A HEALTHY START TO LIFE

7 QUESTIONS
U.K. Department for International Development Permanent Secretary MARK LOWCOCK

• Fighting the Big 4
Impact Magazine sets the tone for the global health community’s conversation, engaging 90,000 readers through the practiced approach of conveying stories – about global health challenges, voices from the field, policy perspectives, innovation in development, the sciences and more. It invites discussion, while bringing informative depth to the issues it covers.

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➤ Contact Mandy McAnally, Managing Editor.
   amcanally@psi.org
   +1 (202) 574-4502
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EDITORS-IN-CHIEF
Marshall Stowell
mstowell@psi.org

MANAGING EDITOR
Mandy McNally
amcanally@psi.org

EDITOR
Jyoti Kulangara
jkulangara@psi.org

ONLINE EDITOR
Leif Redmond
lredmond@psi.org
psi.org

EDITORIAL CONTRIBUTORS
Emily Carter
Malaria Control & Child Survival

Ryan Cherlin
Corporate Marketing, Communications & Advocacy

Neeraj Deshpande
Sexual, Reproductive Health & TB

Stephanie Dolan
Malaria Control & Child Survival

Abel Irena
Malaria Control & Child Survival

Ashley Latimer
Malaria Control & Child Survival

Katharine McHugh
Malaria Control & Child Survival

Jane Miller, Ph.D.
Malaria Control & Child Survival

Elizabeth Petoskey
Corporate Marketing, Communications & Advocacy

Jackie Presutti
Corporate Marketing, Communications & Advocacy

Angus Spiers, Ph.D.
Malaria Control & Child Survival

Scott Thompson
Corporate Marketing, Communications & Advocacy

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PSI is a global non-profit organization dedicated to improving the health of people in the developing world by focusing on serious challenges like a lack of family planning, HIV/AIDS, barriers to maternal health and the greatest threats to children under five, including malaria, diarrhea, pneumonia and malnutrition.
In the past 20 years, mortality of children under 5 has dropped 35 percent. Two-thirds of the 7.6 million child deaths that still take place yearly could be prevented or treated with access to simple, affordable interventions.

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**Pneumonia, Diarrhea & Malaria**

Pneumonia, diarrhea and malaria are the leading causes of deaths of children under 5, accounting for more than 40 percent of deaths. Low-cost interventions (such as antibiotics; sleeping under insecticide-treated nets; oral rehydration therapy and zinc supplements; and water, sanitation and hygiene interventions) can significantly reduce the burden caused by these diseases.

**Malnutrition**

Malnutrition affects one in three people, contributing to disease, early deaths of children, and impaired healthy development and lifelong productivity. Improved water supply, sanitation and hygiene; health education on diet; and healthy foods can prevent malnutrition.

**Neonatal Death**

Three-quarters of all newborn deaths occur in the first week of life. Effective health measures provided at birth and during the first week of life can prevent up to two-thirds of these deaths. Yet, in developing countries, nearly half of all mothers and newborns do not receive skilled care during and immediately after birth.

**HIV:**

Almost 1,000 babies are infected daily with HIV during pregnancy, birth or breastfeeding. Use of antiretrovirals and safer delivery and feeding practices can prevent this problem. In the developing world, only 53 percent of pregnant women with HIV receive antiretroviral drugs to prevent transmission of the virus to their babies.

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**Malaria Diagnosis**

Less than 20 percent of presumed malaria cases were tested in 21 of 42 countries in Africa that reported on malaria diagnosis. Since lack of testing contributes to incorrect diagnosis of malaria and parasite resistance to artemisinin, WHO recommends parasitological diagnosis for malaria (with microscopy or rapid diagnostic tests) before treatment with artemisinin-based combination therapy.

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**Lack of Exclusive Breastfeeding**

Roughly 36 percent of infants younger than 6 months of age are exclusively breastfed. About 20 percent of deaths among children under 5 could be avoided by implementing WHO-recommended guidelines:

- exclusive breastfeeding for 6 months,
- introducing safe complementary foods at 6 months, and
- continuing breastfeeding for up to 2 years or beyond.

**Lack of Sanitation**

About 2.5 billion people lack access to improved sanitation, leading to increased transmission of water-borne diseases. Improved sanitation can reduce diarrhea death rates by a third.

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*Source: UNICEF, WHO*
Health Challenges

1. MALAWI

**Promoting Safe Water and Hygiene**
Some 18 percent of children under 5 in Malawi suffer from diarrhea due to lack of access to clean water and sanitation and poor hygiene practices. With USAID-funding, PSI/Malawi trained 139 community safe water and hygiene promoters to encourage adoption of improved household water treatment, hand-washing with soap, use of latrines and prompt care-seeking when a child develops diarrhea. The result: 12 percent increase in children receiving ORS by the end of the project.

2. SWAZILAND

**Infant Male Circumcision**
Swaziland has the world’s highest HIV prevalence. To address this, PSI, with U.S. Agency for International Development (USAID) funding, is supporting the Ministry of Health to circumcise 80 percent of newborns by 2015. These early infant male circumcisions, along with the scale-up of adult male circumcision, will help prevent 64,000 new adult HIV infections by 2025 and save more than US$330 million in HIV care and treatment costs (USAID 2009).

3. SOMALILAND

**Trained Midwives**
In its first year alone, PSI/Somaliland’s Safe Motherhood program reached more than 5,500 married women of reproductive age – 91 percent of them pregnant or lactating. In addition to focusing on antenatal care, safe delivery, post-natal care and birth spacing, PSI/Somaliland works with trained midwives to promote early and exclusive breastfeeding for the first 6 months of a baby’s life and then introducing age-appropriate and safe complementary food from 6 months to 2 years of age.

4. MYANMAR

**Rapid Diagnostic Tests**
As malaria elimination efforts continue, a growing proportion of fevers are being misdiagnosed as malaria. WHO-recommended rapid diagnostic tests (RDTs) provide diagnosis of malaria and inform treatment to prevent parasite resistance to artemisinin. PSI/Myanmar has distributed 1.2 million RDTs for malaria since 2003. Trained health providers in PSI/Myanmar’s Sun Quality Health social franchise network and community health workers in its Sun Primary Health networks use the tests to diagnose malaria and provide appropriate treatment. (PSI also distributes RDTs in Cambodia, Madagascar, Nigeria and Uganda.)
MARK LOWCOCK was appointed Permanent Secretary of the U.K. Department for International Development (DFID) in June 2011. Prior to this, he held the position of Director General of Country Programmes, responsible for DFID’s programs in 50 countries. Lowcock began his DFID career in 1985 and in 1999 went on to head up DFID’s Regional Office for East Africa, based in Nairobi. Since then he has also served as Director of Finance and Corporate Performance, Director General of Corporate Performance and Knowledge Sharing, and Director General of Policy and International. Lowcock has a B.A. in economics and history from Oxford University and a master’s in economics from Birkbeck College, London. Lowcock is also a Chartered Accountant, a qualification which is proving invaluable in DFID now.

Lowcock speaks to PSI President and CEO Karl Hofmann.

KARL HOFMANN: The U.K. is leading the international aid conversation about value for money these days. Can you tell us how DFID looks at measuring this?

MARK LOWCOCK: I find it helpful to distinguish between the value issue and the money issue. On the value side is how we pick the investments and partners who are going to be really good at delivering maximum results and impact. You have choices you make about the countries and sectors you invest in and the partners to invest through. The money side of the equation is a set of issues, including doing your procurement well so you get the largest volume of product or services for your investment, building a supplier base so you can generate competition for resources and being rigorous in evaluating your expenditure. A lot of value for money is about culture and governance. At DFID we have a management process, strategy and action plan. We have our ‘3-Es’ model, which looks at improving economy (what we can buy for our money, e.g., vaccines), efficiency (converting that money into outputs, e.g., children vaccinated) and effectiveness (achieving development outcomes, e.g., lower burdens of childhood disease). The Secretary of State for International Development Andrew Mitchell has repeatedly said he wants us to ensure 100 pence of value for every hard-earned pound of British taxpayer money that we spend. He looks to me to make sure the organization achieves that. But we also want to go further than that and work with our partners to improve the value of all aid, not just what we spend ourselves.

KH: The U.K. has committed to growing its overall envelope for development to 0.7 percent of gross national income, at a time of tremendous fiscal constraints. How resilient is the U.K.‘s commitment, given many competing pressures?

ML: All the main political parties in the U.K. campaigned in the last election on the basis of sustaining the commitment to the internationally agreed 0.7 percent target. The Secretary of State has made clear that this government is not prepared to balance the books on the backs of the poorest people in the world. The Prime Minister David Cameron and the Secretary of State have frequently set out the rationale for sustaining the 0.7 percent commitment. It’s firstly about moral obligation. Rich countries have a moral obligation to help the poorest people in the poorest countries in the world. The poorest are almost always the hardest hit
by economic shocks and environmental issues, such as climate change and water stress. If we can help others in more desperate straits, as a relatively rich country, we should do that, and we should encourage others to follow suit – particularly when it's so abundantly clear that aid saves millions of lives and so it's a good investment. But beyond that, there is a national interest in trying to promote progress on problems and challenges which may originate in poorer parts of the world but which affect us all closer to home and indeed wherever we are in the world. For example, climate change will affect us all, and if we don't stabilize countries such as Afghanistan and help them grow their economies we may face increased global insecurity further down the road. Many development problems can have impacts which could reach our borders. So there is a national self-interest as well as a moral responsibility. And the public is very supportive.

KH: Over your many years of service to British overseas development, what has changed the most in the U.K.'s approach?

ML: When I started working for DfID in the mid 90s, and indeed up until the late 90s, international development wasn't such a high priority. We then had an interesting period between the late 90s and 2010, where the government wanted to focus on development outcomes, not just aid. There was a strong philosophy that developing countries should be supported to lead their own development. Donors should build partnership relationships with countries which had credible poverty reduction strategies to provide aid and debt relief to achieve their own development goals, to reduce poverty, to promote growth and to consolidate democracy. Since 2010, we've had the same degree of national commitment to this agenda in the U.K., but we've taken an important new direction – a much stronger focus on results, on evidence, on the impact of what we're doing and on the value-for-money agenda. We are also ensuring that what we do reflects the changes in the world we are witnessing now. There is a stronger focus on how we in the U.K. can work with emerging economies such as China, India, Brazil and others, as well as continuing to work with traditional donors including the European Union and the multilateral development banks, to promote progress and poverty reduction in low-income countries. The era we're in now is one of much more collaboration and partnerships between a larger number of donors and recipient countries to support the poorest countries.

KH: A big part of any development agenda these days, in Washington, D.C., and in London, is the whole set of issues around sustainability. As DfID looks at questions of sustainability, what is the role you see for international NGOs in British development policy?

ML: Our view is, in many of the countries in which we work, in addition to supporting democratization and the accountability of government to its people and the responsibility of the government to commission, finance or, in some cases, provide basic services to its citizens, there's a very important role for civil society – in which I include the press, media, academia and traditional NGOs – to help people to hold their governments to account, to demand the proper use of public resources and effective provision of services. I think this is an area where international NGOs have a very, very important role to play. Governments might decide that service provision can best be done by contracting in suppliers from outside the public sector; for example, in the family planning area, where many countries are keen to employ international NGOs in service provision. Then there are those countries where the government lacks the will to do what any decent government should do, in terms of service provision, and international NGOs fill a very important gap pending the evolution of greater stability or a more progressive government.

KH: Related to that, the U.K. has on and off experimented with direct budgetary support to recipient governments. When does it make sense and when does it not make sense to apply budgetary support as a development tool?

ML: Budget support is useful for four main objectives. It's helpful firstly to support macro-economic stabilization. Secondly, it's useful to generate funds, recurrent costs in particular, to finance basic services predictably. Thirdly, it's a useful way of rationalizing transaction costs, especially between heavily aid-dependent countries and their external financiers. And fourthly, it can be used to support public expenditure and public financial management reform. Ten years ago, we were doing budget support in up to 20 countries, where those four objectives were all important. In the past decade, the need for budget support in a range of these countries has declined. That is partly because the earlier objectives have been achieved. So we are now providing budget support to fewer countries. The other thing we look at is the issue of fiduciary risk. We're only interested in providing budgetary support to countries where we're confident the resources will be used to deliver positive development outcomes; for example, to improve education, reduce infant mortality, reduce maternal mortality or provide good-quality basic services to people. In countries where we don't have sufficient confidence in the policy framework or the fiduciary arrangements, we wouldn't provide budget support.

KH: What would you say are the interventions that need to be scaled up now for us to maximize our chances of achieving MDG 4, maximizing impact on child mortality?

ML: We need to complete the delivery of the basics in places where they are not fully delivered. Immunization/vaccination is a very cheap, high-return investment. Providing water and sanitation is a cheap and effective way of reducing child mortality. Improving access to a complete cycle of basic education, especially for girls, is vital. There is a core set of interventions we know well, but which still fail to reach too many people. We also need to help put in place systems to ensure that those interventions can be sustained. I don't think the agenda is so much about new interventions, although technology does make it possible for us to deliver those old interventions in new ways, but I think the core agenda is reaching the unreached.

KH: Britain will host the Family Planning Summit in July. What will the Summit's success look like for DfID?

ML: We're trying to address the fact that more than 200 million women in the developing world don't have access to the services or commodities they need in order to decide when they have children and how many children they have. This is one of the most effective ways we can tackle the scandal of maternal mortality. Working with partners like PSI, Britain has made a commitment to enable at least 10 million more women to use modern methods of family planning by 2015, contributing to a global goal of more than 100 million. It's a cost-effective intervention; it saves lives. Meeting in total the unmet need for family planning could avoid a third of the maternal death or a fifth of newborn death and save billions of dollars. So success for us is about generating a credible, widely shared commitment to reach the unreached in this area with metrics we should set for ourselves by 2015 and some completion tasks for 2020 or shortly thereafter. That is what we're shooting for.
A Healthy
THE GOOD NEWS: More children are living healthier lives around the world than at any other time in history. Child mortality rates are on a steady decline, from 12 million deaths in 1990 to 7.6 million deaths in 2010.

THE BAD NEWS: Nearly half of the deaths that still occur are due to diarrhea, pneumonia, malaria and neonatal causes. Furthermore, under-nutrition is considered an underlying cause in almost a third of deaths of children under five.

As the 2015 deadline for meeting the Millennium Development Goals (MDG) approaches, there is mounting pressure to reduce child mortality by two-thirds (MDG4) and reduce by 50 percent the proportion of people without sustainable access to safe drinking water and basic sanitation (MDG7).

While we have proven and cost-effective interventions to address the major causes of child mortality, accelerated progress is hindered by insufficient and inadequately coordinated funds that would ensure these interventions are implemented at the scale required to significantly improve the health of nations. Cost-effective interventions – such as diarrhea treatment kits (oral rehydration salts and zinc); increasing access to, and rational use of, antibiotics for pneumonia treatment; promotion of hand-washing with soap and micronutrient fortification of food – need to be scaled up if we are to meet the 2015 development goals. However, funding for these interventions lags behind other health interventions despite the relative importance of diarrhea, pneumonia and under-nutrition in causing child mortality. Additionally, donor consensus on integrated programming remains low despite the obvious health delivery synergies and economies of scale. As a result, adequate funding is not flowing.

But how can PSI contribute to this sort of impact for other child diseases? At the American Society of Tropical Medicine and Hygiene conference in Philadelphia in December 2011, PSI launched its new child health strategy – which goes far beyond malaria to explore how PSI can leverage its core strengths to improve the health of the child at scale. This includes an approach that considers all segments of the market to better deliver integrated health services, to improve case management, and to leverage our capacity in developing countries to deliver additional high-impact interventions in water, sanitation and hygiene (WASH), nutrition and neonatal health. By increasing our strategic relevance and working in new partnerships, we aim to bring about the scale of impact on overall child mortality that we have demonstrated, along with many other partners, in malaria.

When it comes to integrated case management of children, PSI puts itself in the shoes of a caregiver of young children, and we try to understand her decision-making process and her options for seeking treatment when one of her children gets ill. She makes rational choices between visiting a public health facility, a drug shop, a private clinic or a community health worker. PSI is improving her options by supporting providers in diagnosis and case management, increasing her access to quality treatment, and educating her to increase the chances of a successful treatment outcome for her sick child – irrespective of the sector from which she seeks treatment. We call this a total market approach.
For example, a 2009 ACTwatch household survey in Uganda found that 68 percent of caregivers seek treatment for fever in children under age five from the private sector. As a result, PSI’s affiliate PACE established a network of existing drug shops and private clinics called Five & Alive in Mubende district. Providers were trained and given support materials, including simple treatment algorithms, and their supply of treatment was strengthened. In return, providers agree to adhere to a set of operating standards for quality of care and affordability of products and services. In addition, volunteer community health workers strengthen the link between caregivers and the network of providers and public health facilities through symptom identification and appropriate referrals. The impact on rates of case management of children is currently being evaluated.

When it comes to improvements in WASH, PSI is utilizing its expertise in private-sector marketing, including designing compelling communications campaigns that resonate with families in rural and urban areas. Currently, we are exploring business models that build on social franchising approaches to provide consumers with financing, and quality products and services that ensure they have access to sustainable and affordable sanitation solutions. Almost 30 percent of the global burden of disease could be prevented each year if people practiced good hygiene and had access to adequate sanitation and water. Hand-washing with soap has been shown to reduce the incidence of diarrhea by 48 percent, pneumonia by 50 percent and deaths among neonates by 41 percent. PSI has developed partnerships with Unilever and Procter and Gamble to go to scale quickly and cost effectively with proven approaches to increasing appropriate hand-washing with soap practices, including working in schools to build habits among children and in communities as part of broader behavior change activities.

So how can PSI help tackle the global problem of under-nutrition that is the largely preventable cause of more than a third – 3.5 million – of all child deaths? In Mozambique and Kenya, we are promoting micronutrient (e.g. iron and vitamin A) fortified foods, such as cooking oil and flour. Food fortification is a cost-effective and sustainable approach to improve micronutrient deficiency. By using mass media to promote the health benefit of fortified foods that carry a seal of approval on the label, relevant food producers are incentivized to comply with appropriate micronutrient fortification standards in order to qualify for their brands to carry the seal of approval. As part of promoting improved maternal, infant and young child nutrition, PSI is promoting exclusive breastfeeding and home fortification of weaning foods with...
An image of a mother and secure water champion sits with her child at her home in Cotonou, Benin.

Micronutrient powders and treating acute malnutrition through the integration of community management of acute malnutrition with case management of pneumonia, malaria and diarrhea.

Neonatal mortality accounts for the greatest fraction of under-five mortality and while child mortality has reduced significantly over the past 20 years, there has been very little change in the rate of neonatal mortality. Each year, 3.3 million newborns die in their first month of life. Infections are particularly devastating because so many births occur at home and without a skilled birth attendant. PSI is working with its partners to scale up the use of chlorhexidine using diverse health service delivery approaches; clean delivery kits, antenatal service-based delivery, private provider networks and community-based distribution. Moreover, PSI is working with its partner Society for Family Health in Nigeria, to improve access to essential newborn care services at the community level.

Some key donor agencies are leading the charge in improving child survival. The Canadian International Development Agency (CIDA) is funding PSI programs in the Democratic Republic of the Congo, Cameroon, Mali and Malawi that train community health workers to treat children for malaria, diarrhea and pneumonia. The U.S. Agency for International Development (USAID) recently released guidance to its field offices on integrated programming in family planning, maternal and child health, and nutrition under its Global Health Initiative. USAID also launched its “Every Child Deserves a 5th Birthday” campaign to promote investment in low-cost, simple interventions that fight the major killers of children. The Bill & Melinda Gates Foundation is investing in innovations for child health, such as development of sanitation tools, technologies and delivery mechanisms that make sanitation services safe and affordable for everyone. And the U.K. Department for International Development (DFID) is in the process of developing a maternal, newborn and child health strategy, indicating a greater focus on integration moving forward.

From pregnancy to birth and through a child’s first five years of life, the prospects for a healthy and bright future are increasing thanks to the availability of more interventions with proven impact on the major causes of child mortality. The challenges are great, but by scaling up cost-effective, high-impact integrated interventions, in the private and public sectors, children can realize a healthier start to life and have a much greater chance of celebrating their 5th birthday.

NOTES
1 World Health Organization, February 2012.
2 One DALY equals one year of healthy life lost due to illness or death. PSI adds a year of health life with every DALY averted.
3 These are preliminary cost-per-DALY numbers since the 2011 financial had not closed at the time of printing.
4 ACTWatch is a research project to inform national and international malaria case management policy through evidence from the public and private sector. Learn more about ACTWatch at www.actwatch.info.

CAUSES OF CHILD MORTALITY

- HIV/AIDS: 24%
- Malaria: 16%
- Diarrhea: 14%
- Pneumonia: 14%
- Neonatal: 35%
- Other: 39%

Estimated funding in US$ millions between 2007-2011

- HIV/AIDS: $6.5 million
- Malaria: $2.3 million
- Diarrhea: $14.8 million

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Diarrhea and pneumonia are the leading killers of children under the age of five. Yet, treatment for both diseases has existed for decades and costs less than US $0.50 per course. Post-partum hemorrhage (PPH) accounts for an estimated 20–25 percent of all maternal deaths worldwide, while preeclampsia/eclampsia accounts for an estimated 12 percent. Similar to diarrhea and pneumonia, low-cost, effective medicines to treat both conditions already exist.

So why is cheap, life-saving treatment not easily accessible to women and children in many countries in the developing world? As with most seemingly simple yet annoyingly persistent global problems, the devil is in the details. If you are a pregnant woman or the mother of a sick child you might not be able to access the essential medicines you need because:

➤ Affordable treatments are not available nearby in health facilities and/or shops;
➤ A trained provider is not available to administer the medicine;
➤ Treatments are not available in appropriate formulations, such as pediatric doses;
➤ Regulatory mechanisms are not in place to protect you from counterfeit medicines; and
➤ You might not know which treatments are appropriate and how to access them.

With 2015 on the horizon and progress toward the health-related Millennium Development Goals 4, 5 and 6 lagging, the United Nations (UN) has launched the Commission on Life-Saving Commodities for Women and Children to address barriers to delivering a range of essential health commodities. The UN’s Every

“Availability of affordable medicines, contraceptives and other health supplies is an essential part of well-functioning health systems that are able to serve people in an equitable manner.”

– DR. BABATUNDE OSOTIMEHIN, UNFPA EXECUTIVE DIRECTOR
Coverage, Cost and Potential Impact of Diarrhea & Pneumonia Treatment

<table>
<thead>
<tr>
<th>Coverage (percentage)</th>
<th>ORAL REHYDRATION SALTS</th>
<th>ZINC</th>
<th>AMOXICILLIN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0.08-0.13/ sachet</td>
<td>$0.25/10 tablets</td>
<td>&lt;$1.00 per course</td>
</tr>
<tr>
<td></td>
<td>an aver estimated 93% of diarrhea deaths</td>
<td>40% reduction in treatment failure; 25% in episode duration</td>
<td>pneumonia case mgt. can reduce mortality by 36-42%</td>
</tr>
<tr>
<td></td>
<td>39%</td>
<td>&lt;2%</td>
<td>37%</td>
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Source: Clinton Health Access Initiative

Woman Every Child campaign is hosting the Commission, and UN Children’s Fund (UNICEF) and UN Population Fund (UNFPA) are vice-chairs.

“Availability of affordable medicines, contraceptives and other health supplies is an essential part of well-functioning health systems that are able to serve people in an equitable manner,” said UNFPA Executive Director Dr. Babatunde Osotimehin. The Commission “will help ensure access to these critical supplies, save lives and improve the health of women, children and young people. This is at the center of UNFPA’s work, and we are very pleased to be co-leaders in this initiative.”

The Commission, launched March 23, brings together various stakeholders from nonprofit, public and private sectors, to pursue the following objectives:

➤ Reduce financial barriers to access through social protection mechanisms, such as fee waivers, vouchers and social insurance, and global financial mechanisms;
➤ Create incentives for international and local manufacturers to produce and innovatively package overlooked supplies;
➤ Identify fast-track regulatory activities to accelerate registration and reduce registration fees for a special list of products to encourage a focus on quality medicines; and
➤ Advocate at the highest levels to build consensus around priority actions for increasing the availability, affordability, access and rational use of overlooked health.

The Commission recognizes that scaled-up interventions to increase access to treatments for the leading killers of young children and mothers have a high potential for impact with modest implementation costs, as compared to other national programs to fight malaria and HIV/AIDS for example. The Commission will also examine commodities for neonatal care and reproductive health.


The Commission is also actively engaging the maternal health community to develop recommendations for consideration. PSI continues to work with the Commission through its work with private-sector providers, relationships with Ministries of Health, and program experience in preventing child deaths and maternal deaths in more than 30 and 18 countries, respectively.

This year, the Commission is set to make recommendations on how to ensure that treatments are accessible to those who need them most. “Once the recommendations are set, we anticipate that there will be a huge call for action, led by the UN, with tangible action points that people can rally around,” says Renee Van de Weerdt, Chief of UNICEF’s Child Health and Emergency Response. “I hope that we can meet the health-related MDGs and say that thanks to this Commission, we were able to meet them.”

PSI Author: Stephanie Dolan, Program Manager, Malaria Control & Child Survival, Washington, D.C.
In his 2012 Annual Letter, U.S. Agency for International Development (USAID) Administrator Dr. Rajiv Shah pointed out that, “Development is full of problems we have too few ways to solve. Helping children reach their fifth birthday is not one of them.”

This June, USAID will launch the “Every Child Deserves a 5th Birthday” call to action to bring together global leaders to tackle the remaining 30 percent of child deaths that occur each year.

This campaign builds on the momentum generated by other initiatives like the UN Secretary General’s Every Woman Every Child strategy, which has secured more than US$40 billion in pledges from international organizations, national governments, multilaterals, the private sector and civil society organizations.

The campaign elevates six interventions that global health experts believe are the main drivers of child mortality:

1. healthy timing and spacing of pregnancy,
2. preventing mother-to-child transmission of HIV,
3. malaria,
4. nutrition,
5. vaccines and immunizations, and
6. community-based management of pneumonia and diarrhea.

Ending preventable child deaths within a generation could very well be the first great humanitarian achievement of the 21st century. PSI will continue to focus its work on high-impact programs that provide the best value for money and achieve the greatest health impact.

“Our goal is to inspire and motivate action against commitments already made,” says Amie Batson, USAID’s Deputy Assistant Administrator for Global Health. “Ending preventable child deaths within a generation is achievable if we can build on the foundation of past success and develop a system of mutual accountability.”

PSI Author: Ryan Cherlin, Manager, Communications, Washington, D.C.

“I wish that all children, regardless of where they are born, are given the same opportunity to survive childhood and make an impact on the world.”

- PSI AMBASSADOR MANDY MOORE, supporting USAID’s 5th birthday campaign with a photo of her at five years old.

Learn more about the 5th birthday campaign at www.5thbday.usaid.gov
AMIE BATSON
Deputy Assistant Administrator for Global Health and
USAID’s Deputy of the Global Health Initiative

Amie Batson joined the U.S. Agency for International Development (USAID) in 2010 after a 20-year career in global health that has included positions at the World Health Organization, United Nations Children’s Fund and most recently, the World Bank as assistant to the managing director. She was one of the original drivers behind the creation of the Global Alliance for Vaccines and Immunization. These efforts provided billions of dollars for global health and helped to vaccinate millions of children against polio, pneumonia, diarrhea and other vaccine-preventable causes of death.

She speaks with Stephanie Dolan, Program Manager of Malaria Control and Child Survival at PSI.

STEFANIE DOLAN: Why has USAID chosen child survival as an issue of significant focus for this year? What was the impetus for the “Every Child Deserves a 5th Birthday” campaign?

AMIE BATSON: What drove USAID to really focus on child survival is the enormous progress that’s been made in countries. Through science, technology and programmatic innovations, many countries have been able to dramatically reduce their child mortality. We’ve gone from 1990, where more than 12 million children died every year, to 2010, with 7.6 million children dying. That’s an enormous rate of achievement, and it’s an achievement that we’ve seen accelerate every decade. The impetus then for the Every Child Deserves a 5th Birthday campaign is our strongly held belief that every child does deserve a 5th birthday. That’s something that resonates well with our technical partners, with the child survival community, obviously, but very importantly, with the American people. We see this campaign as an opportunity to reach out to Americans, to raise their awareness of how many children still die before their 5th birthday, about the simple, cost-effective, very high-impact tools that exist that could prevent those deaths, and also about what they can do – how they can be engaged, how they can support their favorite charities and how they can take action to help really accelerate this progress.

SD: What are the objectives of this campaign, and how would you define success for the Call to Action that USAID will host in June?

AB: For us, success of the campaign is being able to reach millions of Americans so that they can become more aware of the incredible capacity to save children’s lives – to help ensure that all children can in fact reach their 4th birthday – and that they become aware of the simple, cost-effective tools that already exist to prevent so many of these deaths. Success would mean that every country feels more engaged and sees ways that they can take action. It’s really about creating a platform for everybody to help contribute to this goal, because the goal of the world moving towards the end of preventable child death is a goal that’s all about collective action. It’s about what every country has to do, what every type of stakeholder – from the government to the faith community, to civil society, academia, technical partners and private sector – has to do to help realize this goal.

SD: Who are the major players driving the child survival agenda forward, and what role do you believe lower and middle-income countries should play?

AB: This big goal of fighting to end preventable child death is about collective action. It’s about the role every single partner needs to play – every single government around the world, multilateral organizations like WHO and UNICEF, faith communities around the world, civil society, private sector and academia. They all have extremely important roles to play. And they each bring a different skill, a different knowledge set, a different contribution to the goal. It’s not only about the richest countries providing financial support for the lowest income countries – the donor-recipient model. We’re looking to focus on what actions middle income countries need to take on for their own domestic challenges. We need to take a look at what lower incomes countries can do on their own. We want to emphasize that every country – low, middle or high income – has a role to play, both domestically and globally.

SD: In the past, we’ve seen vertical funding of programs under the child survival umbrella. And we’re moving now as a community, with the leadership of USAID, to a more integrated child survival approach. Does that ring true for you?

AB: This is true. Ending preventable child death is a unifying goal. It can help to bring together all of the various partnerships and initiatives that are the backbone of the child survival community – bringing them together with a common end point. So it’s an opportunity to unify the community around malaria, the community around immunization, the community around nutrition, and look at what they all contribute. Every single one of those interventions or partnerships has enormous contributions to make that are absolutely essential if we are to meet the larger goal. This is something that everyone can work towards, and everyone can provide their unique contributions. And that’s another reason why now is the right time. There’s a lot of value in bringing our community back together, recognizing what each of these initiatives and partnerships can contribute. What we need to tackle now are the cross-cutting goals. It’s about how to reach that child in a rural, hard-to-access area of the developing world with all of these key interventions – not just one of them. It’s about empowering the mother of the family so that she’s aware of the services that are available to them. They need to be aware of the kind of actions they can take at home and in their community to have healthier families and healthier children.
In many communities around the world, children are not named until they survive the first month of life. Globally, 3.1 million newborns die each year and another 2.6 million babies are stillborn. This alarming number of newborn deaths is reason enough to focus more attention on newborns, but the fact is that four out of five of these deaths result from largely preventable and treatable conditions. While significant progress has been made in addressing childhood illnesses, progress in reducing newborn mortality remains stagnant, making newborn deaths a growing percentage of child deaths. Today, more than 40 percent of deaths in children under age 5 occur in the first month of life.

What Can Be Done?

For more than a decade, Save the Children’s Saving Newborn Lives (SnL) initiative, supported by the Bill & Melinda Gates Foundation, has worked with valued partners, Ministries of Health and national stakeholders to generate evidence and advocate for low-cost, proven interventions that can be carried out entirely within the framework of existing programs. Since 2000, SnL has supported groundbreaking research studies and contributed to the growing evidence that technically feasible and affordable interventions have great impact on newborn survival. Landmark studies, such as the Projahnmo Project in Bangladesh – which recorded a 34 percent drop in newborn mortality – have proven that delivering essential newborn services through home visits by trained community health workers significantly reduces mortality. The risk of newborn death is highest during childbirth and directly afterward. Some 75 percent of all newborn deaths happen in the first week of life, and nearly half happen in the first 24 hours. The SnL programs and activities have especially focused on this critical first week, generating evidence and advocating for globally accepted solutions and approaches to the top three global causes of newborn deaths: preterm birth, infections and intrapartum-related complications (birth asphyxia).

- Complications from prematurity – When babies are born early, they are often small and need extra care. Today we know that simple and low-cost interventions, including maintaining adequate warmth, appropriate feeding, and prevention and/or treatment of infections can avert most of the 1 million newborn deaths that result each year from preterm birth, the leading cause of newborn mortality.

  Kangaroo Mother Care (KMC) is one of the most effective ways to save preterm babies. Through this low-cost intervention, mothers are shown how to keep their newborns warm through continuous skin-to-skin contact, wrapping their newborns to their bare chests, which encourages breastfeeding, bonding and also prevents infections. Even when compared with incubator care, KMC has been shown to reduce the risk of newborns dying by 50 percent. Up to half a million newborn deaths due to preterm birth complications could be prevented through KMC.

- Infections – Common newborn infections can quickly become fatal without appropriate
PSI, Bill & Melinda Gates Foundation Pilot Safe Delivery Project

In Nigeria, 83 percent of pregnant mothers deliver without the assistance of skilled birth attendants, increasing the risk for complications and maternal and newborn deaths. To address this, the Society for Family Health, PSI’s partner in Nigeria, and Transaid launched a two-year learning project at the end of 2009 with funding from the Bill & Melinda Gates Foundation. The Maternal and Neonatal Health Care Learning project in Gombe, Nigeria, demonstrated the following effective, scalable approaches to improve critical maternal health practices in the home:

➤ The Federation of Muslim Women’s Association trained about 250 community volunteers to counsel and care for pregnant women and newborns;

➤ More than 695 drivers from the Nigerian Union of Road Transport Workers volunteered to transport women and newborns in need of emergency care;

➤ The project launched Nigeria’s first-ever 24-hour, toll-free call center focused on maternal and neonatal care issues to provide information to pregnant women and families and offer linkages to the emergency transport scheme and community volunteers;

➤ 760 vendors provided clean delivery kits to women; and

➤ Staff trained more than 315 traditional birth attendants to conduct safe deliveries, identify danger signs, and provide counseling and referrals to pregnant women and newborns.

The project was associated with a 20 percentage point increase in the number of women who attended antenatal clinics, increases in the use of antimalarials and iron supplements in pregnancy, and a 20 percentage point increase in the number of home births that used a clean delivery kit. Transaid workers transported 3 percent of pregnant women in Gombe to facilities for emergency care; postnatal visits increased by 6 percent; and the call center received an average of 5,500 calls per month.


Life-saving interventions in communities and health facilities,” says David Oot, Associate Vice President of the Department of Health and Nutrition at Save the Children. “The critical gap is translating this knowledge into effective programs at scale. Mothers, newborns and their families cannot wait.”

Authors: Jo Ann Paradis, Communications Specialist, Save the Children’s Saving Newborn Lives Initiative, Washington, D.C.; and Monika Gutestam Hustus, Director of Communications & Advocacy, Save the Children’s Saving Newborn Lives Initiative, Washington, D.C.

Sita, a community health volunteer in Banke, Nepal, provides Bimala, a pregnant mother, information on cord care using chlorhexidine and prevention and management of infections.

➤ Birth Asphyxia – The third major cause of newborn deaths around the world, birth asphyxia claims more than 800,000 newborn lives every year. Responding immediately when newborns fail to breathe in the critical moments after birth could dramatically reduce the number of newborn deaths worldwide. The Helping Babies Breathe initiative enables health workers in low-resource settings to resuscitate newborns with breathing difficulty.

“Saving newborn live is critical to the global effort to accelerate progress towards the achievement of Millennium Development Goal 4. We now have the tools and approaches we know can save lives and better platforms for delivering these life-saving interventions in communities and health facilities,” says David Oot, Associate Vice President of the Department of Health and Nutrition at Save the Children. “The critical gap is translating this knowledge into effective programs at scale. Mothers, newborns and their families cannot wait.”

Authors: Jo Ann Paradis, Communications Specialist, Save the Children’s Saving Newborn Lives Initiative, Washington, D.C.; and Monika Gutestam Hustus, Director of Communications & Advocacy, Save the Children’s Saving Newborn Lives Initiative, Washington, D.C.
Can a Simple Checklist Make Child Birth Safer?

Making the work of health care providers easier to remember and communicate might save as many lives as the most effective drug. In *The Checklist Manifesto: How to Get Things Right*, Atul Gawande tells a remarkable story about how checklists, used for decades by teams of pilots and construction workers, were found to cut the death rate from surgery in poor and rich countries alike by nearly 50 percent.1

Many simple solutions in health care, such as providers washing their hands, become complex as irregular medical teams react to patient needs. Gawande found that checklist items reminding surgical team members to introduce themselves to one another and ask whether there were concerns that should be raised could lead, among other things, to providers noting to one another that their hands needed to be washed, and in turn lower infection and death rates. Checklists remind even the best-trained surgeons and best-equipped teams about critical steps and help them communicate.

PSI/India has joined a team led by the World Health Organization, Harvard School of Public Health, Bill & Melinda Gates Foundation and many others who are asking whether checklists can significantly reduce the nearly 5 million maternal and infant deaths a year associated with childbirth.

There are more than 130 million births that take place each year. About 350,000 mothers die as a result of childbirth. About 1 million children are stillborn for intrapartum-related causes. Another 3.1 million children die during the neonatal period. The major causes of childbirth-related deaths are hemorrhage, infection, hypertension-related disorders and prolonged/obstructed labor in mothers, infection, birth asphyxia and complications of prematurity in babies. The highest incidence of maternal and perinatal mortality occurs around the time of birth with the majority of deaths occurring within the first 24 hours after delivery. Intrapartum-related stillbirths often result from complications during labor. Most of these deaths are avoidable if existing knowledge were applied.

PSI/India and partners have assembled a 31-item list of reminders, from the simple – asking the mother’s companion to be present at the birth – to precise clinical signs of infection and hemorrhage. Their aim over the next three years is to test it in India to see whether childbirth-related harm, including death, in institutional deliveries can be significantly reduced through adherence to essential childbirth-related clinical care standards.

In the state of Uttar Pradesh, 120 rural public sector facilities in 20 districts that deliver at least 1,000 babies per year will be paired and randomized either to use the checklist or not. PSI/India will help clinics adopt checklist use and manage information for the 172,000 births that need to be monitored. Ravi Subbiah, Dr. Jyoti Vajpayee, Atul Kapoor, Dr. Nayara Shakeel and Dr. Shobhana Swami lead the project. Their work could be of the highest public health importance.

 Provision of skilled attendance at every birth is a global priority for achieving the Millennium Development Goals and many countries have organized efforts to encourage women to deliver in health facilities to ease the management of complications. Despite major efforts around the world to improve quality of care, gaps in newborn and maternal care practices continue. Until now, no tool existed that can remind providers of the minimum critical standards around delivery care that can prevent avoidable maternal and neonatal deaths. Checklists, mere job aids, for both expected and unexpected childbirth complications may be one of the most potent interventions in health care.

Early HIV Diagnosis Critical to Child Survival

Sangeeta was one of the first few HIV-positive pregnant women to deliver at PSI’s Project Connect prevention of parent-to-child transmission (PPTCT) center. Connect was a five-year U.S. Agency for International Development-funded project that ended September 2011. For 18 months, Sangeeta anxiously waited to know her child’s status, as the national protocol recommended that children be tested with commonly available lab tests at 18 months of age. This long wait put the child at risk, since 50 percent of HIV-infected children die within two years; in fact, more than 35 percent of the children die in the first year itself. The long wait also tested the project’s ability to follow up with Sangeeta and her child. These were some of the main challenges for the PPTCT team and for the more than 945 HIV-positive pregnant women who have delivered at the Connect-supported PPTCT centers since June 2007. What if there was a faster, more precise test available to Sangeeta and her child? Then, if her child tested positive, he or she could be put on treatment, thereby improving chances of survival.

* Sangeeta is a PSI archetype and not the client’s real name.
** Confirmation depends on the national protocol and breastfeeding practices.

A couple gets counseled at St. Anne’s Hospital, Visakhapatnam, Andhra Pradesh, India. Andhra Pradesh has the highest Adult HIV prevalence among Southern Indian states according to recent estimates of India’s National AIDS Control Organisation.

Connect center staff addressed the issues with waiting period, anxiety and delay in treating HIV-positive children by testing the babies with DNA-PCR (deoxyribonucleic acid polymerase chain reaction) test kits. Using DNA-PCR, babies can be tested as early as six weeks, followed by a repeat test at six months of age to confirm the results. ** The DNA-PCR test detects the actual virus, unlike the more common antibody test, which detects only antibodies. Prior to the advent of the new test, it was difficult to track and follow up with mothers when their infants reached 18 months of age. The much shorter timeframe allowed by the DNA-PCR test drastically reduces the anxiety that families face and also improves the outcomes of HIV-positive children. Project Connect successfully mobilized free DNA-PCR test kits from Roche Laboratories, an FDA-approved manufacturer of the kits, and Hindustan Petroleum Corporation Limited, as the kits were not available in public-sector facilities at the time.

Project Connect counseled and tested more than 42,400 pregnant women, enrolled 945 HIV-positive women in the program and delivered 836 babies. Of the 607 babies tested twice with DNA-PCR, 589 tested negative for HIV — resulting in a transmission rate of 2.9 percent, compared with the average HIV transmission risk of 30 percent without any intervention.

PSI Author: Dr. Shekhar Waikar, Senior Program Manager, Project Connect, PSI/India.
Health and infrastructure challenges in Sub-Saharan Africa and South-East Asia are active contributors to child death. Myanmar, for example, has the lowest level of public funding for health in the world, at 0.5 percent of Gross Domestic Product. The Democratic Republic of Congo (DRC) has only one doctor for every 10,000 Congolese people, despite having a geographic land area greater than Western Europe.

In many cases, parents and caregivers of children are simply unable to access life-saving treatment when their child is sick, putting them at repeated risk of these preventable killers of children. Access to quality case management and medicines is often too far away, expensive or worse, nonexistent.

Multiple Channels, Maximum Results

A More Comprehensive Approach

Working in partnership, the Ministries of Health in Myanmar and DRC, PSI is supporting the expansion of essential services to diagnose and treat malaria, pneumonia and diarrhea: the top three killers of children in these countries.

PSI is increasing access to quality, affordable life-saving services and products by considering the needs of the caregiver and by investing in the channels most likely to meet her/his needs. Whether this service is provided through a public, private or community channel, PSI is supporting improvements in the quality of provider care and increasing access to quality, affordable services.

treatments and diagnosis for the integrated case management (ICM) of malaria, pneumonia and diarrhea and acute malnutrition.

In the DRC and Myanmar, ICM is primarily been implemented by community health workers who serve as a first-line of defense against illness. Since the child will be seen in the community, this type of ICM is known as integrated community case management or iCCM. Depending on the policy in the country and the severity of the illness, community health workers either diagnose and treat childhood illnesses on the spot, or refer cases to the nearest health clinic. This clinic might be a private clinic (also supported by PSI), as is the case of Myanmar, or a public health facility, as is the case in DRC.

Progress in DRC

In 2009, the Ministry of Health of the DRC, PSI, and the Canadian International Development Agency (CIDA), launched an iCCM program focusing on service delivery by community health workers. Within three years, the DRC program recruited and trained 1,192 community health workers (CHWs), who collectively covered a population of 2.5 million people in the Northern Sud-Ubangi district. From November 2010 through March 2012, these Congolese CHWs provided 212,270 treatments of co-formulated artemisinin-based combination therapies (ACTs) for uncomplicated malaria, 227,760 treatments of cotrimoxazole for pneumonia and 75,788 treatments of oRS/Zinc for diarrhea. Within the same period, they referred 13,103 children with severe illness cases to health centers. Such achievements reflect the demand among caregivers for treatment services provided at the community level by trained health workers. In fact, CHWs in the region are now experiencing demand from families living outside of their areas of service.

Progress in Myanmar

In 2009, PSI engaged two existing health provider networks to treat illness in children under five – Sun Quality, a network of private, franchised clinics and Sun Primary, a network of community health workers for rural areas. Since the launch, the two networks have distributed nearly 544,550 pneumonia treatments and more than 700,000 ORS/ZINC kits to treat diarrhea. To reduce the malaria burden, both networks provide rapid diagnostic test kits as well as WHO-approved malaria treatment. Sun Quality and Sun Primary networks have provided more than 1.2 million malaria consultations and treated more than 300,000 malaria cases. By using these two channels, PSI/Myanmar now reaches more than 90 percent of the country with quality treatment for children – when they need it, where they need it.

Future Plans

Expanding ICM programs in Africa and Asia has the potential to increase access to quality affordable health care for children under five at risk of death from malaria, pneumonia and diarrhea. Success of these programs is hitting home with international donors and national governments; many are beginning to support ICM in other countries and to take it to scale.

Authors: Jane Miller, Ph.D., Senior Technical Advisor, Integrated Case Management; and Angus Spiers, Ph.D., Deputy Director, PSI’s Malaria Control & Child Survival Department

Integrated Community Case Management in Action

Community health workers have the potential to significantly increase access to treatment for the major diseases affecting children. The figures to the left, taken from a survey of the CIDA-funded project in Cameroon show that significantly more children received treatment as a result of having trained health workers in their community with appropriate medicines. As a result, 61 percent of children in the areas served by community health workers were treated with ORS, as compared with 7 percent of children in other areas.
In 2011, the Roll Back Malaria Partnership set new goals for further scale-up of impact by 2015. The goals comprise ambitious targets for malaria case management, including in the private sector, which is increasingly recognized as an important point of care for common febrile illnesses. The Affordable Medicines Facility for malaria (AMFm), currently being piloted in seven countries, is a novel financing mechanism established to dramatically increase access to quality assured, artemisinin-based combination therapy (ACT), especially in the private sector, by applying a factory-gate subsidy at the top of the supply chain. The Global Fund to Fight AIDS, Tuberculosis and Malaria, host of the first phase of the AMFm, has commissioned an independent evaluation of the pilot. The evaluation draws on, among other sources, PSI’s ACTwatch market survey data. By the end of 2012, based on the evidence from the evaluation, the Global Fund Board will decide whether to continue hosting this innovative but, to some, controversial mechanism for improving access to malaria treatment.

Even without results from the evaluation being available, opinions on the AMFm have been polarized, and this may jeopardize a purely evidence-based decision on the mechanism’s future. Despite the controversy, the global malaria community should not lose sight of the targets it has set for universal coverage of both diagnosis and treatment in the private sector. The issue is not whether the AMFm is categorically good or bad; rather, what matters is how we will ensure access to high-quality diagnosis and treatment for all, and whether the AMFm, or some derivation of this mechanism, may be a...
relevant tool in certain settings. Two main points are important to highlight:

First, in countries that have participated in the pilot, a transition period after Phase 1 of the AMFm will be essential, regardless of the Global Fund Board’s decision. Patients who need first-line malaria treatment must continue to have access to high-quality recommended drugs. With AMFm co-paid drugs now representing a substantial proportion of the global ACT market, uncertainty around the near-term future of this project and the availability of subsidy for co-payments will negatively influence market dynamics globally and at the country level and could lead to dangerous stock-outs. Planning for the transition phase must become a priority now.

Second, even if the AMFm is judged as a success, pursuing a global subsidy on ACTs is unlikely to be a cost-effective, or even desirable, strategy. The investments in malaria control of the past decade have led to substantial reductions in malaria incidence and a better understanding of the global malaria epidemiology. Initiatives like the Malaria Atlas Project clearly demonstrate that malaria is not highly prevalent everywhere and, therefore, is often not the main cause of febrile illness.

Any strategy aiming at universal access to appropriate malaria case management therefore needs to target true malaria cases, as it otherwise leads to massive overtreatment with antimalarials and misdiagnosis of other potentially fatal febrile illnesses, like pneumonia. Targeting ACTs can be achieved in several ways. A factory-gate subsidy on ACTs (the current AMFm model) may be justified in the short term in areas where most fevers are known to be caused by malaria and where the private sector is known to be the principal point of access to treatment. Our initial analysis shows that geographic areas in this segment are mainly in the West Africa Coastal belt and the Central African region around the Congo and the Democratic Republic of the Congo (Figure 1).

In places where the fraction of fever cases that are caused by malaria is relatively low, suspected cases should be tested for malaria before receiving treatment, even in the informal private sector, which presents a new set of challenges. Several recent operational research projects that introduce malaria diagnosis in the private sector (Zambia, World Bank; Uganda, Clinton Health Access Initiative) have shown encouraging results. Affordable rapid diagnostic tests (RDTs) combined with a robust marketing strategy and the right incentive structure for wholesalers, outlets and the patient can change the behavior of providers and patients, leading to better targeting of ACTs to confirmed malaria cases.

The ultimate goal of any strategy for malaria case management is that all suspected cases are tested, confirmed cases receive the recommended, quality assured malaria treatment, and those who test negative receive appropriate treatment for their illness. The pathway to achieving this goal will be highly context-dependent and will, in an ever-changing malaria epidemiological environment, evolve over time. If the global malaria community wants to achieve its targets, decision makers can benefit from building on the lessons of the AMFm pilot – rather than dismissing it as outdated or heralding it as a perfect model.
Micronutrient deficiency, including anemia, is a silent epidemic, affecting one in three people around the world. Vitamin A deficiency can cause blindness and leave pregnant women and children susceptible to disease and infection; folic acid, zinc and iodine deficiencies pose significant risks to pregnant women and development of children; and iron and iodine deficiencies are linked to intellectual disability.

International health agencies, by and large, have delivered micronutrients to at-risk populations – pregnant women and children – to tackle this deficiency. The United Nations Children’s Fund (UNICEF) has led worldwide campaigns to deliver bi-annual vitamin A supplements to children. More recently, with home fortification options, mothers can sprinkle low-cost or free micronutrient powder over their children’s food.

“These options are valid and important, but they’re interim solutions,” says Dr. Abel Irena, Nutrition Technical Advisor at PSI. “It’s not a sustainable way to address deficiency.” Instead, says Irena, the developing world should look at countries that have combated micronutrient deficiency through national food fortification schemes. For example, iodine has been nearly universally added to salt since before World War II in the U.S., and in much of the developed world, milk is routinely fortified with vitamins A and D.

“Food fortification is widely recognized to be one of the most cost-effective public health interventions,” says Marc Van Ameringen, Executive Director, Global Alliance for Improved Nutrition (GAIN). An investment of US$347 million a year in micronutrient programs, including food fortification, could result in US$5 billion savings from avoided deaths, improved earnings and reduced health-care spending. “At GAIN we are pleased that the fortification of staple foods is increasingly recognized as a key strategy in the fight against malnutrition.”

PSI is piloting projects in Kenya and Mozambique, where food fortification is not mandatory, to promote and market fortified foods. PSI and GAIN are working with the food industry, government and other partners to help create market demand for fortified sugar, cooking oil and flour – essentials in everyday cooking.

At the heart of this strategy is a simple, colorful logo affixed to the label of fortified food. PSI test-marketed the logo and accompanying communications campaign and will launch a mass media campaign later this year to encourage consumers to choose fortified products. “We want mothers to look for this logo when shopping; we want the logo to become a mark of trust for consumers,” says Irena.

The challenges are great. The logo is small and still unfamiliar to consumers. Also, some fortified products can be slightly more expensive. Another challenge comes when communities rely on locally produced flour. This reduces the available options for delivery of micronutrients and makes it more critical that items that must be purchased, like sugar, are fortified.

Still, this market-based approach is ultimately the most sustainable way of ensuring long-term solutions to micronutrient deficiency. “We enrich millions of lives daily through our products and services,” says Vimal Shah, CEO of BIDCO, a food producer in Kenya. “Fortification of our edible fats, oils and margarines is a milestone in our journey to ensure healthy lives on our continent.”

Through these projects in Kenya and Mozambique, the food industry will also gain a wider base of consumers who make savvy nutritional choices. Governments, meanwhile, are freed from part of the burden of providing direct nutritional assistance and can expect better health outcomes over the long term. Most importantly, children and their caregivers are assured a healthier future, free from potentially crippling ‘silent’ nutrient deficiency.

Author: Mark Goldberg, freelance writer, Washington, D.C.
In Gudele Hai Loquilili, a community on the outskirts of Juba, South Sudan, latrines are hard to come by and most residents practice open defecation. Community mobilizers from PSI visited Gudele Hai Loquilili on a hot, dusty day in March. Under the branches of a shady acacia tree, the team looked on as community members mapped their homes, water sources and defecation sites using small bits of colored paper. As residents marked these spots, it became clear that the dry river bed on the edge of town was the most popular place to defecate.

One site, in particular, was only twenty feet downstream from a shallow, hand-dug well where families draw water for drinking and household chores.

Globally more than 1 billion people practice open defecation and another 1 billion people don’t have access to a latrine that adequately protects them from their own feces. This is a dangerous situation for human health given that just 1 gram of human feces can contain 10 million viruses and 1 million bacteria.

The public sector has struggled to keep pace with providing toilets to billions of households worldwide. In the state of Andhra Pradesh in India, the government built more than 2.95 million household latrines; yet, half are not used as intended. In response, the water, sanitation and hygiene (WASH) sector is increasingly working with the private sector to get toilets to communities, as well as applying marketing techniques to demand creation efforts to better resonate with targeted populations.

In South Sudan, only 14 percent of people have access to improved sanitation. This newly independent country has a long way to go towards building its water and sanitation infrastructure. PSI/South Sudan is using a model of community mobilization called community-led total sanitation (CLTS) that is based on a “no public-sector subsidy” approach. CLTS is designed to change the perception of open defecation so that it is viewed as unsanitary and unacceptable by community members. Creating new social norms around the unacceptability of open defecation have been proven to be powerful drivers of behavior change. CLTS encourages communities to come up with their own solutions to their sanitation problems through a facilitated discussion using tools like community mapping.

PSI is complementing efforts to create demand for sanitation by training local masons on latrine construction techniques as well as business development and marketing skills.

Back under the acacia tree in Gudele Hai Loquilili, residents declared that they must stop this unhealthy practice. One of the more vocal residents said, “We cannot wait for the NGOs and the government; we must try to find solutions to these problems now.”

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**Fast Facts:**

- Hand-washing with soap is the most cost-effective of all major disease-control interventions at US$5 per year of healthy life saved.¹
- Hand-washing with soap can reduce diarrhea incidence by 48%.²
- Hand-washing with soap could reduce the risk of respiratory infections by a 23%.³

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¹ World Bank/WHO Disease Control Priorities Project.
Her Royal Highness
Princess Astrid of Belgium

SPECIAL REPRESENTATIVE TO THE ROLL BACK MALARIA PARTNERSHIP (RBM)

PRINCESS ASTRID became Special Representative to the Roll Back Malaria Partnership (RBM) in 2007. In this capacity, she engages in high-level advocacy initiatives to raise awareness and mobilize resources for global malaria control efforts. Princess Astrid has a keen interest in health and global humanitarian issues and has traveled the world with RBM, advocating for adequate financing and partnership to make progress against malaria. She was President of the Belgian Red Cross until 2007 and is Honorary President of the Queen Elisabeth Medical Foundation and of the European Organization on Research and Treatment of Cancer.

IMPACT: Why did you decide to work with the Roll Back Malaria Partnership?

HRH PRINCESS ASTRID: I became the Special Representative for the Roll Back Malaria Partnership because I found it unacceptable that so many people suffer and die from such a preventable and treatable disease as malaria. In my work with RBM, I’ve had the opportunity to travel to several countries in Africa and Asia, where I’ve seen first-hand the devastation of malaria on communities. I’ve also seen the incredible impact that simple, cost-effective solutions – like insecticide-treated nets, indoor spraying with insecticides, accurate diagnostic tests and appropriate treatment – can have. These tools are proven, effective and inexpensive investments that could change the course of history for generations.

IMPACT: Why do you care so passionately about malaria?

HRH PRINCESS ASTRID: Malaria is especially important to me, because of its particular effect on the world’s most vulnerable – pregnant women and children. Despite incredible advances in recent years, we face a financial gap of US$3-2 billion through 2015, and this preventable illness continues to kill a child every minute in Africa. Each of those deaths is not just a number; it is a precious life with great potential not realized. My vision for the future includes pregnant mothers giving birth to healthy children who live to reach their fifth birthdays and complete school uninterrupted by malaria. I believe we can achieve that future, but it will take the investment and commitment of many. It’s our responsibility to ensure adequate resources are available so all can live healthy, productive lives.

IMPACT: What will increased financial commitments mean to the fight against malaria?

HRH PRINCESS ASTRID: In Africa, where 90 percent of malaria deaths occur, the disease costs an estimated minimum of US$12 billion in lost productivity per year. Malaria is simple to prevent and treat, yet it continues to plunge developing countries further into poverty. Investments in malaria prevention and control have been among the best investments in global health and help advance other key global health goals. If adequate financial resources are secured, we could further scale up our efforts to ensure millions of lives continue to be saved.

IMPACT: You were recently in Indonesia with RBM. What was the purpose of your visit?

HRH PRINCESS ASTRID: I visited Indonesia with our partners, the World Health Organization (WHO), the United Nations Children’s Fund (UNICEF), the Ministry of Health and the Global Fund to Fight AIDS, Tuberculosis and Malaria, to highlight the successes the Government of Indonesia and local partners have made in fighting malaria and to help launch the national RBM Partnership Forum. I also went to encourage continued national investment and regional leadership in global malaria control efforts. I met with officials to advance conversations around malaria control and the UN’s Millennium Development Goals (MDGs), specifically MDG 6, which calls for a reduction in neglected diseases like HIV and malaria. While there, I also accompanied WHO, UNICEF, the Ministry of Health and the Global Fund to Bandar Lampung to see some of the innovative and life-saving malaria interventions underway in communities, health centers and hospitals.

IMPACT: What is the biggest issue facing the malaria control efforts in the Asia-Pacific right now?

HRH PRINCESS ASTRID: A major threat to sustained malaria control and elimination is a developing resistance to the most effective course of malaria treatment – artemisinin-combination therapies – in some areas of the Asia-Pacific region. Thanks to a surge in research, we now understand malaria and the mechanisms of drug resistance better than ever, but the window for action against this major threat is small. It is critical that we galvanize political action at the highest level and mobilize countries to fight this disease with a coordinated effort.

The Roll Back Malaria Partnership (RBM) is the global framework for coordinated action against malaria. Founded in 1998 by UNICEF, WHO, UNDP and the World Bank and strengthened by the expertise, resources and commitment of more than 500 partner organizations, RBM is a public-private partnership that facilitates the incubation of new ideas, lends support to innovative approaches, promotes high-level political commitment and keeps malaria high on the global agenda by enabling, harmonizing and amplifying partner-driven advocacy initiatives. RBM secures policy guidance and financial and technical support for control efforts in countries and monitors progress toward universal goals.

To find out more, visit www.rbm.who.int and connect with them on www.facebook.com/rollbackmalaria and Twitter @RollBackMalaria.
U.S. Leadership, Funding Vital to Improving Child Health

In February, President Obama released a Fiscal Year 2013 (FY13) budget proposal that included US$56.2 billion for the International Affairs budget, a 2.4 percent increase from FY12 enacted levels. However, global health programs would suffer cuts under the recommended proposal. In fact, funding for global health fell at 3.5 percent lower than FY12 enacted numbers. Nutrition programs also faced reductions. Despite losing more than 7,000 children to malnutrition every day, the FY13 budget request allocated US$90 million for nutrition, a US$5 million decrease from FY12.

The budget request also provided US$578 million for maternal and child health, which is a US$27.6 million decrease from FY12.

The proposal requested US$619 million to combat malaria, US$31 million lower than was enacted during FY12. Dramatic reductions in funding for these programs could compromise some of the most vulnerable victims of poverty and instability.

U.S. leadership on child survival issues is vital to improving maternal and child health worldwide. Child survival champions will convene in mid-June at U.S. Agency for International Development’s (USAID) Call to Action in Washington, D.C., to address the gains made over the past 50 years in child mortality and discuss the challenges that remain. In collaboration with USAID, PSI and its partners are raising awareness about effective health strategies that help children and their families combat deadly water-borne illnesses, malnutrition, malaria and pneumonia.

PSI provides micronutrients to prevent under-nutrition among children under the age of five. From January to August of last year, PSI provided more than 2.3 million packets of the micronutrient powder Sprinkles to children and 1.2 million iron folic acid tablets to women of reproductive age. Reducing maternal and neonatal mortality are top priorities for PSI.

While seeing the health impact of our effective, life-saving prevention and treatment methods, we must face the harsh reality that the U.S. government’s role as world leader in addressing global health continues to be tested as economic constraints persist. We hope the U.S. government and other countries will come together in the face of economic adversity to fight for the essential funding that saves the lives of millions of children around the world.

PSI Author: Annie Toro, Governmental Affairs Manager, Washington, D.C.
Prime Minister David Cameron paid an official visit to U.S. President Barack Obama in Washington, D.C., earlier this spring. In the midst of the pomp of the color-guard inspections and the star-studded State Dinner, the two leaders updated their commitment to world affairs, particularly the 1.2 billion people at the bottom of the pyramid.

“As two of the world’s wealthiest nations, we embrace our responsibility as leaders in the development that enables people to live in dignity, health and prosperity.”

— U.K. Prime Minister David Cameron and U.S. President Barack Obama

Last year, the two governments created the U.S.-U.K. Partnership for Global Development, which committed them to work more closely in the areas of economic growth; preventing conflict in fragile states; improving global health (with emphasis on girls and women); strengthening mutual accountability, transparency and measurement of results; and mitigating the effects of climate change. In a joint communiqué issued on the first day of Cameron’s trip to Washington, the Prime Minister and President stated: “As two of the world’s wealthiest nations, we embrace our responsibility as leaders in the development that enables people to live in dignity, health and prosperity.”

The partnership has been extremely active during its 10-month existence. According to a factsheet issued by both governments, they worked together to secure pledges to the Global Alliance for Vaccines and Immunization (GAVI) Replenishment Conference (with the pledges exceeding GAVI’s request by more than half a billion dollars). The two countries also “continue to provide strong support to the Global Fund to Fight AIDS, Tuberculosis and Malaria, honoring our significant financial pledges, encouraging new donors, and supporting its new leadership, strategy and reform plan.”

The factsheet also described the partnership’s work in the Alliance for Reproductive, Maternal and Newborn Health, where they are “working to accelerate progress in 10 focus countries that account for the majority of maternal and neonatal mortality worldwide.” The U.K. recently joined the U.S. Agency for International Development’s (USAID) Saving Lives at Birth Grand Challenge for Development, to identify and scale up transformative approaches to maternal and newborn health. The U.K. will also host a major international event in July to mobilize support to expanding women’s access to family planning services. More on this in our next issue.

The U.S.-U.K. Partnership for Global Development also remains committed to achieving the Millennium Development Goals and has promised to “actively participate in international and intergovernmental discussions on reaffirming commitments to post-2015 goals of ending world poverty.”

U.K. Secretary of State for International Development Andrew Mitchell and USAID Administrator Dr. Rajiv Shah made a joint response to commemorate the Prime Minister’s visit: “The partnership outlines specific areas where we are focusing our collective efforts, reaffirming our commitment to saving lives and improving human welfare around the world.” Substance indeed.

PSI Author: Michael Chomnie, Director, PSI/Europe.
Evelyn’s Story

At 6 a.m., Evelyn Kankhuni woke to find her 3-year-old daughter, Ida, vomiting and drenched in sweat from a high fever. Evelyn knew from experience what these symptoms could mean: malaria.

Evelyn and her family live in Moffat village in the Mwanza District of Malawi. Three years earlier, Evelyn’s older daughter, Mary, who was also then 3 years old, almost died from malaria. At the time, the nearest health clinic was 12 kilometers away. Desperate for help, Evelyn carried Mary down a dusty road in the morning heat to reach the clinic, where a blood transfusion narrowly saved Mary’s life.

Today, Evelyn no longer has to fear for her daughters’ lives, thanks to an integrated community case management (iCCM) program operating in Malawi, supported by PSI and the Canadian International Development Agency (CIDA). As soon as Evelyn discovered that Ida was ill, she took her daughter to Aubrey Fraser, her community health worker.* Aubrey carried out a thorough assessment of Ida’s illness and diagnosed her with malaria. He prescribed medication and within three days, Ida had fully recovered.

Aubrey Fraser is one of thousands of community health workers stationed in villages across sub-Saharan Africa. With support from CIDA and other funders, these men and women are diagnosing and providing timely, life-saving treatment for childhood illnesses like malaria, diarrhea and pneumonia.

Availability of community-level services and access to medicines gives parents like Evelyn peace of mind knowing that they can receive immediate care if and when their children become ill. Most importantly, it gives young girls like Ida and Mary the gift of a healthy childhood.

*In Malawi, community health workers are called Health Surveillance Assistants.

Many children in rural sub-Saharan Africa lack access to diagnostic and treatment services for malaria, pneumonia and diarrhea. PSI and partners are increasing access to these services by establishing a network of trained community health workers (CHWs) – like Emmanuel from Azomkout village in eastern Cameroon.

Emmanuel is part of a network of more than 7,000 CHWs across Cameroon, the Democratic Republic of Congo, Malawi and Mali supported by the Canadian International Development Agency (CIDA) in partnership with Ministries of Health. CHWs do not typically have backgrounds in health; however, equipped with training, supervision and effective medicines, they can successfully provide appropriate care to the hardest-to-reach communities. Monitoring the work of CHWs is an essential component of this process.

Monitoring Systems

PSI and health ministry partners establish routine monitoring systems for these CHW networks. Volunteers like Emmanuel are trained to record information about each sick child they manage in a client register, including basic information (e.g. gender and age), symptoms (e.g. fever, diarrhea, cough), assessment results (e.g. respiratory rate), treatments administered (e.g. antibiotics for pneumonia, oral rehydration salts and zinc for diarrhea, artemisinin-based combination therapies for malaria), referral and follow-up. CHWs also keep records of medicines dispensed and received.

At least once per quarter, CHWs receive supervision by a public health facility-based provider. During these sessions, the supervisors summarize the data collected by the CHWs and send it to the district level. There, program managers analyze the data on key performance indicators (KPI) across more than 1,000 villages served by CHWs.

KPIs provide program managers with information on medicine stock levels, number of children receiving services and medicines, percentage of CHWs receiving routine supervision, and performance of CHWs on routine assessments to test their knowledge and application of the case management algorithm.

With information on program performance against targets, program managers can keep the program on track. Where continuous supplies of medicines are not being maintained, they send field staff to investigate the problem and identify solutions. Where low levels of supervision or poor CHW performance are observed, they allocate resources to ensure quality of care. This may include more intensive support to poor-performing CHWs and/or supplementing health facility-based staff supervision with visits from field coordinators. Program managers also review routine data collected through rapid household surveys on demand for CHW services among children’s caregivers.

Mobile phone data collection is being piloted among CHWs in Malawi and Cameroon to tackle some of the challenges of collecting monitoring data, often paper-based, from thousands of CHWs. The CHWs and their supervisors report data to feed into KPIs through their mobile phones. This data is immediately captured in a database, which facilitates rapid access to information for program managers. The program managers can then more effectively support CHWs to ensure achievement of program targets, ultimately contributing to a reduction of severe disease and death among children. ■

PSI Authors: Emily Carter, Associate, Malaria Control & Child Survival, Nairobi; and Megan Littrell, Senior Research Advisor, Malaria Control & Child Survival, Nairobi.

Quality Care in Communities
Karl Hofmann  
PSI President and CEO

The Way Forward

Let’s begin with a fact: when children have a healthy start to life and live beyond their fifth year, their odds of surviving and thriving are greatly improved. Development is full of complexities, but often the simplest solutions are found when you begin with understanding the needs of individuals. In the past, vertical approaches in global health worked to mobilize resources and achieve progress; HIV and malaria are great examples of where a vertical approach to health has done just that. Looking ahead, PSI and other leading global health organizations realize that success will require a shift away from a disease-centered vertical approach to one that focuses on the individual needs of those we serve. The people we serve have many health needs throughout their lives, so PSI works at local, country and international levels to strengthen integrated services and support governments to deliver higher-quality integrated services.

PSI starts by identifying where the need is greatest. We focus our efforts on high-impact health interventions that are consistent with needs and global best practices. Our greatest opportunity to improve child health calls for a focus on effective interventions for prevention and treatment of the four biggest killers of children: pneumonia, diarrheal diseases, malaria and undernutrition. Reducing the number of preventable child deaths is a responsibility that the global community has responded to with force. In the past 50 years, developments in science, technology and service delivery have helped to reduce global childhood deaths by roughly 70 percent. Achieving the last 30-percent reduction will require an integrated approach that addresses the needs of children holistically. It will also require a greater focus on understanding the health needs of children, building health systems that work for those who live in resource-poor settings, and reaching women and families at the community level.

It is important to recognize that there are already existing, cost-effective health interventions for prevention and treatment of many of the leading causes of death among children. An integrated service-delivery approach is critical to achieving health impact in the most efficient and cost-effective manner. PSI’s social franchise model strengthens the private health sector’s capacity to contribute to national health goals, as well as supports and complements the services delivered in public health systems. We do this by strengthening the technical knowledge of providers, standardizing quality of care, and ensuring that products and services are available in hard-to-reach areas at affordable prices.
FOR A MALARIA-\textbf{FREE} WORLD

\textbf{ROLL BACK MALARIA}

www.rollbackmalaria.org