 50 years we envision a family physician for every village in our districts through placement in the health posts and health centers.

We trained 25,000 HEWs in the integrated community based case management of malaria, pneumonia, diarrhea and severe malnutrition. In principle, we have also endorsed a 2013 introduction of community based newborn sepsis management.

We are upgrading HEWs to the level of junior nurses (or community midwives) so that they will be able to provide better quality and more skilled care to meet the evolving demand of the communities.

We have also designed a score card to track child survival progress by district and region. This is a crucial foundation for developing an accountability mechanism across key players of the health sector. We firmly believe that a score card approach would enable us to be result oriented and strengthen our joint monitoring mechanism at all levels of the health system.

And we are also taking some initial steps to revise the national child survival strategy, to internalize and integrate ‘a promise to keep’ with local processes.

*Excellencies, Ladies and Gentlemen,* for Ethiopia the bottom line is – despite being on track in meeting MDG 4 by 2015, we need to increase the current pace more than ever to reach a more challenging goal of reducing child mortality below 20 by 2035. To accomplish this objective we need to move fast in building the capacity of our health system to reach many more millions children with the right care at the right time. This is no small challenge but I believe that we can meet it, given the strong commitment of our Government and the sustained support of all our dedicated partners. This why it is vital that

especially at this critical juncture, that African countries take leadership in clearly demonstrating the significant results that have been achieved to date

**And this brings me to my final message: the need for renewed commitment**

Especially at this crucial juncture in our final sprint towards 2015 and a visioning period for 2035 much will depend on our commitments on the overarching need for country level leadership of taking actions on child survival. I strongly believe we can only accelerate our progress if we renew our commitments and live up to it to provide increased, sustained and more harmonized leadership and support.

I believe that countries must take the lead. Our experience in Ethiopia has shown that strong leadership and commitment at the country level are absolutely key to advancing the principles of harmonization and country ownership our public health programs.

**Last but not least** ...In closing, let me say that I am convinced that it is indeed opportune that our country has the honour of hosting this important conference at this critical turning point. And I hope that our joint call for a renewed commitment on Child Survival here today will resonate loud and clear from our highland capital city far across the continent and the globe and serve to renew the promise necessary to fuel our efforts over the coming years.

I want to take this opportunity to urge you to press on with such efforts for our continent, for our families, for our children and our future; each of us playing a significant role in health policies, mobilizing resources and providing strategic direction for the fight against preventable child death and betterment of child survival. ---- Colleagues, we are really counting on your commitment and support in fostering stronger and more cohesive engagement of African countries to improve survival of African Children. Currently in Africa continent, about 3.5 million under 5 years of age die every year needlessly. By 2035, I hope most of them, if not all, will celebrate their 5<sup>th</sup> birth day, because collectively we have tried our best to give them the opportunity.

Once again a very warm welcome to all of you - I wish you fruitful deliberations and a very pleasant stay in Addis Ababa – THANK YOU!

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**AFRICAN LEADERSHIP FOR CHILD SURVIVAL: A PROMISE RENEWED”**

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**STATEMENT BY  
H.E DR MAXWELL MKWEZALAMBA  
COMMISSIONER FOR ECONOMIC AFFAIRS  
AFRICAN UNION COMMISSION**

**16<sup>th</sup> January 2013  
Addis Ababa, Ethiopia.**

**Excellencies,**

**Honourable Ministers,**

**Distinguished Ladies and Gentlemen**

It is a great honour and privilege for me to stand before this distinguished group of delegates and Experts to deliver this statement on behalf of the Chairperson of the African Union Commission, Her Excellency Dr. Nkosazana Dlamini –Zuma, on a subject that is very close to her heart – “Child Survival and Improving the lives of our children in Africa”. Dr Dlamini - Zuma, regrettably, is unable to be here with you today. Her absence is due to unexpected circumstances, which are beyond her control; and she has asked me to convey her regrets in this regard.

May I express my sincere appreciation to the Government of the Federal Democratic Republic of Ethiopia, UNICEF and all the collaborating partners for inviting the African Union Commission to make a keynote statement at this conference.

**Excellencies,**

**Honourable Ministers,**

**Distinguished Ladies and Gentlemen**

Children represent more than half of Africa's population. The future of Africa, therefore, lies with the well-being of its children. In cognissance of this it is necessary for children to enjoy a healthy environment, and for our Governments to take urgent measures to give them basic education, primary health care, safe and clean water. It is also necessary to protect them during and after conflicts, protect them against HIV/AIDS and other infectious preventable diseases, support the family, and above all, respect the rights of children. It is these factors that make it imperative for us to have a frank discussion on African leadership for Child's survival.

Currently, Africa remains the most difficult place in the world for a child to survive. For most African children, life is harsh and short. Nearly 90% of under-five deaths are attributable to six conditions, namely, neonatal causes, pneumonia, diarrhea, malaria, measles, and HIV/AIDS. Yet these are conditions that could be prevented or treated given the technology and the know-how that we have at our disposal today. Even for those that survive beyond the age of five (5), some will suffer the consequences of malnutrition which are profound, far-reaching and irreversible. They face a cycle of recurring illness and growth faltering, irreversibly damaging their physical development and mental capacity with adverse consequences on their educational performance.

As I am speaking today, the rights of thousands of children are violated in our continent despite the existence of legislation and policies to protect them. Most children will continue to face violence in one form or the other through their adolescence and youth. They will be recruited as child soldiers in conflict situations, some will be trafficked or sold, fall victim of inter-country adoption or child labour, not have access to education or healthcare, and, of course, suffer sexual abuse and other forms of exploitation. Underlining these forms of violence and abuse, is pervasive gender discrimination that frequently causes girls to be regarded as less worthy of care and protection.

The African Union has always shown commitment by prioritising programmes on children on its agenda for more than two decades now. It has also developed and widely disseminated a number of key legal and policy instruments, as well as reports on children, which have been adopted by Member States. Please allow me to mention some of them:

- African Charter on the Rights and Welfare of the Child (1990), with forty-six (46) Member States as Parties to the Charter. It is our hope that all the fifty-four (54) Member States will be Parties to the Charter;
- Declaration and Plan of Action on Africa Fit for Children (2001);
- Call for Accelerated Action Towards Africa Fit for Children (2007);

- The State of Africa's Children Report that covers the priority areas of the Call for Accelerated Action Towards Africa Fit for Children, namely: The African Child Rights Framework; Enhancing the Life Chances of African Children; Overcoming HIV/AIDS for African Children; Realizing the Right to Education of African Children; Realizing the Right to Protection of African Children; Realizing Children's Rights to Participation and Strengthening the Institutional Framework and Policy Response;
- Continental Policy Framework on Sexual and Reproductive Health and Rights and the Maputo Plan of Action for its implementation in 2006;
- Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), which was launched in 2009. So far thirty-seven (37) Member States have taken ownership of the initiative, and has now been broadened to include newborns; and
- The AU.COMMIT campaign launched in 2009, aimed at accelerating the implementation of the Ouagadougou Action Plan to counter Human Trafficking, especially of Women and Children, which focuses on Prevention, Prosecution and Protection of victims.

These are the parameters set and agreed to at the continental level, which are aimed at putting in place policies designed to make Africa and our societies fit for children and to ensure their survival.

The usefulness of these legal and policy instruments depend on how effectively they are implemented. Truly, we all have a responsibility.

I believe that we can make a difference if we work together and not work as individual organisations or Member States. The results of our combined efforts shall certainly be greater than the sum of our individual efforts. The issue of Child Survival is a call to action to save the lives of our children, and promote healthy and productive families and communities. I am hereby calling upon all stakeholders in this room and beyond, to merge and intensify efforts in order to get the maximum impact. Let us therefore link our initiatives.

**Excellencies,**

**Honourable Ministers,**

**Distinguished Ladies and Gentlemen**

I note that the objectives of this meeting include sharpening evidence-based country plans and setting measurable benchmarks, strengthening accountability for maternal, newborn and child survival; and mobilizing broad-based social support.

We do not necessarily have to re-invent the wheel. The African Union already has a monitoring and evaluation framework for Member States to monitor and report on the implementation of the “*Call for Accelerated Action Towards Africa Fit for Children*”. This meeting can take a lot of inspiration from the AU M&E Framework. Indeed, the **2012 State of Africa’s Children Report** was based mainly on the responses from Member States to the M&E Framework.

Regrettably, the response from Member States to the Framework has not been satisfactory, as only fourteen (14) out of the fifty-four (54) Member States responded, despite the importance of the information to be captured by the framework.

I, therefore, call upon all AU Member States to provide biennial progress reports on the implementation of the “*Call for Accelerated Action towards Africa Fit for Children*” using this M&E framework.

Together, we can make Africa fit for children.

With these few remarks, I wish you fruitful deliberations and thank you for your attention.

## African Leadership for Child Survival- A Promise Renewed

Wade Warren  
Deputy Assistant Administrator, USAID  
Wednesday, January 16, 2013  
African Union Headquarters Former Conference Center  
Addis Ababa, Ethiopia

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- *Minister of Foreign Affairs, Dr. Tedros Adhanom*
  - *Minister of Health, Dr. Kesete Birhanadmasu,*
  - *Chairperson of AU commission , Dr. Dlamini Zuma*
  - *Country ministers and representatives*
  - *UNICEF Chief of Health and Associate Director of Programmes, Mickey Chopra*
  - *Ladies and Gentlemen,*

It is an honor for me to be here alongside African colleagues in health and development to represent the United States Government at the **African Leadership for Child Survival- A Promise Renewed**. I would like to congratulate Minister Tedros, Minister Kesete, and the Ethiopian Government for hosting this meeting.

I commend the progress they have made in tackling child survival and strengthening Ethiopia's health sector—and their willingness to share best practices to further Africa's reductions in child mortality.

Since the development of Ethiopia's first national health policy in the mid-1990s, Ethiopia and the United States Government have been partners to increase and expand access of quality health services to Ethiopians nationwide.

The United States is proud to have a long-standing health program in Ethiopia with many of our agencies working in the health sector: CDC, DOD, Peace Corps and USAID. And it is a great for us to see Ethiopia taking a leadership role across the continent.

**By helping children reach their fifth birthdays, their futures become far brighter and we can focus on the broader needs of children to grow into adulthood and become productive members of society.** Improving child survival brings a demographic dividend through fertility declines, reduced mortality, and increased economic productivity.

As you heard this morning, the past few decades brought remarkable gains in child survival. However more than 3.5 million children under five still die every year in Africa, and more than 50% of these deaths are largely from preventable causes like pneumonia, diarrhea and malaria. We know that we can end preventable child deaths, but to achieve that goal we have to accelerate our efforts.

That's why the U.S. Government joined UNICEF and the governments of India and Ethiopia in June to host a Child Survival Call to Action in Washington. As you saw from the video, more than 700 global leaders came together to set a goal of reducing child mortality to 20 deaths per 1,000 births in every country in the world by 2035. Assuming countries already making progress continue at their current trends, achieving this rate will save an additional 5.6 million children's lives every year.

However, to reach our goal, we agreed to accelerate our efforts through five strategic shifts:

1. Intensify our focus and support for the countries with the highest rates of child death—since 80% of child deaths occur in 25 countries.
2. Identify particularly vulnerable communities in urban slums and rural settings.
3. Prioritize high-impact solutions—like injectable antibiotics to prevent newborn sepsis, oxytocin and misoprostol to prevent post-partum hemorrhaging, and oral rehydration solution and zinc to prevent diarrhea, one of the largest killers of children.
4. Invest in mothers' education, literacy, and safe childbirth.
5. And finally, measure our progress much more closely through tools like scorecards and using data for decision-making.

In addition to these strategic shifts, three objectives emerged from the *Call to Action*:

1. To mobilize political leadership to end preventable child deaths.
2. To drive sustained collective action and mutual accountability for result.
3. To establish the importance of transparency and evidence-based planning and reporting to accelerate progress and deliver results.

By implementing these objectives, *A Promise Renewed* led by UNICEF maintains the momentum of the Call to Action. A sustained effort is exactly what is needed to reach our goal – and the U.S. Government is pleased to support UNICEF in this endeavor.

America's legacy in child survival is a proud one. Alongside many of the partners in this room, USAID has played a vital role for decades in the development and delivery of low cost, high impact health interventions to reach the most vulnerable children.

Such innovations include safe injection technologies like auto-disable syringes and vaccine vial monitors, a diagnostic test for anemia and for vitamin A deficiency, safe birth kits and other products that are now used in countries throughout the developing world. USAID is also the leader in supporting family planning worldwide, ensuring women wanting contraceptives have access, particularly long-acting and permanent methods. We know that the health timing and spacing of pregnancies impacts both maternal and child survival.

All of these investments have been paying dividends, among them:

- In 24 countries where we've been heavily involved, maternal mortality declined by 40 to 65 percent.
- Eleven of the President's Malaria Initiative focus countries have had reductions in childhood mortality rates, which ranged from 16 to 50 percent.
- In one year, USAID-supported programs provided 29 million infants and children with vitamin A supplementation in six countries.

To further accelerate progress against maternal and child deaths, we need to sustain these efforts in addition to harnessing the creativity and ingenuity of a range of problem solvers throughout the world. The Saving Lives at Birth Challenge – a partnership between USAID, the Bill & Melinda Gates Foundation, the Government of Norway, Grand Challenges Canada and DFID – is doing just that. The Challenge seeks to leverage energy and innovation to protect mothers and newborns in the poorest places during their most vulnerable hours. The program has already identified 39 of the world's most creative ideas to tackle this challenge, and this week Saving Lives at Birth announced its third global call for transformational solutions.

Finally, through the U.S. Government's Global Health Initiative, we are encouraging country ownership, building sustainability through health systems strengthening, leveraging global health partnerships and private sector engagement. These are all crosscutting elements that contribute to progress in reducing child mortality.

The Call to Action proved that we can come together across communities, see our common purpose and commit ourselves to a goal. USAID Administrator Raj Shah's vision helped make the Call to Action a reality, and his continued dedication keeps child survival at the forefront of global development. I am now pleased to introduce a video message from Dr. Shah.

Thank you

## African Leadership for Child Survival- A Promise Renewed

USAID Administrator  
Dr. Rajiv Shah  
Wednesday, January 16, 2013  
*Video Transcript*

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Hello. I wish I could be with you in Addis Ababa at the African Leadership on Child Survival meeting.

As you know, last year in Washington, the Government of Ethiopia joined with India, the United States, and UNICEF to host a Call to Action on Child Survival.

More than 160 governments—including my own—signed a pledge to end preventable child death. Two hundred civil society organizations pledged their support, and 220 faith-based organizations committed to promoting the 10 best practice healthy behaviors that will help save more women and more children from unnecessarily dying.

This movement is unique because you have all worked to colead it, to create a single coalition that allows us the opportunity to be successful around the world. We've been able to learn from each other as peers so that together, we can advance what Secretary Clinton has said would be one of the greatest things people have ever done for one another.

By taking the pledge, each government and organization is committing resources and integrating child survival as a key element of their global strategy.

Together, we established a road map that would help us reach our goal. We committed to carefully measure and report on our results. We committed to focus on low cost interventions with high impact, particularly for vulnerable populations. We will ensure that our efforts address the basic causes of mortality, which may vary from country to country. And we will leverage technology to bring our results to scale faster and more effectively than ever before.

Your leadership and dedicated focus is an essential part of this unified effort. It is wonderful to see so many countries gathered together in Ethiopia to focus on how to sharpen national plans and develop scorecards to strengthen monitoring and reporting.

I want to thank Minister of Health Tedros, who committed at the time of the Call to Action to convene a meeting of African leaders to help accelerate reductions in child mortality. His extraordinary leadership has elevated the issue of child survival on the continent and across the world, and we look forward to continuing his good work in partnership with Minister Kesete, as he takes the lead on this incredibly important effort.

In the last two decades, Sub-Saharan Africa has experienced a 39 percent decline in the under- five mortality rate, a tremendous achievement that has been called the “the best story in development.” But despite this progress, we know that some countries are doing better than others and too many children perish unnecessarily every day.

By joining together to share best practices and create a strong network, I am confident that we can add to our momentum and save more lives.

I hope the next couple of days are productive and offer you the opportunity to find new and creative ways to ensure that every child lives to celebrate their 5th birthday. Most importantly, the work you are doing will continue when you return to your capital cities—and USAID and the United States government stands ready to support you in your efforts.

As President Obama recently shared when speaking to the nation about the tragic loss of young lives in Newtown, Connecticut, he noted, "This is our first task: caring for our children. It's our first job. If we don't get that right, we don't get anything right. That's how, as a society, we will be judged."

If we act now, we will not only create a more prosperous and peaceful world. We will secure one of the greatest moral victories of our time.

Thank you for your leadership.

# Committing to Child Survival - A Promise Renewed - ending preventable child deaths

GLOBAL STRATEGY  
FOR WOMEN'S AND  
CHILDREN'S HEALTH



United Nations Secretary-General Ban Ki-moon

**Addis Ababa, 16 January 2013**

**Dr. Mickey Chopra, Associate Director Health, UNICEF**

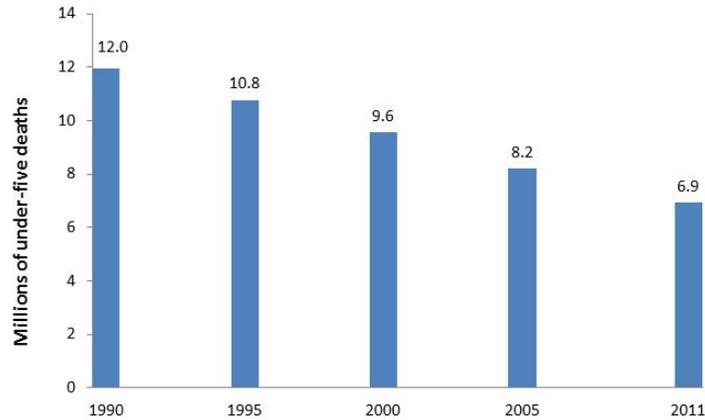


## Key Messages

- Globally and in Africa we are making progress
- However for too many women and children and some conditions progress is too slow
- The ambition of A Promise Renewed for Africa
- The immediate challenges for accelerating progress

## The global burden of under-five deaths has fallen steadily since 1990

Global number of under-five deaths, selected years

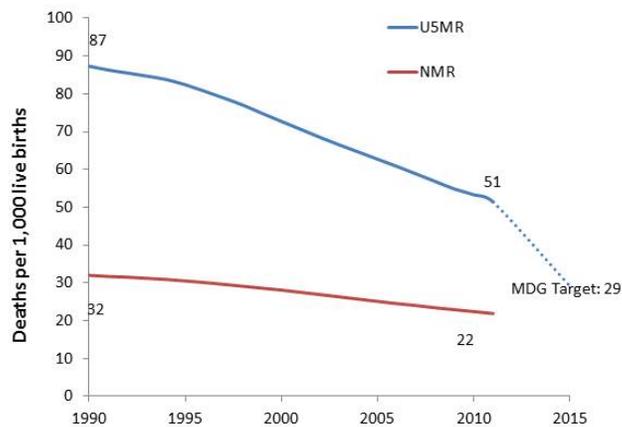


Source: The UN Inter-agency Group for Child Mortality Estimation, 2012; provided by SMS/DPS/UNICEF



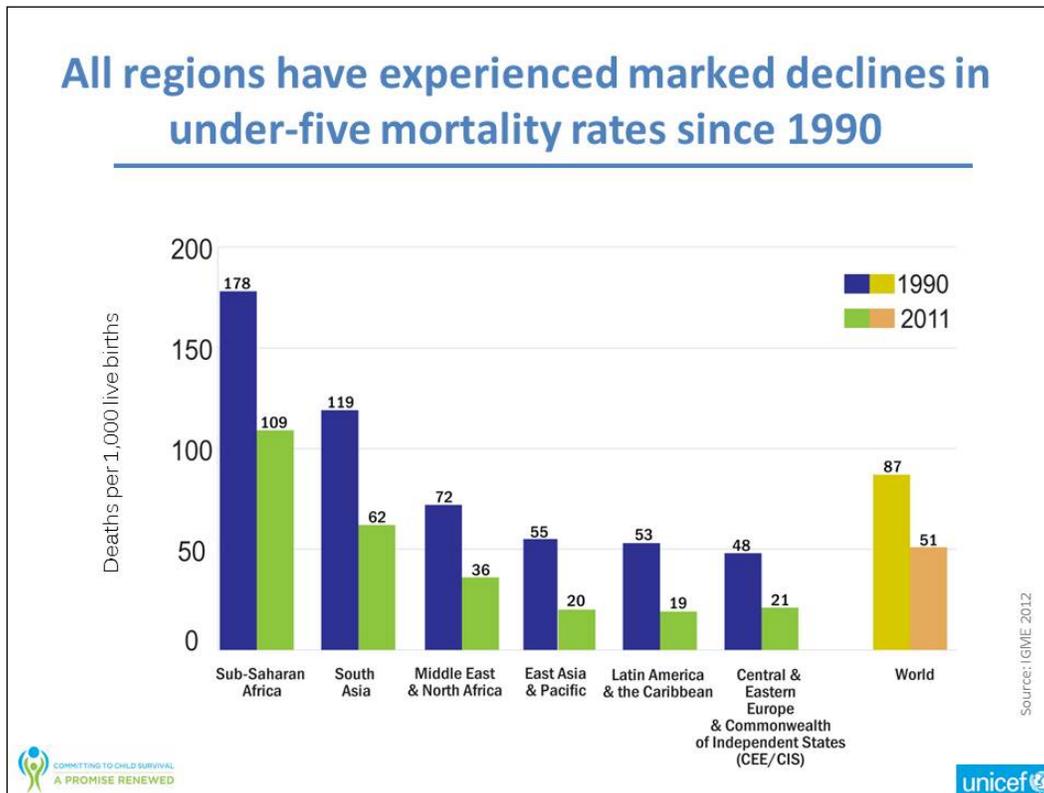
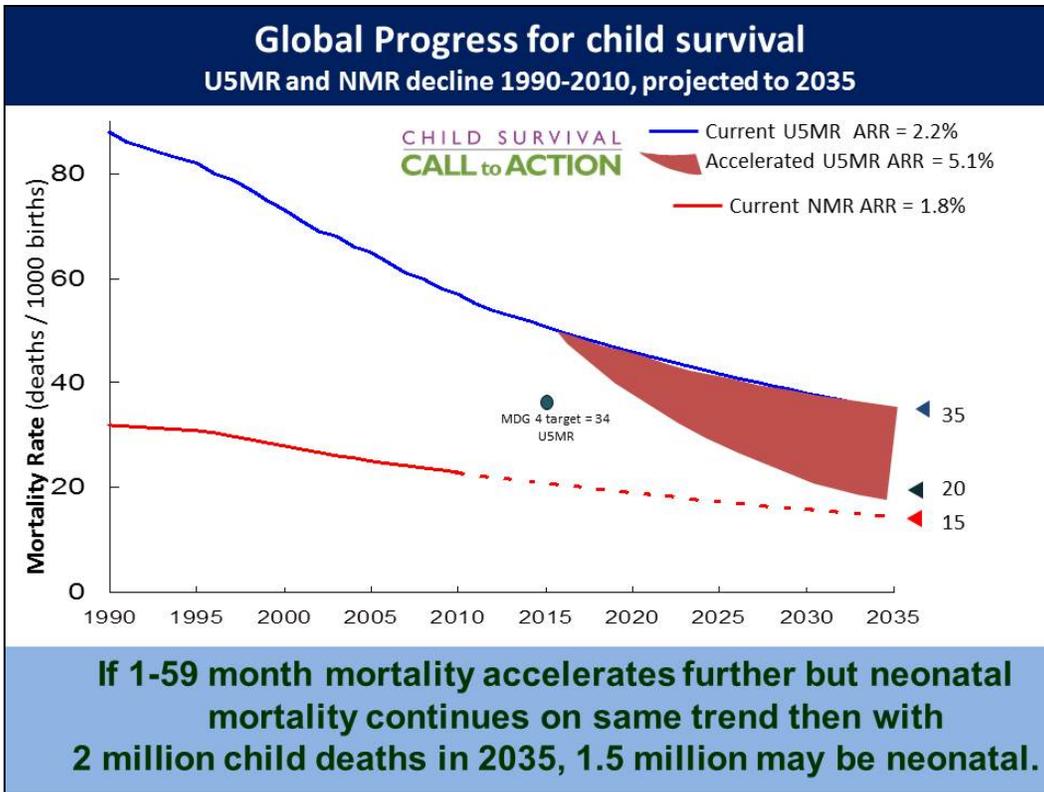
## The global under-five mortality rate has fallen by 41% from 1990 to 2011

Under-five and neonatal mortality rate, 1990-2010



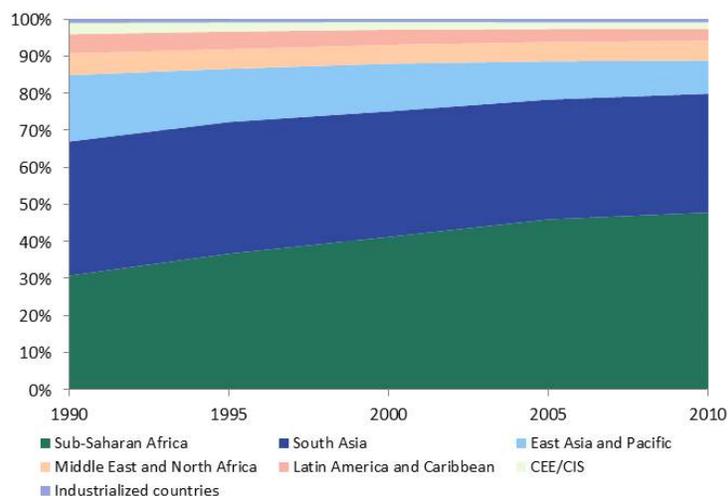
Source: The UN Inter-agency Group for Child Mortality Estimation, 2012; provided by SMS/DPS/UNICEF





## The global burden of under-five deaths is increasingly concentrated in Sub-Saharan Africa

Share of under-five deaths, by region, 1990-2010 (%)



Source: IGME 2011



In 2011, for the first time, the 20 countries with the highest under child mortality rates are all in Africa. There is a strong correlation between conflict, 'fragile situations' and child mortality rates.

- |  |  |
|--|--|
| 1) Sierra Leone (185 per 1000 live births) | 11) Cameroon                             |
| 2) Somalia                                 | 12) Guinea                               |
| 3) Mali                                    | 13) Niger                                |
| 4) Chad                                    | 14) Nigeria                              |
| 5) Democratic Republic of the Congo        | 15) South Sudan                          |
| 6) Central African Republic                | 16) Equatorial Guinea                    |
| 7) Guinea-Bissau                           | 17) Mauritania                           |
| 8) Angola                                  | 18) Togo                                 |
| 9) Burkina Faso                            | 19) Benin                                |
| 10) Burundi                                | 20) Swaziland (104 per 1000 live births) |

Source for mortality rank: UN Inter-agency Group for Child Mortality Estimation 2012; *Fragile Situation countries are shown in red* (source: World Bank 2011)

unite for  
children

unicef

## Top 10 countries in Africa with the largest reductions in child mortality, 2000-2011

Rank	Country	Annual rate of reduction (%)
1.	Senegal	6.4%
2.	Malawi	6.2%
3.	Zambia	5.6%
4.	Ethiopia	5.3%
5.	Namibia	5.2%
6.	Niger	5.0%
7.	Morocco	4.3%
8.	Zimbabwe	4.1%
9.	Kenya	4.0%



### Committing to Child Survival: A Promise Renewed



Progress Report 2012



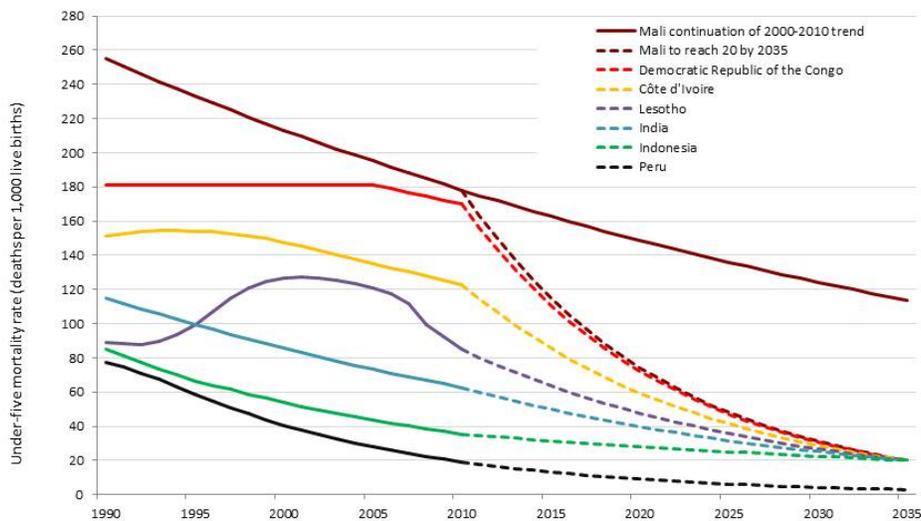
# 170 Governments Pledged to date

*Including 48 of the 54 countries in Africa*  
plus hundreds of

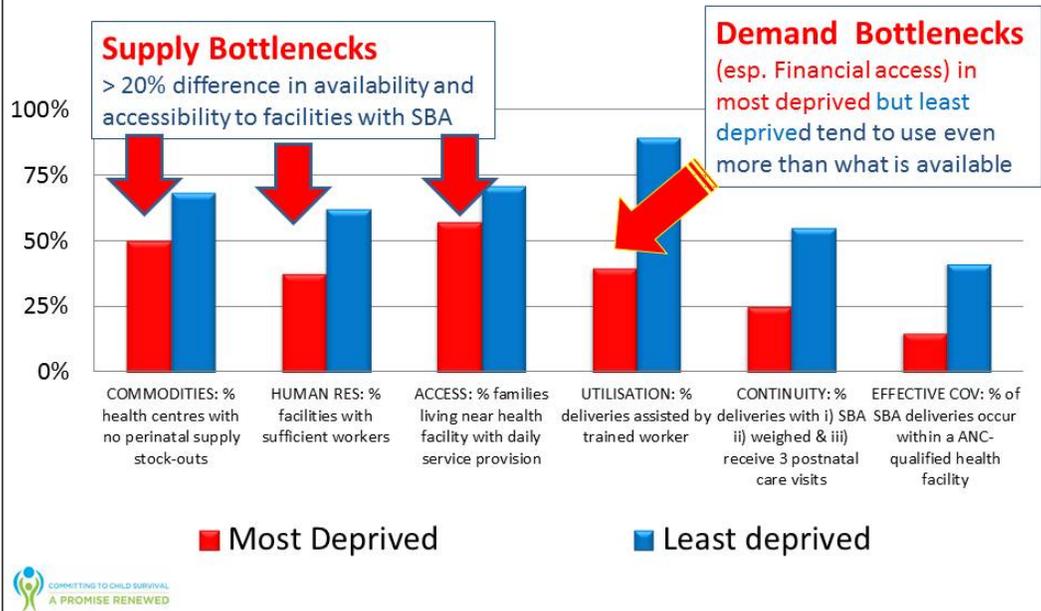
- Civil Society organisations, Faith Based organisations, Individuals, schools and workplaces
- Focus on results and accountability
- But also an important technical component

[www.apromiserenewed.org](http://www.apromiserenewed.org)

## 20 by 2035: selected country U5MR trajectories



## Changing How We Do It: supply and demand bottlenecks for most / least deprived areas analyzed



## Major bottlenecks to achieving results

- **Decentralization & Low capacity:** weak supervision, management, QA and motivation
- **Major barriers to access:** poor enforcement of pro-poor cash transfers and fee-waivers
- **Incomplete uptake of life-saving interventions:** e.g. zinc for diarrhea
- **Ineffective resource management:** especially in decentralized settings
- **Structural barriers:** economic, political, socio-cultural

<b>Potential approach</b>	<b>Shift intervention within channel</b>	<b>Shift intervention to different delivery channel</b>	<b>Improve performance of delivery channel</b>
<b>Description</b>	Change way of delivering interventions within existing channels	Deliver the intervention through a better performing channel	Improve efficiency, capacity and accessibility of delivery channel
<b>Possible strategies</b>	<ul style="list-style-type: none"> <li>Task shifting among different cadres of workers</li> <li>Improving outreach services (including specialist outreach)</li> <li>Shifting to different sets of providers through public-private partnerships, contracting out, or franchising</li> </ul>	<ul style="list-style-type: none"> <li>Task shifting from clinic-based to community-based</li> <li>Shifting interventions from clinic-based to child health campaigns</li> <li>Shifting behaviour change counselling from face to face to social marketing or implementing policy changes</li> </ul>	<ul style="list-style-type: none"> <li><b>Human resources availability:</b> Compulsory service, Hardship allowances, retention of HR in rural settings...</li> <li><b>Geographic access:</b> Increase number of service points</li> <li><b>Financial access:</b> User fee abolitions, Insurance schemes, Conditional cash transfers, Vouchers</li> <li><b>Continuity:</b> PBI, remuneration (salaries)</li> <li><b>Defaulter tracking</b></li> <li><b>Quality:</b> Supervision/mentoring, training, audits, accreditation...</li> <li><b>Demand:</b> Community/individual empowerment, social marketing...</li> </ul>



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## **STATEMENT BY U.S. AMBASSADOR DONALD BOOTH**

Embassy of the United States

Addis Ababa, Ethiopia

### **WELCOME RECEPTION - AFRICAN LEADERSHIP FOR CHILD SURVIVAL January 16, 2013**

I am delighted to be here with you all this evening and want to thank Minister Kesete and the Government of Ethiopia for hosting this meeting. I also want to commend former Minister of Health Dr. Tedros Adhanom for his initiative in raising this call to action for child survival across Africa. I salute the health ministers and their advisors here who day to day champion the fight to end preventable child deaths, the majority of which occur among newborns in the first year of life.

To all the participants here, I applaud your determination to renew and expand commitments for child survival in your respective countries. I have had the privilege of serving in many countries of this great continent and I have witnessed the progress made on child survival over the last two decades. Many of your countries will achieve Millennium Development Goal Four – reducing under 5 mortality by 2/3 by 2015. It is important to maintain the momentum. For this reason, in June of the past year, the U.S. Government joined with the Governments of India and our hosts here in Ethiopia, as well as UNICEF, to issue a Call to Action to ensure the survival of newborns and children under 5 around the world.

President Obama is committed to promoting the dignity of each and every human being and considers health and, specifically, child survival as an important component of human dignity. The President believes that every child in the world, no matter where she or he is born, deserves the opportunity to thrive. This is a fundamental aspiration that unites us despite religious, cultural, economic and social differences. And as the President laid out in his 2010 National Security Strategy, the United States has both a moral and a strategic interest in promoting health across the globe. Doing so not only aligns with our moral values but contributes to economic development and peace. Simply put, the health and security of your children is enhances the health security of all our children.

Economists have shown that improving child survival with investments in educating girls can change the demographics of countries and add as much as 2 percentage points to economic growth over a period of just a few years. Another important factor for child survival is maternal health and, therefore, maternal health is a centerpiece of our support to global health and child survival.

Denis McDonough, the Deputy National Security Advisor to the President, speaking at the June Call to Action stated that a country's infant mortality is an indirect but important indicator of a country's risk of instability. According to some estimates, high infant mortality rates suggest that a country is four to seven times more likely to experience instability. So protecting children is not only a moral obligation, it is how governments can better protect the welfare of all their citizens.

Preventable child deaths and child stunting rob a country of energy, creativity, and talent — they rob a country of its future. To invest in child survival is to invest in a country's future. And this is a virtuous circle: when families and communities see more children have a greater chance for survival, they will invest more in each of those children.

So on behalf of the American people, and on behalf of the U.S. government, I am here to express our support and enduring commitment to this simple but ambitious goal: to end preventable child deaths, to allow children to not only survive but also to thrive. As Secretary of State Hilary Clinton said in her

keynote speech at the Call to Action: A Promise Renewed for Child Survival in Washington DC last June:

***“We can only meet our ambitious goal if we keep up our efforts day after day and year after year, and if we are relentless about holding each other to the task.”***

Thank you.

## **ANNEX FOUR – Closing Remarks**

**CLOSING REMARKS**  
**African Leadership for Child Survival- A Promise Renewed**

**Dennis Weller**

Mission Director, USAID

Friday, January 18, 2013

African Union Former Conference Center

Addis Ababa, Ethiopia

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It is an honor for me to present closing remarks on behalf of the United States Government and the American people.

Over three intense days we have seen how countries who have committed to reducing child mortality face great challenges and achieve progress by using proven cost-effective and high impact interventions, building health care delivery systems, working directly with and on the community level, investing in the education of girls and women, and by forging political will and determination. These improvements in maternal, infant, and child health are critical for overall development of nations.

For many years, USAID has championed the cause of child survival and is proud to partner with UNICEF in supporting governments and nongovernmental organizations in many countries of Africa to enable them to achieve their goals.

Here in Ethiopia USAID is very proud to support and assist the Ministry of Health's workforce and the extension workers at health centers and health posts in the most populous regions of the country; we are working with Ethiopia to build human resources for health and sustainable health systems, to prevent the spread of HIV/AIDS and to assist children affected by HIV/AIDS, to promote reproductive health, and above all, family health. And in Ethiopia while we celebrate great gains in child survival, we also join the Ministry of Health and all donor partners and nongovernmental organizations in tackling the greatest challenge of reducing maternal and newborn deaths.

In Ethiopia and around Africa USAID is pleased to serve as a convener of public and private partners, of scientists and health workers, of international and local organizations to achieve the goals of A Promise Renewed for Child Survival: to end preventable newborn and child deaths, and to promote the health and education of mothers so they can nurture their children.

For the country action plans that you have developed and the scorecards, I reiterate the statements of USAID Administrator Rajiv Shah and his representative here USAID Deputy Assistant Administrator for Global Health Wade Warren at the opening plenary: USAID stands with you and will support your efforts to make preventable deaths an issue of the past.

The call to action is also about working together and I believe that is why this meeting of African countries coming together on child survival is so important. No country is tackling this problem alone, we are here to support each other, learn from each other, and action is required by all stakeholders.

Finally, I would like to congratulate again and express my appreciation to the Government of Ethiopia and to Minister Tedros and Minister Kesete for their strong leadership and their commitment to child survival. This meeting would not have been possible without their initiative and leadership. I want to thank all the organizers of this meeting from the Ministry of Health, UNICEF, and USAID.

To the delegates and experts here, many from countries where I have served, I applaud all of you for your enormous dedication to improve the lives of many thousands of children and their families. You are the champions of child survival; your experience, your innovations, and your knowledge transcends borders. As US Ambassador Booth noted in his remarks at the Welcome Reception: “the health and security of your children benefits all our children...it is not only a moral obligation, it is how governments can better protect the welfare of all their citizens”. In other words, child survival contributes to stability and to economic development; it is good governance.

Finally, It is in working together, holding each other accountable to our pledges, sharing knowledge and experience, that will allow many more children and their families to celebrate their fifth birthday—and many more after that.

I wish you all success and perseverance in the year ahead and I look forward to hearing of measurable progress at the global follow-up Call to Action--Promise Renewed meeting to take place in 2014.

Children *are* the promise of the future and so *we* must keep the promise and invest in all children, everywhere. It's in our best interest for prosperity and for peace in years to come. I close quoting from Dr. Kesete's Opening Plenary address: “We simply cannot claim to have a strong nation if we do not reach our children with basic health services.”

Thank you.

**Statement by Dr. Peter Salama,  
UNICEF Representative to Ethiopia**

**On the occasion of the African Leadership for Child Survival**

**18 Jan 2013 at AU conference room**

Excellency, Minister of Health, Dr. Kersetebirhan Admasu, Honourable Ministers, government representatives, USAID Ethiopia mission director, Dennis Weller, UN colleagues, and colleagues from other development agencies, Civil Society Partners, Members of the Media, Distinguished Guests

It is a real honour and privilege for me to be here today to deliver the closing remarks on behalf of UNICEF. In June 2012 – during the first Call to Action – Promise Renewed meeting in Washington D.C – Dr. Tedros had committed that Ethiopia would host an African Leadership for Child Survival Conference – linked to the AU summit. That promise is now fulfilled. So let me start by thanking Dr. Tedros and Dr. Kesete and all of the colleagues at the Ministry of Health and on the steering committee for making this All African meeting a reality and a success.

The pledge signed by the African countries present and the consensus reached by the conference are both significant and historic. The event has marked a new era for the African continent in which it is no longer acceptable for any child to die an untimely and preventable death.

Ladies and Gentleman, in terms of global child survival, there is much to celebrate. Today, more children survive to their fifth birthday than ever before. The global number of deaths among children under-five has fallen from around 12 million in 1990 to an estimated 6.9 million in 2011. The gains have been widespread. Diverse countries, ranging from low-income, middle income, but also high- income countries have radically reduced their under-five mortality rates in the past two decades – demonstrating that progress is possible across diverse economic and geographic contexts.

As we have seen at this meeting, in many ways the progress made in the health sector in Ethiopia as well as many other African countries has become a powerful global symbol of what can be achieved in resource-constrained environments and has given many international partners renewed faith in the development enterprise.

As Minister Richard Kamwi from Namibia just highlighted - To accelerate progress we need to do some things differently. Dramatic reductions in preventable child deaths can be achieved through concerted action in five critical areas, outlined in the global roadmap- geographical focus, high burden populations, high impact solutions, gender equality and mutual accountability and financing. Dennis Weller has dealt with the high impact solutions area very well so I will focus on the 4 others.

First, the theme of equity, in all its dimensions, has come out very strongly through the conference conclusions on geography, gender equality and high burden populations. We know that as much as we have made global progress on child survival in recent decades so too have we seen an increasing concentration of child deaths in Africa which now accounts for around half of all the world's child mortality. These trends will be further compounded as births also become increasingly concentrated on Africa. Put simply, we cannot continue to achieve progress on global development goals without accelerating progress on this continent. In addition, we also know that within countries enormous progress can be achieved merely by ensuring that the poorest economic quintile of the populations has

the same access to basic services as the richest quintile. Furthermore, maternal and newborn health are inextricably linked- while there is much we can do to reduce newborn mortality now, and I particularly liked Joy Lawn's 3 by 2 slide, we will not be able to fully address the 1 million newborn deaths, without linking newborn to maternal health. And nor should we try for women's health clearly deserves to be prioritized on its own merits

We have also seen in the opening presentations that the highest rates of death are now overwhelming in fragile states and conflict-affected countries and regions. This demands that our attention also be placed on governance issues and on human security. There is a major role here, not only for the United Nations but also for regional institutions- this is why the role of the AU will be even more paramount as we move forward on this initiative- indeed we are very hopeful that with the Ethiopia government taking over the chair of the AU in 2013, that maternal and child survival will be seen as not only a health and development issue but as a security issue. It seems auspicious that the African Leadership for Child Survival has taken place right before the AU heads of state meeting next week. I sincerely hope that the recommendations of this conference are shared with the AU leadership and head of states for their endorsement.

Second, through the theme of mutually accountability and financing, we have seen a strong focus on the ideas of developing robust monitoring systems to track results, national scorecards to provide objective means of comparison, and more systematic attention being paid to analyses of bottlenecks at national and subnational level in order to both breakdown challenges into manageable components and also to be able to better track disparities within countries. UNICEF is committed to helping support the capacities of countries to conduct such analyses and tracking. We have seen at this meeting that resource constrained countries can reduce child and maternal mortality and in fact sometimes such constraints may spur important innovations. The effective use of available resources under committed leadership is very essential. But while we all can agree that it is not only about how much money we spend but about what we prioritize and how we spend it, we should certainly not forget that a major part of our mutual accountabilities relates to how we support health systems with sustained financing from both domestic as well as donor financing. This should also be a critical component of our monitoring agenda.

As many of your countries begin or will begin discussions on the post-MDG development agenda, I think we should also collectively anticipate and manage one major risk in this regard. It is clear much of the world's attention is turning to focus more on environmental issues including those of green economies, biodiversity, water and food security. At the same time, many of our ministers of finance still regard the social sectors as the non-productive sectors. I think we have seen from our session on stunting that in fact, nutrition, health and water interventions addressing such critical issues may in fact be some of our most productive sector in terms of preserving human capital and ultimately achieving sustainable economic growth. It will be up to leaders in this room to make such a case.

Finally, we have seen the strong leadership of African governments in this process. This is not an initiative led by UNICEF or USAID or any other partner. In an era of global health partnerships which have brought enormous new financing and momentum on certain issues but also carry real risks of fragmentation and lack of alignment, it is very refreshing to see that this initiative and the commitments being made are home grown. All countries have existing strategies and plans for improving maternal, newborn and child health. Integration of the ALSC/APR initiative with local processes, rather than setting up vertical mechanisms, will be important. Government should also coordinate efforts of various partners and the different initiatives such as APR, SUN, EWEC (Every Women Every Child), UNSG's

initiative on commodities, the E8 for Malaria Elimination.....and synthesize them at the country level.

Indeed, one of the most exciting aspects of the meeting and the overall process for me is to have seen the peer to peer dynamic in action. I know the lesson learning and sharing of good practices from country to country will continue over the coming months and that many countries are planning study visits to other African countries. We should nurture this dynamic at all costs. I believe the seeds of success and of sustainability have been planted by all of you at this meeting. Of course, at all levels of the organization, UNICEF remains 100% committed to accompanying you through the process of ending all preventable maternal, newborn and child deaths and thus completing the work begun under the child survival revolution.

I thank you.