The Millennium Development Goal Four (MDG4) was to reduce Under Fives Mortality (UFM) by two thirds between 1990 and 2015. The indicators for this were the UFM rate, the infant mortality rate and the proportion of 1 year olds immunised against measles.

What has happened?
Globally from 1990 to 2013 under fives deaths declined from 12.7 million to 6.3 million per annum and UFMR decreased 49% from 90/1000 to 46/1000. But this overall achievement was uneven and Oceania, Sub-Saharan Africa, The Caucasus, Central Asia, and Southern Asia did not achieve the MDG4. In Sub-Saharan Africa the average annual rate of reduction of the UFMR was 0.8% in 1990–1995 and 4.2 % in 2005–2013. Despite this the region has the highest UFMR of 92 deaths per 1,000 live births, 15 times the average for developed regions. Infant mortality
The global neonatal mortality rate declined 40% from 33/1000 live births in 1990 to 20/1000 live births in 2013. This slower reduction means that the proportion of under-five deaths that occur within the first month of life has increased from 37% in 1990 to 44 % in 2013. The leading causes of death in under fives include: Preterm birth complications (17%); Pneumonia (15%); Intrapartum-related complications (11%); Diarrhoea (9%); Malaria (7%). Globally, nearly half of under fives (UF) deaths are attributable to under-nutrition.
Pneumonia causes 1.1 million UF deaths/year, a decrease of 35% since 2000. Malaria deaths had decreased by 45% by 2000; in part due to more children sleeping under treated bed nets and the change in first line malaria treatment to more effective artemisinin combination therapy (ACT). Diarrhoea causes 1600 UF deaths, mainly in South East Asia and sSAfrica, per day.

Malawi

Malawi has a population of about 16 million with 2.859 million children under five. The UFMR is 68, Infant MR is 46 and neonatal mortality is 23/1000. The absolute decline in neonatal mortality was from 50/1000 in 1990 to 23/1000 in 2013. Stillbirth rates were 24/1000 in 2009 but not all births were registered. In 2013 there were 3,400 maternal deaths.

It is clear that reductions in child deaths require combined efforts in maternal and child care that are broad-based and cover the continuum of care from antenatal to under fives health programmes. Malawi has taken this approach. In antenatal care mothers are counselled, and given malaria prophylaxis, a treated bed net, tetanus toxoid immunization, early antiretroviral therapy if appropriate, and iron and folic acid. The number of deliveries by a skilled attendant increased from 50% to about 75% from 2000 – 2010, more babies are being put to the breast within an hour, more are being weighed and, importantly, post-natal care is being improved and increased with home visits to newly delivered mothers.

The pentavalent vaccine was introduced into the extended immunization programme (EPI) in 2002, pneumococcal 13 valent vaccine in 2012 and oral rotavirus vaccine shortly afterwards. Hib infections have fallen dramatically and the effect of the other two vaccines is yet to be assessed.

Malawi was one of the first countries to adopt Option B+ for HIV positive pregnant mothers who now receive HAART from diagnosis in pregnancy until after stopping breast feeding or for life. Breast-feeding is encouraged for 2 years. There are community supplementary feeding programmes, because it is known that under nutrition underlies at least half of UF deaths.

Malawi is not sitting back on its laurels, there is still a long way to go, and particular efforts are now being focused on delivering good, basic neonatal care in district and rural health units.

What is needed is not high tech, labour intensive, expensive interventions, but simple, good efficient care delivered by trained and motivated staff in a well-functioning health system.

ICHG Spring Meeting will take place on April 29th at 1 pm

Details of the programme here

Looking forward to seeing you there
An introduction and warm hello from Dr Dan Magnus, new Chair of ICHG

It gives me a great pleasure to introduce myself and on behalf of the ICHG Committee to briefly share with you some of the ICHG plans for the coming months. ICHG has enjoyed success in recent years and it would be remiss for me not to mention and thank Dr James Bunn for his hard work as previous ICHG Chair. I am delighted to be taking over at the helm and hope to both represent the membership and take forward a programme of activity to develop the group and what it hopes to achieve. As the MDGs draw to a close in 2015, I am mindful that whilst great success has been achieved in improving child health around the world there is still much to be done and we, as child health professionals, have an important role in this. ICHG will seek to support us all in this work.

So what exactly does ICHG do?
The ICHG committee recently agreed that the group will focus on 3 key streams of activity in the next 3 years:

1. **Education and Training**: In collaboration with the RCPCH, ICHG will focus on developing a Global Child Health Track for UK paediatric trainees to develop specific training, knowledge and experience in global health. It will also continue to oversee and help deliver the Child Health in Low Resource Settings (CHiLS) course at the RCPCH. ICHG will be open to discussing any additional initiatives focused on global health training and education.

2. **Advocacy**: ICHG will formulate a strategy for advocacy for global child health which may be focused on global health issues in the UK as well as in low and middle income countries. ICHG will do this in conjunction with and possibly in collaboration with the RCPCH Advocacy group.

3. **Supporting professionals and networks**: ICHG will support UK health professionals in global health work and signpost links to global health opportunities. ICHG will also look at a programme of work supporting UK and other health professionals in low and middle income countries. This will include continuing its support of CHIFA (Previously CHILD2015) and actively promoting membership of RCPCH’s global health consultancy.

ICHG has also launched a new website ([www.ichg.org.uk](http://www.ichg.org.uk)) with updated information on the work of the group, the latest news and ways to get involved. We will be updating our newsletters and will be increasing the communication and engagement with ICHG members in the coming months.

In the meantime I would like to highlight a few key points for members to consider:
**Sign up for the RCPCH Global Health Consultancy.** The GHC is a register of paediatricians and other health professionals who are interested to engage in global child health, particularly in low and middle-income settings. [See here](http://www.ichg.org.uk) for more details.

**Register for the RCPCH Spring meeting and come to the ICHG session on Wednesday 29th April.**
You can see the provisional ICHG programme as well as the link to register on the [ICHG website](http://www.ichg.org.uk).

**David Morley Bursary** aims to fund an medical student elective bursary in memory of David Morley, a founder member of ICHG, who died in 2009. The bursary of £500 will be awarded to the best proposal from a medical student planning to study child health in a low income setting during an elective. More details can be found [here](http://www.ichg.org.uk).

Suggestions and correspondence from the ICHG membership are welcome and the committee is keen to foster a culture of inclusivity and contribution from all. So please do stay in touch and get involved. Please also spread the word about ICHG to your colleagues and connections. You are all welcome.

Best wishes, Dan Magnus, ICHG Chair
In September 2014, the UN General Assembly adopted the Sustainable Development Goals, the set of goals, targets and indicators that will replace the Millennium Development Goals and determine approaches to global poverty and inequality for the next 15 years. This makes it extremely important that the framework is well thought-through and addresses the most important issues. For the health goal, Save the Children has focused on three areas:

1. We think that we must **build on the progress that has been made under the MDGs**. Child mortality has been halved since 1990, which is not the two-thirds reduction that was aimed for but shows that huge progress is possible. We need to keep momentum and go further, and we are pleased that the Open Working Group document proposes the target to end preventable maternal, newborn and child deaths. The global target of 25/1000 by 2030 would see low income, high-mortality countries reach the level achieved by many middle income countries. To achieve this, countries will need to tackle newborn mortality which, as our report Ending Newborn Deaths showed, requires universal and quality skilled care at birth.

2. One failure of the MDGs was to **reduce inequality**. By only counting national averages, some countries have seen a lack of improvements in the poorest and most marginalised communities. The targets of the SDGs need to be measured across all social groups and we are delighted that UN Secretary-General Ban Ki-Moon has endorsed our call that no targets should be counted as achieved unless in all social groups.

3. As the Ebola crisis in West Africa has shown, a decision to focus only on certain outcomes does not necessarily build the kind of comprehensive health service which can cope with any problems which arise. For this reason we are part of the movement for **Universal Health Coverage**, the principle that everyone in a society is entitled to access essential health services and without facing financial hardship. This cannot happen if health is left to the market where those who can afford it get high quality services and the poor cope without or buy poor quality care and face financial ruin. Universal Health Coverage is ambitious but achievable, especially if countries raise more public funds fairly and spend it on the most needed services first.

Save the Children has been heavily involved throughout the debates about what can replace the MDGs. And we will continue to be onwards into implementation in every country. Action/2015 is a global movement of charities, people’s movements and grassroots organisations calling for the SDGs to be ambitious and to tackle poverty and inequality. 2015 needs to be a remarkable year to start the transformation of our world and to stop the injustices of early deaths, lack of access to healthcare and denial of rights.

www.savethechildren.org.uk/policy
http://www.action2015.org/
Dr Dan Magnus is a final year registrar in Paediatric Emergency Medicine at the Bristol Children’s Hospital with a special interest in global child health. He is the Unit Lead for Global Child Health at the University of Bristol and is a co-organiser of the Child Health in Low Resource Settings (CHiLS) course at the RCPCH. Dan is the founding trustee of Kenyan Orphan Project (www.kopafrica.org), a registered charity working with communities in western Kenya to support child health, nutrition and education programmes linked to global health education for students in the UK. He has been going to Kenya for more than 10 years and has experience of planning and running rural medical camps, programmes for street children and a range of medical, education and social welfare projects for orphans and vulnerable children. His current interests include school health and nutrition programmes for improving health and educational outcomes for children and improving paediatric trauma outcomes in low resource settings.

CHILD2015 is now CHIFA but its function is unchanged: to bring current and evidence-based information to all involved in global child health, and (a) to explore the information and learning needs of those who are responsible for the health care of infants and children in developing countries, and how we and others can be more effective in meeting those needs; and (b) to explore issues around social paediatrics, child health and child rights.

Most of us would agree that information alone is not enough to bring good health and that health workers need to advocate for change just as is the case in UK in relation to child abuse, accident prevention and obesity. So CHIFA is also about evidence-based advocacy.

Contributions are always interesting and I think helpful. However when members pose a question on a public health topic there tend to be few responses, which I expect is because of the expertise available. Also most members are clinicians and may prefer to focus on the problems they face in the clinic. We do still need to reach out to find more members, there are few contributions from East and Southern Africa, Asia and South America (no doubt a language problem in relation to the latter).

Recent topics for discussion have been child poverty in Japan (yes: it exists there too), whether a ban on smacking will reduce corporal punishment in the home, and care seeking behaviour for children with suspected pneumonia. The smacking ban discussion has brought out clearly the difference in perspective across different continents on child rights issues and the education which is still needed for health professionals on ways and means of protecting children from violence. Clearly CHIFA is meeting an important need and we would like to take this forward in
other ways than simply internet discussion. One such way is through the organisation of webinars.

Two successful webinars have been held on CHIFA in the last six months using technology provided by the University of Iowa. It is easy to tune in and if the webinar audience is not too large, participants can ask questions of the speakers in real time. A recording should be made available though we are still working on this part of the system.

Both webinars took the form of a panel and were on child abuse: the first on problems raised by CHIFA members before the discussion and the second on the prevention of corporal punishment.

The former was part of the International Society for Social Pediatrics annual meeting in Gothenburg and there was a local as well as an international audience; in the second, the speakers were from Canada, Ethiopia and Turkey (the Turkish speaker was in a car driving through a snowstorm at the time but still managed to connect!) There will be further webinars later this year on topics suggested by members and we hope that this will become a regular series.

Spanish version of CHIFA
With the assistance of Raul Mercer (Argentina) and the Pan American Health Organisation (PAHO) a Spanish language version of CHIFA is being developed, this will be of great value to health professionals living in Latin America (as well as Spain of course). We would like to see other language versions being developed particularly in Russia, China and the Arab world and anyone with an interest in setting these up, please be in touch.

And do please be sure to spread the message about CHIFA and use it to reach the ultimate goal of child health information for all. See here for more information.

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Table 1. Current membership of CHIFA: 2892 members in 140 countries.
GLOW Meeting 2015

Reaching Every Woman, Every Newborn: The post-2015 research agenda

Dr Helen Brotherton
Paediatric Speciality Registrar, Edinburgh
ICHG executive committee member

GLOW (Global Women’s Research Society) is a society for academics and postgraduate students engaged in Global Maternal and Child health research. This year’s conference at Royal College of Obstetrics and Gynaecology, London, focused on maternal and neonatal priorities in the post-2015 research agenda with a focus on encouraging the next generation of academics. It featured an impressive line-up of global experts from the maternal and neonatal research community and a high quality selection of short oral and poster presentations from trainees or young researchers in this field.

The day began with a key-note lecture by Professor Richard Horton, Lancet Editor and Co-Chair of the United Nations Independent Expert review Group, who gave his usual passionate and inspiring call for action in further improving maternal, neonatal, child and adolescent health (MNCAH) and summary of progress over the last 20 years. He emphasised the importance of including adolescent and stillbirth indicators in the sustainable development goals (SDG) which will inform research priorities over the next 15 years.

Afternoon workshops were one of the highlights of the meeting and I attended “Research in Reality”, led by Professor Peter Brocklehurst, Director of the Institute of Women’s Health, UCL and Professor Wendy Graham, University of Aberdeen. These experienced researchers gave fantastic practical insight into the minefield of grant applications and valuable advice on how to write successful proposals. Other workshops included “Human Rights Approach to Women’s Health” and “Lessons from Maternal Death and Near Miss Reviews to Inform Scale up of Perinatal Audit Programmes”.

This was a highly stimulating and engaging meeting with lots of time and opportunity to meet old friends and develop new collaborations and networks. I came away inspired by the talks, invigorated by the dedication and energy of participants and ready to book my place on GLOW 2016.

Videos of presentations from GLOW2015 are highly recommended and can be viewed here

More information on GLOW can be found here
From April to June 2014, I had the opportunity to visit Delhi, India and Cape Town, South Africa for my medical student elective. With the generous support of the David Morley bursary from the ICHG, I set out an ambitious agenda to make meaningful improvements to paediatric healthcare in developing world settings, using a mixture of technology and good will. Below is a summary of the main outputs.

1. Implemented a Paediatrics Play Team at both AIIMS and Red Cross Children’s Hospital

Building on what was accomplished at St. Mary’s Hospital, London, we were able to set up a play team at AIIMS Hospital in partnership with the CPAA (Cancer Patients Aid Association, Delhi). This is an established organisation operating at AIIMS Hospital and the wider New Delhi area. I was able to train local medical students on basic play therapy and recruit local volunteers to visit students out of hours. In addition, we purchased a new set of infection-control friendly toys, bags and consumables.

Similarly, in Cape Town we were able to work with SHAWCO (the medical students’ association) and complement the hospital’s play set up by recruiting a cadre of volunteers for play therapy out of hours in the hospital, as well as in the surrounding area of the Cape Town townships of Guguletu and Philippi. We are using the Kirk-Patrick model alongside Dr. Ralph Diedricks (UCT) to longitudinally evaluate the project.

2. Implementing phase 2 of a MOBILE-DOTS plan: Use of mobile phones as an innovative way of implementing DOTS (Directly Observed Therapy, Short Course) in Tuberculosis medication.

This encouraged patients to send an MMS message to their physician to report their medication use via a video-enabled mobile phone, rather than incurring significant cost to travel to the health clinic. I am now collaborating with the Public Health Foundation, India (based in Gandhinagar, Gujarat) in order to develop free and low-cost mobile apps to improve prescribing practices for TB medications, and to use psychological incentives to encourage patients to complete TB medication even after cessation of symptoms.
Since returning to the UK, I have worked with technology developers in Oxford to create an Android app for rural health workers to screen for acute malnutrition. We are now piloting this in 3 centres in Northern India and seeking to collaborate with mTOTO, a service which offers SMS health advice in rural Kenya.

3. Trained Community Leaders in Bhavnagar (Gujarat) and Lucknow (UP) as well as New Delhi in Basic First Aid, Sanitation, Hygiene during Religious Celebrations, and Lifestyle Modification.

We were also able to form a collaboration with the department of Social Affairs in Gujarat to provide nutrition and nutrition education to school-aged children currently suffering from parasitic worm infestation and poor diet. With an interest in paediatric infectious disease, I was keen to explore healthcare worker awareness of TB-HIV co-infection, particularly since both India and South Africa have high rates of TB and HIV. In New Delhi there was near ubiquitous awareness (96%) of side effects of first-line TB medication, but awareness of the importance of maintaining treatment after cessation of symptoms was subpar (36%).

“When we get better we don’t need to keep taking medication”

At Red Cross hospital, Cape Town, there was 100% awareness of TB being contagious, as well as the common symptoms. However, comparatively little awareness of the social factors contributing to TB predisposition.

I would like to re-iterate the support received from the ICHG in facilitating this elective, as well as the encouragement to focus on sustainable endeavours, which may bring about lasting improvement in developing world contexts.