BEYOND SURVIVAL

– A JSI SERIES ON CHILD HEALTH

Improving Child Health through a Life-Course Perspective

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JSI's approach to supporting the health of women and children is rooted in a life-course perspective, which acknowledges that events occurring early in one's life greatly influence later outcomes. This perspective recognizes that biological or behavioral factors, as well as environmental and socio-economic circumstances, especially geographic location, poverty, and ethnicity, determine health outcomes. Health equity is therefore integral to our work.

BACKGROUND

In 2018, an estimated 6.2 million children and adolescents under the age of 15 years died worldwide, mostly from preventable causes. Of these deaths, 5.5 million occurred in the first 5 years, and almost half of them in the first month of life.[1] For children under the age of 5, neonatal deaths and infectious diseases are the leading causes of death[2] (see figure 1). However, many sick children have more than one condition at the same time and clinical signs are often non-specific, making a single diagnosis sometimes impossible or inappropriate.

Half of all under-five deaths in 2018 occurred in five countries: India, Nigeria, Pakistan, the Democratic Republic of the Congo, and Ethiopia. All six countries with mortality rates above 100 deaths per 1,000 live births were in sub-Saharan Africa (see figure 2), where 2.8 million children under age 5 died in 2018[3] and neonatal deaths have stagnated at 1 million annually from 1990 to 2018.[4] This slowdown in reducing neonatal mortality compared to the mortality of older ages has led to the share of neonatal deaths increasing relative to all under-five deaths. More than ever, this makes the first 28 days of life the most vulnerable time for a child's survival.

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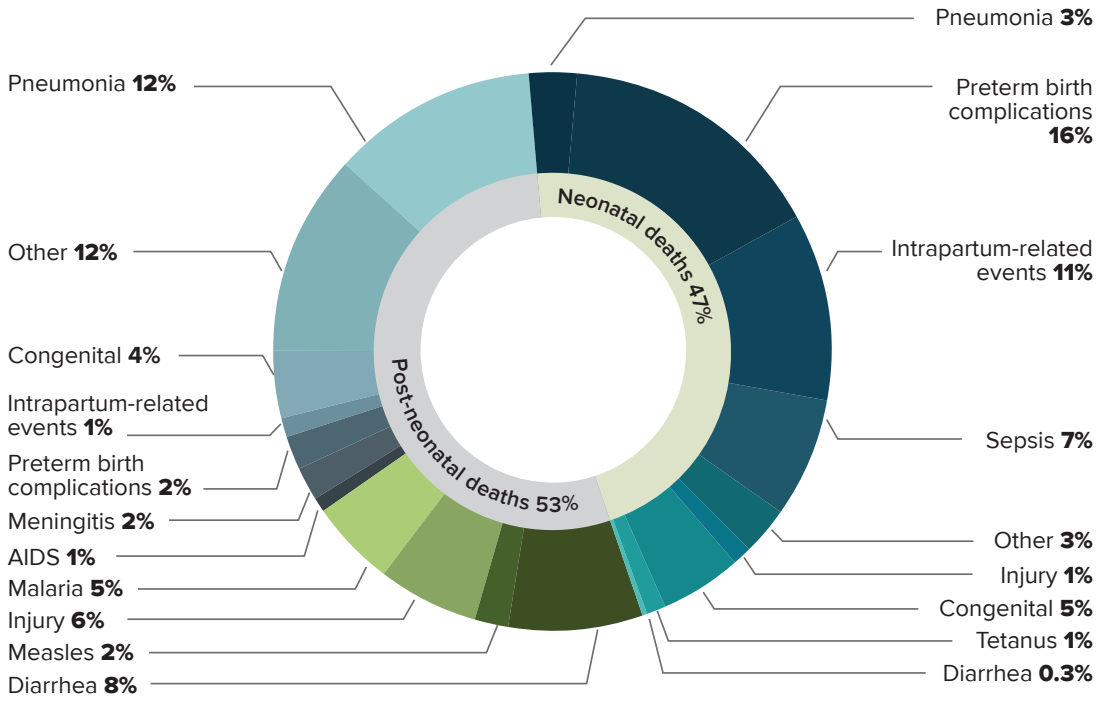
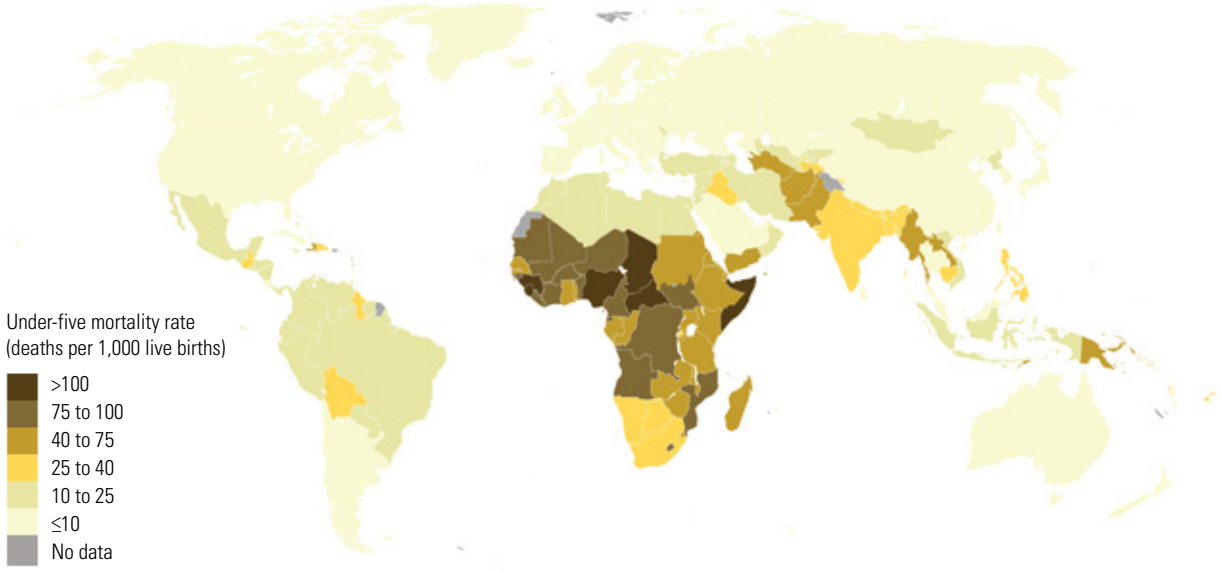
Figure 1. Global Distribution of Deaths among Children under Five by Cause, 2018



Source: UN IGME Levels and Trends in Child Mortality 2019

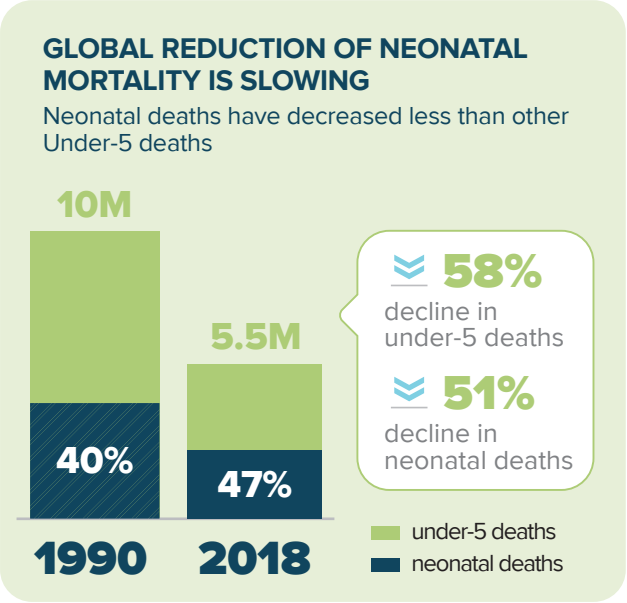
Figure 2. Under-five Mortality Rate by Country, 2018

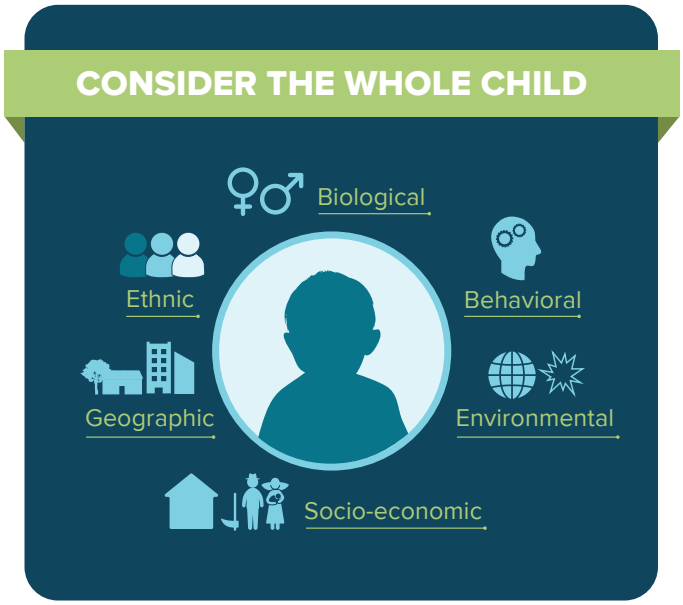


Note: The classification is based on unrounded numbers. This map does not reflect a position by UN IGME agencies on the legal status of any country or territory or the delimitation of any frontiers.
Source: UN IGME Levels and Trends in Child Mortality 2019

GETTING BEYOND SURVIVAL

We need to shift our focus from diseases to health, using the definition provided by the World Health Organization (WHO) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Focusing only on the prevention and treatment of acute illnesses, such as pneumonia, diarrhea, and malaria, ignores other key determinants to health and the fact that the health of a child, its cognitive abilities, and productivity in adulthood are influenced by exposures and opportunities in early childhood. The health and nutritional status, especially of the mother, and the opportunities and environmental factors that parents are exposed to also greatly impact a child's health and well-being. Therefore, we need to emphasize a life-course approach that includes parents, children, and adolescents and is designed to maximize their health status in each stage of life.





The WHO's Global Strategy for Women's, Children's and Adolescent's Health 2016-2030 embraces the life-course and promotes an integrated and multisectoral approach to the "whole child." It recognizes that health-enhancing factors including nutrition, education, water, clean air, sanitation, hygiene, and infrastructure are essential to achieving the Sustainable Development Goals (SDGs). It is, however, less clear how countries will implement the strategy. For this reason, WHO; UNICEF; The World Bank; the Partnership for Maternal, Newborn, and Child Health; and others developed the Nurturing Care for Early Childhood Development (ECD) framework,[5] which offers a roadmap for providing optimal nutrition, quality interactions, and care during pregnancy and the first three years of a child's life. The aim is to transform societies so women, children, and adolescents everywhere can realize their rights to the highest attainable standards of health and well-being.

The recognition of the need to invest in a life-course approach has led to calls for multisectoral investment in maternal and child nutrition and nurturing care of children, as well as involvement of other sectors, such as education.[6] The hope is that such investment in human capital—the stock of knowledge, skills, attitudes, health, and other personal characteristics—will enable individuals to realize their potential and become productive and responsible members of society.[7]

To reduce neonatal and child mortality and make the shift toward a life-course approach that realizes the potential of the child, donors, partners, and countries must work toward cohesion in all programs that support reproductive, maternal, newborn, child, and adolescent health (RMNCAH). Changes will be needed in each of the areas below.

HEALTH EQUITY

Major inequalities in child mortality persist. An estimated 53 percent of preventable deaths in children younger than 5 years of age, and 45 percent of neonatal deaths, are in settings of conflict, displacement, and natural disasters.[8] In sub-Saharan Africa and other low- and middle-income countries (LMICs), socio-economic and other factors play an important role in these mortality differentials, and in the uptake of efforts to prevent child death. Factors include mother's educational level,

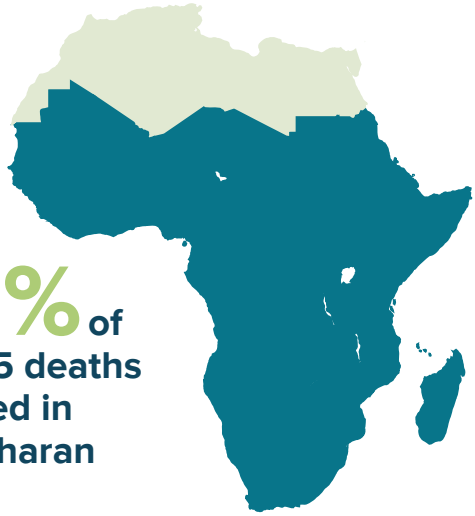
53%

of preventable under-5 deaths occurred in settings of conflict, displacement and natural disasters

household wealth/poverty, conflict, migration, sex of the child, ethnicity, and place of residence.[9,10,11] Concerning residence, this is true both when comparing countries to each other as well as within countries, especially rural versus urban areas. However, intra-urban disparities between the poor and non-poor are often greater than rural-urban differences.[12] Currently, many LMIC RMNCAH strategies and action plans are not clear on how to address these inequities and other social factors that influence health.

QUALITY OF CARE

In many LMICs, health workers provide less than half of the recommended clinical actions during typical preventive and curative visits. Diagnoses are frequently incorrect for serious conditions such as pneumonia and newborn asphyxia. These incorrect diagnoses lead to delayed or incorrect treatments and over-use of antibiotics that can contribute to antimicrobial resistance.[13] Moreover, caregivers and patients sometimes experience disrespectful care, short consultations, poor communications, or long wait times, which may lead to delayed health care utilization. There is a need to improve quality of care and add aspects of human rights into maternal and child survival programs. This includes improving the experience of care by providing emotional and psychological support, showing respect for caregivers and children, improving communication, and encouraging meaningful caregiver and



52% of under-5 deaths occurred in sub-Saharan Africa

This equals 1 in 13 children who died before their fifth birthday

patient participation in the care of children and adolescents. Current implementation of global guidelines and strategies—such as Integrated Management of Newborn and Childhood Illness (IMNCI) and integrated Community Case Management (iCCM)—that brought big wins for child health will not suffice to reach the health-related SDGs if quality of care is not also monitored and improved.[14]

STRONG HEALTH SYSTEMS

As highlighted by the Lancet Global Health Commission on High Quality Health Systems,[15] a health systems approach to improving quality of care will be necessary for making sustainable changes in (child) health. Most LMICs have been slow to change their focus from infectious diseases and maternal and child health to universal health coverage, but with global changes such as aging populations, environmental degradation, and climate change, health needs and expectations are shifting. Health crises, such as the recent Ebola epidemics and the COVID-19 pandemic, illustrate the need for resilient health systems that are prepared for, and can effectively respond to, crises while maintaining core functions. High-quality health systems also require accountable leaders who respect and motivate their frontline staff.

NUTRITION AND EARLY CHILDHOOD DEVELOPMENT

In most LMICs, child health efforts mainly focus on survival while at least 250 million children under the age of 5 risk not reaching their full physical or cognitive potential because of stunting and extreme poverty.[16]

Kate Holt/MCSP

150 million young children have stunted physical and mental development because of chronic malnutrition

45% of global under-5 deaths affected by nutrition

Globally, nutrition-related factors contribute to about 45 percent of the deaths in children under 5 years of age. Moreover, 150 million young children have their long-term physical and mental development stunted by chronic malnutrition[17] and over 60 percent of children enrolled in primary schools in developing countries fail to meet minimum proficiency in learning.[18] As many as 93 million children, or one in 20 of those under age 14, have a disability of some kind[19] with the greatest risk of death and disability among preterm and low-birth-weight newborns.[20] It is therefore important to adopt a life-course approach, include early childhood development, and strengthen the integration of nutrition in maternal and child health interventions.[21]

SEXUAL AND REPRODUCTIVE HEALTH

It is essential to invest in sexual and reproductive health, especially for adolescents and girls. Programs promoting Healthy Timing and Spacing of Pregnancy (HTSP) help girls, young women, and families delay and space pregnancies to achieve healthy outcomes for women, newborns, infants, and children, as well as reducing the need for, and negative consequences of, abortions. Of equal importance is a pregnant woman's participation in preventive health services such as antenatal care. Other priorities are screening for and treatment of anemia, sexually transmitted infections, mental health problems, stress or domestic violence and provision of tetanus toxoid immunization, de-worming, iron and folic acid supplementation, intermittent preventive treatment of malaria in pregnancy, and insecticide-treated bed nets. Investing in these service packages benefits the mother as well as the fetus and child.

LEADERSHIP IN CHILD HEALTH

To drive the new global agenda in child health, strong high-level leadership and commitment is required. A recent editorial in the Lancet highlighted that the UN leadership's focus has moved away from health and that new priorities have weakened the attention given to child, newborn, and adolescent health.[22] Current leadership needs to be strengthened and child health repositioned to attain better outcomes.[23] As a sector and within organizations, child health is fragmented and siloed; it is divided into diseases, population subgroups, and intervention packages that rarely come together and are often juxtaposed. This fragmentation contributes to competition, sometimes encouraged or reinforced by donors and development partners. At the same time, fragmentation means that child health and programs that meet the needs of the whole child become less visible within key organizations, and that they are increasingly separate from maternal and newborn health, immunization, nutrition, malaria, HIV, and other areas that deal with specific aspects of child health. Strong leadership from trusted organizations can help to bring these programs in alignment.

TOWARD A LIFE-COURSE APPROACH AND UNIVERSAL HEALTH CARE

To reach the ambitious Ending Preventable Child and Maternal Deaths (EPCMD) target of reducing child mortality to 20 deaths per 1,000 live births or below by 2035, while also building human capital, child health programs need to improve the quality of care and encourage an integrated health systems approach. To address the inequity in access and health outcomes within countries and provide universal access to quality health care, we also need to address the underlying socio-economic factors of ill health.

A shift of this magnitude will require integration of technical areas (i.e., RMNCAH, nutrition, immunization, and other child health priorities) and a focus on multisectoral approaches to holistically address children's health. Child health programs must collaborate with sectors outside of health to ensure that childcare services, child protection, social services, education, security, housing, and a safe, clean environment are accessible to all families.

Approaches that take into consideration the life-course perspective cut across programs, sectors, ministries, and donor funding streams. Actors from all of these, in new partnership constellations, are needed to create resilient systems that support the child through its life course. Governments and donors play important roles in leading new initiatives, but holistic and sustainable changes in child health must be rooted in communities and include local partners from a variety of institutions and civic organizations.

Reaching beyond traditional partners and seeking the voice and ideas of young people may uncover new ways to support children's health and well-being. As the child health community looks to reposition how it invests, new solutions and partnerships are needed to realize each child's potential and build the human capital that will carry the next generation.

ABOUT THE AUTHOR

Dr. Michel Pacqué is a senior child health expert at JSI with more than 35 years of international maternal, child health, and infectious diseases experience in Africa and Asia. He has worked as a clinician, researcher, program manager, and strategic advisor to nongovernmental organizations, ministries of health, and multilateral organizations. He has worked extensively for USAID-funded programs, most recently as child health team leader for the Maternal and Child Survival Program, where he provided strategic technical direction for the child health portfolio in 14 countries.

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