

PN-ABP-988
12/17/92

*Policy Aspects of Child Health Programs
Considerations for A.I.D.
Technical Assistance Programs*

*Consultancy for
Agency for International Development
Bureau for Research and Development
Office of Health
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*Atlantic Resources Corporation
Contract #DPE-5929-C-00-0049-00
October 1992*

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Submitted To The
Office of Health
Bureau for Research and Development

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9 October 1992

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POLICY ASPECTS OF CHILD HEALTH PROGRAMS
Considerations for A.I.D. Technical Assistance Projects

The Office of Health of the Bureau for Research and Development of the Agency for International Development (A.I.D.) is reviewing its experience in promoting Child Survival through Washington-based technical assistance projects. The results of the review will inform the design of future global projects directed to (a) disease-specific technical interventions and service delivery systems; (b) women's and neonatal health; (c) health care financing and sustainability; and (d) applied research services.

This paper offers some thoughts about the policy context for global projects of technical intervention and service delivery.

SIGNIFICANCE OF POLICY IN CHILD SURVIVAL PROGRAMS

A Factor in the Enabling Environment

National and sectoral policies affecting institutional and technical operations can be important factors in the likelihood that external technical assistance can promote Child Survival.

If a country's policies affecting child health programs are negative on the whole, and are likely to continue to constitute a negative environment for improvement in child health, then the likelihood of success and sustainability of technical intervention by a global project will be minimal.

Illustratively, an environment so negative as to discourage intervention from a global project would exist if: (a) the budgetary allocations to preventive and primary health care are minimal and not likely to increase; (b) the government insists that the public sector alone is responsible for the health of the country's citizens; (c) health ministry policy prohibits the collection of fees for health services; and (d) systems for training of public health personnel in new technologies or in cost effective delivery of services are lacking or ineffective.

On the other hand, if the USAID mission in the country, perhaps in conjunction with other major donors to the country, is engaged in promoting changes in national policy and in health sector policies and regulations that will improve the enabling environment for health projects, interventions from global projects could be considered.

An Influence on Specific Project Achievement

Policies can influence two basic aspects of the outcomes of projects. Firstly, using an immunization project as an illustration, policies can affect the feasibility and potential success of project interventions, whether these be the introduction of immunization technology, the organization of vaccine and service delivery systems, or the training and communication that will be necessary if the outcomes of the project are to be capable of replication and continuation.

If, say, the health delivery policies segregate the treatment of sick children and prenatal care services from immunization services, neither the sick children nor the well children accompanying their mother to a prenatal examination will be checked for their immunization status. Thus, an A.I.D. project aimed at universal coverage in immunization may not achieve its objective, because it will reach only those children who participate in a national immunization campaign, or those taken to the clinic by their mothers on the day that immunization services are available.

Secondly, policies are bound to affect the sustainability of project innovations. Even though the project may introduce oral rehydration salts to a health service, train health personnel in oral rehydration therapy (ORT) and promote the administration of ORT to children suffering from diarrhea, the children of that community may not all have access to oral rehydration salts after the project has ended. Continuing fiscal policy could impose to high an import tariff on the raw materials needed for production and packaging of the salts that local manufacturers may be discouraged, and the clinics may experience shortages. Or, if policy discourages project personnel, or the country's own health personnel, from seeing that messages about ORT are conveyed to the mothers of the community by teachers in schools and by community development workers, those mothers are not likely to receive or retain the information they need about treatment of diarrhea diseases.

HOW POLICY AFFECTS CHILD HEALTH STATUS AND PROGRAMS

The Table at Attachment D, Policies Affecting Child Survival, illustrates the various functions or policies that influence achievement of Child Survival goals, identifies a number of policy instruments that may govern activities and priorities in the health arena, and designates the principal levels at which the dominant policies operate to affect Child Survival.

Kinds of Policy Instrument

Governments have available to them a number of instruments to establish and enforce policies to promote health and prevent mortality among infants, children and mothers.

1. **Law and regulation** are in the purview of the government as a whole, at the broadest level, and of the ministry of health at the sectoral level.

Laws enabling the establishment and powers of the ministries of government are decreed by the chief of state or head of government, or enacted by national legislatures. Laws affecting government revenues and annual budgets for expenditure are enacted at the national level.

Typically, health ministries exercise considerable independent regulatory powers over such matters as quality and quantity control of pharmaceuticals and other supplies, licensing of public and private practitioners, establishment of fees, referral procedures, advertising and other matters. On some matters, the minister of health will propose regulations to the governing ministry. He or she might propose to the minister of finance, for example, some modifications in the regulation of imports of health-related goods.

2. **Communication and persuasion** are manifestations of leadership, and tools used by governments to promote improved health practices.

Exhortation from the top leadership of the country can set the stage for a communication campaign. To promote better health practices, an intersectoral approach involving the leadership of the sectors of agriculture, education and information as well as health, is often most effective in promoting the changes in behavior that will improve Child Survival. Mass media and other modern communication technologies have been used, for example, in the mass mobilizations for immunization of the past decade.

As long as government policy either advocates or tolerates attention to particular issues, communication programs can be mounted in communities, in schools and in retail outlets to promote breastfeeding, nutritional weaning practices, child spacing and disease prevention.

3. **Fiscal policies** are influential in promoting or discouraging institutional and individual health practices.

Finance ministries propose laws and establish regulations affecting customs, taxes of various kinds, subsidies, uses of donor funds and allocation of budgets to public functions.

High tariffs and non-tariff import barriers and the various income, consumption and value-added taxes are instruments that can discourage consumption of cigarettes, alcohol and infant formulas and constrain public distribution and private commerce in the drugs and commodities that support Child Survival.

A policy of subsidies can be used to promote desired behavior, as, for example, location by a health practitioner in a remote area, or purchase of oral rehydration salts or contraceptives.

4. **Investment** serves health policy to the extent that it enables or enhances the performance of health practice.

Infrastructure, in the form of physical structures and laboratory and clinical equipment, is a prerequisite to an adequately functioning health system.

Staff training represents an investment in technical skill, efficiency and management.

Funding for research, whether as a direct public investment or as a subsidy to the private sector, is essential to progress in technical and operational effectiveness.

Levels of Policy Action

Policies operate at various levels, from the most technical and specific to the most general and political, to enable, foster, inhibit or prohibit the commitment of individual and institutional attention and resources to the functions of a national society.

At the technical level in health delivery, specifically the delivery of Child Survival services, certain policies are uniquely applicable. These policies comprise the technological guidelines and protocols that have been applied and tested on a worldwide basis and are recommended by World Health Organization (WHO) and United Nations Children's Fund (UNICEF). A.I.D. recommends that these technological policies (as set forth in Attachment A) be adopted for all national Child Survival programs.

At the level of service delivery institutions, are found organizational structures embodying the powers of decision-making and priority-making, administrative procedures affecting assignment and transfers or personnel, and

regulations specifying which credentials a health worker must have to perform certain services. Such institutional policies, which are essential to the operation of a public health system, serve to supplement and modify the policies of the nation and the health ministry as a whole. A.I.D. projects are fundamentally concerned with the policies that govern institutional structures and procedures, in the first instance by identifying which policies are supportive of successful intervention in Child Survival, and in the second, by seeking to modify those that are constraints to success.

Policies at the level of the health sector as a whole dictate such elemental matters as the roles and responsibilities of the public and private sectors in health services, the relative importance of Child Survival in the allocation of public health resources (leadership, personnel and finances), and the production and marketing of goods essential to Child Survival services. Sector policies also dictate the priorities for apportionment of human and financial resources around the country and among subsets of the country's population. A.I.D. believes that a certain level of sectoral commitment is necessary to ensure that the international goals for Child Survival will be met. The Agency seeks also to modify policy to ensure that the commercial sector of private health practitioners and manufacturers is enabled to play an effective role, and that equity in service delivery is achieved.

In view of the multifold influences on the health of a family, A.I.D. looks beyond the health sector itself to the level of national and cross-sectoral policy to identify adjuncts to health policy that can be positive factors in health status. For instance, employers can be encouraged to provide child care and preventive health services, appropriate family leave and opportunities for breastfeeding, as can pharmacists be urged to offer advice on weaning foods and nutrition, and manufacturers of fruit drinks to promote oral rehydration therapy. National policy can prohibit child labor, or nighttime working hours for women. And the curricula of the education system can cover primary health care and nutrition.

As regards health, at the level of national values, the fundamental unit of decision in policy terms is the family. For it is the family unit that attaches relative priority to the health of its male members, its females of childbearing age and older, and its male or female children. The attitudes of a family stem from the values of the national society—or of a cultural subset of that society—and those values in turn are likely to be embedded laws and nationally established rights and privileges.

A country exhibiting full political commitment to Child Survival is likely to follow policies that go beyond the health sector itself. Because it is universally recognized that low status of women in a society is associated with low health status of mothers and their children, A.I.D. is interested, at the broadest level, in the national constitutional and legal protections (or lack of protections) of the rights and status of women and female children. For the sake of the improvements in Child Survival that have been shown to follow when the status of women itself is ameliorated, A.I.D. promotes civil rights, education and opportunities for gainful employment for women.

A SUGGESTED APPROACH FOR A.I.D.

Systematic Assessment of Country Policy

Presumably an analysis of the country situation, and of the policy factors underlying that situation, will be carried out before a decision is made whether a global project of technical intervention and service delivery for Child Survival will be active in that country. Such an analysis should cover, at a minimum, the country's political, social, cultural and economic conditions; the status of maternal and child health; the epidemiological picture (including identification of population groups at high risk); the institutional structure, both public and private, and managerial capacities of the health sector; and the degree of political commitment to Child Survival.

An analysis of the results of studies of the sustainability of A.I.D. health projects in five countries in Central America and Africa by Bossert (see reference in Attachment C) indicates that the relatively weaker economic and political context in the African countries influenced the viability and sustainability of the A.I.D. country projects beyond the project-specific factors that were shared with some of the projects in the Latin American countries. Bossert suggests that donors will have to support broad efforts to provide for general economic and institutional development in countries with weaker economies and will have to continue to support social services until the capacity for sustainability has been developed.

Systematic assessment will therefore identify the differing characteristics of countries that will dictate different decisions about the nature, quantity and duration of assistance that will be effective toward Child Survival.

The Decision Process

Consideration of the Country Situation

A low health status of mothers and children, as measured by morbidity, infant mortality rates and rates of coverage of immunization and oral rehydration therapy, together with a numerically large population size, should predispose a positive decision for project activity, according to A.I.D.'s Child Survival strategy. Yet other factors should also be taken into consideration. The A.I.D. Strategy and Sub-strategies for Child Survival (see Attachment B) recognize that sustainability depends on the political commitment and human, institutional and financial capacities of the country as well as on inputs from A.I.D.

In countries with weak economies and institutions, for example, a project is more likely to succeed in its immediate and longer term objectives if the USAID mission and other donors are actively working to build the economic and institutional base and if the project can establish a longer term in-country presence, with substantial financial, technical and commodity resources.

A country's commitment to promoting child health by improving the health status of children and mothers is manifested specifically in its adoption of international guidelines and objectives for child health, as well as its requests for assistance from international, bilateral and benevolent donors. Commitment is more broadly indicated by the laws, regulations and practices affecting the civil, educational, economic and health status of women and children. It is often the case that women who have civil rights, control over their own financial resources, access to education and opportunities for formal employment are more inclined to space the births of their children and otherwise take steps to assure their own good health and the good health of their children.

Policy commitment is also measured by a government's allocation of public revenues. All A.I.D.-assisted countries will be facing fiscal constraints that prevent them from committing public resources in amounts that are sufficient to meet the country's health needs. Moreover, these countries commonly have not raised their health sector budgets beyond a certain percentage of the total budget even though the sectoral budget cannot maintain its historic level of commitment to each of the expanding numbers of citizens requiring services. Furthermore, the proportion of health sector budgets dedicated to personnel costs has been growing steadily, to the detriment of resources for supplies, vehicles, facilities and services. The decision on project

feasibility and sustainability must, therefore, take into consideration the present and future fiscal situation, in terms of quantity, availability and allocation of resources.

As Jamison, Mosley and others (see references in Attachment C) have pointed out, many countries are in the process of a demographic transition that is bringing with it an epidemiological transition. The younger cohorts of a population are diminishing in relative size, and the older cohorts gaining in significance. The population is becoming more urbanized and the economy more industrialized. Thus, the diseases of older people and of polluted atmospheres will be statistically more important than ever before. Yet in the countries in the lowest income bracket, mostly in Sub-Saharan Africa and South Asia, health problems will continue to be dominated by the infectious and parasitic diseases of children and the nutritional deficiencies that contribute to childhood vulnerability to those diseases.

Public health policy, which should be dealing with the effects of this epidemiological transition, is faced with difficult alternatives, one of which might entail reduction in current commitments to child health. A.I.D. should, as a matter of course, seek to help a country maintain a sufficient allocation of resources to the health of its large numbers of mothers and children. In an situation where a country has, unfortunately, firmly negated its commitment to child health, a global technical assistance project should, regretfully, delay its work in that country until the USAID mission and others have been able to turn that policy around.

In the developing countries of the world, and especially in the more recently independent countries of Africa, it is the rare government that has broadened its view of responsibility for health to include private practitioners. The philanthropic work of nonprofit non-government organizations has been recognized and accepted, but the for-profit sector has not been engaged in discussion priorities and policies in health care. As an outside donor, A.I.D. can identify ways for a government to reduce its role as care-giver and take on a role of care-manager, engaging all the relevant country resources, both public and private, in the provision of health care. It is often hard for the assisted government to envisage such a role, and difficult for the country's private sector to promote the changes that will bring commercial, for-profit health practitioners into the picture. A.I.D. can help the process, through a combination of policy dialogue, program aid and project assistance. A global technical assistance project could appropriately contribute to the analysis, dialogue and planning while at the same time offering technical Child Survival interventions.

Consideration of the Donor Context

The activities of a Washington-based global project will be immensely more effective if they take place in the context of donor and non-government commitments to promoting Child Survival. Thus, the likely existence of the following should be considered:

- 1) Bilateral funding for Child Survival activities that will be available for at least the next three to five years.
- 2) Existence of a collaborative relationship between the USAID mission and the country government that will enable discussion of policy matters and A.I.D. assistance in policy reform.
- 3) Ability of the USAID mission in the country to access technically competent personnel to oversee child survival programs.
- 4) Opportunities for collaboration with other international, bilateral and non-government organization (NGO) programs.
- 5) Opportunities for collaboration with the country's profit-seeking employers, insurers and private health practitioners.

Establishment of Priorities Among Countries

A global project will of necessity have to establish priorities among the countries in which the USAID mission or the country government has invited its interventions. Because the health of every child is important, and because dedicated people with technical knowledge and experience are available, it is tempting, within the resources of a project, to answer every call to help needy children. Based on the country assessment, however, a decision must be taken as to whether a project should be implemented in a country and, if so, the degree of project involvement to be undertaken.

Each country should be approached in a manner fitting to its context. In the face of a congeries of negative country policies, for example, project intervention may not be feasible or timely. On the other hand, a country with low health status of children and mothers, and lacking a well developed system of delivery of child health services, but showing political commitment and a conceivable capacity to respond, could benefit from project activity directed to a limited number of disease-specific interventions, to health

system management and to coordination of public and private health providers.

In a different instance, in a country with better, if uneven, health status and supportive policies but handicapped by ineffective delivery systems, a project could be more specifically focused on improving policies and systems at the institutional level as well as on additional technical interventions (such as case management of acute respiratory infections).

The more developed case, of a country achieving relatively effective primary health care for the majority of its citizens, would call for a project to broaden the participation of the commercial private sector and to help the public system reach neglected high-risk groups of citizens (such as urban residents or geographically and ethnically isolated families).

The Country Sub-project Design

Policies, regulations and practices that are embedded in sectoral institutions are more amenable to reform during the course of an in-country technical assistance project than are many national policies. Yet many of the latter can also be addressed.

A.I.D. projects necessarily involve changes—in objectives, in attitudes, in behavior, in technical procedures and in institutional relationships—but change does not come about smoothly or easily.

The design of a country sub-project must consider realistically the positive and negative factors in the current situation, and must seek to address (i.e. change, rather than simply get around) the negative factors.

Even in designated "emphasis" countries, i.e., those that have been selected for concentrated efforts in child survival on the basis of such factors as infant mortality rates, total numbers of infant and child deaths, government commitment, current capacities and opportunities for effective donor collaboration, a Washington-based global child survival project should assess the country situation. The purposes of the assessment process are (1) to identify possible institutional and policy constraints to successful and sustainable project outcomes and (2) to discern potential project interventions that will improve the policy environment.

SOME POLICY-RELATED QUESTIONS FOR THE ASSESSMENT

A number of questions can be posed for the assessment of a country's positive and negative policy factors. A suggested list follows below (refer also to the Table at Attachment D).

Does the country's health policy recognize the significance for the health status of its citizens of attention to preventable deaths of children and mothers?

Is the country's health policy consistent with the methods of disease prevention and case management for Child Survival that are widely accepted today?

- To what degree has the country specifically adopted and implemented:
 - a) the guidelines of World Health Organization;
 - b) A.I.D. child survival strategies and guidelines?
- Does the health program include standardized interventions to prevent infant and child deaths? Which ones?
 - Treatment of diarrhoea with oral rehydration therapy (ORT)
 - Immunization
 - Case management of acute respiratory infections (ARI)
 - Promotion of breastfeeding and improved weaning practices
 - Growth monitoring
 - Birth spacing

What institutional capacity exists to enable sustained attention to and impact from child survival programs?

- Are sufficient numbers of health personnel trained for and assigned to manage and deliver child survival services? or available for training and assignment?
- Are there incentives and rewards for effective performance in delivering mother and child care services?
- Are delivery systems sufficiently developed to permit integrated administration of multiple services (thus ensuring economies in the use of staff, training and operational and financial management)? Or is integration of services premature, considering the capacity of the system?

- Is it possible to offer in a single health facility the various interventions in disease control, breast feeding, weaning and nutrition, and birth spacing that affect Child Survival?
- Are non-physician health practitioners authorized to prescribe and administer oral rehydration salts, injectable vaccines, and antibiotics? to attend births? to instruct in breastfeeding, weaning foods and nutrition?
- Can public health practitioners be released from daily duties to attend initial and refresher training courses?
- Are the principles and techniques conveyed through training supported by the supervisors of the trainees and by the availability of required facilities and supplies?

Are adequate resources available for child survival programs?

- Are sufficient public revenues allocated to health and, within the health budget, to child survival?
- Does current policy permit or encourage payment of fees for preventive as well as curative health services?
- Is it likely that costs to the public sector currently carried by donors can be paid from local resources (from recurrent public budget and user fees)?
- Do health practitioners have access to the supplies, transport, and refrigeration necessary to sustain child survival service delivery?

What legal and regulatory financial disincentives to preventive and curative care of children and mothers can be removed?

- Duties and taxes on imported pharmaceuticals and family planning supplies?
- Restrictions on the supply of pharmaceuticals and other health products by donors duty-free to private sector producers and distributors engaged in social marketing?
- Prohibitions on fees for services.
- Strong central control over provincial and district budgets and purchase of supplies.

How does the country gather and use information to improve its technical and managerial approaches to Child Survival?

- Is the health delivery system capable of disease surveillance and collection and analysis of data to guide management decisions on the health program.?
- Does public health leadership understand the use of statistical data in strategic planning? Is it committed to establishment and use of a health management information system?
- Does the system encourage research programs related to Child Survival?

Are child survival services accessible to individuals of both genders? in any geographic area? in formal urban, squatter urban and rural settings? in any ethnic or social group?

- Does the health delivery system fail to reach certain subsets of the population, thus putting the children and mothers of those subsets at greater risk of morbidity and mortality?
- How do political attitudes and interest groups influence commitment to equity in service delivery?

Does the country follow a plan of information dissemination and demand creation for child health services that employs mass media communication and social marketing as well as person-to-person communication strategies?

- Is there active participation at the community level in demanding, organizing, financing and benefiting from services?
- How are midwives, traditional birth attendants and traditional healers involved in informing families about practices that will promote the health of children?
- Is it likely that messages of information and instruction in child health can be conveyed to mothers and other family members in the community and in schools, places of employment, audio and visual media and retail sales outlets as well as in health facilities?
- Does policy sanction the use of advertising to deliver health education messages by commercial manufacturers and distributors of hygienic and therapeutic products (e.g., cleaning agents, contraceptives, oral rehydration salts)?

Does national policy encourage private sector involvement in child survival?

- Does the government recognize and coordinate the contributions of all purveyors of child health services: public, private nonprofit and private for-profit?
- Are private practitioners encouraged to collaborate in the effort to reach national Child Survival objectives? are they offered training in technologies of Child Survival? are they included in access to required supplies?
- Are private physicians engaged in prescribing, distributing and promoting ORT and in providing other child survival services?
- Are private commercial and private voluntary non-physician health practitioners encouraged and enabled to carry out child survival strategies?

INTERNATIONAL GUIDELINES AND GOALS FOR CHILD SURVIVAL

The currently accepted international goals for Child Survival services by the year 2000, as developed by World Health Organization (WHO) and other organizations, were formally adopted at the United Nations Children's Fund (UNICEF)-sponsored World Summit for Children in September 1990.

The annual UNICEF publication, *Status of the World's Children*, reviews the demographic and health status of the children of the world and progress toward World Summit for Children goals.

A.I.D. and international organizations recognize that each country must set its own goals in terms of the current health status of its children and mothers and its own capabilities. Those goals will be established in the context of international goals as follows:

General Goals

- Reduction of mortality of children under 5 years of age by one third, or to 70 per 1000 live births
- Reduction of the maternal mortality by half

Immunization

The initial WHO-and UNICEF-sponsored and internationally adopted goal of 80 percent immunization coverage against six childhood diseases by the end of 1990, known as Universal Child Immunization (UCI), was reached on a global level for most childhood vaccines. However, the global achievement comprised better coverage for some diseases and for some regions than for others; coverage in tetanus toxoid and in the African region lagged notably behind the goal. Moreover, coverage has dropped in some countries following their initial push to achieve the UCI target.

World Summit for Children goals are:

- Achievement and maintenance of at least 90 percent infant immunization coverage
- Global eradication of polio
- Elimination of neonatal tetanus by 1995
- A 90 percent reduction in measles cases and 95 percent reduction in measles deaths by 1995

Acute Respiratory Infections (ARI)

Case management protocols have been published and distributed by WHO.

World Summit for Children goals are:

- Case management of 50 percent of cases of pneumonia
- 33 percent reduction in mortality from ARI

Control of Diarrheal Disease

The global strategy promoted by WHO emphasizes appropriate case management of diarrhea through oral rehydration therapy (ORT) for children with diarrhea, supplemented by continued feeding and breastfeeding, education of caretakers in the home and timely referral of severe cases.

The strategy calls for a staged approach to development of national country programs, with initial stages focused on improving diarrhea case management in health facilities and later stages on promoting case management in the home and expanding education and communication and on production and distribution of oral rehydration salts (ORS).

World Summit for Children goals are:

- Oral rehydration therapy for 60% of cases of diarrhea
- A 50 percent reduction in mortality from diarrhea

Nutrition

International efforts are directed to promotion of breastfeeding for the first 4 to 6 months of life and education in the importance of nutrition for mothers and children.

Specific World Summit for Children goals are:

- Reduction of malnutrition in children under 5 years of age by half the 1990 rate
- 50 percent vitamin A supplementation in appropriate areas

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A.I.D. Child Survival Strategy and Sub-strategies

The A.I.D. Child Survival Strategy to improve the health and survival of children and mothers has first priority in the Agency's health program.

A.I.D.'s objective is to use proven, effective interventions to prevent infant and child death and disability. In broadest terms, the goals for A.I.D., in collaboration with other international and recipient country efforts, are the reduction of infant mortality to less than 75 per 1000 babies under one year old and to less than 10 per 1000 children under five years of age.

A.I.D.'s focus is on developing a sustained capacity in each country effectively to provide immunization, oral rehydration therapy (ORT), and other interventions—as in nutrition (breastfeeding, improved weaning practices, growth monitoring) and birth spacing—to vulnerable populations.

Following are summaries of program sub-strategies for immunization, control of diarrheal disease, acute respiratory infections, nutrition, breastfeeding, and birth spacing.

Immunization

A.I.D.'s objective is to collaborate in an international effort to develop a sustained capacity to immunize the world's children, to include development of the role of the private sector. Achievement of the objective is expected to contribute to significant declines in mortality rates in targeted countries.

Factors to be considered in selecting countries for A.I.D. attention include high infant mortality, low current immunization coverage rates, the overall size of the population, country commitment, the potential for institutional development and the possibility of collaborative activity with other donors to maximize effective use of resources.

Recognizing that sustainability depends on political commitment and human, institutional and financial capacity of a country, as well as physical inputs, the A.I.D. strategy is to work toward country-specific immunization programs with country-specific coverage targets.

The program emphasis is on immunization of children and of women in their fertile years against six diseases (measles, neonatal tetanus, polio, diphtheria, pertussis, tuberculosis), with special emphasis on measles vaccine for infants and tetanus toxoid for women.

Among children, the focus is on those under one year of age.

Sustainability in institutional capacity is defined to include delivery of immunization services that are accessible geographically, temporally and economically throughout a country.

Provision of commodities (vaccines, cold chain equipment, syringes, needles) is focused on filling gaps in provision by UNICEF, other donors and the country itself.

Immunization campaigns will be supported if they are appropriate to a country setting, and therefore likely to achieve high levels of coverage, and are combined with development of a sustained capacity for continued delivery of immunization services.

Control of Diarrheal Disease: Oral Rehydration Therapy

A.I.D.'s dual objective is to control mortality from diarrheal disease principally through oral rehydration therapy (ORT) and to reduce morbidity through changes in family behavior (personal hygiene, breastfeeding, ensuring that food is clean, feeding during diarrhea). Progress is to be measured in terms of:

Availability of ORT, that is: (a) the percentage of the target population within reasonable reach of a health provider trained in ORT and having oral rehydration salts (ORS) on hand, and (b) the percentage of providers in the home with capability in ORT.

Use of ORT, defined as the percentage of diarrheal episodes in children under 5 years of age that are treated by ORT.

Effective use of ORT as determined by: (a) proper preparation of the replacement fluid, (b) appropriate feeding during and after diarrhea, and (c) appropriate referral of the more seriously ill child to more intensive care.

The strategy supports the World Health Organization formula for oral rehydration salts and an appropriate combination of home-mix and packet-based programs.

Countries selected for assistance are to be those in which a maximum number of deaths are likely to be prevented for a given investment, as indicated by: high infant and child mortality rates and a high proportion of deaths from diarrhea; large population size; country commitment to establish an effective diarrheal disease control program, make supportive policy, and commit resources; existing capacity for implementation and health infrastructure; and the potential for collaboration with other donors.

A.I.D. guidelines for development of country-level strategies call for:

A comprehensive approach, to include: attention to policy; planning; finance; management; training; production, distribution and sales of ORS; communications and public education; monitoring, supervision and evaluation; and linkages with preventive measures.

A balance between health system and home-based activities to ensure effective case management of diarrhea, of most cases in the home and community, and the more severe cases at health facilities.

Nutritional management of diarrhea in conjunction with fluid therapy, and referral of serious cases.

A primary target group of children under 2 years of age (those among whom mortality and morbidity are highest), with other children under 5 years of age a secondary target.

Emphasis on sustainability through organizational and managerial strength and financial self-sufficiency stemming from retention of income from sales of ORS, recovery for the program of savings from reduction in hospital and drug costs, and recouping of treatment costs from consumers.

Inclusion of the private sector in plans and programs for promotion of ORT and production of salts.

Active coordination and collaboration with other donors.

Efforts to link ORT activities with programs of primary health care, nutrition, immunization (especially against measles), and water and sanitation.

Because the establishment of ORT programs that increase access to ORT through training of providers and provision of oral rehydration salts and that promote expanded effective use of ORT will require an effective primary health care system, A.I.D. expects support for ORT to serve as a mechanism through which health system changes can be initiated. A program may therefore include appropriate investment in functions of training and supervision, financial accounting and management, drug purchase and distribution, and health management information systems.

Policy dialogue to strengthen government commitment, and to ensure adequate breadth and comprehensiveness of the program and enhance its sustainability, is deemed critical to successful country program implementation.

Acute Respiratory Infections (ARI)

The A.I.D. objective is to decrease mortality and serious illness from pneumonia in children under 5 years of age.

The strategy is to prevent life-threatening pneumonias using known techniques such as immunization, promotion of exclusive breastfeeding of infants and improved nutrition and to complement the preventive program by introducing into the national primary health care system the use of standard case management of ARI in children under 5 years of age.

Standard case management is defined by the World Health Organization's Acute Respiratory Infection protocols covering pneumonia, otitis media and acute pharyngitis.

A.I.D. country programs will initially be limited to application of ARI case management protocols to acute lower respiratory infections (those associated with measles and whooping cough), pneumonia caused by bacteria, fever and wheezing caused by certain viruses, and septic bacterial infections of newborns.

Programs may include treatment for malaria in young children with the standard ARI program antibiotic, co-trimoxazole.

Because existing vaccines could prevent up to one-fourth of all deaths from ARI, the strategy emphasizes that children brought to a health clinic for any reason should be checked for their immunization status.

Special attention is to be paid to the nutritional status of mothers and children (especially those under 2 months of age), breastfeeding and weaning practices.

Feeding programs are to be targeted to children under two years of age and pregnant women.

Sustainability of a country program is to be sought through: cost containment; integration with other health services; promotion of efficiencies and standards in procurement and use of pharmaceuticals; cost recovery; training and strengthening of management and supervision; and policy dialogue to ensure continuing country priority and commitment.

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Nutrition

The A.I.D. objective is to reduce mortality and morbidity in infants and children through prevention of nutritional deficiencies and improvement in overall nutritional status.

A.I.D.'s priorities for action in child nutrition are: (a) improved infant and child feeding and (b) growth monitoring.

Specific objectives of the strategy are to:

- promote breast-feeding, and reverse its decline;
- improve density, quality, frequency and amount of food given to weaning-aged children on a routine basis and during and following diarrheal episodes;
- increase the coverage and improve the effectiveness of growth monitoring activities;
- ensure that supplementary feeding programs are targeted to mothers and young children at high risk of inadequate nutritional intake; and
- strengthen impacts of other child survival technologies through campaigns to improve child nutrition.

Additional activities identified as likely to affect nutritional status are prevention, treatment and research on vitamin A deficiency and iron deficiency anemia and attention to the nutritional status of pregnant and lactating mothers.

Guidelines for implementation emphasize:

- the need for frequent contact of service delivery personnel and active involvement of communities and families;
- a focus on prevention of malnutrition rather than rehabilitation;
- use of growth monitoring as an entry point and management tool for promoting growth, educating and maintaining contact with mothers, monitoring nutritional status and establishing a system for delivery of child survival technologies;
- targeting of children under 2 years of age, and of children in child survival program emphasis countries;
- operational integration of nutrition interventions with ORT and immunization programs;
- use of social marketing to improve nutritional practices;
- education and in-service training of health professionals as well as paraprofessionals, traditional healers, community workers, and agricultural extension agents;
- involvement of the private sector to develop and market weaning foods;
- collaboration with other donor and NGO programs;
- training for supervision, monitoring and evaluation.

Breastfeeding

The A.I.D. objective is to protect and promote breastfeeding by creating an environment of awareness and support so that those women who choose to breastfeed are able to do so.

The targets of the program are to increase the percentage of infants who are:

- breastfed within one hour of delivery;
- exclusively breastfed from birth through 4 to 6 months;
- fed appropriate complementary foods in addition to breast milk by 6 months of age; and
- breastfed for one year or longer.

Guidelines for implementation call for:

- promotion and support of breastfeeding within ongoing efforts aimed at diarrheal disease control, immunization, nutritional improvement, child spacing, etc.;
- assessment of the breastfeeding situation in assisted countries and development of country-specific sub-strategies;
- training of hospital-based and other health workers in lactation management, communication and social marketing and mother-to-mother support groups;
- improvement in practices in hospitals and in maternal and child health and maternity services, where these interfere with breastfeeding;
- efforts to facilitate breastfeeding by working women and to reach women outside the formal health sector.

Birth Spacing

The A.I.D. objective is to prevent pregnancies which would expose mothers and children to high risks of mortality or morbidity.

The highest risks for child survival stem from:

- births spaced less than two years apart;
- childbearing before the age of 19 and following age 34;
- the birth of more than three children to one mother.

A.I.D. identifies the programs most likely to lead to child survival through child spacing as:

- promotion of breastfeeding, and
- voluntary family planning services.

A.I.D. aims to respond to the desires of couples for the knowledge and ability to make informed decisions about the timing and spacing of their children, as these decisions affect many aspects of family welfare, especially the health of mothers and children.

A.I.D.'s population assistance, recognizing that family planning provides critically important health benefits for mothers and children, focuses on the delivery of information, voluntary family planning services and contraceptives to those who choose to practice family planning on a voluntary basis supported by informed choice.

The Sector Strategy for Population recommends integrated family planning and maternal-child health services which promote child spacing as one strategy to reduce high infant mortality rates.

The strategy on child spacing is to:

- include child spacing in child survival programs;
- integrate child spacing concepts (and services as appropriate) into health, nutrition, education, population and women in development programs;
- target programs to those women who themselves are most at risk and whose children are most at risk;
- provide information on child spacing and breastfeeding to service providers and information and services to clients;
- support research to identify, reach and protect those mothers and children most at risk.

Implementation guidelines call for (a) policy dialogue, especially in countries lacking national family planning programs, to make national leaders aware of the importance of child spacing and aware that family planning and breastfeeding programs are important, safe, inexpensive lifesaving interventions; and (b) close coordination with other donors to ensure that all necessary elements for sustainability of child spacing programs are provided in each country program.

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POLICIES AFFECTING CHILD SURVIVAL

FUNCTION OR POLICY INFLUENCING CHILD SURVIVAL	POLICY INSTRUMENTS AFFECTING ACTIVITIES AND FUNCTIONS	LEVEL OF POLICY INVOLVED			
		Technical	Institutional	Health Sector	Cross-Sectoral
Technical Commitment, to use proven, effective interventions to prevent infant and child mortality					
Disease prevention and management	WHO guidelines World Summit for Children goals	X	X	X	
Promotion of breastfeeding and other nutrition practices	Publicity; instruction to health providers; permission for retailer displays		X	X	
Promotion of child spacing	National population policy Civil rights, education and jobs for women Training of all formal and traditional health workers		X	X	X X
Health Service Delivery					
Structure: hierarchy of facilities; staffing patterns; personnel assignment, training, supervision, incentives; integrated or separated Child Survival interventions	Priorities established by health ministry; availability of funds; personnel policies Internal organization; negotiation with supporting donors		X X X	X X	
Service Support: construction, vehicles, equipment, drugs	Funding availability; sectoral priorities			X	
Barriers to Supply of Services: Import duties and restrictions Restrictions on sales of generic drugs, contraceptives Limitations on services by non-physician health workers Lack of recognition of skills of traditional practitioners Restrictions on services by employers, cooperatives, etc.	Fiscal and customs policy Need for quality control; ties to certain suppliers Licensing standards; protections on status of physicians and formally trained health workers Licensing; standards for approval; supervision		X	X X X X	X X
Inadequate priority to Child Survival in health services	Health sector priority for primary health care			X	
Prohibitions on fees for service in public facilities	Commitment to health service for all as a public good			X	
Disincentives to Demand for Services: Policies (e.g. free education) favoring large families High costs due to price controls, taxes, duties Restrictions on client eligibility for services	National population policy Policy toward markets and prices; public revenue policy Policies for services to unmarried women, women of a certain age, women of low parity			X	X X

FUNCTION OR POLICY INFLUENCING CHILD SURVIVAL	POLICY INSTRUMENTS AFFECTING ACTIVITIES AND FUNCTIONS	LEVEL OF POLICY INVOLVED			
		Technical	Institutional	Health Sector	Cross-Sectoral
Resources					
Health budget size and share in total public expenditure	Policy of health services for all; free health services Priority for health in relation to defense, education etc.				X
Internal allocation of health budget and health personnel to Child Survival	Priority for primary health care and Child Survival in relation to curative and other health services			X	
Research directed to Child Survival programs	Priority in relation to other demands for funds, and among other research needs			X	
Cost analysis	Cost consciousness and commitment to cost effectiveness			X	
Cost recovery: authority and mechanisms	Sectoral policy Community consultation and mobilization Decentralization of authority Management and accounting systems		X	X	
Information Management			X	X	
Collection and analysis of data on demography, services, coverage, etc.	Commitment to efficiency in delivery and comprehensiveness in coverage			X	
Managerial use of data analysis to improve response to demand and expand effective coverage	Commitment to efficiency and effectiveness at service delivery level; and to coverage at the national level		X	X	
Equity in Health Service Coverage					
Concern for women as consumers of health services, educators at home and controllers of household resources	National commitment to women's status and civil rights				X
Inclusion of women on health service staff and as educators in the community	Training and staffing guidelines Community mobilization		X	X	X
Coverage of all ethnic and cultural groups, urban and rural residents, more and less accessible settlements	Reallocation of budgets and staff Decentralization of authority and financial control Subsidy to certain subsets of health client Subsidy to private, including traditional, providers Licenses to non-physicians to deliver certain services		X	X	

FUNCTION OR POLICY INFLUENCING CHILD SURVIVAL	POLICY INSTRUMENTS AFFECTING ACTIVITIES AND FUNCTIONS	LEVEL OF POLICY INVOLVED			
		Technical	Institutional	Health Sector	Cross-Sectoral
Communication and Persuasion					
Leadership from the highest levels of government	National commitment to Child Survival				X
Health education messages through communities, schools, agricultural cooperatives, places of work, etc.	Leadership of health ministry			X	X
Advertising to deliver health education messages	Sanction of advertising and approval of messages			X	
Involvement of the For-profit Private Sector:					
Strong private sector role in providing services for those who are willing to pay fees	Government recognition of how the private sector can contribute to overall impact on Child Survival Government acceptance of role of market forces in private sector health services; elimination of public subsidy to those who can afford to pay for services Ministry role established less as provider and more as coordinator of all sources of health services			X X	X X
Employer conditions of employment: parental leave; day care; child health services; opportunity for breastfeeding; hours of work for children and women	Labor-management policy Guidelines and standards from health ministry			X	X
Social marketing by employers, pharmacists, food producers, etc.	Relief from taxes and duties on importation, production Subsidy of costs of production or distribution				X X

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