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Workshop on prevention and treatment of childhood pneumonia and diarrhoea

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ABSTRACT

Substantial progress has been made in achieving Millennium Development Goals in child survival in the WHO European Region, but progress is uneven across and within countries. Pneumonia and diarrhoea have overlapping risk factors and targeted interventions with coordinated actions can reduce incidence and mortality from both illnesses. The integrated global action plan for pneumonia and diarrhoea (GAPD) provides a cohesive approach for integrated efforts by bringing together relevant health services and ensuring that every child has access to proven interventions. Achieving the GAPD goals requires commitment and actions from national governments and regional partners in introducing innovations and scaling-up highly effective interventions. This report summarizes outputs from a WHO Regional Office for Europe meeting on integrated prevention and treatment of childhood pneumonia and diarrhoea for policy-makers and programme managers of the national immunization and child and adolescent health programmes of Armenia, Azerbaijan, Georgia, Kyrgyzstan, the Republic of Moldova, Tajikistan, Turkmenistan, Ukraine and Uzbekistan in Copenhagen, Denmark, on 10–12 December 2013.

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Acronyms and abbreviations

CEE	central and eastern Europe
CIS	Commonwealth of Independent States
EPI	WHO Expanded Programme on Immunization
GAPPD	Integrated global action plan for pneumonia and diarrhoea
GDP	gross domestic product
GNP	gross national product
Hib	<i>Haemophilus influenzae</i> type b
ICATT	Integrated Management of Childhood Illness Computerized Adaptation and Training Tool
IMCI	Integrated Management of Childhood Illnesses
LMICs	lower- and middle-income countries
MDGs	Millennium Development Goals
NGO	nongovernmental organizations
P&D	pneumonia and diarrhoea
SES	socioeconomic status
UN	United Nations
UNICEF	United Nations Children's Fund

Introduction and context

Substantial progress has been made in achieving Millennium Development Goals (MDGs) in child survival in the WHO European Region, but progress is uneven across and within countries. The burden of diseases associated with poverty remains high in poor populations.

Preventable pneumonia remains one of the major causes of child mortality, accounting for more than 14 000 deaths. Diarrhoea causes more than 5500 avoidable deaths. Pneumonia and diarrhoea (P&D) have overlapping risk factors and targeted interventions with coordinated actions can reduce incidence and mortality from both illnesses.

*The integrated global action plan for pneumonia and diarrhoea (GAPPD)*¹ provides a cohesive approach for integrated efforts by bringing together relevant health services and ensuring that every child has access to proven interventions. Implementation of GAPPD will allow substantial reductions of preventable child deaths and will contribute to meeting strategic objective on improving health for all and reducing the health divide. Other contributing initiatives include the Global Vaccine Action Plan, WHO/UNICEF Integrated Management of Childhood Illness Strategy and Global Strategy on Infant and Young Child Feeding, and Global Strategy for Women's and Children's Health, which provide strategies for preventing childhood diseases through vaccination, quality health services and improved nutrition.

Achieving the GAPPD goals requires commitment and actions from national governments and regional partners, more cooperation and coordination in the introduction of innovations and scaling-up of highly effective interventions. To this end, the WHO Regional Office for Europe held a meeting on integrated prevention and treatment of childhood P&D for policy-makers and programme managers of the national immunization and child and adolescent health programmes of Armenia, Azerbaijan, Georgia, Kyrgyzstan, the Republic of Moldova, Tajikistan, Turkmenistan, Ukraine and Uzbekistan. The meeting was held in Copenhagen, Denmark, on 10–12 December 2013.

The objectives of the meeting were to:

1. present and discuss regional and country-specific burdens of P&D and implementation of national programmes targeting control of morbidity and mortality due to P&D;
2. introduce integrated approaches in scaling-up coverage with innovative and well-known interventions to prevent P&D, as outlined in the GAPPD;
3. review implementation of key activities to prevent and treat P&D and existing coordination mechanisms;
4. define further steps in strengthening integration for prevention and control of P&D; and
5. outline the need for support from WHO and partners.

¹Ending preventable child deaths from pneumonia and diarrhoea by 2025. The integrated global action plan for pneumonia and diarrhoea (GAPPD). Geneva: World Health Organization/United Nations Children's Fund; 2013 (http://www.who.int/maternal_child_adolescent/documents/global_action_plan_pneumonia_diarrhoea/en/, accessed 21 January 2014).

Meeting outcomes were:

1. increased visibility and prioritization of prevention and control of P&D;
2. raised country stewardship and political will to eliminate preventable deaths from P&D;
3. a common understanding and commitment to implement strategies and actions set up by the GAPDD;
4. improved coordination between programmes on preventive and treatment interventions to control P&D; and
5. defined further steps in improving existing plans for integrating prevention and control of P&D.

Plenary sessions

Regional overview of child health and mortality

Vivian Barnekow, Programme Manager for Child and Adolescent Health and Development

At the WHO Regional Office for Europe, reported on progress achieved in reduction of child morbidity and mortality in the Region. Good progress had been seen in relation to achieving MDG 4 on reducing infant and under-5 mortality: the former has reduced from 28 per 1000 live births in 1990 to 11 in 2011, and the latter from 34 to 13. Inequities nevertheless persist between and within countries, and it is anticipated that some will not meet the MDG targets by 2015.

P&D as causes of death among neonates and under-5s did not change radically between 2008 and 2011, remaining at around 11% for pneumonia and 5% for diarrhoea. Data on morbidity are lacking, but it is known from country work that acute respiratory infections, diarrhoea and fever are the most frequent causes of morbidity in children under 5 years.

Work is progressing to improve the quality of hospital care to reduce infant mortality from P&D, but a public health approach that promotes integration is required to address under-5 morbidity and mortality. National information systems in many countries require support to be able to monitor appropriately child morbidity and mortality. WHO is attempting to strengthen health systems to improve quality of care and access to quality services by, for example:

- adopting and implementing packages of effective interventions on child health;
- strengthening health system support through assessing health system performance, quality of services, supervision and monitoring, and health staff development and training; and
- engaging in community participation.

Integrated approach in prevention and control of P&D

Carsten Mantel, Department of Immunization, Vaccines and Biologicals/Expanded programme on Immunization Priority Area Leader for New Vaccines and Innovation at WHO headquarters, discussed the GAPPD, the primary purpose of which is to improve the integration and coordination of approaches to prevent and control P&D.

Globally, significant progress has been made over the last 20 years in reducing mortality among children under 5 years, with mortality decreasing by 41% from 87 per 1000 live births in 1990 to 51 in 2011. This still means, however, that 6.9 million children die each year before their fifth birthday, 3 million of them in the first month of life.

P&D are the leading causes of mortality in children under 5, accounting for 29% of all child deaths globally in 2010, despite effective interventions and management approaches existing. If recent trends continue, the global MDG target of 29 deaths per 1000 live births in 2015 will not be achieved. The time to deliver on the commitments made on the MDG goals is fast approaching: P&D must be addressed to change the trend significantly. The rate of mortality reduction has, however, increased over the last decade, with over 20% of countries on track to meet the MDG 4 target through better coordination, prioritization and increased investment.

Effective interventions can be delivered through different channels of the health system, but coverage for some is low. For instance, in 2013, only 39% of infants less than 6 months were

exclusively breastfed, 31% of children with pneumonia received appropriate antibiotic treatment and 35% of those with diarrhoea received oral rehydration therapy. There are also inequities in distribution of interventions in countries, with the poorest children being disadvantaged. Opportunities to change this situation exist with, for example, unprecedented commitment from the United Nations' (UN) Every Woman, Every Child² strategy, the Decade of Vaccines Collaboration, new vaccines for P&D, improvements in case management and evidence-based preventive modalities.

P&D are caused by multiple pathogens and no single interventions will address the entirety of the problem. Multiple interventions of proven effectiveness exist, but are not implemented in a coordinated fashion. Establishing better coordination between existing programmes can lead to synergies and efficiencies that will maximize the benefits of individual interventions. WHO has carried out regional consultations on coordinated approaches related to the GAPPD since 2011.

The GAPPD has a vision of ending preventable P&D deaths through creating a healthy environment and ensuring that every child has access to proven and appropriate preventive and treatment interventions. The vision, goals and coverage targets for interventions are ambitious but achievable and take the long view to 2025 (2030 for some). It is not a new programme, but a coordinating approach that makes a strong case for efficient integration of efforts to prevent and treat P&D by identifying key steps to be taken at country and global levels and key roles to be played by all concerned. Key actions include:

- promoting an integrated approach to saving lives;
- engaging all sectors and actors;
- focusing on country impacts; and
- encouraging action at country level by strengthening national leadership, fostering intersectoral collaboration, prioritizing interventions, closing the equity gap, increasing investment in research, being open to innovations and ensuring accountability for results.

Pilot projects for integrated approaches are being taken forward at district level in Bangladesh and Zambia.

No single government or agency can do it on their own. Coordination and integration is key to success. The philosophy and approach behind the GAPPD is that children's lives can be saved only if the integrated plan is embraced and implemented by national governments with support from all relevant stakeholders.

Liudmila Mosina, Technical Officer, Vaccine-preventable Diseases and Immunization at the Regional Office, focused on how the implementation of new vaccines can be a catalyst for promoting the use of other preventive and curative measures. Much progress has been achieved in introducing the *Haemophilus influenzae* type b (Hib) vaccine in the Region since 2006, particularly in lower- and middle-income countries (LMICs). All countries have now introduced the vaccine, with the exception of Belarus, which has implemented it partially. Countries very rapidly achieved high coverage figures.

² Every woman, every child [website], New York, NY: United Nations; 2013 (<http://www.everywomaneverychild.org/>, accessed 21 January 2014).

Pneumococcal vaccine is currently available in 28 countries, mostly high-income countries that can afford the vaccine, but LMICs are now also involved, some with support from the GAVI Alliance. Rotavirus has been implemented in eight countries and is planned for another four: it is not used extensively in countries in western Europe due to the very low mortality from diarrhoea. Post-introduction evaluations of rotavirus vaccine have been conducted in Armenia and the Republic of Moldova, showing overall a smooth introduction with good acceptance by medical workers and parents and an average 80% coverage (in Armenia) across 28 health facilities visited by WHO. In the Republic of Moldova, there is evidence of reduced admissions of children to hospital because of all-cause diarrhoea and fewer rota-positive cases following introduction of the vaccine.

Current data suggest that Hib, pneumococcal and rotavirus vaccines are highly effective. Their introduction will support the achievement of MDG 4 targets, but on their own will not fully address mortality and morbidity associated with P&D.

Elimination of preventable P&D requires concerted efforts from governments, civil society and medical communities. It is time to initiate these kinds of cooperative efforts to take best advantage of the vaccines. Ministries of health are truly supporting introduction in those countries now using the vaccines; the momentum being created can be used to strengthen, expand and improve the implementation of other activities and interventions to promote acceleration in the reduction of morbidity and mortality from P&D.

The introduction of rotavirus and pneumococcal vaccines brings opportunities to scale-up complementary interventions. Plans to introduce new vaccines are underway, with communication and social mobilization activities and intensive training for health care workers supported by education materials being implemented at country level. Ministries of health and WHO support supervisory visits to health care facilities 2–3 months after introduction of a new vaccine to see how implementation is taking place and identify and eliminate challenges.

Integration has been seen in the development of education and training materials, which include not only vaccine-specific measures, but also other interventions. However, more needs to be done to realize the full potential of integration.

Integration can be an effective tool in addressing the major problem of immunization programme –vaccine hesitant populations. Coordinated efforts will help to provide relevant and consistent information for parents from immunization programme specialists and health care workers.

In summary, integration contributes to implementation of new vaccines within the context of maternal, neonatal and child health and provides opportunities to reinforce and expand other P&D interventions. Collaboration among programmes strengthens immunization advocacy efforts and communication.

Discussion

- Surveys conducted in countries in Africa and Asia on the effectiveness of oral live attenuated rotavirus vaccines showed lower effectiveness than in Europe (50–60% against 80–100%), but considering that the incidence of severe gastroenteritis and related mortality in those regions is higher, vaccination is actually helping to prevent a larger number of cases and deaths in low-income countries.

- Very few side-effects of the rotavirus vaccine have been observed. A slightly increased risk of intussusception in the order of 1 per 50 000–100 000 infants vaccinated was observed, which is substantially lower than that of an earlier vaccine. WHO continues to recommend its use as part of a comprehensive strategy to control diarrhoeal diseases in view of the clear vaccine benefits as compared to the risks of naturally acquired disease.

Experience in the Region on coordinated actions and integrated service delivery

Juan Tello, Programme Manager, Health Services Delivery, Division of Health Systems and Public Health of the Regional Office, addressed the issue of coordinated/integrated health services delivery in the Region.

Approaches to P&D require public health, health care services and intersectoral actions. The current fragmentation of primary health care and hospital-based health services, vertical programmes that target only one disease or population group, protocols and clinical guidelines that focus exclusively on one disease or condition and incompatible health care information systems make a coordinated/integrated approach necessary.

Integration is a process, moving from fragmentation and segregation to full integration with several levels of integration intensity in between. The potential for the integration of services to secure improvements in health system performance is now well understood, but important challenges and bottlenecks remain to be addressed for the full effects of integrated care to be realized. These include:

- obstacles to scaling-up location- or disease-specific initiatives commonly seen across the Region, largely due to health system barriers: many projects are driven by the personal commitment and motivation of individuals, but lack of appropriate leadership and management mean that these projects tend to fail when progressed to systems level;
- persisting health system bottlenecks and insufficient information flows: information is often collected but not communicated to the public, patients, health professionals and different levels of care;
- misalignment of incentives: incentive schemes do not encourage staff to reach out to poor and vulnerable populations or promote good public health practice with mothers and families; and
- financial hardship: lack of finance is often used as a reason not to integrate as some evidence shows that integration is more expensive, but convincing arguments for the benefits of integration in improving quality, outcomes and compliance can also be made.

Key actions to promote coordinated/integrated approaches at local level include:

- strengthening primary care to deliver public health services
- supporting multidisciplinary care teams or practices
- creating networks of health care, social services and communities.

Experiences in the Region show how integration can be taken forward, but only a few examples are found at national level and represent a comprehensive strategy for integration. Most initiatives are still local, small-scale and not sustainable.

Coordinated/integrated services delivery means that people perceive services as being provided by a single system. Three dimensions for strengthening health systems towards more coordinated/integrated service delivery can be described:

- the service dimension, incorporating health protection, health promotion and disease prevention;
- the settings dimension, including public health, primary health care, secondary care, long-term care, community, home and social care, and pharmacies; and
- the processes dimension, encompassing delivery systems, alignment of incentives, common information systems and decision-support mechanisms.

The goal is to ensure that services across the full continuum of care are organized according to individuals' needs and are focused on improved quality, efficiency and continuity in service delivery. To this end, WHO is working on a framework for action towards coordinated/integrated health services delivery, focusing on collating evidence, creating country case studies and developing tools and a curriculum for change management. It is anticipated that the framework will be complete by 2016, following full consultation with stakeholders.

Discussion

- Vertical programmes serve specific objectives and are very important. Sometimes the only way to achieve quick gains in terms of improvements are through vertical programmes. That does not need to be abandoned. New countries adopting screening programmes tend to develop vertical programme, and that is fine – it is the way to start. But to make these programmes sustainable over the longer term, they need to be embedded within health systems.

Aigul Kuttumuratova, Technical Officer, Child and Adolescent Health and Development at the Regional Office, discussed experiences and lessons learned from Integrated Management of Childhood Illnesses (IMCI) implementation. The word integrated is frequently used to refer to a package of preventive and curative health interventions for a particular population group. IMCI is an example of such a package that has been adopted by 15 countries in the Region.

The IMCI approach features three integrated components:

- health system support
- clinical management of childhood diseases
- family and community practices.

None of these components works on its own – they are integrated and interrelated.

From the child and family perspective, IMCI provides opportunities to adopt a holistic approach to child health and development, focus on major causes of mortality and morbidity, and address child health problems at all levels of care. It provides a technical programme that coordinates and unites relevant initiatives and instils flexibility and regular adaptation. From a health system perspective, IMCI minimizes lost opportunities for integration, promotes investment in the health system and harmonizes health sector responses.

Experience in the Region shows IMCI has been included in key national government programmes, policies and strategies in maternal and child health, is integrated in the curricula of public medical teaching institutions and has been instrumental in streamlining essential drug lists for children. It is being offered as part of the basic service package of primary health care, and IMCI clinical protocols have been approved as clinical standards for treatment of sick children in primary and referral care. In addition, it has promoted collaborative work with local communities: some countries, for instance, have developed and implemented national and district plans on improving family and community practices in child health.

Use of the Integrated Management of Childhood Illness Computerized Adaptation and Training Tool (ICATT) in the Region has hastened the adaptation and update of IMCI clinical guidelines and increased the number of training options and tailored courses for different groups of health workers. ICATT has been found to be suitable for individual training, including self-learning, and can be used as a comprehensive reference source. It provides a cost-effective option that shortens the duration of training.

Challenges to the IMCI approach are mainly presented by health system barriers and include:

- inconsistent policy and regulations in relation to issues such as criteria for hospitalization of infants and young children;
- human resource shortages;
- organizational and management problems in health services leading to communication and coordination barriers; and
- outdated ways of working with families and communities.

The following lessons on how to scale-up IMCI implementation have been learned:

- bringing on board experts from key programmes (such as public health, strategic planning, pharmaceuticals, human resources and quality assurance) from the outset is vital to the success and sustainability of IMCI;
- having a clear and functioning coordination mechanism, with national group, national focal point and district coordinators, supports implementation;
- district management capacity is crucial for priority setting, resource allocation, training and monitoring, particularly in decentralized health care systems;
- training that is linked to results and performance can produce rapid changes, and supportive supervision, coaching and incentives can be very helpful in creating and maintaining health workers' motivation;
- support from, and regular monitoring by, health authorities and administrations are crucial in helping to create an enabling environment;
- strengthening of health system components, such as essential medicines, supervision and monitoring, are very important; and
- recording and sharing experience provide good support for advocacy and sustainability.

Oya Zeren Afşar, Immunization Specialist, United Nations Children's Fund (UNICEF) Regional Office for central and eastern Europe (CEE) and the Commonwealth of Independent States (CIS), reported on home visiting services and IMCI implementation in CEE/CIS.

Community-based interventions in prevention of P&D are crucial in educating families, creating awareness and demand and promoting behaviour changes – all are key prevention interventions at family level. Key outcomes can be affected by home visiting nurses, but most countries in CEE/CIS switched to a family physician model following independence, with some home nursing services being dismantled. Some countries continue to provide such services, but they are neither extensively nor adequately implemented. Evidence from Canada and the United Kingdom shows, however, that they can:

- improve health care and health outcomes
- improve breastfeeding rates
- promote better nutritional status and vaccination coverage
- encourage safer home environments and reductions in unintentional injuries.

UNICEF started to try to improve the situation in 2010. An evaluation was carried out, showing that:

- the medical culture was almost entirely based on a reductionist, narrow view of human health, rather than prevention;
- the health sector was entirely devoted to the prevention and cure of physical diseases and disorders, rather than focusing on causative factors;
- a women's and children's rights perspective was not well conceived; and
- home visitors lacked training in communication skills, health promotion, evidence-based medicine and patient rights.

While some countries are providing sufficient quantity of home visits, they are not yet meeting the desired quality in terms of child outcome indicators. Home visits therefore represent a significant but largely untapped opportunity to build the capacity of communities, particularly vulnerable families and marginalized populations.

The evaluation also found that the basic package of home visiting services was not informed by needs assessment, that protocols were outdated, and that visits tended to focus on identification of disease. Rural areas were deficient of services.

A conference on the role of community nurses and home visiting outreach services in CEE/CIS was held in Ankara, Turkey in 2012, with participation from 17 countries, following which an international technical advisory group was established to work on standards, guidelines and frameworks and build capacity. This work is being taken forward under child well-being, one of the ten key focus areas of the UNICEF Regional Office.

UNICEF has worked with WHO and the Ministry of Health in Armenia on successful implementation of the IMCI strategy in that country over the last decade, particularly in relation to prevention and treatment of childhood P&D. All three components of IMCI – primary health care, community and hospital levels – are reflected in the strategy. Around 1900 health workers have been trained in community-based IMCI and guidelines on the organization of paediatric hospital care were approved as part of quality of care standards in 2007.

An assessment of the strategy showed its strengths and weaknesses and proposed a number of recommendations for moving forward. Among the strategy's key strengths were its focus on addressing child mortality and decreasing the number of hospitalizations for some diseases. Weaknesses included lack of communication and advice for parents on nutrition and care for sick children and an inadequate system of assessment and monitoring of strategy implementation. As a result of implementation, the percentage of children with diarrhoea who applied to a health facility increased between 2005 and 2010 and the numbers receiving inappropriate care decreased dramatically. A similar positive picture emerged in relation to pneumonia.

Kamchybek Uzakbaev, Director, National Centre of Mother and Child Care at the Ministry of Health of Kyrgyzstan, discussed the country's experience of taking an integrated approach to the provision of health services for children, supported by WHO.

Implementation of IMCI started in 2000 and an IMCI national centre was set up in 2004 to coordinate strategy implementation. The programme was expanded to the whole country in 2006 following a Ministry of Health order, backed by training being introduced to nursing and medical curricula. IMCI drugs have been included in the national essential drug list and indicators included in official health statistics.

The reduction in child mortality rate in 2006 has been linked to IMCI implementation. Evaluation of children's physical development showed improvements in children's health status, including reductions in the incidence of anaemia one year after introduction of the vitamin and mineral nutritional supplements component of the IMCI programme.

Implementation of the IMCI programme in hospitals commenced in 2012, supported by WHO and UNICEF. Assessments of hospital care for children were conducted by WHO in 2006 and 2012, showing that serious gaps and deficiencies remain in relation to issues such as unnecessary hospitalization, suboptimal disease management and lack of evidence-based guidelines. The WHO pocket book of hospital care for children has been adapted and disseminated and training courses for hospital staff rolled out.

While moving in the right direction, Kyrgyzstan has faced multiple challenges in implementing the IMCI strategy. These include low public awareness of mother and child health, poor intersectoral cooperation, insufficient funding for training of rural and urban health workers, and absence of social support services for the most vulnerable populations. There is also an imbalance in specialists between urban and rural areas, linked to low motivation: this is now being addressed through provision of incentives for those in rural areas. Problems of health worker migration are being tackled through re-tasking and training nurses to carry out some functions of doctors.

Trudy Wijnhoven, Technical Officer for the Nutrition, Physical Activity and Obesity Programme at the Division of Noncommunicable Diseases and Life-course of the Regional Office, presented on breastfeeding and nutrition promotion.

WHO's recommendations and guidance are to have exclusive breastfeeding (with no extra water or food) for the first 6 months of life, beginning within the first hour. Breastfeeding should be on demand, as often as the child wants it day and night, and bottles or pacifiers should be avoided. Mashed solid foods should be introduced as a complement to continued breastfeeding at 6

months. It is estimated that optimal breastfeeding and appropriate complementary feeding practices save the lives of 220 000 children under 5 years annually. Suboptimal breastfeeding is one of the 20 main risk factors for disease globally.

Prevalence of exclusive breastfeeding in the first 6 months of life is very low in the European Region compared to the other regions. European country-based surveys, where they exist, show varying prevalence rates, ranging from 10% to over 50% in the countries represented at the meeting. UNICEF experience in Africa, however, shows that it is possible to dramatically increase breastfeeding rates in countries. Prevalence rates vary according to socioeconomic status (SES), with higher-SES mothers having greater prevalence.

WHO has set six global targets for nutrition to be attained by 2025, one of which aims to increase the rate of exclusive breastfeeding in the first 6 months to at least 50%. Breastfeeding also features as an important component of the Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020.

An overview of the 53 Member States of the Region in 2012/2013 showed that 30% had no actions related to breastfeeding promotion, 40% had partly implemented and 30% fully implemented breastfeeding promotion. All data collected are included in the WHO European Database on Nutrition, Obesity and Physical Activity. No policy documents within the database from countries represented at the meeting refer to breastfeeding.

It is recommended that Member States monitor the global 2025 targets for improving maternal, infant and young child nutrition and adopt policies such as the International Code of Marketing of Breast-Milk Substitutes. In addition, they should consider:

- implementing the Ten Steps to Successful Breastfeeding specified in the Baby-Friendly Hospital initiative;
- providing supportive health services with infant and young child feeding counselling during all contacts with caregivers and young children (WHO headquarters has developed a course in this area that is now being disseminated in the Region); and
- offering community support, including mother support groups and community-based health promotion and education activities.

Oya Zeren Afşar returned to the podium to present on the UNICEF Communication Framework for New Vaccines and Child Survival,³ with a focus on P&D control.

Each country needs to develop its own national communication plan to address this issue, but country programmes will greatly benefit from a standardized framework. Realizing this need, UNICEF, WHO and other partners developed the communication framework in 2011. The online framework is gradually being enriched with accounts of country examples and practices and includes a template to help countries develop their own communication plans. Versions in Russian are available from UNICEF country offices.

The framework recognizes the synergies between P&D interventions and supports the development of coordinated (rather than separate and vertical) communication plans focusing on

³Communication framework for new vaccines and child survival [website] Geneva: UNICEF; 2014 (<https://sites.google.com/site/commframe/>, accessed 21 January 2014).

analysis, design, implementation and monitoring and evaluation. Collaboration of different departments from the very beginning is necessary to take these plans forward, with priorities identified and monitoring of not only activities and inputs, but also behaviour change and health outcomes.

Several countries in the Region have been using the framework to help them address issues around introducing pneumococcal and rotavirus vaccines, but it has not been used so far to integrate other interventions in communication plans. More experience is now required in this area.

Kamola Safaeva, Health Officer in the UNICEF Uzbekistan country office, described the hygiene championship initiative in the country.

Poor hygiene can detract from all efforts to prevent P&D. UNICEF work in the country on deworming revealed that while schoolchildren understood hand hygiene, their practice was poor. It was recognized that school hand hygiene programmes were not allowing children to develop practical skills and that sanitary facilities in some schools were inadequate.

UNICEF then worked with the health and education ministries, municipality mayors, the mass media, schools, parents and children to conduct the hygiene championship initiative in schools (few children attend kindergarten, so schools were chosen as the project setting) in five selected regions. Schoolchildren took on the role of knowledge couriers, taking what they learned back into their homes. Better hygiene facilities were installed in some schools and educational modules were integrated into the school curriculum, with training for teachers.

Overall, the approach made good progress. Handwashing points greatly increased in all settings. Sanitation facilities improved more in cities than in rural areas due to income differences and greater compliance with the project, and gender inequity still prevailed in rural schools. Introduction of a certification and awarding system and the integration of hygiene issues into post-diploma teacher education were recommended to maintain progress.

Discussion

- Tajikistan passed a law in 2006 protecting breastfeeding and advertising of formula feeds was banned in 2011. Exclusive breastfeeding coverage consequently has risen from 25% in 2005 to 34% in 2012, but supplementary feeding is still being introduced later than 6 months, leading to worsening of children's health status, diarrhoea and other diseases. Few health workers are trained to offer counselling to parents who are insisting on antibiotic use.
- It is difficult to change people's behaviour in relation to antibiotics. Pharmaceutical company promotion, dominant medical cultures prioritizing drug use and induced public demand are among the factors that conspire to complicate the issue. Changing behaviour requires that all of these issues be addressed. Lessons learned from the breastfeeding experience, with a ban on advertising of formula feeds, may be put to use in antibiotics.
- Kyrgyzstan also has a law on exclusive breastfeeding to the age of 6 months, but advertising of breast-milk substitutes is proving very challenging. Women in the country sometimes do not agree with exclusive breastfeeding. Coverage has not been increasing in the last few years, particularly in urban areas. Children are suffering as a result.

- The International Code of Marketing of Breast-Milk Substitutes is not currently being implemented by all Member States, and the influence of the industry is still apparent in health centres and the way mothers are counselled on infant feeding. Much more needs to be done to address this.
- Exclusive breastfeeding coverage is very low in many western European countries outside Scandinavia due to mothers' perception that breastfeeding is for countries where infant formula is not available. Breastfeeding is now included in health policies in these countries to try and change that perception.
- Azerbaijan also passed a law promoting exclusive breastfeeding in 2003, with support provided to mothers. The expression "breast-milk substitute" actually acts as positive advertising for the industry – it was decided to refer to it as "artificial mixtures" that have to be used only when breastfeeding is not available.

Advocacy and communication for coordinated actions

Mikael Ostergren, Programme Manager, Maternal, Newborn, Child and Adolescent Health at WHO headquarters, addressed the need to generate political will at many different layers to reduce child deaths from P&D.

There is currently very strong political will to improve the health of women and children and reduce mortality and morbidity. The UN Secretary-General launched the global strategy for women's and children's health in 2010. Since then, different initiatives that set global targets beyond 2015 have been launched – these are aimed at ending preventable maternal and child death by 2035. To achieve this, P&D, two of the main causes of death in children under 5 years, need to be addressed.

The *A promise renewed* strategy commits to reducing child mortality to no more than 20 deaths per 1000 live births by 2035. Some countries have already reached this – under-5 mortality in Denmark, for instance, is around four per 1000 – but there is still some way to go to achieve the target throughout the Region. An action plan to end preventable deaths among newborns will be launched in May 2014, setting a global target of a newborn mortality rate of less than seven deaths per 1000 live births by 2035.

The political will is clearly present, but advocacy and communication still need to be pursued to influence and persuade people to take actions. This includes:

- global and local donors and financial foundations;
- national governments (the biggest "donor" by far in terms of resources to reduce maternal and child death) and local authorities;
- health workers and professionals working in integrated ways; and
- the public.

A communication strategy to engage people on a defined issue requires three steps:

- raising awareness: educating or informing to raise awareness among people whose involvement is important to ensure they know there is a problem;

- motivating: it is not sufficient that people know about the problem – they also need to want to do something about it; and
- acting: showing people what they can do about the problem.

Examples of communication actions include an initiative in which the Cameroon Paediatric Association negotiated with the country's largest mobile phone company to send an SMS message in French and English reminding people of World Pneumonia Day, and the Government of Kenya launching a wide media campaign to support its policy guidelines on control and management of diarrhoeal diseases.

Saidmurad I. Ismailov, Head of the Main Department of Mother and Child Health of the Ministry of Health of Uzbekistan, spoke on his country's experience in advocacy and coordinated actions to improve child health.

Uzbekistan has a population of approximately 30 million, of whom 8 million are women of reproductive age and 10 million are children. Thirteen laws and 20 presidential decrees focusing on health and programmes on a wide range of issues have been launched, including effective perinatal care, breastfeeding and healthy nutrition, IMCI, prevention of mother-to-child transmission of HIV and programmes on flour fortification, salt iodization and vitamin supplementation for pregnant women and children under 5 years.

Exclusive breastfeeding coverage in the first 6 months exceeded 50% in 2012, up from 14% in 1991. Ministry of Health data show the infant mortality rate declined from 35.3 to 9.9 per 1000 live births between 1991 and 2012, and under-5 mortality from 48.2 to 13.8.

More than 17 000 health workers have been trained in evidence-based medicine and around 67% use it in their daily work. WHO/UNICEF maternal and child health modules have been integrated in pre-and post-training curricula.

Immunization remains one of the main priorities for public health. Efforts are directed at ensuring safe, free vaccination for children according to the national vaccination calendar. High coverage against many targeted diseases has been achieved. The Ministry of Health was able to secure sustainable financing for vaccine procurement within the WHO Expanded Programme on Immunization (EPI): 90% of all vaccines for routine immunization are now funded by the Government, with 10% coming from the GAVI Alliance.

Vaccination against rotavirus infection starts on 1 June 2014. The proportion of children under 5 years admitted to hospital for acute gastrointestinal infections who were found to be rota positive reduced from 33% in 2005 to 22% in 2009. The mortality rate for rotavirus between 2005 and 2009 among over 20 000 children surveyed was 0.25 per 1000. Most cases of rotavirus infection are seen in children aged 6–24 months.

The burden of Streptococcal pneumonia according to a WHO assessment in 2006 was 22 975 cases and 3639 deaths; 8587 cases of pneumonia in children under 14 were registered in 2012.

The main factors in reducing child mortality are vaccination, breastfeeding and decreased congenital and genetic diseases. Ninety-eight per cent of children are covered by vaccination against tuberculosis, polio, diphtheria, hepatitis B, pertussis, tetanus, measles, rubella, parotitis

and Hib. The percentage of children receiving exclusive breastfeeding in the first six months is increasing, and the rate of births of children with congenital and genetic diseases has reduced more than 1.7 times since 2000.

Progress at political level includes a national strategy on deworming and improvement of sanitary and hygiene conditions, guidelines on infant and children feeding and home fortification and the development of the National Maternal and Child Health Coordination Council. The plan for vaccination for 2011–2015 was developed and funded from the state budget.

Challenges in implementation of the vaccination programme include:

- introducing the immunization passport;
- continuously improving general practitioners' knowledge;
- implementing an e-system for monitoring vaccination coverage and distribution at all levels; and
- improving collaboration between the ministries of health and education.

Objectives for the programme are to:

- ensure financial sustainability
- continue to ensure 95% coverage by EPI vaccines at all administrative levels
- strengthen epidemiologic surveillance
- prevent the importation of infectious agents and communicable diseases
- monitor and evaluate the national EPI
- introduce new vaccines to the national calendar of immunization.

Discussion

- The three-steps strategy provides a simple and effective way to move political opinion in favour of national immunization programmes. Anti-immunization campaigns are localized and are driven by different underpinning beliefs in different countries. It is important to engage them in relation to their own convictions and ideas. Much work on vaccine hesitancy carried out in the Region is now being replicated globally; experience in the Region has been gathered because the issue is probably most prevalent in Europe.
- No matter to whom the communication is directed, be it a minister of health, physician, parent or member of the public, the important thing is to conduct it in coalition, ensuring that the same strong message that vaccines are safe, effective and save children's lives is conveyed by paediatricians, medical specialists, clinicians and academics. The message loses impact when the communicator is hesitant.
- Globally, reductions in under-5 mortality are related to lower fertility rates and fewer children being born. Better spacing and family planning will also reduce the rate. In the European Region, however, where fertility rates are already low, it is likely to have less of an impact.

Nedret Emiroglu, Deputy Director, Communicable Diseases, Health Security and Environment at the Regional Office, spoke on achieving results through integrated action on the MDGs and the post-2015 development agenda.

The MDGs were adopted by the UN in 2000. All eight MDGs are linked and have been crucial in progressing the development agenda, reducing poverty and increasing people's health and well-being.

Overall, substantial progress has been made towards achieving MDG 4 in all newly independent states. Despite the accomplishment, the current trends in mortality reduction suggest some countries will not achieve MDG 4 targets by 2015. More rapid progress is needed, and all countries need to continue efforts to sustain the achievement into 2014 and beyond. Most of the lives lost could have been saved through low-cost prevention and treatment measures such as vaccines, antibiotics, breastfeeding, oral rehydration and zinc therapy.

Political awareness, commitment and leadership need to be increased to ensure resources to accelerate progress towards MDG 4 achievement. Integration requires strong health systems; those that are weak and fragile will not be able to provide the effective child survival strategies that are crucial to reducing under-5 child and, especially, neonatal deaths. Access to care needs to be improved through universal coverage, but quality of care should also be addressed. Discussions on how a new vision of an integrated, easily accessible, inclusive, resource-efficient and high-quality primary health care system can be achieved are now underway in the Region.

Action in the health sector will not be sufficient, however. Cross-sectoral action is needed to address increasing health inequalities and their social determinants, with minorities and socially disadvantaged population groups being carefully monitored and their needs appropriately met.

Significant progress in reduction of child deaths has been achieved since 2000, but it is uneven and insufficient in some countries. More efforts and investment are necessary to prevent setbacks and to accelerate progress: time is short – urgent action is needed.

Health will have a crucial role in the development agenda in the follow-up to the MDGs post 2015. There is consensus that what happens in health influences other development pillars (social, economic and environmental), but health is also affected by developments in other areas, such as reducing poverty, improving education or increasing transportation access. So there is a strong relationship between health and other sectors. The fact that health outcomes can be measured helps to justify its central role in the post-2015 agenda, as this will influence political thinking and distribution of resources.

It is believed that most countries will achieve the MDGs by 2015 but that some will not be able to do so. Some countries that achieve them at national level will still have population groups for whom the targets will not be met. The MDGs will therefore still need to be tackled after 2015, but new burdens and health challenges such as noncommunicable diseases will also have to be addressed. The means to achieve this, which might include universal health coverage that provides not only access to services but also prevention, health promotion and rehabilitation and financial protection measures, is currently under discussion. Decisions will be made at the UN General Assembly in September 2015.

Discussion

- The MDGs are unfinished business. New policies are already in place to progress the agenda after 2015.
- There is no room for complacency, however – countries should accelerate actions now to achieve them by 2015.
- Global targets need to be adjusted to country contexts: there is nothing to stop countries being more ambitious than the global targets. Achieving the targets does not necessarily mean the numbers are good.
- Countries should not accept that they will not meet the target goals. Actions such as adopting integrated approaches to addressing deaths from P&D over the next two years will accelerate progress.
- This is a good time for countries to identify the obstacles to MDG achievement and seek support from the Regional Office for their removal.

Partnerships

Leen Meulenbergs, Executive Manager, Strategic Partnerships at the Regional Office, spoke on the advantages of strategic partnerships in advancing the GAPPD agenda.

There is great diversity in the Region, with very different needs within countries and between countries. This diversity calls for close collaboration with partners to bring policy coherence and support implementation. Partnerships increase the impacts of messages and the outreach of interventions. This is reflected in Health 2020, which has partnership as one of the main elements, reflected in whole-of-government and whole-of-society approaches that focus on joint working to reduce inequalities and improve health.

Complex problems cannot be solved in isolation. Strategic partnerships present an opportunity to deal with complex problems in innovative and new ways by combining the different strengths of partners. Instead of sectors challenging each other, they are all on board from the beginning, setting joint objectives and agreeing on plans of action. In terms of GAPPD, all of the partners working on implementation need to understand the policy, be involved and take part in moving it forward.

A partnership strategy has been developed for the Region: while this does not focus specifically on GAPPD, it does provide broad elements of how collaborations can be organized.

Working in partnership often does not happen in a coordinated and strategic way, but occurs in a more ad hoc, opportunistic fashion. For more strategic collaboration, some steps need to be followed. Organizations should consider mapping their current partners and potential future partners against the objectives of the GAPPD, aiming to identify those who can contribute at different levels to achieving the objectives. A broad range of partners should be involved, such as ministries of health, education, development and others, national institutions, schools, cities, and national and local nongovernmental organizations (NGOs). Obvious partners for GAPPD implementation include, of course, UNICEF, the GAVI Alliance and the United Nations Development Programme.

Once the various partners have been mapped, tools that can be used in joint work should be clarified. Legislation, strategies, action plans, bilateral agreements, conferences and working groups all have potential to put partnership into action that will provide platforms from which genuine agreed progress on achieving objectives can be made and specific actions, such as targeting identified vulnerable groups or developing advocacy campaigns, identified and implemented.

Partnerships need to engage at three levels – regional, country and community/service – to ensure that the GAPPD idea of protect, prevent and treat is translated into action within countries. At community level, health workers, social and environmental workers, mayors, local politicians and representatives of vulnerable populations can help in getting the message out. The main element of bringing stakeholders together in a strategic way at country level is to support the ministry of health and health workers. They should do not be left to implement the GAPPD on their own: that is unlikely to work, as implementation of the GAPPD objectives requires much wider partnerships. Many country examples exist of how strategic partnerships can make progress on objectives – lessons can be learned from these and adaptations made to enable them to work in other countries.

The benefits of investments in strategic partnerships include policy coherence across sectors, coordinated communication across government, services and civil society, better use of services and more rational use of resources. Challenges, however, are also present, including the whole process of partnership development – identifying partners, engaging with them, negotiating positions, ensuring a commitment to action and raising awareness of resource limitations. These tasks can sometimes appear prohibitive and deter people from engaging in partnerships. Strategic partnership collaboration is nevertheless a very productive way of implementing strategy and making best use of limited resources and capacity.

At regional level, the WHO Regional Director for Europe is on record as saying she believes that health can only be improved through partnerships – the Regional Office cannot progress the agenda without partnerships, so it collaborates strategically with governments (not only ministries of health but also other ministries), donor organizations, fellow UN agencies and others to advocate for what is needed at regional level to influence action at country level.

Discussion

- **The GAVI Alliance** has been successful in introducing coordinating mechanisms at country level and facilitating their implementation. The intention is not to create new systems, but to support countries to facilitate better coordination and integration by building on existing good work and introducing new players as appropriate. Health systems investments can be used as catalysts for coordination and integration issues within countries, although they must be tailored to countries' specific contexts.
- **The UNICEF Regional Office for CEE and the CIS** believes that it must have a strong coordinated approach in place across different sections of the organization before it works with countries on strengthening their coordination. This includes health, communication, immunization, nutrition and water and sanitation sections thinking about how their different activities contribute to the common agenda and how effectively they are supporting countries to achieve the goals of ending preventable deaths from P&D and reducing under-5 mortality. Rather than creating separate vertical processes and monitoring mechanisms for the GAPPD, UNICEF is planning to provide support within

existing country plans and ongoing regional initiatives. This will include: strengthening district health management and quality of care for mother and child health; strengthening home visiting and community nursing systems; supporting IMCI programmes through technical assistance, funding, training and promoting change; supporting the introduction of pneumococcal conjugate vaccine and rotavirus vaccine at country level, in partnership with the GAVI Alliance, particularly focusing on vaccine supply and communication; and creating positive behaviour change in families, communities and among health professionals in adopting health actions to address P&D.

- **WHO headquarters** emphasizes the importance of maintaining the efficacy of existing programmes, but also of enabling better and more fruitful interaction between them. Many policies exist in countries, but implementation lags behind development. Sharing experiences between countries can help in implementation. There needs to be a rethinking of coordination committees within countries to ensure a broadening of agendas for their meetings – this would be a relatively simple way of building bridges between programmes. Countries are asking for training and indicators to measure progress in developing integrated approaches to P&D, and WHO headquarters is able to support this going forward, including support for health management information systems that include relevant indicators. Successful programmes in areas of countries can be analysed to determine important lessons for implementation elsewhere in the country and in other countries. Importantly, WHO, working with UNICEF, the GAVI Alliance and other partners, has a role in assisting countries to find resources to support programme implementation and promote integrated approaches to delivery.
- **The Regional Office** will continue to support countries through the country offices to improve the quality of care, recognizing the diverse challenges Member States face. This will include assessing hospital and primary health care for children, reviewing and updating national guidelines and promoting better working with communities and families. Particular attention will be focused on supportive supervision – work on building integrated supportive supervision through technical support has already begun in six Member States – and completing an e-learning tool on district health management capacity. Support for countries in developing strategies and policies on maternal, newborn, child and adolescent health in line with Health 2020 and other important regional policy documents will continue, as will support to help countries make decisions the introduction of new vaccines, ensuring sustainable implementation. Countries will be encouraged to see the introduction of new vaccines as a catalyst for improving coverage of other programmes to prevent P&D. Discussions with colleagues from child and adolescent health will be held to establish more collaborative approaches to this.

Closing summary

Vivian Barnekow of the Regional Office provided a closing summary.

Good progress is being made in achieving MDG 4 in the Region, and progress in countries will not end in 2015. Improvements in approaches to P&D will promote the process.

The GAPPD presents an action plan that can be used at regional level and within countries. One of its main recommendations is a focus on prevention, protection and treatment. The focus has been too much on treatment in some countries, so the opportunity now exists to concentrate on prevention and protection – not neglecting treatment, which is of course important, but shifting

the emphasis towards prevention and protection. P&D are avoidable in most cases, and it is better to protect and prevent illness than treat it after it is established.

Despite countries' attempts to take an integrated approach, health is found only in health policies in most. Health 2020 provides a firm theoretical basis for health in all policies, but some countries seem to be only at the starting point of this process. Bridges need to be built between different ministries and sectors, with mechanisms being developed to, for instance, improve sharing of information on health and taking intersectoral approaches at local level in areas such as social affairs, health, education and environment.

Fragmented health systems, lack of continuity in processes, overlapping responsibilities and lack of vertical and horizontal collaboration among health facilities remain problems in many countries. These are compounded by lack of integration in information, monitoring and evaluation systems, in some cases resulting in overflows of information and indicators and in others in significant gaps. Relevant indicators for monitoring and evaluating interventions have not yet been developed in some areas and many countries lack infrastructure for integrated supportive supervision. These areas have to be strengthened in each country.

The problem of inadequate involvement of families and communities cannot be solved simply through provision of education. Broader approaches are required to involve families and communities, moving them away from powerful anti-vaccination movements in some countries. This is a very difficult and sensitive area to tackle, but it must not be forgotten within implementation plans.

Problems related to human resources for health persist. Pre-qualification and in-service training for health professionals remains insufficient in almost all countries represented at the meeting. This is influenced by professionals' lack of motivation due to low salaries and poor working conditions. Training, salaries and working conditions are key motivational elements, but tend to be administered and controlled by different bodies in countries: all are therefore amenable to integrated approaches.

Unequal access to services is closely linked to lack of professionals in rural areas in countries with unequal distributions of workers. Quality of services is also an issue for most.

Financing is always a challenge, but with support from WHO and other agencies, intergovernmental approaches to financing can be adopted in relation to, for instance, vaccination programmes and professional training.

The way forward seems to be about promoting more comprehensive implementation of the various policies, strategies and decrees that most countries already possess. It may be time to review and revise existing policies and evaluate how effectively they have been implemented.

Integration is the key word for the meeting. Integration between different programmes can be promoted by using existing mechanisms, but expanding their terms of reference and agendas: if the mechanisms do not yet exist, they should be developed. Joint planning is a good place to start – it is always difficult to merge planning after the fact, so programmes have a better chance of implementation if they are jointly planned from the beginning. Effective monitoring and evaluation mechanisms will also be required, with appropriate indicators that may not only be health-related, but which also focus on well-being.

Partnerships add value. They take time to build and require investment of energy and time, but produce positive results. Further steps that can be taken to strengthen integration and partnership at country level include:

- establishing a working group, if it does not already exist
- analysing the implementation of key interventions carried out within the country
- developing recommendations on coordinated actions
- amending existing plans or development of a new plan for coordinated actions
- developing a monitoring and evaluation framework

Countries have already commenced this work during the meeting, and will be able to draw on support from partners at country and international level as they progress with their plans.

Discussion

- The Regional Office has a contract and framework work plan with ministries of health of each of the countries at the meeting. Technical programmes therefore have a responsibility to contact ministries of health to start developing detailed work plans for the next biennium, commencing January 2014. The timing of this meeting is therefore optimal for influencing detailed work plans. Monitoring of agreed work plans will be taken forward over the next two years.
- WHO and UNICEF country offices and national professional officers will have an important responsibility in disseminating and following up the outputs of this meeting at country level.
- GAPPD is a global initiative, so multiple stakeholders will be involved in implementation at country level in addition to ministries of health and national agencies. In these circumstances, it would be very useful to organize a conference at national level to facilitate communication sharing and enable commitments on implementation to be confirmed. It will be very challenging to implement the GAPPD approach at country level without a strong commitment from the ministry of health.

Country working group reports

Aigul Kuttumuratova of the Regional Office introduced the country working group sessions by reviewing GAPPD implementation in the Region.

The GAPPD framework's interventions are evidence-based and well-known, but have been implemented to different degrees in countries and with a greater focus on treatment rather than disease prevention and protective interventions. Some, such as IMCI and community-based programmes on nutrition, water and sanitation, are delivered via integrated service packages, but coordination between programmes, involving planning, resource management, implementation and monitoring, tends to be weak. A number do not include calculations of cost associated with their action plans. Further challenges are encountered in promoting intersectoral working and collaboration with local communities and NGOs. Examples of good strategy implementation can nevertheless be identified, including comprehensive multi-year planning for immunization with integration within broader health plans. Challenges moving forward include those in Table 1.

Liudmila Mosina described how the working groups would use a template to record progress. The objectives of the sessions were to:

- review implementation of key interventions for P&D prevention and control presently included in existing countries policies/strategies/plans;
- review existing coordination mechanisms between ministries, departments, programmes and with relevant partners;
- define further steps and actions needed to develop and implement integrated approaches for prevention and control of P&D, with assigned responsibilities and agreed time frames; and
- outline needs for support from WHO and partners.

Armenia

Implementation of interventions for prevention and control of P&D

Achievement of performance indicators in key areas is shown in Table 2.

Major barriers to achieving high coverage of performance indicators include the following.

- There is poor implementation of national strategies and programmes, with insufficient financing from the state budget. Health spending equates to 1.4% of gross domestic product (GDP), which is one of the lowest in the Region.
- Health staff in primary care lack motivation due to an absence of incentivizing finance mechanisms. They have very low salaries and few incentives that would allow them to improve their financial situations.
- Admissions to hospital are increasing, as parents see this as offering a better option than treatment at home.
- Free health care for 0–7-year-olds had an unintended consequence of increasing hospitalizations, and primary care services became reluctant to treat.

Table 1. Challenges moving forward

Policy and strategy development	Planning, management and coordination	Service delivery	Human resources	Communication and social mobilization	Monitoring and evaluation	Financing and partnerships
<p>Ensuring:</p> <p>intersectoral collaboration;</p> <p>operational and costed plans of action; and</p> <p>collaboration with local communities.</p>	<p>Ensuring:</p> <p>harmonization and collaboration among programmes and sectors based on defined areas;</p> <p>effective coordination mechanisms are strengthened; and</p> <p>coordinated activities in areas such as EPI, IMCI and nutrition programmes are prioritized and implemented.</p>	<p>Ensuring:</p> <p>staff are properly trained and motivated;</p> <p>care standards improve;</p> <p>institutional capacity at local levels improves;</p> <p>free-of-charge services in primary care and hospitals increase; and</p> <p>nurses' responsibilities increase and their roles are revised.</p>	<p>Ensuring:</p> <p>coordinated updates of pre-service training curricula;</p> <p>increased numbers and better deployment of primary health staff;</p> <p>provision of integrated supportive supervision and monitoring;</p> <p>staff training in use e-learning tools;</p> <p>development and use of quality job aids; and</p> <p>development of effective incentives.</p>	<p>Ensuring:</p> <p>planning and implementation of coordinated communication strategies;</p> <p>strengthening of health workers' communication and counselling skills; and</p> <p>capacity-building of groups and peer counsellors.</p>	<p>Ensuring:</p> <p>the quality, appropriate analysis and use of relevant data and health statistics; and</p> <p>development of a set of common monitoring indicators.</p>	<p>Ensuring:</p> <p>costing of integrated action plans;</p> <p>effective use of existing resources;</p> <p>allocation and mobilization of resources to implement the integrated plans; and</p> <p>involvement of the private sector, civil society and NGOs.</p>

Table 2. Achievement of performance indicators in key areas: Armenia

Key performance indicators	Achievements
Vaccination (routine vaccines coverage, introduction of new vaccines)	A wide range of vaccines is available, with coverage for each ranging from 82% to 99% in 2013. Rotavirus vaccine was introduced in November 2012, with good outcomes being seen in the first year.
Breastfeeding and complementary feeding	Exclusive breastfeeding between 0 and 6 months is 35%. Thirty-four per cent of babies who are breastfed receive supplements of milk formula. Only 32% of children older than 6 months receive supplemental feeding according to WHO guidelines.
Treatment of children with diarrhoea (% with oral rehydration and zinc supplementation)	Very good progress is being seen in treatment rates, with the numbers of mothers bringing their children to health care increasing. Zinc is now being introduced, in compliance with the GAPPD guidelines.
Care-seeking for pneumonia, antibiotic treatment (%)	A database developed for children with pneumonia shows that people are receiving care more often and antibiotics are being put to good use.
Handwashing (% of households and health care facilities)	Just over 88% of households have handwashing facilities.

- There is a lack of medical staff and uneven distribution across the country, with an absence of neonatologists and paediatricians in some regions. Few experts in children's health in rural areas.
- Medical staff levels of professional knowledge and skills are insufficient, with a poor continuing education system. The quality of services consequently goes down.
- National protocols for primary health care exist, but assessments show that physicians rarely follow them.
- There is much pressure on physicians from mothers to prescribe antibiotics, in the belief that without antibiotics, the child is not being properly treated.

In relation to existing strategies, policies and plans for coordinated actions, there is strong political commitment from the government to maternal and child health, with three significant strategies on mother and child health, children and adolescents and reproductive health. These are huge umbrella intersectoral programmes with clear action plans. A health certificate programme has been launched for children aged 0–7, with free health services.

Effective mechanisms for intersectoral coordination are lacking, however, with insufficient programme coordination: the mother and child programme is still active, but implementation is hampered by poor coordination. National strategies for children and adolescents, immunization and hospital care for children are divorced from each other, running in parallel but with lack of coordination and integration.

Integration/coordination between ministry of health departments and programmes

National level

Policy development

Integration between the Mother and Child Health Department and national immunization programme is poor. The child and adolescent health strategy has an immunization component, but implementation is separate. Coordinating mechanisms need to be developed.

Planning and financing

There is separate planning and financing for different programmes. The absence of an integrated action plan is the biggest challenge. A joint action plan needs to be developed.

Communication and social mobilization

Planning is taken forward in relation to priorities, with planning and financing tending to be reactive to situations rather than proactive. An integrated social mobilization plan is required.

Training and supervision

The immunization programme works very well but other programmes not so well, highlighting the need for better supervision to promote integration. There is no integration mechanism for training and supervision. Integrated training programmes and mechanisms for supportive supervision are needed.

Reporting and evaluation

Reporting and evaluation is separate for different programmes, with no common vision of problems emerging. A common set of indicators and integrated systems for reporting are required.

Health-facility level

Service delivery

While there is a common infrastructure for service delivery, health facilities have their own separate delivery programmes and monitoring mechanisms. Service delivery is therefore fragmented; coordination among services needs to be strengthened.

Further steps in strengthening integration

A working group from the mother and child health and immunization programmes will be convened during the first quarter of 2014. This will enable better analysis of implementation and promote better coordination and cooperation. Recommendations on coordinated actions will be delivered in the second quarter, with existing action plans being amended and a new plan for coordinated action developed in the third quarter and a monitoring and evaluation framework in the fourth.

Support requested from WHO and partners

Technical support from WHO is requested to facilitate development of the integrated plan. Armenia would like to take part in piloting of the integrated approach. The country has good experience in piloting programmes, working closely with partnership organizations and sharing experiences with other countries.

Azerbaijan

Implementation of interventions for prevention and control of P&D

Achievement of performance indicators in key areas is shown in Table 3.

Table 3. Achievement of performance indicators in key areas: Azerbaijan

Key performance indicators	Achievements
Vaccination (routine vaccines coverage, introduction of new vaccines)	Coverage is 95% and above. Children are vaccinated for 11 diseases. Several new vaccines have been introduced in recent years, with coverage of 92.8%. At subnational level, 10% of areas have coverage below 90%.
Breastfeeding and complementary feeding	Coverage in children under 1 year is 48–50%; it is more common in rural (almost 98%) than urban areas. Only 25% were breastfed in the early 1990s: exclusive breastfeeding is now 30% and 90% of children have supplementary feeding at 6 months.
Treatment of children with diarrhoea (% with oral rehydration and zinc supplementation)	Official statistics state that more than 90% of children with diarrhoea receive oral rehydration, but zinc is rarely used.
Care-seeking for pneumonia, antibiotic treatment (%)	All children (100%) receive antibiotics for pneumonia after the diagnosis is confirmed. Antibiotics are overprescribed, however, being used for children with upper respiratory infections.
Handwashing (% of households and health care facilities)	This is widely spread in health facilities and households, amounting to 70%.

Major barriers to achieving high coverage of performance indicators include the following.

- The biggest barrier is insufficient funding of the health care sector. In 2011, 3.2% of the state budget was allocated to health care – 1% of gross national product (GNP).
- Other barriers include high migrant numbers (over 1 million), low training availability for health care staff and lack of health workers (especially family doctors) in remote areas.
- Health workers are poorly motivated with little incentives to work better.
- At national level, there is no collection of good data on diarrhoea cases.

In relation to existing strategies, policies and plans for coordinated actions, several laws regulate protection of mothers' and children's health, sanitation and nutrition for babies. A law on screening of children to improve disease detection was passed in 2013. Poverty reduction laws are in place and a programme on rural areas development was launched in 2009 (this is due to complete in 2017). A vaccination programme was launched in 2006 (running to 2015) and biological passports have been issued for all citizens. A national coordinating committee ensures coordination between departments and there is a council on certification of medical practitioners.

Integration/coordination between ministry of health departments and programmes

National level

Policy development

The health sector is currently undergoing significant reform.

Planning and financing

Integration and coordination between finance and health departments remains problematic. There is lack of funding for health and conflicts of interest arise when funds are suggested for reallocation. Resources need to be used more effectively.

Communication and social mobilization

A health ministry website has been developed, and the Department of Information and Communication works with the mass media and organizes education campaigns in health facilities. Better coordinating mechanisms are nevertheless required.

Training and supervision

A council certifies health practitioners and pharmacists. A unified curriculum has been introduced to medical schools. Many difficulties relate to reforms of the health and education sectors. A concept and strategy for integration are required.

Service delivery

A legislative framework and hospital protocols have been created.

Reporting and evaluation

Central statistical services have put an electronic database in place. There are issues related to recording and reporting forms, and the current electronic system is not very efficient.

Regional level

Policy development

There is a lack of coordination mechanisms at regional level and human resources problems, with many problematic issues related to the decision-making processes of local authorities.

Planning and financing

Management in the regions needs to be improved.

Communication and social mobilization

There is no unified regional approach, with human and other resources lacking. Managerial capacity and administration need to be improved.

Training and supervision

There is no integrated programme for supervision. Methodological and education materials need to be developed.

Reporting and evaluation

There is much bureaucracy, with many cumbersome forms to be completed and a lack of coordination between statisticians and local health authorities. Better computers and equipment are required.

Health-facility level

Planning and financing

Health workers lack appropriate qualifications and motivation.

Communication and social mobilization

Staff are not well motivated. Improved training for health workers is necessary.

Service delivery

Staff need better training.

Reporting and evaluation

Infrastructure, resource and human resource assets vary among health facilities.

Further steps in strengthening integration

Indicators on maternal and child health need to be created at every level and become part of the state programme to achieve MDG goals.

Support requested from WHO and partners

Support is required for analysis of current infant and child mortality through use of international and national indicators developed as part of the state programme. It would be helpful to be able to access experiences of other countries in implementing integrated approaches to reducing P&D.

Georgia

Implementation of interventions for prevention and control of P&D

Vaccination coverage (routine vaccines coverage and the introduction of new vaccines) is about 92%. Rotavirus vaccination was introduced in March 2013 with a target coverage rate for year 1 of 60%, but coverage is still quite low – 13% for first dose and 10% for second for children under 1 year. For the entire target population, the coverage will be 55% for first dose and 38% for second. The Ministry of Health has decided that the second dose has to be given to children by the age of 24 weeks; many countries give this by 32 weeks, which improves their coverage rates.

Integration/coordination between ministry of health departments and programmes

National level

Policy development

A plan for integrated action on diarrhoeal diseases has been developed with international assistance, but is not being implemented. To change this situation, the plan needs to be reviewed and weaknesses identified, and it needs to be aligned with information from this meeting and the GAPPD.

Planning and financing

Planning and financing is fragmented among different agencies and state programmes. There is a lack of coordinated actions between agencies and departments and effective distribution and utilization of donor funds, with a need for an inter-agency coordination group or mechanism for integrated planning and financial sustainability and to ensure all components of the plan are implemented.

Communication and social mobilization

An integrated advocacy and communication approach exists at Ministry of Health and National Centre for Disease Control and Public Health levels, which facilitates the promotion of different activities. There is also a Department for Health Promotion. There is, however, a need to involve others sectors, such as the Environment Ministry, to coordinate communication and social mobilization. In addition, an inter-agency coordination group or mechanism is needed to coordinate communication activities.

Training and supervision

No integrated training and supervision is available. Funds for integrated training and supervision and relevant training materials are lacking. Involvement is required to develop training and materials, train trainers and create a methodology for supervision (with supervision of supervisors).

Service delivery

Priority services for universal health coverage have been identified, with a basic benefits package developed, but the latter does not cover all essential needs for an integrated approach. Integrated approaches should be taken into consideration during revision of the basic benefits package.

Further steps in strengthening integration

A working group should be established. Implementation of key interventions should be subject to analysis and recommendations on coordinated actions should be developed. Existing plans should be amended, or new plans created, to promote coordination of actions, and a monitoring and evaluation framework should be developed.

Support requested from WHO and partners

Technical support to enable a review and updating of the plan for integrated actions for diarrhoeal diseases would be helpful. A plan for diarrhoea already exists, but it would be useful to get support to develop a similar plan for pneumonia. Technical and financial support is required for the development and distribution of implementation guidelines, training materials and indicators for performance monitoring and evaluation.

Kyrgyzstan

Implementation of interventions for prevention and control of P&D

Achievement of performance indicators in key areas is shown in Table 4.

While there are no major barriers in relation to the introduction and implementation of policies at national and regional level, barriers to achieving high coverage of performance indicators include the following.

- Health care worker motivation to achieve high standards is low and migration levels are high, with many well-trained specialists leaving the country. Some positive trends in this regard have nevertheless been seen in recent years.
- Government funds do not provide sufficient means for programmes and equipment is lacking in health care facilities, particularly in remote areas.
- Funding shortages are also found in relation to procuring vaccines and consumables, although the GAVI Alliance is providing invaluable support.
- Access to services is difficult in remote locations and service continuity between hospitals and primary care is inadequate.
- Hospital funding is based on outcomes, leading to high rates of unjustified admissions and treatments.
- Antibiotics are available in pharmacies without prescription.

In relation to existing strategies, policies and plans for coordinated actions, there is an IMCI Centre under the National Centre for Mother and Child Health Protection. People with responsibility for IMCI are lacking at oblast and district levels, however, and motivation is low.

Table 4. Achievement of performance indicators in key areas: Kyrgyzstan

Key performance indicators	Achievements
Vaccination (routine vaccines coverage, introduction of new vaccines)	Total coverage with all types of vaccines within the immunization schedule was 95.6% in 2012 (measles 98.5%, pentavalent vaccine 95%). Pneumococcal vaccine is scheduled to be introduced in 2015 and rotavirus vaccine is currently under consideration.
Breastfeeding and complementary feeding	Coverage with exclusive breastfeeding up to 6 months was 51% in 2012, although it was lower in larger cities. Advertising breast-milk substitutes is prohibited by law and pharmacies in maternity and general hospitals are not allowed to sell them. Monitoring is conducted annually and an action plan on increasing exclusive breastfeeding coverage has been developed. A course on exclusive breastfeeding and correct prescription of complementary feeding for those over 6 months has been introduced into the curricula of under- and postgraduate training in high schools and colleges. Special booklets on exclusive breastfeeding were published for the population, supported by regular publications in the mass media and advocacy work with village health committees. Eighty-two per cent of children aged 6 months to 2 years were covered by a vitamin and mineral complex supplement programme.
Treatment of children with diarrhoea (% with oral rehydration and zinc supplementation)	The WHO pocket book was adapted and implemented in hospitals in all regions, with antibiotic prescribing for diarrhoea reducing from 97% of cases to 60%. Administration of hydration within the first six hours increased from 20% to 80%. Zinc supplements are neither developed nor procured, but the production of low-osmolality oral rehydration salts will commence in 2014.
Care-seeking for pneumonia, antibiotic treatment (%)	The fatality rate within 24 hours of disease initiation and in children with severe pneumonia remains high.
Handwashing (% of households and health care facilities)	A UNICEF survey in 2009 found substandard handwashing facilities in homes, but the demographic household survey in 2013 showed some improvements. Handwashing regulations are being implemented in 90% of health care facilities, but nosocomial infection rates in hospitals remain at high levels.

Integration/coordination between ministry of health departments and programmes

National level

Policy development

The Coordination Council sits under the Ministry of Health. Equipment and software to support implementation of effective coordination are lacking: their supply, along with relevant training, is necessary.

Planning and financing

Planning is inadequate due to lack of financing. Financial support is therefore necessary.

Communication and social mobilization

A system has been developed at national level, but financing is a challenge and technical support is required.

Training and supervision

Training and supervision has been introduced into under- and postgraduate curricula, but financing is a challenge and technical support is required.

Service delivery

A system has been developed at national level, but financing is a challenge and technical support is required.

Reporting and evaluation

A system is under development at national level, but financing is a challenge and technical support is required.

Regional level**Policy development**

Coordination councils on health sit under authorized representatives of regional governments. Equipment and software to support implementation of effective coordination are lacking, with a need for supply and training.

Further steps in strengthening integration

A working group on strengthening integration has been established and a monitoring and evaluation system has been developed, with the main implemented measures being monitored on an ongoing basis. Recommendations on coordination of activities have been developed and current plans for coordinated activities have been amended and new plans created.

Support requested from WHO and partners

Technical support is required – this is the main need. Assistance is needed with technical support, provision of equipment and software with relevant training, monitoring and evaluation and developing evidence-based clinical guidelines and protocols.

Republic of Moldova**Implementation of interventions for prevention and control of P&D**

Achievement of performance indicators in key areas is shown in Table 5.

Table 5. Achievement of performance indicators in key areas: Republic of Moldova

Key performance indicators	Achievements
Vaccination (routine vaccines coverage, introduction of new vaccines)	The overall vaccine coverage rate among children less than 1 year is over 90%. Rotavirus vaccine was introduced in July 2012 and pneumococcal vaccine in October 2013.
Breastfeeding and complementary feeding	Exclusive breastfeeding up to 6 months is approximately 85%, with 7.5% being breastfed between 6 and 24 months. No data on complementary feeding are available.
Treatment of children with diarrhoea (% with oral rehydration and zinc supplementation)	Access to safe water is 60% in urban settings, but less in rural.
Care-seeking for pneumonia, antibiotic treatment (%)	Oral rehydration is available for all children at primary health care and hospital levels. Over-prescription of antibiotics is common for P&D, however.

Major barriers to achieving high coverage of performance indicators include the following:

- the migration process, which particularly affects breastfeeding when mothers migrate for work in the first two years of their children's lives;
- local customs and traditions on nutrition, with many children being educated by grandparents holding traditional views;
- an active anti-vaccination movement in society;
- a lack of links to performance payment for vaccination at primary health care level;
- weakness of the national procurement mechanism for vaccination, with poor advocacy and communication (and inadequate media messages);
- health featuring only in health policies;
- a lack of local intersectoral approaches to address sanitation and hygiene issues;
- fragmentation of the health system, with lack of continuity, overlaps and lack of vertical and horizontal collaboration among health facilities;
- lack of integration in the health information system; and
- the continued domination of a disease-centred, rather than person-focused, approach.

In relation to existing strategies, policies and plans for coordinated actions, several laws, policies and strategy exist to promote integrated approaches, but health mainstreaming in national policies is not strong.

Integration/coordination between ministry of health departments and programmes

National level

Policy development

Strategies for child and adolescent health, public health, health reform and the national immunization programme are in place, but implementing health system reforms and integrating health service delivery are difficult. Stakeholder commitment to, and involvement in, policy development is low – there is a need for improvement in this area – and the budget is in deficit.

Planning and financing

A mid-term expenditure framework for 2014/2015 has been created with costed action plans. The national health insurance company plans and finances the health care system. There is a gap between needs and provision, however, with insufficiently effective use of the prevention fund by the national health insurance company.

Communication and social mobilization

Information campaigns have focused on specific health issues such as pneumonia, diabetes and tobacco programmes. Parents are supported to follow the development of their children through a special handbook prepared for them. The communications strategy lacks an integrated approach, however, with little funding and few partners, particularly from civil society. An integrated strategy is a priority, with efforts made to collaborate positively with the media to help get health messages across to the population.

Training and supervision

Under- and postgraduate and continuing medical education accreditation systems are in place, but training curricula tend to be outdated and do not coordinate well across specialties. There is a need to update training curricula and improve continuity for different specialties.

Reporting and evaluation

A national reporting system, a health reporting system and a national insurance company database are in place.

Regional level

Policy development

Local documents based on nationally endorsed policies exist, but communication with stakeholders is challenging.

Planning and financing

Regions develop their own budget frameworks.

Communication and social mobilization

There are no budget lines for, and therefore little involvement in, communication at regional level.

Service delivery

Perinatal and emergency paediatric systems are regionalized.

Reporting and evaluation

Reporting forms and mechanisms are in place, but reporting and evaluation tools are outdated and interaction among the levels is insufficient. A strengthened system of integrated management is required to improve data quality.

Health-facility level

Planning and financing

Budgets are developed by facilities in accordance with health insurance company budgets and other sources of finance. Local action plans are based on the costed action plans at national level. Human resources limitations, poor planning and lack of financing management skills hamper progress.

Communication and social mobilization

There are no budget lines for, and therefore little involvement in, communication at health-facility level.

Service delivery

The immunization programme is integrated in primary health care and a follow-up system for premature and low-birth-weight babies exists, with evidence-based clinical guidelines. Referral system procedures are outdated, however, and service delivery is discontinuous. Inappropriate hospitalization persists, and tools for monitoring quality standards are needed.

Further steps in strengthening integration

To facilitate the implementation of an integrated approach, there is a need to:

- generate political will
- establish a supervision group consisting of stakeholders
- establish a technical working group
- analyse the current situation in the country

- develop recommendations on coordinated actions
- develop a national health programme centred on children (not on diseases)
- amend existing plans to ensure an integrated approach
- develop monitoring, evaluation and reporting indicators.

Support requested from WHO and partners

A regional intersectoral high-level advocacy meeting on a coordinated/integrated health service delivery approach is needed, as is technical assistance in evaluating the current national situation and developing evaluation and monitoring indicators. Support is required to engage in advocacy and communication with stakeholders to inform the decision-making process and to build planning and financing capacity at all levels.

Tajikistan

Implementation of interventions for prevention and control of P&D

Achievement of performance indicators in key areas is shown in Table 6.

Table 6. Achievement of performance indicators in key areas: Tajikistan

Key performance indicators	Achievements
Vaccination (routine vaccines coverage, introduction of new vaccines)	Routine immunization coverage is 93–95%. Rotavirus vaccine will be introduced in 2015, pneumococcal vaccine in 2016 and human papillomavirus vaccine in 2017. Pneumococcal vaccine for individual population groups was introduced between 2010 and 2013.
Breastfeeding and complementary feeding	Exclusive breastfeeding up to 6 months was approximately 34% in 2012, compared to 25% in 2005. Complementary feeding is at 60%.
Treatment of children with diarrhoea (% with oral rehydration and zinc supplementation)	Eighty-two per cent of children with diarrhoea receive oral rehydration and 70% have zinc supplements.
Care-seeking for pneumonia, antibiotic treatment (%)	Most recent data show that 57% of children seek medical treatment for pneumonia and 50% receive antibiotics.

Major barriers to achieving high coverage of performance indicators include the following:

- inadequate funding of the health system, with lack of personnel in primary health care and low staff motivation;
- a weak health system infrastructure, with lack of transportation and basic equipment;
- inadequate implementation and weak monitoring of standards;
- low social mobilization, with insufficient working with communities;
- complicated climatic and geographic conditions; and
- only 56% of the population having access to safe drinking water.

In relation to existing strategies, policies and plans for coordinated actions, only 20% of the immunization programme is funded by the government, the remainder coming from the

country's partners and international organizations. Intersectoral coordination of programmes is weakly integrated.

Integration/coordination between ministry of health departments and programmes

National level

Policy development

The country has many national documents regulating areas such as health protection, maternal and child nutrition, maternal health and immunization against communicable disease.

Implementation is supported by a number of international organizations (WHO and UNICEF support for the national IMCI strategy, for instance), but additional technical support and increased funding are necessary.

Planning and financing

The Ministry of Health develops annual plans and budgets for all programmes, reflecting regional plans and budgets. Programme implementation plans are developed annually, but insufficient funding means implementation is limited – the Ministry is trying to improve funding for the health sector.

Communication and social mobilization

A national programme to promote healthy lifestyles is in place, but funding is inadequate and training processes are insufficient.

Training and supervision

National plans include health worker training, with monitoring, assessment and supervision systems being developed. Supervision lacks integration, however, and there is inadequate funding to support supervisory visits. Technical support is required to develop an integrated approach to supervision.

Service delivery

There is a legal framework for service delivery and a well-developed network of health care facilities in the country. Transitioning to an integrated system is nevertheless a challenging process, and technical assistance is required to develop a package of mandatory medical services.

Reporting and evaluation

Recording and reporting forms exist, but they are paper-based, with no uniform system in place for the collection, entry and processing of data. The country is nevertheless gradually moving towards an integrated health information system.

Regional level

Policy development

All regional activities are based on the national documents, with local authorities approving regional instruments.

Planning and financing

The regions develop plans and budgets and send them to the Ministry of Health.

Communication and social mobilization

Implementation plans are based on the national programme.

Health-facility level

Planning and financing

Health facilities develop plans and budgets and send them to the regions.

Communication and social mobilization

Implementation plans are based on the national programme.

Service delivery

There is a well-developed network of health care facilities in the country, but the infrastructure and logistical supply base is weak.

Further steps in strengthening integration

To facilitate the implementation of an integrated approach, there is a need to:

- establish working groups
- implement analysis of main measures
- develop recommendations for coordination
- amend existing plans or develop a new coordinated action plan
- develop a monitoring and evaluation system.

Support requested from WHO and partners

The country has significant experience in working with WHO on developing a roadmap to an integrated approach to preventing P&D, but further technical assistance is required in this area to enable the Ministry of Health and other stakeholders to identify priority activities and establish which donors can help with identified activities. The roadmap will include the implementation schedule, funding sources and identified support organizations.

Turkmenistan

Implementation of interventions for prevention and control of P&D

Achievement of performance indicators in key areas is shown in Table 7. Figures are for 2006.

Table 7. Achievement of performance indicators in key areas: Turkmenistan

Key performance indicators	Achievements
Vaccination (routine vaccines coverage, introduction of new vaccines)	Routine immunization coverage was more than 98% and included measles–mumps–rubella and pentavalent vaccines, the latter being introduced in 2010. A working group to prepare the country for the introduction of pneumococcal and rotavirus vaccines was established in 2012.
Breastfeeding and complementary feeding	Exclusive breastfeeding up to 6 months was improving.
Treatment of children with diarrhoea (% with oral rehydration and zinc supplementation)	Forty per cent of children with diarrhoea received oral rehydration and this percentage has been increasing in recent years. Ninety-seven per cent of the population has access to safe drinking water.
Care-seeking for pneumonia, antibiotic treatment (%)	Fifty-eight per cent of children sought medical treatment for pneumonia and 50% received antibiotics.

Major barriers to achieving high coverage of performance indicators include:

- the commercial activity of manufacturers of breast-milk substitutes
- advertising of antibiotics.

In relation to existing strategies, policies and plans for coordinated actions, a Ministry of Health ordinance makes provision for regular home visiting for children from birth to age 15. High-quality vaccines procured through UNICEF are administered according to the immunization schedule, with additional vaccination for identified groups.

The national health programme, launched in 1995, includes components on immunization, breastfeeding, family medicine, free medical services for children and compulsory annual medical examination of children and adolescents. A sanitary code makes provision of safe drinking water mandatory and promotes handwashing in child care facilities. Iodination of salt and fortification of flour is compulsory.

Integration/coordination between ministry of health departments and programmes

National level

Policy development

There is full coordination and integration in policy development, although it takes a long time to reach consensus.

Planning and financing

Budgets are set at six-monthly intervals, with centralized planning of activities.

Communication and social mobilization

The national Health Information Centre provides health education in schools and for the public, with regular visits and supervision, but there is a need for better involvement of nongovernmental partners.

Training and supervision

A national supervisory-visits plan exists, with regular team visits promoting integrated approaches. There are nevertheless no professional associations that have the capacity to promote integration. There is a need to include integrated approaches in the mandatory accreditation of doctors.

Reporting and evaluation

All reporting and evaluation is fully coordinated.

Regional level

Planning and financing

Budgets are dispersed to regions from the centre.

Communication and social mobilization

Communications are coordinated from the centre. There is a need to establish regional departments of the national centre.

Training and supervision

There are regular team visits promoting integrated approaches.

Reporting and evaluation

All reporting and evaluation is fully coordinated, but integration indicators are required.

Health-facility level

Communication and social mobilization

Health facilities are independent but have to act within the framework of central plans. Family doctors are overloaded, with a shortage in rural settings.

Training and supervision

There are regular team visits promoting integrated approaches.

Service delivery

Oral rehydration salts are available and prescribed to children. Any child with suspected pneumonia is screened, but there is a need to improve workers' knowledge and practice, particularly in relation to antibiotic prescribing, and address doctors' workloads.

Reporting and evaluation

All reporting and evaluation is fully coordinated.

Further steps in strengthening integration

Facilitating the implementation of an integrated approach involves a partnership including Ministry of Health departments, regional health departments, population representatives, academic institutions, NGOs and other partners, who will be working on this during the first two quarters of 2014. In addition, there is a need to:

- further develop the action plan and indicators for the strategy of mother, child and adolescent health, which was presented on 6 December 2013;
- extend the mandate of the working group on rotavirus and pneumococcal vaccines; and
- strengthen the monitoring and evaluation system.

Support requested from WHO and partners

Methodological support and support for developing guidelines and training materials is required.

Ukraine

Implementation of interventions for prevention and control of P&D

Achievement of performance indicators in key areas is shown in Table 8. The figures are for the first 10 months of 2013.

Major barriers to achieving high coverage of performance indicators include the following.

- There is a very strong anti-vaccination lobby, with health workers sometimes concocting new contraindications to justify non-administration.
- Procurement of vaccines is difficult, with irregular supply.
- The adoption of good manufacturing practices guidelines for vaccines has led to the lack of availability of some.

Table 8. Achievement of performance indicators in key areas: Ukraine

Key performance indicators	Achievements
Vaccination (routine vaccines coverage, introduction of new vaccines)	Immunization coverage among children aged under 1 year ranged 19.5% for hepatitis B to 72.4% for tuberculosis. Rotavirus and pneumococcal vaccines are recommended within the national schedule: a national working group is determining how they should be introduced.
Breastfeeding and complementary feeding	Exclusive breastfeeding up to 6 months was 19.7%.
Treatment of children with diarrhoea (% with oral rehydration and zinc supplementation)	Oral rehydration is provided at home in most cases, but zinc-containing drugs are not approved for children and are not registered. WHO supported the adaptation of its pocket guideline for treatment of diarrhoea, which was distributed throughout the country. The unjustified use of antibiotics for treatment of diarrhoea remains a problem.
Care-seeking for pneumonia, antibiotic treatment (%)	Pneumonia is a serious problem, with around half of the 80 000 cases annually occurring in children under 6. Antibiotic use is extensive.

In relation to existing strategies, policies and plans for coordinated actions, a healthy child management protocol that is implemented at all levels and was developed in partnership with WHO is in place. Protocols for P&D management that call for integrated action also exist. A programme on establishing and expanding regional perinatal centres is underway and a national policy on improving sanitary and hygiene standards in children's establishments has been developed. Tobacco use in public places is prohibited by law. There is nevertheless insufficient coordination and integration of these initiatives at national and regional levels.

Integration/coordination between ministry of health departments and programmes

National level

Policy development

Health reforms are currently being developed, but coordinating and integrating mechanisms are required. There is insufficient coordination among different Ministry of Health departments and programmes.

Planning and financing

The health reforms are not yet completed, but there is a need for coordination between departments at national level and those at regional and health-facility levels.

Communication and social mobilization

There is a need for workshops to educate medical personnel on vaccination and prevention of P&D.

Training and supervision

Integrated supportive supervisory teams are in place, but they lack capacity to carry out their roles.

Service delivery

The healthy child protocol brings services at different levels together. The implementation of the family medicine system also promotes concerted efforts. An electronic registry of patients that

will further improve continuity of care is being developed. Family doctors, however, receive insufficient training on early childhood issues.

Reporting and evaluation

Systems are being developed as part of the health reforms.

Further steps in strengthening integration

To facilitate the implementation of an integrated approach, there is a need to:

- improve discussions within the country
- analyse international experience
- plan and develop recommendations on integrated activities
- review current, or develop new, plans on coordinated activities
- develop a monitoring and evaluation framework.

Support requested from WHO and partners

There is a need for:

- education and training in supportive supervision
- surveys and trials for promoting pneumococcal vaccine (serotyping in case of pneumonia)
- technical support in developing plans and strategies.

Uzbekistan

Implementation of interventions for prevention and control of P&D

Achievement of performance indicators in key areas is shown in Table 9. The figures are for the first 10 months of 2013.

Table 9. Achievement of performance indicators in key areas: Uzbekistan

Key performance indicators	Achievements
Vaccination (routine vaccines coverage, introduction of new vaccines)	Immunization coverage according to the vaccination schedule is at least 95%. Rotavirus vaccination will be introduced in June 2014 and an application has been made for the introduction of pneumococcal and human papilloma virus vaccines in 2015.
Breastfeeding and complementary feeding	Exclusive breastfeeding rate up to 6 months is 50%, according to data from the Institute of Paediatrics.
Treatment of children with diarrhoea (% with oral rehydration and zinc supplementation)	Children with diarrhoea are hospitalized in communicable diseases hospitals. Rehydration salts are available. Uzbekistan procures all vaccines with government money, except for those funded through co-funding mechanisms.
Care-seeking for pneumonia, antibiotic treatment (%)	Forty-two per cent receive antibiotics for pneumonia.
Handwashing (% of households and health care facilities)	Twenty-four per cent of households have access to proper handwashing facilities.

Major barriers to achieving high coverage of performance indicators include the following.

- The management supervisory system needs to be improved. While WHO support has enabled the country to develop a strong supervisory system, it needs to be decentralized and expanded through an integrated approach. There is currently insufficient coordination inside the Ministry of Health and between agencies, with weak implementation of regulatory and legal documents.
- Human resource policy within the Ministry of Health and in other government departments is suboptimal. Migration issues create personnel problems, especially with specialist posts.
- Initial preparation and the need for continuous upgrading of qualifications for health workers (doctors, nurses and midwives) present challenges.
- Information supply and monitoring systems are lacking.
- There are gaps in service delivery due to poor human resource policy, migration and other factors. Health facilities, especially those in hard-to-reach areas, have insufficient water and electricity supplies and there is a lack of specialists such as epidemiologists and immunologists.
- Management personnel turnover is high at regional level.
- Patients tend to visit their doctors late in the course of their illness, consequently leading to late hospitalization.

In relation to existing strategies, policies and plans for coordinated actions, the country has a powerful legislative framework of laws and standards and a strong regulatory base. The health care facility infrastructure is strong, with adequate staff, equipment and medical supplies in the country's more than 5000 medical facilities in rural settings.

A coordinating committee was set up at the Ministry of Health in 2012 to address issues such as mother and child health and immunization. A national strategy on protection of women and children's health has been put in place for 2014 to 2020: it will include integrated approaches to P&D and is currently being considered by the government. A number of international organizations are very active in the country.

Integration/coordination between ministry of health departments and programmes

National level

Policy development

A decree on immunization specifies that government ministries, including finance, have to allocate resources for the procurement of vaccines. A coordinating committee at the Ministry of Health conducts monthly meetings. The Ministry of Health workload is too large, however, and the system of integration and evaluation is suboptimal. Other government ministries and departments, such as those for agriculture and water supply, provide insufficient support to developing health care priorities. The supply of safe drinking water is a particular problem, and an integrated approach is needed to secure this and effectively prevent diarrhoea. There is also a need to strengthen integration and create implementation monitoring mechanisms.

Planning and financing

Budgets are usually planned prospectively for three years, with approval granted annually at the highest level. Funding for the vaccination programme requires greater sustainability.

Communication and social mobilization

The Institute of Health is in place nationally with branches throughout the country, but integration with public organizations is weak. Much training and effort is required in this area.

Training and supervision

The gap between academic education and practical application in health settings is too wide and needs to be reduced. The focus on mother and child health, sanitation and hygiene needs to be sharpened in medical curricula through coordinated efforts. WHO and UNICEF provide valued technical support in this area, and its continuation will be necessary to ensure success in the future. No integrated supervisory support tool is currently available.

Reporting and evaluation

A strong system of evaluation and monitoring is lacking.

Service delivery

Standards and rules for sanitation have been developed, but implementation is patchy due to weaknesses in the monitoring and assessment system, which needs to be developed.

Regional level

Policy development

Specialists participate in national events and medical council conferences, as do staff from health care facilities and local authorities. Staff turnover is high, however, with insufficient capacity to analyse and make decisions about gathered data. Management skills and integration with local administrations need to be improved.

Planning and financing

Funding is decentralized, with regions working from local budgets. The timing of allocation of funds, however, is sometimes not conducive to supporting the vaccination programme, so better planning is necessary.

Communication and social mobilization

Institute of Health regional departments are in place, but integration with NGOs is weak.

Service delivery

A joint P&D incidence data collection system has been implemented, but strong analysis of collected data is lacking. The potential of regions in data analysis needs to be strengthened.

Reporting and evaluation

A common statistical reporting form is available, but analysis of the data it produces is not sufficiently strong.

Health-facility level

Planning and financing

Financing is mixed: some comes from local authorities and some from federal budgets.

Prioritization of budget dispersal is vital, which calls for better planning: training is required for health administrators in this area.

Service delivery

Each health facility is staffed with general practitioners and group of nurses, but they receive insufficient support in delivering innovative services: regular training within health facilities is required.

Reporting and evaluation

Health facilities present daily statistical reports on disease classification, but forms are currently paper-based. An automated data collection system is required.

Further steps in strengthening integration

A working group is being developed to support analysis of implementation, develop recommendations on how to coordinate activities, introduce amendments to current plans to create a new coordinated action plan, and develop a monitoring and assessment system.

Support requested from WHO and partners

Technical support from WHO is requested to: support new vaccine introduction; allow comparisons with international experience; revise and update relevant documents; provide continued support for existing programmes; and support supervisory visits.

Annex 1

PROGRAMME

Tuesday 10 December

09.00 Objectives of the Meeting Vivian Barnekow

Session 1. Regional overview of child health and mortality

Chairs: Kubanychbek Choibekov, Aigul Kuttumuratova

9.30–9.55 Progress achieved in reduction of child morbidity and mortality Vivian Barnekow

Session 2. Integrated approach in prevention and control of pneumonias and diarrhoeas

9.55–10.20 The Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea Carsten Mantel

10.20–10.35 Introduction of new vaccines as an opportunity to introduce integrated approaches in prevention of pneumonias and diarrhoeas Liudmila Mosina

10.35-10.55 Discussion

Session 3. Experience in the Region on coordinated actions and integrated service delivery

Chairs: Nasib Guliyev, Nilgun Aydogan

11.25–11.50 Coordinated/Integrated Health Services Delivery in the WHO European Region Juan Tello

11.50-12.00 Discussion

12.00–12.25 Experiences and lessons learned from IMCI implementation Aigul Kuttumuratova

13.25–13.50 Coordination between health facilities and communities to improve family and community practices Oya Zeren Afşar

13.50–14.05 Experience in integrated service delivery from Kyrgyzstan

14.05-14.30 Discussion

14.30–14.55 Breastfeeding and nutrition promotion Trudy Wijnhoven

14.55–15.20 Improvement of hygiene awareness and promotion of behaviour change Oya Zeren Afşar

15.20–15.40 Discussion

Session 4. Advocacy and communication for coordinated actions

Chairs: Rodica Scutelnic, Oya Zeren Afşar

16.10–16.35 Generating political will to reduce child death from pneumonia and diarrhoea Mikael Ostergren

16.35–16.50 Experience in advocacy and coordinated actions to improve child health from Uzbekistan

16.50–17.10 Discussion

Wednesday 11 December

Session 4. Advocacy and communication for coordinated actions (contd)

Chairs: Said Davlatov, Liudmila Mosina

9.00–09.25 Achieving results through integrated action: the MDGs and the post-2015 development agenda Nedret Emiroglu

9.25–09.35 Discussion

Session 5. Working groups

Chairs: Svitlana Ostashko, Carsten Mantel

9.35-10.00 Regional approach in GAPPD implementation Aigul Kuttumuratova

10.00-10.10 Discussion

10.10- 10.30 Introduction to working groups Liudmila Mosina

11.00–12.00 Working groups

13.00-14.30 Working groups (contd)

14.30- 15.00 Feedback from working groups Armenia
Azerbaijan
Georgia

15.00-15.20 Discussion

15.50- 16.20 Feedback from working groups (contd) Kyrgyzstan
Republic of Moldova
Tajikistan

16.20-16.40 Discussion

16.40- 17.10	Feedback from working groups (contd)	Turkmenistan Ukraine Uzbekistan
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17.10-17.30	Discussion	
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Thursday 12 December

Session 6. Plenary discussion and next steps

Chairs: Ismailov Saidmurod, Mikael Ostergren

09.00–09.25	Strategic partnership	Leen Meulenbergs
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09.25–10.30	Partners panel discussion	
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11.00-11.30	Conclusions and recommendations	
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Annex 2

MEETING PARTICIPANTS

ARMENIA

Dr Vaan Pogosyan
Deputy Minister of Health
Ministry of Health

Dr Karine Saribekyan
Head of Mother and Child Health
Department
Ministry of Health

AZERBAIJAN

Dr Afag Aliyeva
Deputy Director
General of Republican Centre for Hygiene
and Epidemiology
Ministry of Health

Dr Nasib Guliyev
Director
National Research Institute of Paediatrics
Ministry of Health

GEORGIA

Dr Lia Jabidze
Head of Immunoprophylaxis Planning and
Monitoring Division
Ministry of Health

Dr Lela Shengelia
Head of Mother and Child Health Division
National Centre of Disease Control and
Public Health

KYRGYZSTAN

Dr Kubanychbek Choibekov
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