



CHILD SURVIVAL

USAID's Child Survival Program has helped expand the coverage of primary health care services to mothers and children and has contributed to major reductions in infant and child mortality in USAID-assisted countries. Progress toward making child survival service improvements sustainable has been less encouraging. The Agency's management of the program has been a good example of "managing for results." Future USAID efforts should give greater emphasis to strengthening local institutional capacities and to planning for financial sustainability of health services delivery systems.

Background

USAID initiated its Child Survival Program in 1985 to join with other donors and international agencies in reducing the very high child mortality rates in developing countries. Working most intensively in 22 "emphasis countries," USAID has used simple, low-cost primary health care interventions targeted at mothers and children—e.g., immunizations, oral rehydration therapy, breastfeeding, and child-spacing—to reduce infant mortality rates and, simultaneously, to strengthen primary health care delivery systems. Between 1985 and 1992, the Agency committed \$1.56 billion to the worldwide program.

In 1993, USAID's Center for Development Information and Evaluation (CDIE) prepared a synthesis report of separate field evaluations of the Agency's child survival activities in six emphasis countries—Bolivia, Egypt, Haiti, Indonesia, Malawi, and Morocco—selected to be representative of USAID efforts worldwide. The CDIE report, *USAID's Child Survival Program: A Synthesis of Findings From Six Country Case Studies* (October 1993), is the basis for this summary.

Findings

- **Many health interventions were successful.** USAID's Child Survival Program has achieved quick results in many countries, rapidly expanding the coverage of basic health care services for needy mothers and children. In the 22 emphasis countries, for example:

- Infant mortality rates fell by an average of 10 percent, from 97 deaths per thousand live births in 1985 to 87 per thousand in 1991. (Although this decrease in mortality rates could not be attributed with precision to USAID assistance in particular, it was clear from several different kinds of evidence that USAID's contribution had made a substantial difference.)

- DPT3 vaccination coverage for children aged 12 to 23 months rose from 39 percent in 1985 to 67 percent in 1991, and measles coverage more than doubled from 24 to 60 percent.

- Family planning to reduce high-risk births, promotion of breastfeeding, and attention to localized child-killing diseases are other child survival interventions that were found to be successful, based on the six country case studies.

- **Others were less successful.**

- Oral rehydration therapy (ORT) to control infant deaths from diarrhea has been effective where adequately supported with educational and logistical services.

- Combatting acute respiratory infections (ARI) and malnutrition has proven difficult and expensive, but research and experience are leading to more effective services.

- Infrastructure for water and sanitation has proven to be too expensive to achieve widespread impact with USAID's relatively limited capital resources.

- **Sustainability is moving slowly.** USAID's work to strengthen health care institutions and to promote financial sustainability of services has been uneven, with some notable successes along with some serious problems and neglect.

- In several countries, USAID helped develop innovative low-cost institutional mechanisms to deliver basic lifesaving health services to mothers and children.

- In Bolivia, USAID led breakthrough efforts to bring child survival services closer to financial self-sustainability through fee-for-service arrangements and a large endowment fund for PVO providers.

- In some countries, USAID had difficulty extricating itself from providing continued heavy support for service delivery, and the Agency's lack of commensurate attention to institutional development and financial sustainability had resulted in large national health services that could not sustain themselves.

Heavy support from donors, including USAID, for child survival has created serious donor dependency in many countries. Thus, gains made in increasing the coverage of health services and reducing infant mortality could be jeopardized if future assistance does not give *more* attention to strengthening local institutional capacity and financial sustainability.

• **USAID management has been effective.** The Agency's Child Survival program strategy of concentrating resources in emphasis countries has led to greater impact than would otherwise have been possible. Use of private sector organizations and effective donor coordination have strengthened the program. USAID's practice of programming budgetary resources for specific measurable health impacts and annual tracking and reporting are a good example of "managing for results." However, the Agency's professional health staff has been stretched very thin managing such a large program.

Recommendations

• **Update USAID's Child Survival Strategy** to clarify objectives, phase-out criteria, "emphasis country" selection, guidelines for country strategy development, staffing practices, and overall program emphases.

• **Select specific health interventions at the country level according to their potential for producing further reductions in infant and child mortality at low cost.** Interventions selected for support should be limited in number, suitable for national-scale implementation, and (in the long run) sustainable without permanent USAID support. Overall, with regard to specific interventions, USAID should:

- Provide support for immunizations even in countries where other organizations have historically taken the lead.

- Strengthen logistical, education/training, and communications support services and institutional linkages for oral rehydration therapy ORT programs, and raise the priority of ORT in the Agency's Child Survival policy and strategy.

- Feature family planning to reduce high risk births in USAID Child Survival programs, and encourage greater coordination between health and population programs at all levels.

- Avoid providing financial support for water and sanitation infrastructure from child survival resources. Encourage other donor financing of infrastructure, with USAID providing support services such as education, promotion, and community mobilization.

- Increase emphasis on Vitamin A supplementation and exclusive breastfeeding. Support other nutrition interventions in specific country programs if evaluations show they are cost-effective.

- Support research and development of more cost-effective interventions for acute respiratory infections.

• **Provide country program assistance in three activity areas—health services for mothers and children, institutional strengthening, and financial sustainability.** Generally, in countries where infant mortality rates are high, coverage of health services deficient, and other donor resources inadequate, USAID should initially emphasize health services. Subsequently, as coverage of health services increases to acceptable levels, USAID's emphasis can shift to institutional strengthening activities. Finally, as health services for mothers and children and the local institutional base are consolidated, USAID emphasis can be shifted to promoting permanent financial sustainability. From the outset in all countries, however, USAID should pay attention to institutional capacity and financial sustainability issues.

• **Give greater emphasis programwide to the strengthening of LDC institutional capacities and to planning for the financial sustainability of health services delivery systems.**

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