The “Child Survival Revolution”
- vertical programs

HServ 531
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Synonyms

Selective Primary Health Care  
(Walsh, Warren)

Child Survival  
(USAID)

GOBI-FFF  
(UNICEF)
  Growth monitoring
  Oral Rehydration Therapy
  Breast Feeding
  Immunizations

Family Planning
Female Literacy
Food
Selective Primary Health Care

**Rationale**
- PHC is great, but can’t afford it
- PHC requires political will that isn’t there
- PHC need immense organizational support

**Ideology of Cost-effectiveness**
- Establish priorities (Can’t do everything at once)
- Quick fix (short term goals)
- Trust in power of technology to address social & economical problems
Selective Primary Health Care

- Components of SPHC *(Walsh, Warren Model)*
  - Flexibility (fixed or mobile units)
  - Limited interventions of “proven efficacy”
    - Oral rehydration therapy
    - Immunizations
    - Breast feeding
    - Local disease control (malaria, schistosomiasis, tuberculosis)
Justification for 'selective' interventions - 1986

Estimated annual deaths of children under 5 by cause*, 1986

Diarrhoea 5.0 million (35.4%)

Measles 2.1 million (14.9%)

Other 1.3 million (9.2%)

Neonatal Tetanus 0.8 million (5.7%)

Pertussis (Whooping cough) 0.6 million (4.3%)

Other ARI** 1.3 million (9.2%)

Malaria 3.0 million (21.3%)

Estimated total annual child deaths: 14.1 million.

Notes: * For purposes of this chart, one cause of death has been allocated for each child death when, in fact, children die of multiple causes.
** Other acute respiratory infections (ARI): Tuberculosis, diphtheria, pneumonia, influenza, pleurisy, acute bronchitis and bronchiolitis, otitis media and other respiratory tract diseases.

Source: WHO and UNICEF estimates.
Estimated contribution of undernutrition to under-five mortality by cause, global, 2000

Sources:
For cause-specific mortality: EIP/WHO using 1999 data.
For deaths associated with malnutrition: Caulfield LE, Black RE. Malnutrition and the global burden of disease: underweight and cause-specific mortality. Paper in preparation; NOT FOR CITATION.
Child Survival Principles

1. Prioritize condition of most importance
   Focus on kids

2. Assess feasibility of interventions
   Consider intervention of “proven efficacy”
   ORT/Immunizations
   “Cost-effectiveness”

3. Postpone interventions that are either
   too expensive – Water/sanitation
   unproven efficacy-schisto/trypanomoiasis

4. Organizationally, consider mobile teams, campaigns, fixed units

5. Gradual, cost-effective way to achieve PHC
Primary Health Care Framework

- MCH Integrated Programs
  - Health Center
    - Health Post
      - CHW
      - CHW
      - CHW
    - Health Post
      - CHW
      - CHW
      - CHW
    - Health Post
      - CHW
      - CHW
      - CHW

Support:
- Managers and providers
- Referral systems
- Facility maintenance
- Lab, pharmacy systems
Child Survival Projects

Integrated MCH programs in MOH

Support
- Vaccination Campaigns
- Mobile Units
- Cold Chain

Immunizations
ORT
Health Education
Questions regarding child survival programs

1. Do Child Survival interventions reduce overall mortality in children under 5 years old?

2. Do they strengthen efforts to establish primary health care?

3. Do they address felt needs?

4. Do they facilitate community development?

5. Do they encourage reallocation of resources?
Fig. 1—Schematic representation of cumulative survival in an unvaccinated group (unbroken line) and vaccinated group (broken line) according to three hypotheses.
Fig. 2—Survival, by age, of the different groups.
Evolution of disease-specific (vertical) approaches – donor driven

- Family Planning (pre-Child Survival)
- ORT-Immunizations (Child Survival, Gobi) - 1979
- Vitamin A - 1983
- Maternal mortality, TBAs - 1986
- ALRI (Acute lower respiratory diseases) - 1986
- Polio eradication ~1990
- Malaria - Integrated management of childhood illnesses (IMCI) - 1990, 2000
- Tuberculosis ~1995
Underlying reasons for child survival

1. Results (rapid)
2. Efficiency
3. Application of new, appropriate technologies
Underlying reasons for child survival (1)

1. Results

- Donor agencies tired of big programs with little chance of measurable impact
- Need for short-term results (3-5 years)
- Funding cycle, tenure of administrations is also short
- Single outcome, measurable results (EPI vs water)
2. Efficiency

Change organizational structure to achieve measurable goals (e.g. immunization programs often work better outside of the usual MOH structure; cold chain, distribution, supervision can be more efficient if created for specific purposes)

Thus, there is a tendency for:

- Independent organizational structure (usually within MOH)
- Singular focus
- Mobile teams/campaigns
- CHWs (esp for ORT, mobilization for Immuniz)
- Central Planning (already have interventions in mind)
- LESS NEED FOR complex organization of PHC (e.g., training of mid-level health providers, distribution system, referral network, link with hospitals)
3. Application of new, appropriate technologies

- faith in capacity of vaccines, ORT
- less faith in organizational structure to cope with diseases
- magic bullet ideology
Ideological shifts

Public responsibility → Individual responsibility

Government health services → Government bureaucracy

Resource reallocation → Resource scarcity

Spending appropriateness (education vs. military) → Cost-effectiveness

Comprehensive & integrated interventions → Priority disease control

Broad ranging interventions → Interventions with low recurrent costs

Health systems focus → Community focus
Child Survival Strategies
Summary of Theoretical Problems

1. Validity of effectiveness assumptions - Shifting mortality
2. Cost-effectiveness approach - Undervalues externalities
3. PHC organizational structure ignored
4. Resource draw from PHC systems (money, people)
5. Inadequate response to “felt needs”
6. Depoliticized - low resistance, no reallocation
7. Feeds myth of resource scarcity
Child Survival & Health Reform (1985-present)

**Cost sharing**
- user fees, cost recovery
- Revolving drug funds
- Community control

**Decentralization**
- Financial accountability at provincial/district level
- Different mechanisms in each country
- Fewer total resources

**Health budgets**
- Half of 1980’s levels
  - Benin 9% - 4%
  - Mali 8% - 4%
  - Mozambique 11% - 3%
- Donor dependence
- Support of NGOs for health care

**Quality assurance**
- Mostly Donor driven

*PRIVATE SECTOR ROLE!*
Millennium Development Goals
United Nations 2000 (Alma-Ata revisited)

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria, other diseases
7. Ensure environmental sustainability
8. Develop a global partnership

Poor achievement in sub-Saharan Africa
Poverty reduction – some progress, but not in Africa
Primary education progress everywhere except Africa

Source: U.N.; World Bank staff estimates.
Gender equality in education is improving – except Africa
Africa lags behind in mortality reduction