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**Child Survival in Africa  
Africa Bureau R4 FY 2000 Wrap-Up  
June 1998**

**I Health in Africa A Sector in Transition**

The health sector in Africa can be characterized by ongoing structural and conceptual changes

Health Sector Reform  
Decentralization  
Health Care Financing  
Personnel Reform

Sector Wide Approaches  
New Donor Partnerships  
African Ownership  
Public/Private Partnerships  
New Initiatives for Polio Eradication and Infectious Diseases

These reforms and changes are being actively supported by many countries and donors. The most significant change affecting health programs recently is decentralization, which is rapidly occurring throughout Africa. Approximately seven USAID-assisted countries are actively decentralizing the public provision of health services, four are decentralizing to a lesser extent and four more are planning for decentralization. USAID is assisting with the transition to decentralized health services by supporting technical assistance to help countries plan and by disseminating approaches (WHO study funded by AFR/SD) to influence decentralization strategies throughout the region.

This past year has demonstrated mixed effects of decentralization reforms on health status and programs. Most significantly, some countries are showing declining health status indicators concurrent with decentralization reform (Zambia). Among other problems occurring are delays in data collection and reporting disruptions due to unclear allocation of responsibilities, lack of resources, and skills transfer to decentralized levels.

USAID will continue to monitor the effects of decentralization reforms, assist with planning, provide technical assistance to countries, and participate in Sector Wide Approaches (SWAP) discussions.

**II Child Mortality Progress and Challenges**

Reductions in child mortality continue but at a slower rate. A better understanding is emerging of why the rate of decline is slower in Africa than in other regions and slower than was originally projected almost 15 years ago when the child survival movement began. The major contributors

to under five mortality (measles, malaria, acute respiratory infections, malnutrition diarrheal diseases and high birth rates) are currently being addressed in a number of programs

However, in Africa HIV/AIDS is having an impact on infant and child mortality in ways that are only now beginning to surface. In some countries, the trend of decreasing child mortality has been slowed as a result of HIV infection associated with vertical transmission between mother and child. The implications are that in high HIV prevalence areas, further gains in child survival will be difficult to achieve unless we address the issue of mother to child transmission as well as continuing to focus on HIV prevention as an important part of a child survival strategy.

In addition to the biological and social impact of HIV/AIDS on children and their families, the diminishing gains in child survival illustrated in this presentation are also caused by inadequacies in health systems and the widespread emergence of antimicrobial drug resistance. All three of these factors must be addressed as we strive for further reductions in child mortality. Adequate and responsive health systems must be ensured and equipped with effective therapeutic agents and strategies for combatting childhood illness, and interventions to diminish the impact of HIV/AIDS on child health must be sought, tested, and implemented. A focus on health systems, antimicrobial resistance, or HIV alone is not likely to produce measurable impact on child survival in Africa.

**Progress** is nevertheless being made in several areas affecting child mortality

- *Vaccine-preventable diseases* are being addressed through increases in immunization coverage. Immunization coverage levels are slowly increasing across countries in a sustainable manner. This is being achieved with our partners WHO/AFRO and UNICEF. According to a recent evaluation of a USAID grant to UNICEF, immunization coverage declines have been halted in Africa, 14 out of 18 grant recipient countries have increased their immunization coverage levels, 12 of these countries have a line item in their national budget for vaccines, and 13 countries have functional inter-agency coordinating committees.
- USAID is also supporting the *Polio Eradication Initiative* in the region and in 1997, 31 out of 41 countries have held successful National Immunization Days (NIDs) resulting in high vaccination rates. Reported cases of clinical polio have been steadily decreasing. In 1996, 1,949 clinical polio cases were reported and confirmed in the Africa Region, which is a 10% decrease compared to the 1995 reported cases. As of November 1997, 35 cases had been confirmed.
- In the Africa Region USAID supports significant efforts to strengthen *malaria control* programs at district and national levels. Our understanding of malaria has improved and we have learned that treatment and prevention strategies for malaria that are targeted only to facilities will not succeed without simultaneous

development of community-based strategies. Studies have found that 70-80% of fevers are treated initially at home and the majority of children who die from malaria were never taken to a health facility. Insecticide-treated materials -- i.e., bednets-- have been demonstrated to be the most sustainable and effective means for the prevention of malaria. Antimalarial drug resistance, however, is complicating advances in malaria prevention and control and needs to be monitored closely.

- According to recent Demographic and Health Surveys, *malnutrition* appears to be increasing in a number of countries. To better address the complex and critical role nutrition plays in child morbidity and mortality, USAID missions are incorporating nutrition more directly in their child survival strategies.

### III R4 Highlights

**Benin** Through a grant to the Family Health and AIDS/West and Central Africa program (FHA/WCA), USAID/Benin provided support to PSI to expand its social marketing activities to the three northern regions of Benin and thus increase access to oral rehydration salts (ORS) as well as condoms. Four hundred sixty-three (463) new points of condom and/or ORS sales were established and a total of 1,748,010 ORS packets were distributed (a 33% increase from 1996). A total of about 1,500 community-based distributors were trained or retrained to distribute ORS as well as family planning commodities, 23 ORT/ORS training workshops were conducted with 657 participants.

**Eritrea** According to UNICEF statistics, the percentage of children 12-23 months of age who are fully vaccinated, increased from 41% in 1995 to 55% in 1997. As a result of USAID-supported initiation of salt iodization in the major salt works in Assab and Massawa, nearly 95% of all salt produced is iodized. The availability of iodized salt has increased markedly with approximately 30% of retail outlets in the USAID/MOH target zones selling domestically produced salt, up from zero in 1995. Impressive progress was made in the policy area, including the development of the Quality Assurance Policy, guidelines for decentralized planning, the National Primary Health Care Policy Guidelines, the National Drug Policy, and the National Standard Treatment Guidelines.

**Ethiopia** Vaccination coverage targets for DPT and measles were exceeded in 1997. Immunization coverage for DPT went from 59.7% in 1996 to 80.4% in 1997. Measles immunization coverage increased from 45.7% in 1996 to 61% in 1997. The National Immunization Days for polio resulted in 83% coverage in the first round and 100% coverage in the second round.

Following USAID/Ethiopia's NPA conditionality, budgetary allocations to health have continued to increase over the last two years, by about \$25 million. Moreover, there has been a shift in the composition of the national budget in favor of health from 3% in 1992 to 6.3% in 1998. Within

the health budget, there has been a shift in favor of PPHC from 43% in 1993 to 52% in 1998. This has meant an 11% annual increase over the last three years of resources allocated to family planning services pre- and post-natal care and delivery, ORT, ARI management, malaria treatment, immunizations, STD/HIV/AIDS control and infant nutrition. Furthermore, the HSDP now under design clearly indicates the government's commitment to increase resources to PPHC.

**Kenya** USAID/Kenya exceeded its target to facilitate development of two GOK multi-year plans. First, a Sessional Paper on AIDS in Kenya was passed by Parliament in 1997, Second, a Health Reform Secretariat workplan was developed, providing the basis for guiding the reform process and Third, a malaria policy paper was completed by the Government of Kenya (GOK) and work on guidelines for treatment started. A result is that in chloroquine-resistant areas, such as Bungoma District (where over 80% of malaria cases are not treatable by chloroquine), sulphur-based antimalarials are now the first-line drugs for malaria treatment. These policy formulations and strategic planning instruments are critical tools to heighten donor confidence and willingness to invest in the sector and provide a rational basis for determining internal and external financing requirements. They must be developed within coherent policy frameworks and have the full involvement and commitment of all partners, including donors, GOK, and NGO implementors.

**Madagascar** Innovative social mobilization approaches in two target districts have raised full immunization coverage in these areas from 40 percent in 1996 to 60 percent in 1997 according to 1997 Demographic and Health Survey data. Efforts will be made to generalize these approaches to increase immunization coverage nationwide. National Immunization Days resulted in 99% of children under five being immunized against polio in both rounds. This achievement gave new impetus to the national EPI, especially to the morale and commitment of Ministry of Health staff. Collaboration among partners has also been reinforced with the development and signing of a memorandum of understanding of the roles and responsibilities of the MOH/UNICEF/WHO and USAID in EPI and polio.

Community approaches to improving child health, in particular nutrition, are also seeing success in Madagascar. The behavior change strategy is based on intensive research in target communities to understand dietary and other practices, formation of effective advocacy groups, and development of outreach approaches. Health messages and materials were first tested in two pilot districts, revised, and are now being generalized for use by all child survival partners.

**Malawi** The availability of first-line anti-malarial drugs--Sulphadoxine-pyrimethamine, or SP--in rural private outlets increased from 20% in 1995 to 70% in 1997. As local manufacture of SP increased, the price of the drug fell from the equivalent of \$2 per treatment dose in 1995, to \$ 10 in 1997. Based on this success, the target for 1999 has been revised upward to 90%.

Sixty-four drug revolving funds (DRFs) were set up by Africare and SCF/US in their respective districts. These DRFs include a supply of SP for treating malaria in children within 24 hours of the onset of disease and a supply of oral rehydration salts for diarrhea. DRFs have been

established by PVOs under BHR/PVC Child Survival Grants and more will be established in the six districts participating in the CHAPS Project. Medications are sold on a cost recovery basis to villagers and are managed by women volunteers under the supervision of health surveillance assistants of the MOHP and PVOs. There are two volunteers per DRF to ensure that drugs will be available as and when needed in the community.

**Mozambique** In rural Mozambique where formal health services are still extremely limited, community-based approaches have an important impact on the health of women and children. Community health workers, trained by USAID-funded PVO's and the Ministry of Health, are part of a community-based network of "care groups" using an existing structure of the Mozambican Women's Organization. The network includes 141 groups with over 1500 volunteers, each of whom works directly with 10 facilities. Volunteers use simple health education materials to teach prevention and treatment of diarrheal diseases, respiratory infections, and malaria, and the importance of sanitation, hygiene, breastfeeding, nutrition and immunizations. In only two years, this approach has expanded health coverage in two districts in Gaza province.

In Gaza, DPT3 coverage increased from 37% to 80%, ORT use from 47% to 64%, and exclusive breastfeeding from 16% to 30%. Program activities in Zambezia increased DPT3 coverage from 20% to 62%, ORT use from 54% to 82%, and exclusive breast-feeding from 67% to 82%. Improvements in child survival indicators were registered in other target areas as well.

**Tanzania** USAID/Tanzania conducted a review to identify opportunities to further support child survival interventions. The assessment indicated that the mission should strengthen integration of the child survival strategy into the national reproductive health program. To address this recommendation, USAID helped the training unit of the Family Planning Unit of the Ministry of Health complete a fully integrated skills training curriculum, which now includes modules on exclusive breastfeeding, maternal and childhood nutrition, and management of childhood illnesses among other reproductive health subjects. After more than two years of discussions with the Ministry of Health, WHO and Tanzanian health institutions, this activity represents a major accomplishment. Community-Based Distribution (CBD) agents have also been trained and provided with materials focusing on child survival messages, thereby expanding access.

The MOH of Tanzania with the support of all its partners, including USAID, has successfully conducted National Immunization Days for polio for two successive years. Greater than 98% of children under the age of five are now immunized against polio.

**Zambia** USAID's latest public-private health initiative supports the Government of Zambia's program of fortifying all domestically-produced sugar with Vitamin A. Vitamin A deficiency is very high throughout Zambia, with approximately 50-60% of children younger than five suffering from moderate to severe deficiency. Zambia will be the first Sub-Saharan African

country to fortify all domestically-produced sugar with Vitamin A. USAID supported accelerated distribution of supplementary Vitamin A capsules during National Immunization Days (NIDs) in 1997. According to MOH statistics, in 1997 over 91% of under-five children received supplementary capsules during the NIDs. The combined impact of these strategies of supplementation and fortification is expected to reduce by 50% the levels of moderate and severe Vitamin A deficiency in Zambian children.

The second year of the NIDs for polio proved slightly more successful than the first year, a rate of 96% coverage of all children under five was achieved in the first round, and 87% coverage in the second round.

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