

A photograph of a woman with braided hair, wearing a green and white striped shirt, holding a newborn baby wrapped in a pink blanket. The woman is looking down at the baby with a gentle expression. The background is bright and slightly out of focus, suggesting an outdoor setting.

INVESTING FOR IMPACT



ADVANCING GLOBAL HEALTH
FOR CHILDREN



Investing for Impact

INVITATION TO INVEST IN GLOBAL HEALTH FOR CHILDREN

The best investment we can make is in childhood, especially ensuring every child has a healthy start in life. It's an investment that yields remarkable results — not only in the lives of children most in need, but also for the future we all share. When children are healthy, they can go on to lead healthier, more productive adult lives, disrupting intergenerational cycles of poverty. The earlier we invest in children's health, the higher the return on that investment for us all.

THE PROBLEM: PREVENTABLE CHILD DEATHS

Remarkable progress has been made over the past two decades in global health for children. Yet tragically, 5.6 million children under the age of 5 still die each year from mostly preventable causes, which equates to nearly 15,000 every day.¹

Approximately 1.6 million of these deaths are attributable to just three causes: pneumonia, diarrhea and malaria, most of which are preventable and treatable through early diagnosis and the delivery of low-cost, proven interventions. Many of these children who need lifesaving care never receive it.

Many factors contribute to and increase a child's risk of early death — including prematurity, newborn infection, limited access to water, sanitation and hygiene, and undernutrition. These risk factors, like child mortality itself, do not affect all children equally. Families in rural areas are half as likely to have piped water at home as families in urban areas, and on average, rural under-5 mortality rates are 1.7 times those in urban areas. Children from the poorest families are nearly twice as likely to die before age 5 as children from the richest households.²

This challenge is exacerbated by the fact that the mothers of many of these children often lack education and/or are limited by cultural barriers that prevent them from seeking care, which increases the risk that children will die from preventable causes. Children of mothers who lack education are 2.8 times as likely to die before age 5 as children whose mothers have at least a secondary education. Violence, political instability and volatile economic conditions can also undermine essential components of the health systems necessary to reduce child deaths.³

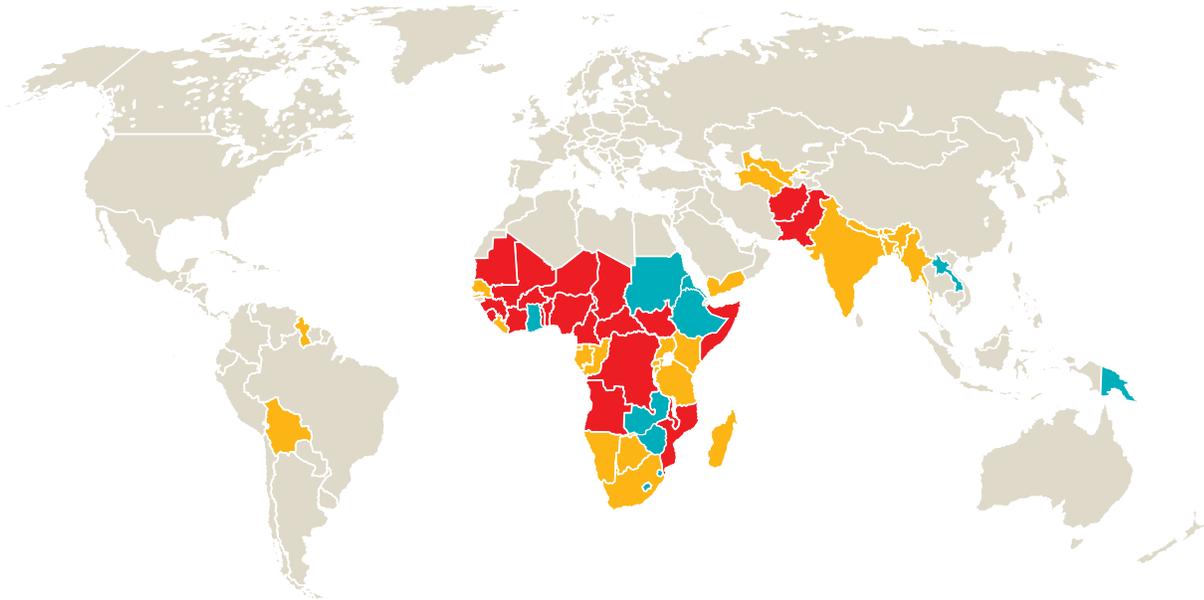
The highest concentration of deaths among children under 5 is in sub-Saharan Africa, where one in 13 children dies from a preventable cause before reaching age 5.⁴ In fact, more than half of all childhood deaths occur in just six countries: China, Ethiopia, India, Nigeria, Pakistan and the Democratic Republic of the Congo, all of which have large populations living in poverty.⁴

These statistics are sobering. No newborn baby or young child anywhere should die of a preventable cause. The global development community is committed to ending these deaths.



2015 Under-5 Child Mortality Rate

PROBABILITY OF DYING BY AGE 5, PER 1,000 LIVE BIRTHS



TOP 10 COUNTRIES WITH THE MOST CHILD DEATHS

India 1,081,000	China 168,000
Nigeria 733,000	Indonesia 131,000
Pakistan 424,000	Tanzania 117,000
DR Congo 304,000	Bangladesh 106,000
Ethiopia 187,000	Angola 96,000

MAP KEY PROBABILITY OF DYING BY AGE 5 PER 1,000 LIVE BIRTHS

● < 14.50	● 55.90 – 78.50
● 14.50 – 32.90	● > 78.50
● 32.90 – 55.90	

Map Source: World Bank





Photo: Tommy Trenchard

A GLOBAL EFFORT TO REDUCE CHILD MORTALITY RATES

In 2000, all 189 United Nations member states agreed to try and achieve eight Millennium Development Goals related to combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women by 2015. One of the goals was to reduce the under-5 mortality rate by two-thirds. While this goal was not fully reached, the total number of child deaths decreased from 9.8 million in 2000 to 5.9 million in 2015 – an enormous accomplishment.

In order to continue the success of the Millennium Development Goals, the UN member states decided to create 17 Sustainable Development Goals (SDGs), to be completed by 2030. To accomplish the SDG target on child mortality, all countries will need to achieve an under-5 mortality rate of 25 per 1,000 live births by 2030. This goal is a direct challenge to the global under-5 mortality rate of 43 per 1,000 live births recorded in 2015 and represents an ambitious plan to save even more young lives.⁵

A KEY SOLUTION: INTEGRATED COMMUNITY CASE MANAGEMENT

Millions of poor and marginalized families do not get basic health care because it is simply unavailable, too far away or too expensive. This remains the primary reason why 15,000 children under 5 die every day from mostly preventable or treatable causes.

Integrated Community Case Management (iCCM) saves children's lives by delivering essential health services to those most at risk. Integrated Community Case Management complements and extends the reach of public health services by providing timely and effective treatment of pneumonia, diarrhea and malaria among populations with limited access to health facilities, with a focus on children under 5.

When a young child shows symptoms of a deadly illness, it is critically important to get help to that child within 24 hours. If the child lives in a remote place, or comes from a poor family, going to a health facility may not be an option. Having a trusted, well-trained and well-equipped community health worker (CHW) nearby can mean the difference between life and death for that child.

“The vast majority of childhood deaths worldwide result from causes that we know we can beat – because we’ve already beaten them here in the U.S. and in other affluent nations.”

– Bill Gates

Integrated Community Case Management programs train and equip CHWs to diagnose and treat common childhood illnesses, and to refer severe cases to facility-based providers. This strategy is especially effective at reaching children who otherwise have limited or no access to lifesaving treatments.

Because the CHWs are part of the community and are close to home, parents with sick children are more likely to seek care quickly, before the child becomes sicker. CHWs also play a critical role in educating parents about the danger signs to watch for, which encourages timely care-seeking. Because every minute counts when a child is sick, CHWs have a profound impact on curbing preventable deaths of children.

THE HISTORY OF INTEGRATED COMMUNITY CASE MANAGEMENT

Countries began various forms of iCCM as far back as the 1990s, when the World Health Organization (WHO) determined that CHWs with minimal education and limited literacy skills were capable of managing pneumonia adequately in the community, using simple guidelines for classifying severity of cases diagnosed.

Since early 2000, the number of countries that have implemented iCCM to deliver pneumonia, diarrhea and malaria treatments to children under 5 has dramatically increased. At present, there is no global count of how many countries have adopted iCCM. However, in 2013, a survey of Ministries of Health and UNICEF offices found evidence of iCCM policies, CHW involvement and iCCM financing mechanisms in at least 35 countries in sub-Saharan Africa alone (up from 10 in 2000).

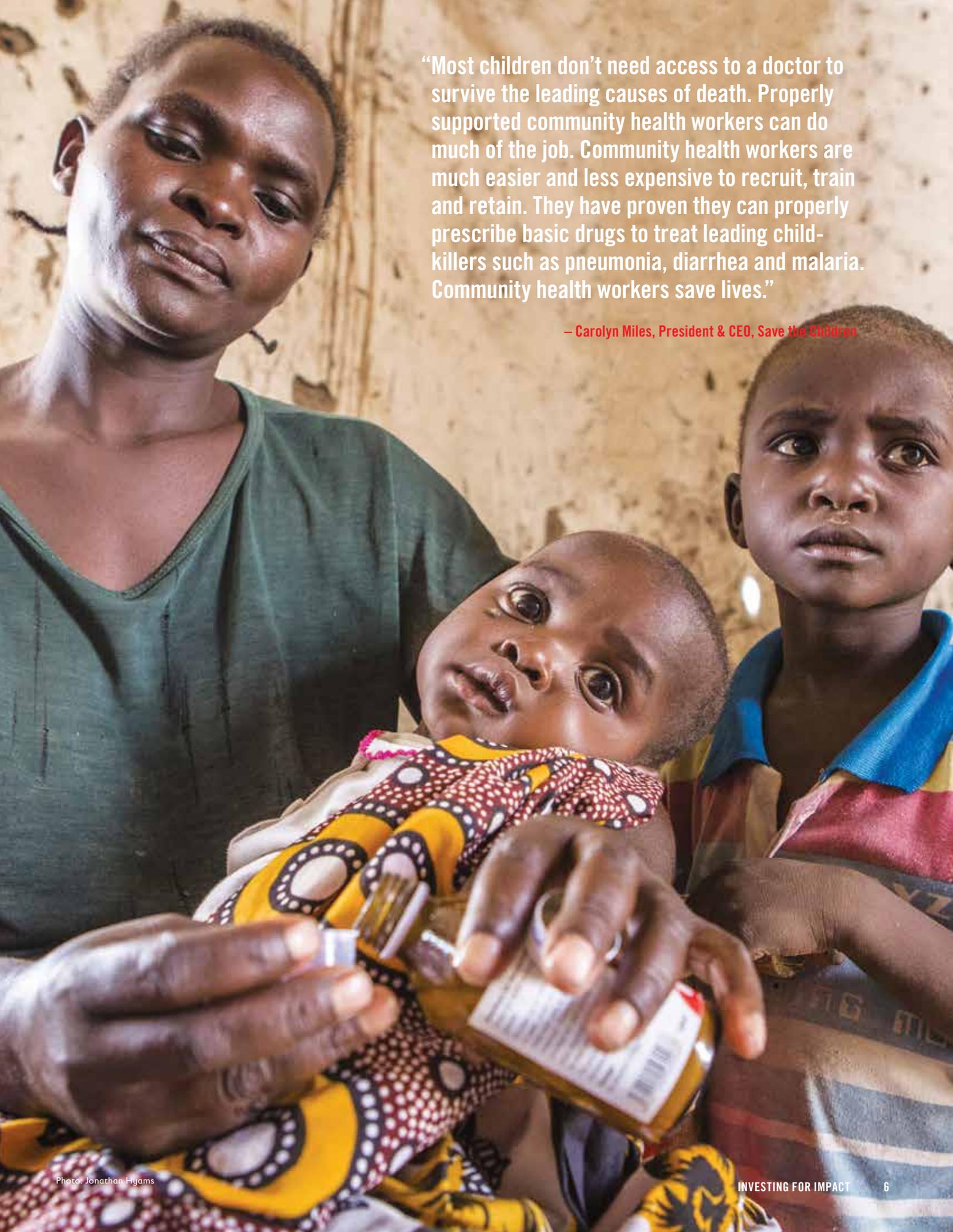
COMMUNITY HEALTH WORKERS SAVE LIVES

Community health workers (CHWs) are key to saving lives through Integrated Community Case Management (iCCM). They are the first and often the only link to health care for millions of children in poor communities around the world. They are based in the community and often come from the community they serve, providing a variety of lifesaving interventions close to where people live. Families rely on CHWs as trusted sources of information who have valuable skills in preventing, treating and managing a variety of leading causes of death, including pneumonia, diarrhea and malaria. CHWs have become a true force for good and are revered in the communities they serve.

CHWs do not need to be highly educated to be successful. Experience in many developing countries has shown that health workers with basic schooling and several weeks to months of well-designed training, followed by on-the-job supervision and mentoring, can master the skills needed to diagnose and treat common illnesses, promote lifesaving health practices and counsel families about nutrition, hygiene and family planning.

Ministry of Health officials, local leaders and nonprofit organizations contribute to the selection and training of CHWs, who are managed and compensated in myriad ways. Some countries pay health workers, while other countries deploy CHWs with significant skills who operate in conjunction with volunteers receiving other types of incentives. Most incentives are in the form of goods, equipment or supplies related to frontline health work. Qualitative evidence from one study suggests that both intangible incentives (recognition, interest by supervisors, reassurance and promotion) and tangible incentives (small signs of distinction, training and work-related equipment) are important for health worker motivation and performance. Equally important motivators include community relationships, respect and appreciation.⁶





“Most children don’t need access to a doctor to survive the leading causes of death. Properly supported community health workers can do much of the job. Community health workers are much easier and less expensive to recruit, train and retain. They have proven they can properly prescribe basic drugs to treat leading child-killers such as pneumonia, diarrhea and malaria. Community health workers save lives.”

– Carolyn Miles, President & CEO, Save the Children

Channels Through Which Child Health Interventions Affect the Economy

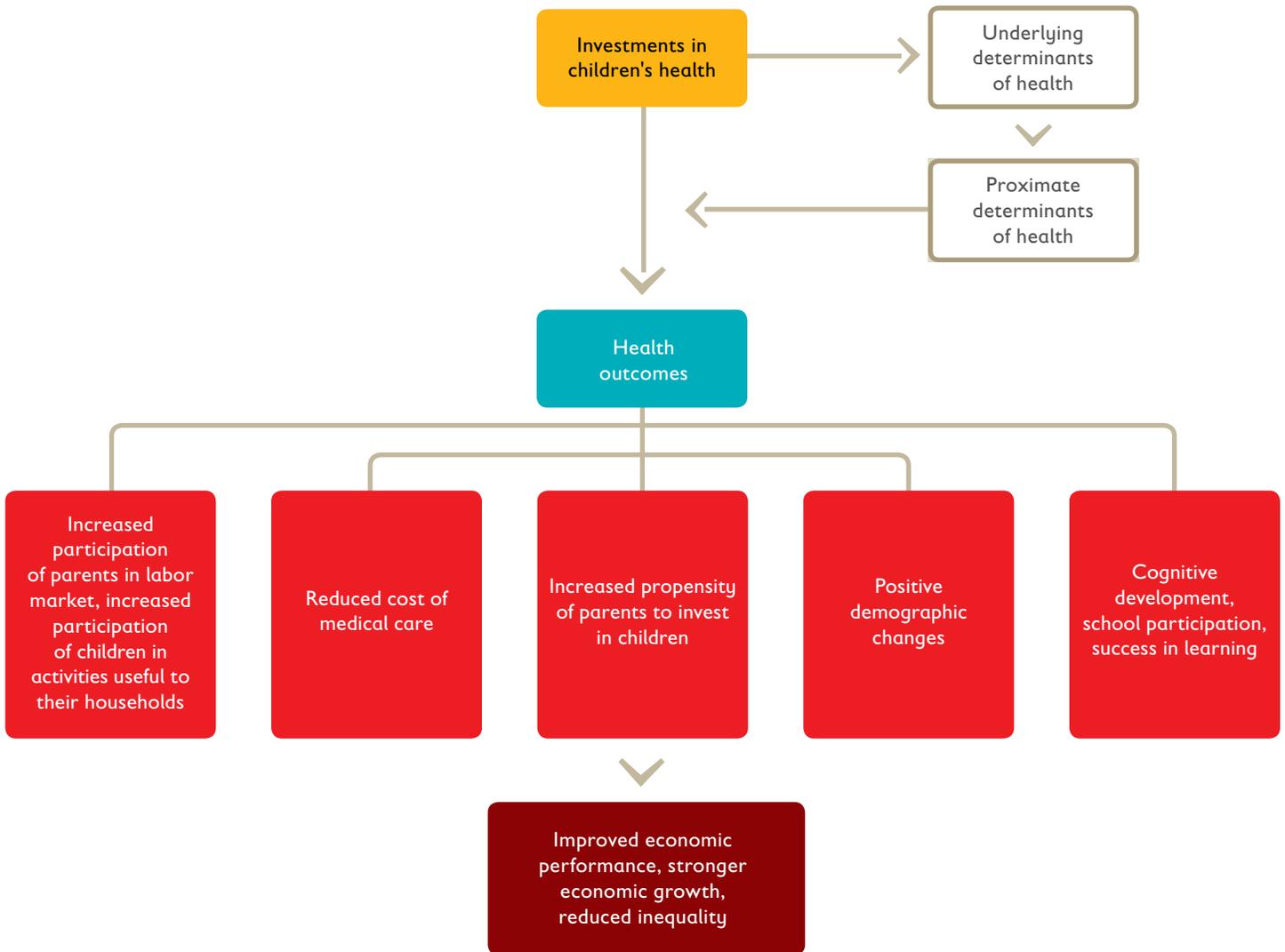


Diagram Source: World Bank



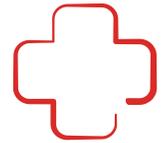
INTEGRATED COMMUNITY CASE MANAGEMENT: WHAT IS POSSIBLE?

The UN-led Child Health Epidemiology Reference Group estimates that access to community-based treatment could reduce child deaths from malaria by half, deaths from pneumonia by nearly two-thirds and deaths from life-threatening diarrhea by up to 90 percent.⁷ Simply put, if community-based treatment is scaled up in developing countries, the global health community could save the lives of over one million of the 1.6 million children who die under age 5 each year from a combination of the three greatest killers. This translates to nearly 500,000 lives saved from pneumonia, over 400,000 lives saved from diarrhea and over 100,000 lives saved from malaria.

According to UNICEF, current treatment levels for pneumonia, diarrhea and malaria in developing countries are unacceptably low – only 39 percent of children receive correct treatment of diarrhea, and less than 20 percent of children with fever in sub-Saharan Africa receive a finger/heel stick for malaria testing.⁸

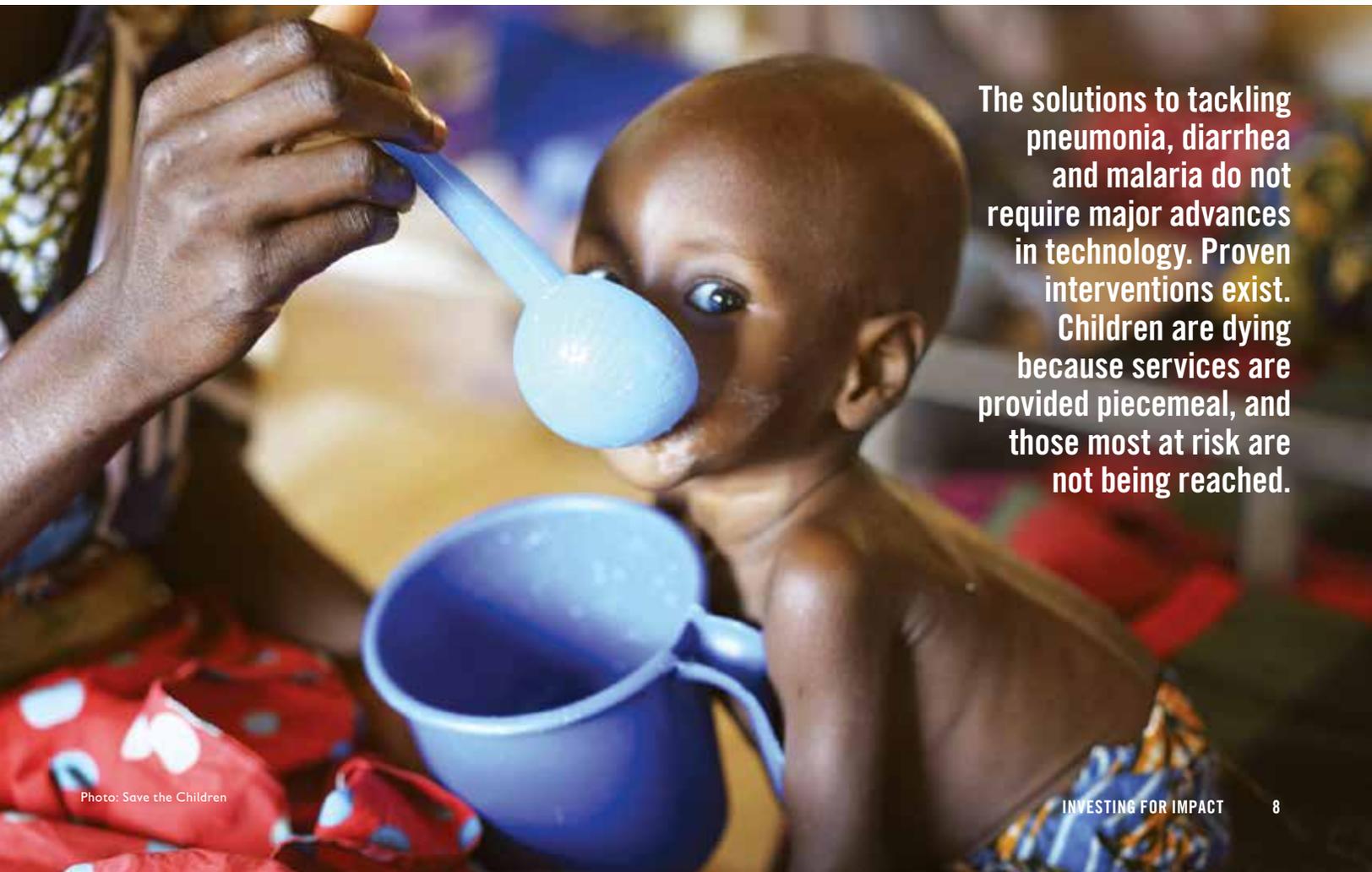
Given the proven lifesaving impact, Save the Children, WHO and others are encouraging countries throughout the world to adopt the iCCM strategy. It is clear that adding a set of community-based interventions to care for children under age 5 in sub-Saharan Africa has demonstrable returns.

EFFECTIVE CHILD HEALTH INTERVENTIONS



Research demonstrates that the following interventions and activities work to save children's lives:

- **Use of vaccines against streptococcus pneumonia and haemophilus influenzae type B**, the two most common bacterial causes of childhood pneumonia, and against rotavirus, the most common cause of childhood diarrhea deaths, substantially reduces the disease burden and deaths caused by these infectious agents.
- **Use of vaccines against measles and pertussis** substantially reduces pneumonia illness and death in children.
- **Oral rehydration salts, along with zinc supplements**, are proven lifesavers for treating children with diarrhea.
- **Water, sanitation and hygiene interventions**, including access to and the use of safe drinking water and sanitation, provide health, economic and social benefits.
- **Use of antibiotics substantially reduces deaths** from pneumonia, and use of anti-malarials, reduces deaths from malaria.⁹



The solutions to tackling pneumonia, diarrhea and malaria do not require major advances in technology. Proven interventions exist. Children are dying because services are provided piecemeal, and those most at risk are not being reached.

INSUFFICIENT SOURCES OF FINANCING

Sources of financing for CHWs exist, but many countries have experienced challenges in assembling financing for their iCCM programming. Countries that have successfully financed strong national programs with paid, well-trained CHWs have done so through the coordination of numerous traditional financing sources, including international donors and domestic resources. In 2015, a WHO report recommended creating an Africa-based Financing Support Unit to help countries access financing for health, beginning with community health and potentially expanding to other aspects of primary care.¹⁰

The same report argued that high-performing community case management programs can be financially self-sustaining in the long term by sharing the financing burden among program beneficiaries, which include private employers and private health care providers, and by capturing gains that result from economic growth.¹¹

RETURNS ON YOUR INVESTMENT

Researchers from WHO and other organizations have evaluated the economic benefits of investing in children's health on a global scale. Their findings indicate that significant economic benefits are associated with the enhanced survival of young children. For example, a review by the World Bank concluded that, "The literature shows that making greater investments in children's health results in better educated and more productive adults, sets in motion favourable demographic changes, and shows that safeguarding health during childhood is more important than at any other age because poor health during children's early years is likely to permanently impair them over the course of their life.

In addition, the literature confirms that more attention should be paid to poor health as a mechanism for the intergenerational transmission of poverty. Children born into poor families have poorer health as children, receive lower investments in human capital, and have poorer health as adults. As a result, they will earn lower wages as adults, which will affect the next generation of children who will thus be born into poorer families."¹²

The scale up of trained CHWs can also create significant cost savings. A cost-effectiveness analysis of malaria case management in Zambia, for example, revealed that home-based management was more cost-effective than facility-based management (\$4.22 per case at home versus \$6.12 at a facility).¹³ An analysis from Pakistan found that home management of chest in-drawing pneumonia by CHWs was associated with a substantially lower cost to the household than for children who were referred to facilities for treatment.¹⁴

Other studies suggest that investments in CHWs in sub-Saharan Africa can result in an economic return of up to 10:1 – due to increased productivity from a healthier population and the economic impact of increased employment, which in turn helps to slow the intergenerational transmission of poverty.¹⁵

Community health worker participation in iCCM programs yield additional societal benefits including female empowerment given that the majority of CHWs are women and, in some cases, are compensated for their services. Wages – and even non-wage incentives – for iCCM services can provide increased respect for women in their communities, contribute to their role in household decision-making and increase income generation for improving their family well-being.¹⁶

AN INVESTMENT WORTH MAKING

Community health workers in sub-Saharan Africa can result in an economic return of

up to 10:1

due to increased productivity from a healthier population, potentially reducing the risk of epidemics such as Ebola, and the economic impact of increased employment, which in turn helps to slow the intergenerational transmission of poverty.



Save the Children's Community-Based Health Programs

OUR EXPERIENCE

In 1999, Save the Children initiated its first iCCM program in Nepal. We worked with the government to expand the reach of its community case management services to remote communities with great need for health care. Today, three out of every four children under age 5 in Nepal have access to lifesaving care for diarrhea and pneumonia.

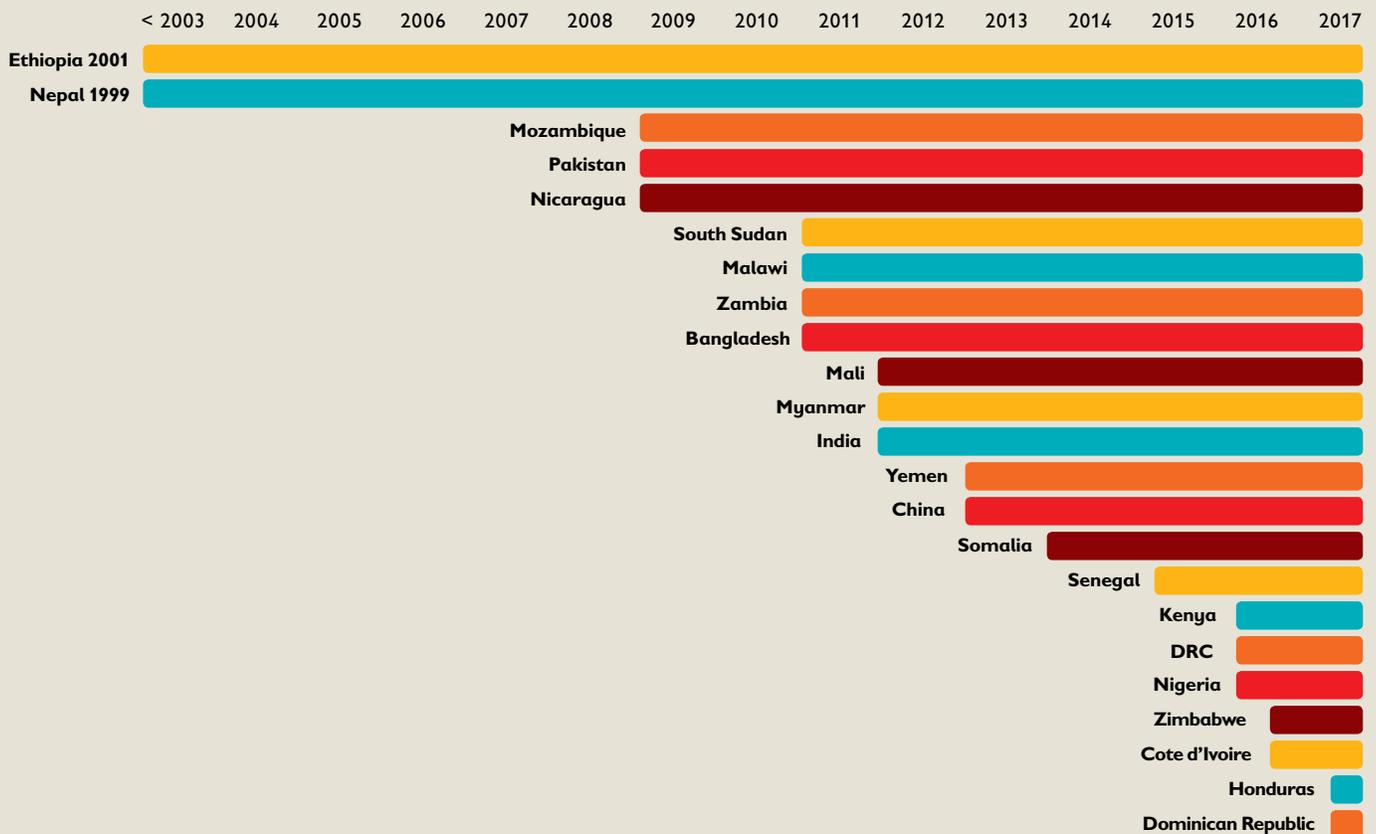
In 2012, Save the Children played a central role in developing the evidence base for the joint statement issued by WHO and UNICEF that demonstrates the importance of iCCM in delivering lifesaving care to hard-to-reach children.¹⁷

WHERE WE WORK

In line with this global effort to accelerate the replication of iCCM, Save the Children is implementing child health programs in 23 countries in Latin America, sub-Saharan Africa and Asia (see graph below). We prioritized these 23 countries based on the strength of our health programs, our previous experience with iCCM programming in those countries, the potential for quality delivery of health programming, and our ability to improve effective coverage of interventions for childhood illness at scale.

These countries represent 3.7 million annual under-five deaths, which is equivalent to nearly two-thirds of all global deaths each year, a substantial proportion of whom could be saved through the delivery of cost-effective, community case management services.¹⁸

PROGRAM TIMELINE: WHEN SAVE THE CHILDREN INITIATED PROGRAMMING, BY COUNTRY





Our Integrated Community: Case Management Results

As of mid-2017, Save the Children supported the introduction and scale-up of iCCM in 23 countries, including large programs in Ethiopia, Malawi, Mozambique, South Sudan, Bangladesh and Pakistan.

A recent statistical snapshot of our cumulative work shows we have supported the treatment for 3.7 million cases of malaria, 3.1 million cases of pneumonia and 2.8 million cases of diarrhea as of December 2015. Save the Children has also helped train 115,000 community health workers.¹⁹



CASE STUDIES

MALAWI, MOZAMBIQUE AND SOUTH SUDAN

Save the Children led a four-year iCCM effort to reduce child deaths among children under 5 in Malawi, Mozambique and South Sudan from 2009 to 2013. We trained nearly 2,500 CHWs to assess, classify and treat children with signs of malaria, pneumonia and diarrhea. Save the Children also trained local Ministry of Health partners to support, supply and supervise health workers. In addition, families were educated to recognize and seek care for signs of serious disease, adhere to treatment and seek referral treatment for severe disease. Between 2010 and 2012, CHWs assessed and treated 1.4 million cases of malaria and 638,300 cases of pneumonia.²⁰

NICARAGUA

In 2006, Save the Children introduced iCCM to Nicaragua to build the capacity of the Ministry of Health. The focus was to train volunteer *brigadistas* who are community health care providers to assess, classify, treat, counsel and facilitate referrals for sick children. *Brigadistas* also encourage household and community practices to prevent disease and promote health, especially for women and children. Since its inception, the program has trained more than 360 *brigadistas* who treat more than 5,000 episodes of illness each year. The program has since been scaled up to reach approximately 1.3 million people. Rates of mortality due to pneumonia, diarrhea and dysentery have dropped by more than 50 percent in participating areas.²¹ As a result of this success, Nicaragua has adopted iCCM as national policy for all communities located more than two hours from a health facility.

BANGLADESH

Pneumonia is a major cause of death for children under age 5 in Bangladesh. Save the Children implemented iCCM in southern Bangladesh, where we focused on decentralizing pneumonia and diarrhea treatment within the public health system to community-level facilities. We also engaged informal providers to increase access to quality health services where public facilities were not available. Over two years (2012-2014), the project developed the capacity of 470 community clinics and 145 health sub-centers to provide pneumonia and diarrhea treatment following national protocols. Additionally, some 300 informal providers, known as village doctors, were trained on iCCM of pneumonia and diarrhea following national protocol. More than 1.2 million sick children received services for childhood illnesses from improved health facilities and trained village doctors, and approximately 2,000 sick children were properly referred from village doctors to government health facilities for treatment.



Photo: Rik Goverde

OUR DISTINCTION IN INTEGRATED COMMUNITY CASE MANAGEMENT

Save the Children has a robust policy, advocacy and global representation agenda. Since 2010, we have served on the global iCCM Task Force steering committee, along with WHO, UNICEF and USAID. In 2017, the Task Force reorganized as the Child Health Task Force and expanded to include DFID, the CORE group, and the Global Financing Facility. We are currently co-chairs of two new subgroups, the Expansion of the Child Health Package Group and the Innovations and Digital Health Group and are active in several other sub-groups. The CH TF works together to more effectively establish a strong and comprehensive child health agenda at the global, country and local levels.

We have co-authored a number of widely used guides for iCCM practitioners, including *Community Case Management Essentials*, the *Indicator Guide: Monitoring and Evaluating Integrated Community Case Management*, and *Caring for Newborns and Children in the Community Planning Handbook for Programme Managers and Planners*.

In addition, our child health experts are actively engaged in more than 30 ongoing research projects. These projects include evaluating new malaria rapid diagnostic tests in Malawi, evaluating a new device to help assess children with signs of pneumonia in Kenya and assessing model supervision systems in Mozambique.

DRIVING INNOVATION IN CHILD HEALTH

Save the Children's child health team has been working to drive innovation in collaboration with corporate partners. For example, we worked with Royal Philips Research Group to design an automated respiratory rate counting device to improve the tools for diagnosing pneumonia. This device automatically measures the respiratory rate and classifies the condition according to WHO guidelines. We are now working with Philips to conduct proof-of-concept testing in Kenya. The study will assess the accuracy, usability and acceptability of the device for large-scale community use in the management of pneumonia in children. We also facilitated the development of counting beads to improve assessment and classification of fast breathing by illiterate CHWs in South Sudan. This approach was replicated by UNICEF, the International Rescue Committee and the Malaria Consortium for their programs in similar settings. We are now testing the use of diagnostic devices for childhood pneumonia including pulse oximeters and lung ultrasound in lower level health facilities and community settings.

As a member of the advisory board of the Global Digital Health Network, Save the Children has helped design the Global Digital Health Forum and its predecessors, as part of the Health Summit, since 2012.

We have tested and implemented various mobile phone applications. In partnership with D-tree, we tested cell phone applications with algorithms and counseling tools for CHWs and guides for supervisors in Malawi. We have also worked with WHO and UNICEF to develop video-based case management training for settings where distances to appropriate facilities preclude standard facility-based training, such as in South Sudan. In China, we helped link communities, village doctors and health facilities to improve children's immunization rates.

OUR THEORY OF CHANGE

Save the Children uses a four-part theory of change to achieve maximum impact in programs, to work at scale, to inform global thought leadership on issues affecting children and to leverage partnerships with the private sector, other nongovernmental organizations, governments, UN agencies, academia and institutional donors.²²

Here are examples of how we have used the theory of change as a catalyst for government uptake of iCCM:

- **Research:** In Nicaragua, our iCCM strategy, delivered in partnership with the Ministry of Health, has trained and equipped *brigadistas* to treat sick children with, for example, antibiotics for pneumonia, or to refer them to a health facility. Based on the results of our iCCM pilot program, Nicaragua expanded the iCCM strategy to Matagalpa and Jinotega, home to more than 1.3 million people, 18 percent of whom are children under 5.
- **Advocacy:** In Nicaragua, we worked with the Ministry of Health and the Pan American Health Organization, UNICEF and USAID to promote children's rights to good health. Integrated Community Case Management iCCM provided the first opportunity for many children who had not had curative health services to have a voice at the national level. We gained support to permit volunteer health care providers to deliver iCCM, and we also engaged more than 25 local and national organizations to advocate for health care for children in remote communities.
- **Partnerships:** Save the Children typically works collaboratively with governments and partners to implement iCCM both globally and at the country level. Locally, we work in partnership with Ministries of Health at the national, provincial and district levels to ensure lifesaving curative interventions are delivered through trained and supervised volunteers and CHWs in remote, rural communities lacking health facilities.
- **Scale-Up:** The CCM pilot in Nicaragua resulted in national iCCM health policy for all communities that are more than two hours away from a health post. Save the Children now supports the Ministry of Health in implementing iCCM in 175 communities in 32 districts across Nicaragua. In 2014, some 3,850 girls and boys under age 5 benefited from iCCM in Nicaragua. Among these children, 40 percent suffered from pneumonia, 17 percent from diarrhea and 9 percent from dysentery. *Brigadistas* successfully treated the vast majority of cases and referred only 2 percent of cases of severe child illness to health units. Through increased use of accessible, high-quality preventive and curative interventions, appropriate community structures and national policies, iCCM is reducing mortality among the most deprived children in Nicaragua.²³



Photo: Susan Warner

The Case for Investment

Over the past decade, there has been a great decrease in the number of children dying worldwide. While this is encouraging, the decline has been slow and uneven, stalling or even reversing in many countries, particularly in sub-Saharan Africa. While new preventive interventions will also help reduce mortality, prompt and effective treatment of pneumonia, diarrhea and malaria remains essential.

The delivery of health services is often weakest where the needs are greatest. Low coverage of the most needed interventions results in a significant unmet need for treatment of the three main child-killers. Although we have made remarkable progress with the iCCM programs we currently have in place, we still have substantial funding shortfall in 2018-2019.

By investing in iCCM, you are enabling us to continue to train and support CHWs so they can provide curative interventions and scale up lifesaving programs for children in the 23 countries around the world where we are implementing iCCM.

Your investment in Save the Children's iCCM programming could significantly increase our ability to ensure that no child dies of a preventable cause before his or her fifth birthday.

Improve our existing iCCM programming:

- **\$10 million** – will enable Save the Children to expand iCCM programs in three to four countries that are ready to be taken to a larger geographic scale. Some countries have developed national costed iCCM implementation plans, which require

partner support for scale-up. Other countries will first require additional technical support to conduct gap analyses to develop their national iCCM plans. The potential scale-up depends on the country size. In Nigeria, Save the Children would support iCCM scale-up in one of the 36 states, while in other countries Save the Children would support scale-up in multiple regions. Countries on the cusp of national scale include, the Democratic Republic of the Congo, Mozambique, Myanmar, Nicaragua, Nigeria and Zambia.

- **\$1 million** – will enable Save the Children to make a difference in a targeted country from the list above. Your funding will help train, supervise and support 60 CHWs and provide the equipment and supplies they need to treat 12,000 children under 5 suffering from pneumonia, diarrhea or malaria. This investment will train and support local CHWs, help families recognize signs of disease and seek prompt care, and ensure that ill children receive adequate and timely treatment.
- **\$100,000** – will help us supply 150 CHWs with mobile phones and provide training on mobile applications that will enable more accurate diagnoses of common childhood diseases. This investment will include initial application development, cell phones, airtime, training and any follow-up we provide.
- **\$10,000** – will allow us to train 25 CHWs and their supervisors and ensure they have the supplies they need to treat preventable diseases for five years.²⁴





Photo: Jordi Ruiz Cirera

Conclusion: Invest in Global Health for Children

Your investment in Save the Children's iCCM programs will yield powerful returns. It will ensure more children survive, live healthier lives and become better educated, which will lead to increased productivity from a healthier, more intelligent population and a reduction in the intergenerational transmission of poverty. This is an investment with the power and potential to yield transformative results for children – changing the course of their futures and ours.

“Wealth does not have to determine destiny. Past performance does not have to overshadow future potential. The child mortality curve can be bent.”

– Levels and Trends in Child Mortality Report, authored by UNICEF, WHO, World Bank and UN-DESA Population Division



Endnotes

- ¹ UN Inter-Agency Group for Child Mortality Estimation. *Levels & Trends in Child Mortality Report*. 2017.
- ² UNICEF. *Committing to Childhood Progress: A Promise Renewed Progress Report*. 2015.
- ³ UNICEF. *Committing to Childhood Progress: A Promise Renewed Progress Report*.
- ⁴ UN Inter-Agency Group for Child Mortality Estimation. *Levels & Trends in Child Mortality Report*. 2017.
- ⁵ UN Inter-Agency Group for Child Mortality Estimation. *Levels & Trends in Child Mortality Report*. 2015.
- ⁶ World Health Organization. *Strengthening Primary Health Care Through Community Health Workers: Investment Case and Financing Recommendations*. July 2015.
- ⁷ Young, M., et al. "World Health Organization/United Nations Children's Fund Joint Statement on Integrated Community Case Management: An Equity-Focused Strategy to Improve Access to Essential Treatment Services for Children." *The American Journal of Tropical Medicine and Hygiene*, 2012.
- ⁸ Young, M., et al. "World Health Organization/United Nations Children's Fund Joint Statement on Integrated Community Case Management: An Equity-Focused Strategy to Improve Access to Essential Treatment Services for Children." *The American Journal of Tropical Medicine and Hygiene*. 2012.
- ⁹ UNICEF and WHO. *The Integrated Global Action Plan for Pneumonia and Diarrhoea*. 2015.
- ^{10,11} World Health Organization. *Strengthening Primary Health Care Through Community Health Workers: Investment Case and Financing Recommendations*.
- ¹² Belli, P. C., Bustreo, F., & Preker, A. (2005). Investing in children's health: what are the economic benefits?. *Bulletin of the World Health Organization*, 83, 777-784.
- ¹³ Chanda, P., et al. "Relative Costs and Effectiveness of Treating Uncomplicated Malaria in Two Rural Districts in Zambia: Implications for Nationwide Scale-Up of Home-Based Management." *Malaria Journal*, 2011.
- ¹⁴ Sadruddin S, Shehzad S, Bari A, et al. Household Costs for Treatment of Severe Pneumonia in Pakistan. *The American Journal of Tropical Medicine and Hygiene*. 2012;87(5 Suppl):137-143. doi:10.4269/ajtmh.2012.12-0242.
- ^{15,16} World Health Organization. *Strengthening Primary Health Care Through Community Health Workers: Investment Case and Financing Recommendations*.
- ¹⁷ Young, M., et al. "World Health Organization/United Nations Children's Fund Joint Statement on Integrated Community Case Management: An Equity-Focused Strategy to Improve Access to Essential Treatment Services for Children." *The American Journal of Tropical Medicine and Hygiene*, 2012.
- ¹⁸ This number includes the benefits from our nutrition programming.
- ¹⁹ Save the Children Integrated Community Case Management presentation.
- ²⁰ Save the Children. *Presumptive Treatment of Fever Final Report*. 2013.
- ²¹ Rivera, Dixmeret et al. Integrated community case management (iCCM) of childhood infection saves lives in hard-to-reach communities in Nicaragua. *Revista Panamericana de Salud Pública*. 2017, v. 41, e66
- ²² Save the Children's theory of change is built upon four strategies: (1) to develop evidence-based, replicable solutions that can be implemented at scale, (2) to advocate and mobilize for better practices, programs and policies for children and to build commitment in donor and recipient countries for implementation at scale, (3) to support effective implementation of those practices, programs and policies that ensure impact for children at scale, and (4) to partner with communities, governments and others at local, national and global levels to create the will and ensure the actions necessary for lasting, positive change for children.
- ²³ Rivera, Dixmeret et al. Integrated community case management (iCCM) of childhood infection saves lives in hard-to-reach communities in Nicaragua. *Revista Panamericana de Salud Pública*. 2017, v. 41, e66.
- ²⁴ Information and estimates based on costs for one country, Mozambique, which can be quite expensive. Other countries may be able to make the money go farther.



Photo: Susan Warner



Photo: Jordi Ruiz Cirera

INVESTING FOR IMPACT



Save the Children®

Save the Children believes every child deserves a future.

In the United States and around the world, we work every day to give children a healthy start in life, the opportunity to learn and protection from harm. When crisis strikes, and children are most vulnerable, we are always among the first to respond and the last to leave. We ensure children's unique needs are met and their voices are heard. We deliver lasting results for millions of children, including those hardest to reach.

We do whatever it takes for children – every day and in times of crisis – transforming their lives and the future we share.

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