

Resources for Child Health

REACH



A John Snow, Inc. project

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SUSTAINABILITY OF EPI: UTOPIA OR SURVIVAL?

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Before I start I would like to thank all colleagues who reviewed the successive drafts of this presentation.

A - INTRODUCTION

Today's topic is the sustainability of health programs and the members of this panel have been asked to share with you our thoughts on our specific technical areas and activities. Mine is EPI and EPI I shall therefore entertain you with.

I must begin by expressing my uneasiness with the way the issue of sustainability to date has been presented, discussed, handled in the literature or in meetings. For me the topic of sustainability of health services is a swamp, a marshy affair where every step is risky and where, at every corner, common sense assumptions and answers reveal themselves as will-o'-the-wisp-like deceptions. I have no answers and am no more enlightened than others. Then why am I here? Probably because I believe we should start asking the questions related to sustainability differently and expect to find one or two leads in the discussion following our papers.

I am convinced we should not rush into a discussion on the sustainability of EPI without first returning to a broader perspective, not even to sustainability of health services in general but indeed further back and question the sustainability of development itself and the nature of the relationship between North and South. Such an opposite use of the spy-glass offers, in my opinion, the only adequate perspective to understand such a specialized and "focused" topic in EPI.

The Book of Maccabees in the Bible teaches us that "it is a foolish thing to make a long prologue and to be short on the story itself". Let us start!

B - DEFINITION OF SUSTAINABILITY

You are all aware that the word sustainability does not exist (yet ?) in dictionaries. Sustainable does however. Three definitions of sustainability could provide a start.

1) A.I.D. Center for Development Information and Evaluation (CDIE) recent paper entitled "Sustainability of Development Programs: A Compendium of Donor Experience" suggests that "A development program is sustainable when it is able to deliver an appropriate level of benefits for an extended period of time AFTER (emphasis is mine) major financial, managerial, and technical assistance from an external donor is terminated".

2) The CCCD sustainability strategy document defines a sustained program as one "in which: a) health behavior and status improvements, as well as essential project activities, continue after the end of AID funding and technical assistance; and all local currency and some foreign exchange costs are assumed by governmental or private/personal sources (rather than by other donors) after AID funding ceases".

3) In a recent paper Dr. Carl Taylor proposes as a working definition "sustainability is the capacity to maintain service coverage at a level that will provide continuing control of a health problem."

These three definitions are examples among many others and I had to keep in check my gallic love of definitions not to confuse us further. You noticed that the first 2 definitions emphasized: the availability of resources; the limited duration of foreign external aid (in a context of they/us) and the responsibility of assisted countries to bear certain type of costs (whether local, recurrent, etc...); the last definition does not refer specifically to resources but suggests that a certain level of credibility is a pre-condition to sustainability.

C - BACKGROUND: OUR WORLD

Reading the 1988 World Development Report, the State of the World or the State of the World's Children provide us with grim but unavoidable facts. Although I leave to UNICEF the responsibility of their figures, let me quote the opening verses of "The State of the World Children 1989":

"For almost nine hundred million people, approximately one sixth of mankind, the march of human progress has now become a retreat. In many nations, development is being thrown into reverse. After decades of steady economic advance, large areas of the world are sliding back into poverty.

Throughout Africa and much of Latin America, average incomes have fallen by 10% to 25% in the 1980s. The average weight-for-age...is falling in many countries... In the 37 poorest nations, spending per head on health has been reduced by 50%, and

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education by 25% over the last few years... It can be estimated that at least half a million young children have died in the last 12 months as a result of the slowing down or the reversal of progress in the developing world.

It is happening because of the unfolding economic drama which the industrialized nations play a leading role in... It is spreading hardship and human misery on a scale and of a severity unprecedented in the post-war era... For most of the countries of Africa, Latin America, and the Caribbean, almost every economic signal points to the fact that development has been derailed. Per capita GNP has fallen, debt repayments have risen to quarter or more of all export earnings, share in world trade has dropped, and the productivity of labor has declined by one or two percentage points each year throughout the 1980s. Developing countries now transfer at least \$20 billion a year to wealthy nations, whereas in 1979 a net \$40 billion flowed from the northern hemisphere to the developing nations. The latter owe a total of \$1.2 trillion to foreign governments, banks, and development funds."

As a side note, I would like to add that, although it can be reasonably argued that because of the increased access to and use of efficient strategies like EPI, ORT, etc... a growing number of under five children deaths are avoided every year, we should keep in mind that, because of the demographic situation, the ABSOLUTE number of under five children dying every year worldwide has not changed for the last 20 years. The mortality rates have decreased but there are more and more children born every year.

The points I would like to make are that:

+ in the present context of impoverishment of the majority of the developing countries the issue of the sustainability of development is indeed vital to be addressed but not in terms of "passing the buck" from North to South countries.

+ because at national (but also at regional and probably at the global level) level the issues related to the sustainability of EPI are not specific of EPI but are interlocked with other issues related to health in general, the economic situation, the commoditization of agriculture and food products, social justice and the role of women in the society it is misleading to attempt a narrowly focused, pigeon-holed, technical reading of the sustainability of EPI.

+ Chernobyl, the degradation of the rain forest in our planet, Mexico defaulting on its debt, the problems of cocaine and heroin in the U.S. or in Pakistan, the cholera and the AIDS pandemic, the Bretton-Woods agreement, the variations in the value of the US dollar, UNICEF and WHO efforts towards UCI and Health for all, France and Canada considering the remittance of the external debt of francophone countries ... all of these examples point to a growing consciousness among nations that MORE AND MORE ISSUES

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ARE GLOBAL AND CANNOT BE SOLVED WITHIN NATIONAL BOUNDARIES ONLY. A DISTINCT FEATURE OF THE 20TH CENTURY IS THE ACCELERATION OF THE INTERDEPENDENCE BETWEEN COUNTRIES INDUCING THE ALLOCATION AND [B]MANAGEMENT OF RESOURCES AT A GLOBAL LEVEL. MORE AND MORE DECISIONS ON HOW A COUNTRY SHOULD RUN ITS ECONOMY, ITS POPULATION AND HEALTH PROGRAMS, ETC... IN ORDER TO PROMOTE A COMMON GOOD FOR BOTH ITS OWN CITIZENS AND ITS NEIGHBORS, ARE MADE WITH THE PARTICIPATION OF INTERNATIONAL AGENCIES. IT IS LOGICAL TO EXPECT THAT THE RESOURCES NEEDED AND THEIR SOURCES WILL BE IDENTIFIED ACCORDINGLY.

D - ISSUES IN SUSTAINABILITY

Many papers exist on sustainability and its possible solutions. It reminds me of the quote by Anton Chekhov in the "Cherry Orchard" "When a lot of remedies are suggested for a disease, it means it cannot be cured".

However the 15-year experience of USAID in implementing health projects has shed some light on several aspects which I would like to describe now.

It might be useful to distinguish between financial and managerial sustainability. Each aspect is subtly intricately with and sometimes dependent upon the other but they are nevertheless of a different nature.

I - FINANCIAL SUSTAINABILITY: SUMMARY OF AID EXPERIENCE IN THE SUSTAINABILITY OF EPI

Through the centrally-funded REACH Project which deals with EPI and Health Care Financing, AID has conducted several studies on the cost and cost-effectiveness of EPI as well of their sustainability. I would like to share with you a summary of the main findings of these studies.

A. The cost per fully immunized child of \$13.00 supports previously reported findings at the Bellagio Conference in 1984. This figure varies only slightly according to the particular strategy or region under consideration. Routine services through fixed facilities have the lowest cost per fully immunized child on average (\$11.74). Immunization campaigns have a higher cost per fully immunized child at \$15.62. However, the differences are small for these two strategies. An average figure of \$13 per fully immunized child could be used to approximate the cost EPI worldwide, regardless of approach used. However, because few cost-effectiveness studies have used similar methods for calculating costs and, more importantly, effectiveness of EPI, this estimate of cost per child should be verified with information from future studies utilizing similar methods.

B. The contributions of national governments to immunization programs, approximately 50% of total program cost, is lower than generally expected. For routine services through fixed facilities, the proportion of government contribution is greatest at 55% of total; this proportion diminishes to 40% for campaign strategies. In addition, government contributions to the EPI tend to be in the form of salaries for health workers, building depreciation costs and, in some instances, transport costs. However, the bulk of EPI

costs, particularly those which require foreign exchange such as vaccines, syringes, cold chain equipment[B, vehicles, and even local training costs, are being borne by international organizations and outside donor agencies. The study found that countries with lower GNP/capita make less of a contribution to the EPI from government resources.

C. The larger the population reached by EPI, the larger the cost per child and therefore the total program cost. This relationship supports earlier impressions and has implications for the ability of highly populated countries (Nigeria, Indonesia, for instance) to finance a national EPI at high coverage levels. The results from Mauritania, showing a cost-effectiveness ratio for the national campaign nearly half that of the campaigns in Cameroon and Senegal, support this finding as well.

D. To maintain EPI at the 1987 coverage level will require, on average, 2% of the G.D.P. in Latin America, 5% in Asia and 11% in Africa.

E. Sustaining immunization programs and strategies using only government resources will be difficult in some countries, particularly when government health expenditures are low. It was expressed at the Bellagio Conference in 1984 that the implementation of the EPI cannot occur without the continued high commitment of international donor organizations.

E - COST RECOVERY

The Alma-Ata emphasis on community participation in Primary Health Care has been quickly interpreted in some quarters as meaning the introduction or raising of user fees. User fees are often justified on ideological grounds (emphasis on the private sector) or on the genuine belief that people are willing and able to pay for health services. A review of the literature by Richard Yoder published in the latest issue of Social Science and Medicine concluded that the few available studies are surprisingly rather inconclusive. In his own study in Swaziland of the impact of increased fees on overall patient use of health services, on type of services affected, and on health service utilization by higher paying and lower paying groups, Yoder showed: (overhead) and found that the reduction in the use of services was higher in the lower income groups.

More studies are needed to explore scientifically the revenue generating potential of essential drugs; and community insurance scheme like the Savar Project in Bangladesh in which people are charged according to their economic status. Of interest is the impressive example of the Christian Medical College Hospital in Vellore (India) which is financially auto-sufficient and where, nevertheless, indigent patients are treated free of charge.

One of the 4 strategies of the A.I.D. being the conservation of resources, let us now turn to managerial sustainability, i.e. what can we do with what we have, how can we better manage the already available resources?

II - MANAGERIAL SUSTAINABILITY

1. OBTAIN COMMITMENT FROM NATIONALS

Political will and support is the sine qua non condition for the implementation and continuity of programs as demonstrated in several socialist countries and in the preparation of National Vaccination days in Turkey.

The more open and participatory the negotiations between the national government and donors at the beginning of the program, the stronger the commitment. When Government officials feel that the priority, the content, the design of a program have been imposed, that a project is a donor project, their sense of ownership decreases rapidly.

Addressing the issue of the sustainability of outcomes from the very beginning of a program is crucial. To bolster commitment several strategies have been suggested by different authors of review papers on sustainability of health programs:

- + maintain contact with a BROAD spectrum of political leaders and potential leaders. As we all know, leadership changes and health projects must not be associated in the eyes of the public with a particular political faction.
- + make leaders aware of public demand for services and that it is politically astute to satisfy it.
- + encourage the media to report successes and lessons learned.
- + create large networks of public support for immunization.
- + pay special attention to the health staff. Health staff are generally a neglected group in our interventions. In fact they are the backbone of programs. Too often, instead of being agents of change and crusaders, the health staff, particularly doctors, are vocal critics of Child Survival interventions.

2. PLAN LONG TERM INVOLVEMENT AND ADDRESS SUSTAINABILITY FROM BEGINNING

Sustainable programs need a context of stable bilateral political relationship. National MOH need to know that they will be partners in development for many years and that they are building for the future. Such a perception induces a positive frame of mind which fosters compromises, commitment, etc... The example of marriage comes naturally to mind. The continuity of the relationship and of the donor community's commitment is of concern to political leaders, not unwisely when they look at the volatility of health fads in the past. Family planning provides a clear example where international concerns stimulated national action but continuity has been difficult to maintain.

A review of 52 AID-supported projects found that a condition (not a guarantee) of sustainability was that projects should be launched for a minimum of 10 years and that the issue of sustainability should be addressed from the very beginning of the project (at the feasibility phase) sustainability should be specifically spelled out as an outcome of the project: an implementation plan with phases and benchmarks should be prepared early and monitored during the length of the project.

3. DECENTRALIZE ACTIVITIES

Ability to make decisions, plan, supervise and have a sense of ownership by mid- or local-level managers is a significant factor of sustainability. The example of Zaire's health zones is full of lessons. However, in many countries decentralization has historically often been used to strengthen the control of the central government on people at the periphery (particularly minorities) or to pass on to them the economic burden of supporting financially expenses previously paid for by the central government.

4. IMPROVE EFFECTIVENESS OF AVAILABLE RESOURCES

In a world of shrinking resources, proper management of what is already available is essential. This entails a reallocation of resources within a national budget which is a symbol of the government's political commitment. Within the health budget, resources should be reallocated to promote social justice and cost-effective interventions. On a more realistic level, better management could improve the majority of health programs which are presently plagued with severe deficiencies at all levels:

+ staff: ghost staff, absenteeism, lack of supervision, lack of career structure in public health, low morale, no training incentive with emphasis on competence, ... Human resources have always appeared to us as the best possible sustainable investment a country can make.

+ lack of maintenance of equipment: no inventory, no spare parts, no qualified mechanics, no petty cash for regular maintenance, competition of donors among themselves leading to the experience that it is easier to buy a new car than to maintain the one you have.

Integration of various survival strategies (MCH, EPI, CDD, etc...) would seem to be a logical choice in the name of cost-effectiveness and sustainability. It seldom happens though! Meanwhile vertical programs or Selective Primary Health Care projects keep going in the name of their apparent efficacy, defeating the longer term prospect of their sustainability.

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F - Conclusion

It is time to conclude. My conviction is that the prevention of childhood diseases by available technology is an unavoidable moral imperative. Fortunately its cost is relatively inexpensive, compare to the cost of morbidity to society. The fact that the implementation and maintenance of public health programs seems to be still beyond the reach of many national budgets implies that priorities should be reassessed: national priorities within national budgets and priorities in the economic relationship between North and South. In the century of the abolishment of national borders within the European Economic Community, the worldwide Smallpox Eradication, Universal Childhood Immunization, the goal of Polio Eradication, etc... it is time to continue to think in terms of the GLOBAL mobilization of resources to achieve global public health goals. If individuals or countries cannot finance or sustain their access to preventive or public health programs, then the community (and in our case the global community) which is benefiting as much as the individuals from the success of Immunization programs must bear the greater burden of its costs. The welfare of a billion of already existing children is at stake and is worth us giving serious consideration to the thought that "the world was not left to us by our parents but was lent to us by our children".

Thank you for your attention.

A.I.D. CENTER FOR DEVELOPMENT INFORMATION AND EVALUATION
(CDIE) RECENT PAPER ENTITLED "SUSTAINABILITY OF DEVELOPMENT
PROGRAMS: A COMPENDIUM OF DONOR EXPERIENCE" SUGGESTS THAT "A
DEVELOPMENT PROGRAM IS SUSTAINABLE WHEN IT IS ABLE TO DELIVER AN
APPROPRIATE LEVEL OF BENEFITS FOR AN EXTENDED PERIOD OF TIME
AFTER (EMPHASIS IS MINE) MAJOR FINANCIAL, MANAGERIAL, AND
TECHNICAL ASSISTANCE FROM AN EXTERNAL DONOR IS TERMINATED".

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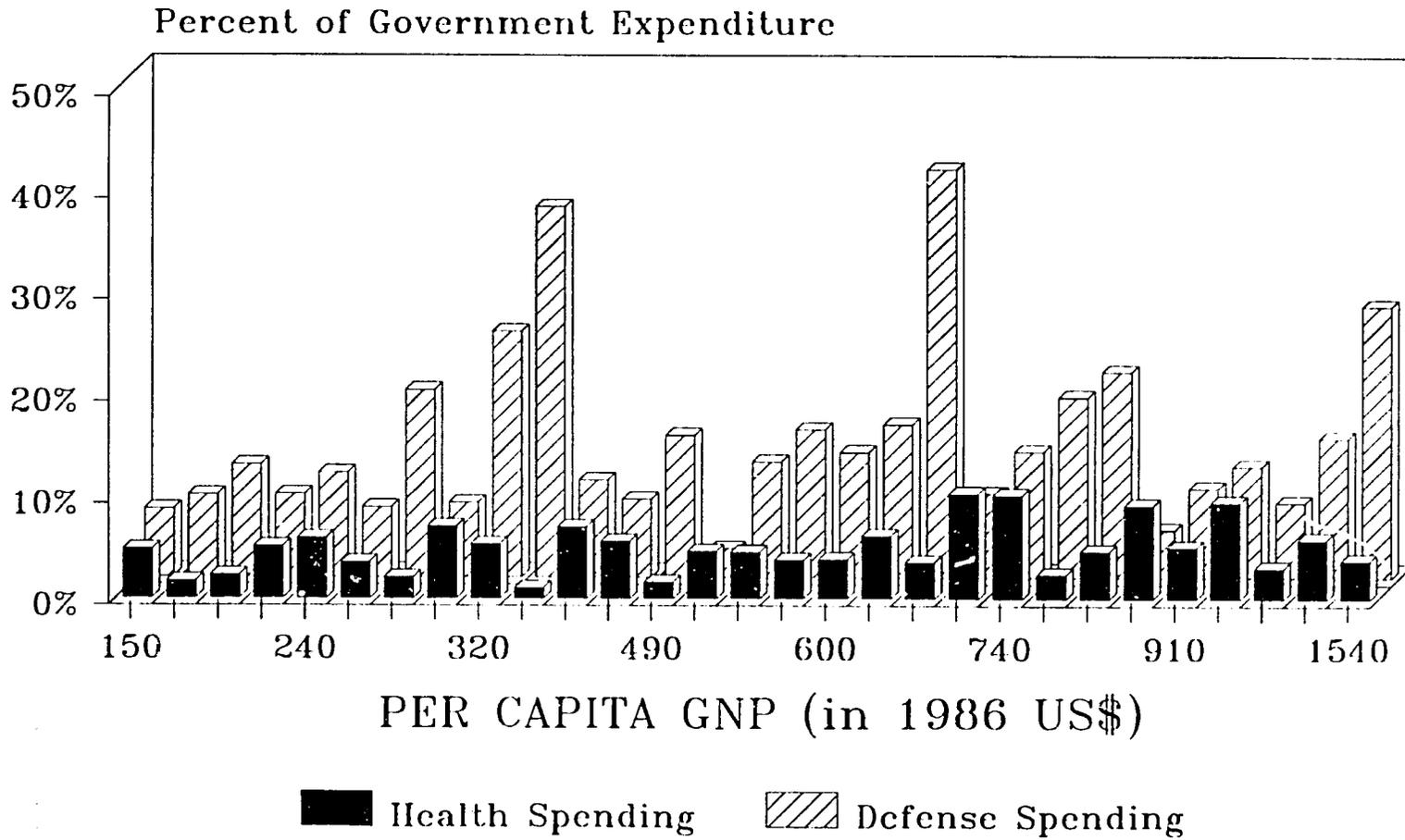
THE CCCD SUSTAINABILITY STRATEGY DOCUMENT DEFINES A SUSTAINED PROGRAM AS ONE "IN WHICH: A) HEALTH BEHAVIOR AND STATUS IMPROVEMENTS, AS WELL AS ESSENTIAL PROJECT ACTIVITIES, CONTINUE AFTER THE END OF AID FUNDING AND TECHNICAL ASSISTANCE; AND ALL LOCAL CURRENCY AND SOME FOREIGN EXCHANGE COSTS ARE ASSUMED BY GOVERNMENTAL OR PRIVATE/PERSONAL SOURCES (RATHER THAN BY OTHER DONORS) AFTER AID FUNDING CEASES."

IN A RECENT PAPER DR. CARL TAYLOR PROPOSES AS A WORKING
DEFINITION "SUSTAINABILITY IS THE CAPACITY TO MAINTAIN SERVICE
COVERAGE AT A LEVEL THAT WILL PROVIDE CONTINUING CONTROL OF A
HEALTH PROBLEM."

"FOR ALMOST NINE HUNDRED MILLION PEOPLE, APPROXIMATELY ONE SIXTH OF MANKIND, THE MARCH OF HUMAN PROGRESS HAS NOW BECOME A RETREAT. IN MANY NATIONS, DEVELOPMENT IS BEING THROWN INTO REVERSE. AFTER DECADES OF STEADY ECONOMIC ADVANCE, LARGE AREAS OF THE WORLD ARE SLIDING BACK INTO POVERTY. THROUGHOUT AFRICA AND MUCH OF LATIN AMERICA, AVERAGE INCOMES HAVE FALLEN BY 10% TO 25% IN THE 1980S. THE AVERAGE WEIGHT-FOR-AGE...IS FALLING IN MANY COUNTRIES... IN THE 37 POOREST NATIONS, SPENDING PER HEAD ON HEALTH HAS BEEN REDUCED BY 50%, AND EDUCATION BY 25% OVER THE LAST FEW YEARS... IT CAN BE ESTIMATED THAT AT LEAST HALF A MILLION YOUNG CHILDREN HAVE DIED IN THE LAST 12 MONTHS AS A RESULT OF THE SLOWING DOWN OR THE REVERSAL OF PROGRESS IN THE DEVELOPING WORLD.

"IT IS HAPPENING BECAUSE OF THE UNFOLDING ECONOMIC DRAMA WHICH THE INDUSTRIALIZED NATIONS PLAY A LEADING ROLE...IT IS SPREADING HARDSHIP AND HUMAN MISERY ON A SCALE AND OF A SEVERITY UNPRECEDENTED IN THE POST-WAR ERA... FOR MOST OF THE COUNTRIES OF AFRICA, LATIN AMERICA, AND THE CARIBBEAN, ALMOST EVERY ECONOMIC SIGNAL POINTS TO THE FACT THAT DEVELOPMENT HAS BEEN DERAILED. PER CAPITA GNP HAS FALLEN, DEBT REPAYMENTS HAVE RISEN TO QUARTER OR MORE OF ALL EXPORT EARNINGS, SHARE IN WORLD TRADE HAS DROPPED, AND THE PRODUCTIVITY OF LABOR HAS DECLINED BY ONE OR TWO PERCENTAGE POINTS EACH YEAR THROUGHOUT THE 1980S. DEVELOPING COUNTRIES NOW TRANSFER AT LEAST \$20 BILLION A YEAR TO WEALTHY NATIONS, WHEREAS IN 1979 A NET \$40 BILLION FLOWED FROM THE NORTHERN HEMISPHERE TO THE DEVELOPING NATIONS. THE LATTER OWE A TOTAL OF \$1.2 TRILLION TO FOREIGN GOVERNMENTS, BANKS, AND DEVELOPMENT FUNDS."

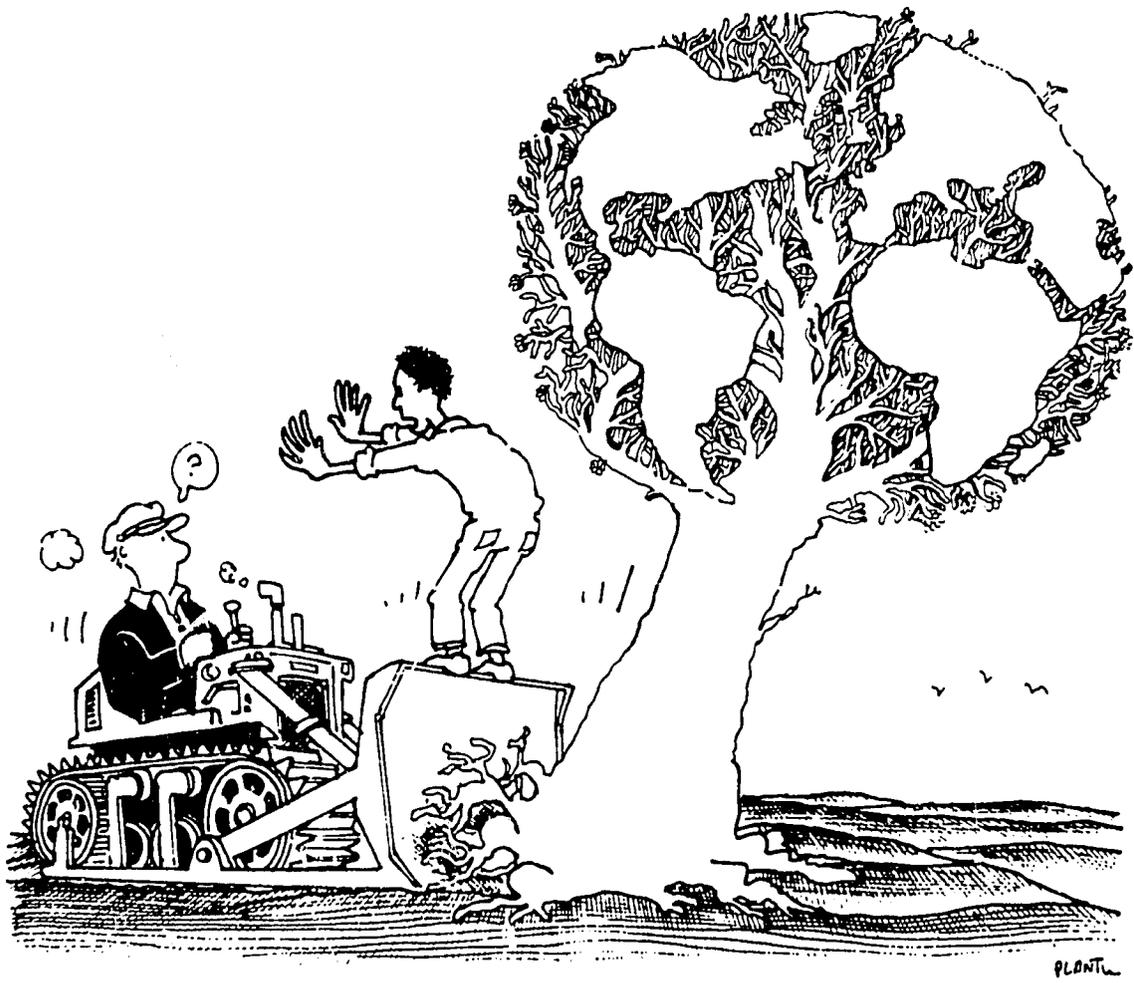
PRIORITIES AS INDICATED
 BY RELATIVE RESOURCE ALLOCATION
 IN CHILD SURVIVAL COUNTRIES

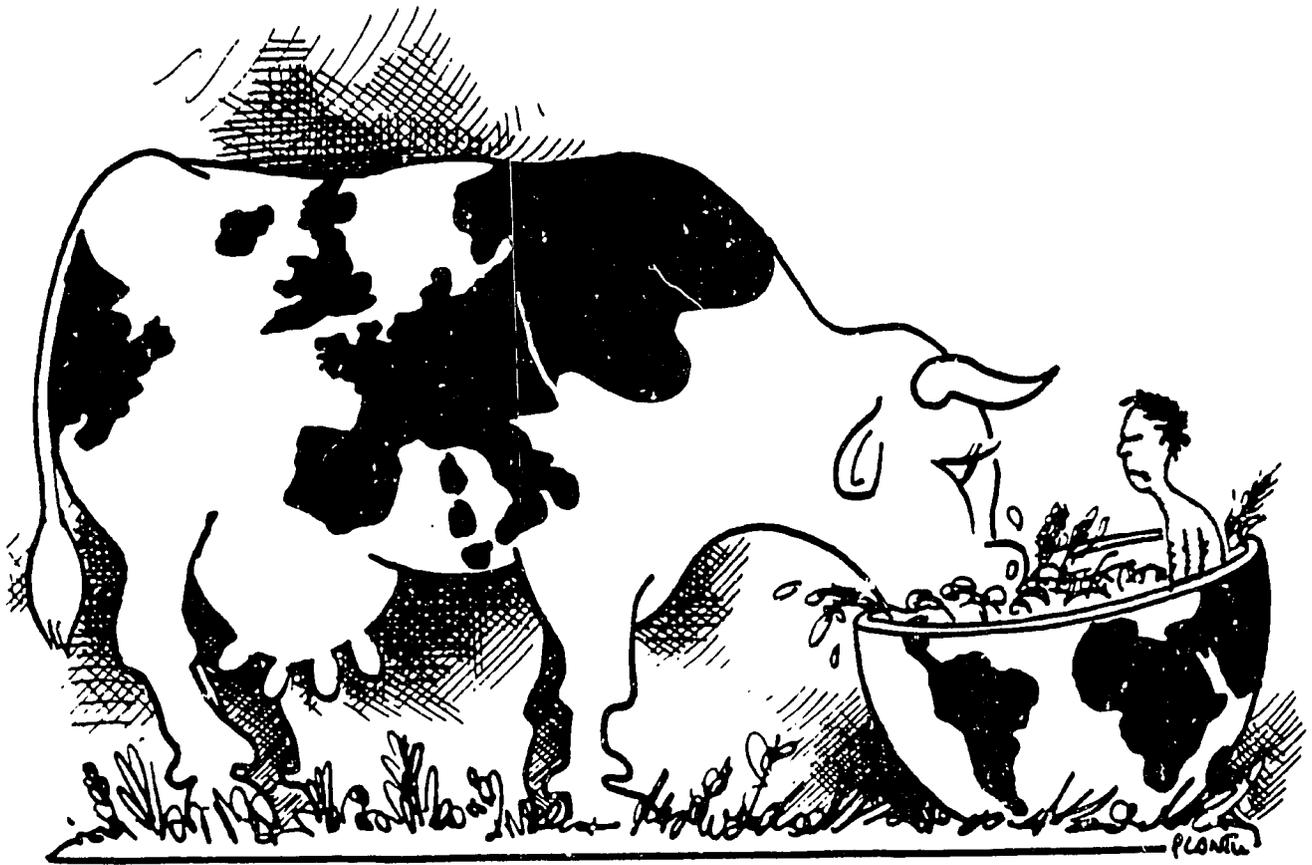


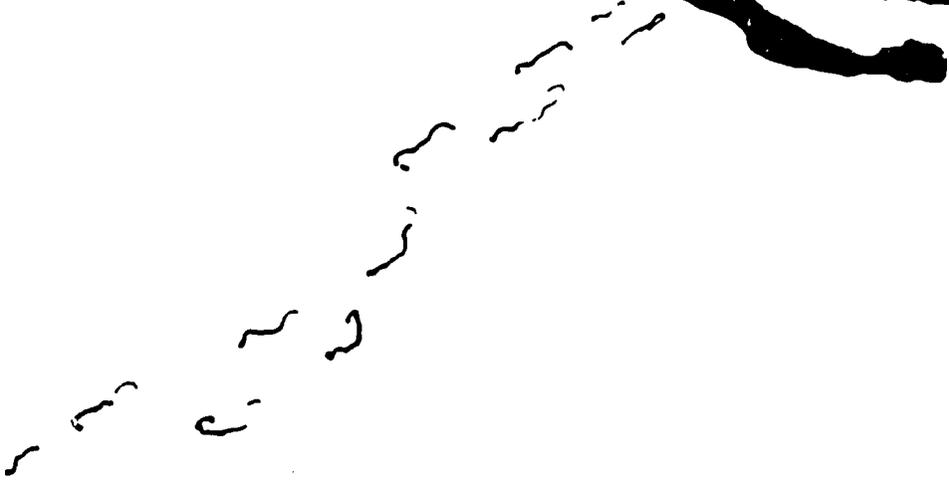
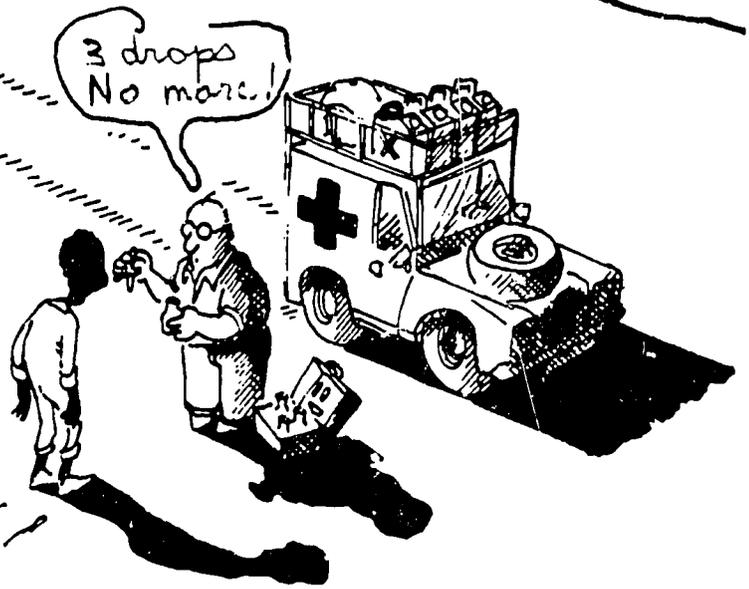
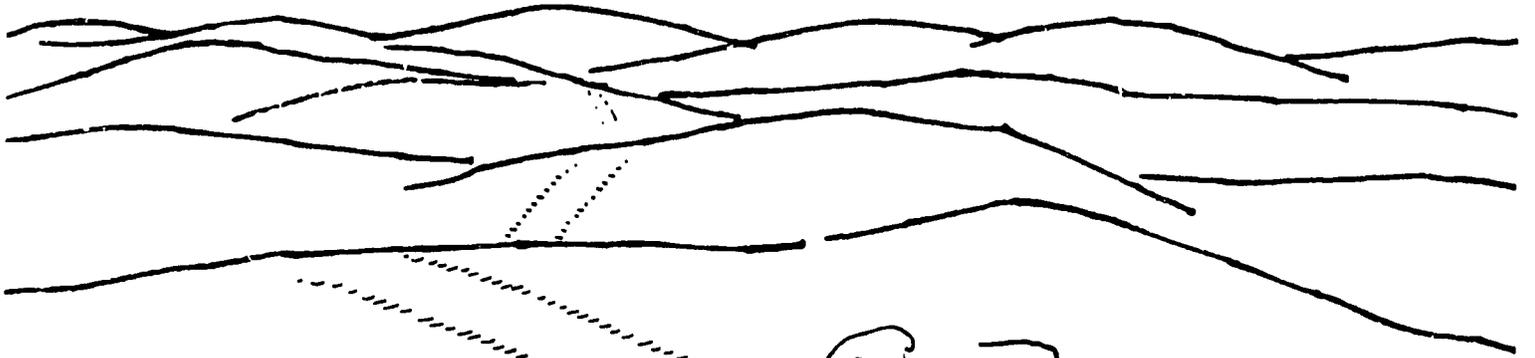
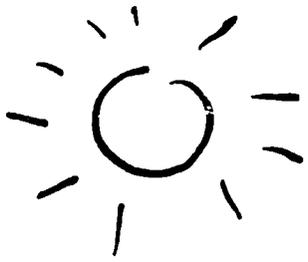
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IMMUNIZATION OR DISEASE TREATED	GOVERNMENT	MISSION	GOVERNMENT & MISSION
	% CHANGE	% CHANGE	% CHANGE
BCG IMMUNIZATION	-25.6	-11.2	-16.4
DPT 1 IMMUNIZATION	-37.6	5.1	-18.7
DIARRHEA AGE < 5	-41.2	-8.6	-24.4
DIARRHEA AGE > 5	-45.5	-12.2	-32.1
STD	-39.6	3	-21.8
RESPIRATORY DIS.	-43.7	.8	-20.6
MUSCULOSKELETAL DIS.	-46.6	32.6	-1.2
TOTALS	-41.6	-1	-21.2

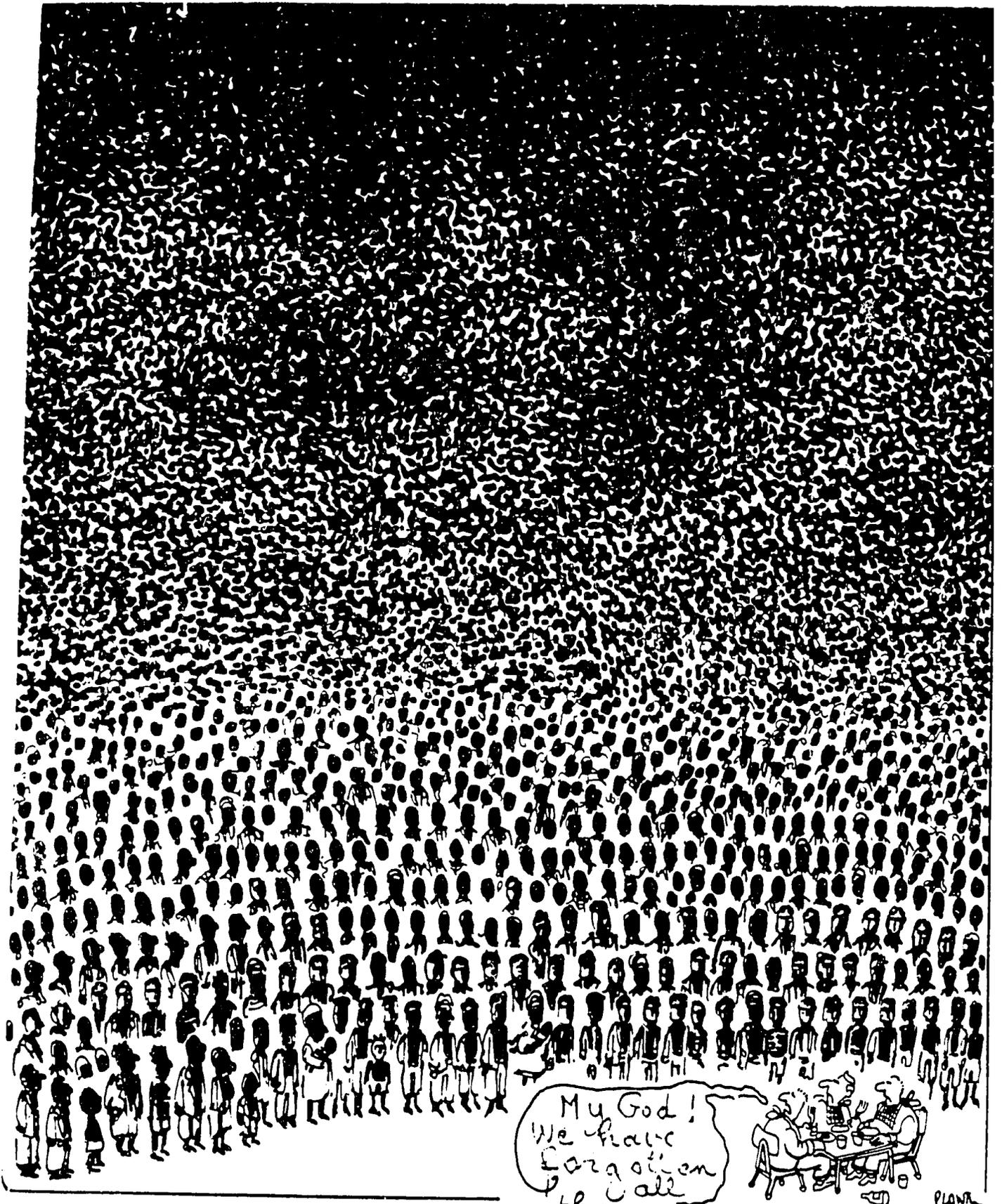
CHANGES IN MONTHLY AVERAGE ATTENDANCE BEFORE AND AFTER CHANGES IN
FEES STRUCTURE BY SECTOR AND SELECTED IMMUNIZATION AND DISEASES
From R. Yoder Soc Sci Med Vol 29, no 1, pp 35-42, 1989











My God!
We have
forgotten
all
these -

PLANT

Managerial Sustainability

Committment
Long-term
Decentralize
Effectiveness

Financial Sustainability

**Cost per F.I.
Contributions
Global Costs
Foreign Exchange
Cost-recovery**