Evaluation of accelerated Child Survival and Development programme in West Africa

Summary of published research

UNICEF implemented the Accelerated Child Survival and Development (ACSD) programme in 11 West African countries between 2001 and 2005, to reduce child mortality by at least 25% by the end of 2006. Three packages of interventions were implemented: immunisation 'plus' (i.e. including vitamin A supplementation and distribution of insecticide treated nets (ITNs)), antenatal care and improved management of pneumonia, malaria and diarrhoea. Researchers from John Hopkins University undertook a retrospective evaluation of the programme in Benin, Ghana and Mali.

Data from Demographic Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) were used to compare changes in coverage for 14 ACSD interventions, nutritional status (stunting and wasting), and mortality in children younger than 5 years in the ACSD focus districts with those in the remainder of every country (comparison areas), after excluding major metropolitan areas.

The study found that mortality in children younger than 5 years decreased in ACSD areas by 13% in Benin, 20% in Ghana and 24% in Mali. However, these decreases were not greater than those in comparison areas in Benin or Mali. ACSD districts showed significantly greater increases in coverage for preventive interventions delivered through outreach and campaign strategies in Ghana and Mali than did comparison areas, but not in Benin. Coverage in ACSD areas for correct treatment of childhood pneumonia, diarrhoea, and malaria did not differ significantly from before to after programme implementation in Benin and Mali. However correct treatment decreased significantly in Ghana for malaria (from 78% to 53%, \( p < 0.0001 \)) and diarrhoea (from 39% to 28%, \( p = < 0.05 \)). No significant improvements in nutritional status attributable to ACSD were recorded in the three countries.

The authors concluded that the ACSD project did not accelerate child survival in Benin and Mali focus districts relative to comparison areas, probably because coverage for effective treatment interventions for malaria and pneumonia were not accelerated, causes of neonatal deaths and under-nutrition were not addressed, and stock shortages of ITN restricted the potential effect of this intervention. Changes in policy and nationwide programme strengthening may have benefited from inputs by UNICEF and other partners, making an acceleration effect in the ACSD focus districts difficult to capture.

The authors also stated that future programmes should learn from these results. Examples of steps to be taken include:

1. Active promotion of country policies supporting community case management for pneumonia and malaria and the incorporation of zinc into the management of diarrhoea.
2. Incorporation of simulation models to estimate potential lives saved into programme planning exercises nationally to ensure that decision makers have access to up to date information about local causes of child deaths and reliable evidence for intervention effectiveness
3. Definition and implementation of stronger compensation, motivation and supervision approaches for community-based workers, and
4. Strengthening the nutrition component of country programmes.

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