# The bitterest pill of all:
## The collapse of Africa's health systems

## Acknowledgements

This report was written by Chris Simms, Mike Rowson and Siobhan Peattie. Original research and consultations with stakeholders was undertaken by Chris Simms. Comments on earlier versions of this text were received from Andrew Green, Gill Walt, Christopher Kuurowski and Valeria Oliveira-Cruz. Responsibility for the final text lies solely with the authors.

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## Executive summary

**World leaders are currently discussing the establishment of a multi-billion dollar package of initiatives aimed at tackling major diseases in poor countries such as HIV/AIDS, TB and malaria. This would be a welcome step forward. However it is important that lessons from the last 30 years are learned before such vast resources are committed.**

This report, informed by consultations with 50 donor representatives and others involved in the health reform process in Africa, including Kenya, Zambia, Madagascar, Tanzania and Senegal, argues that:

- Many target nations do not have adequate health systems to make this work.

- Health sector reforms continue to exacerbate existing weaknesses within health systems with dire and unfair effects on the poor, a key target group for the initiatives.

- Macro-economic adjustment has led to a decline in public sector wages and employment, making it difficult for health systems and local government to implement decentralisation and integration and other health reform measures.

- Potentially important efforts at integration and decentralisation of health services have often severely undermined health service delivery.

- Reforms have been exceedingly complex and difficult to implement and concentrated on improvement of financial and management systems to the exclusion of health service delivery.

- Direct charges (user fees) for health services, promoted by the World Bank and UNICEF have led to a decline in the use of maternity and other health services in the poorest communities, contributing to a rise in infant deaths and putting women's health at risk.

- Income from user fees contributes less than 5% of the cost of health care in most African countries and high administration and running costs may soak up around 40-60% of any revenues raised.

- Health facilities which over-rely on user fees for their running costs cannot collect revenues in times of economic hardship and are forced to close, making services unsustainable.

*Key facts:*

- Despite previous declines in national child mortality rates, in 1999 an estimated 10.5 million children died of diseases which were mostly preventable, the majority in sub-Saharan Africa and South East Asia.

- Economic crisis in the 1980s coupled with large debt interest payments squeezed out spending on health, education and other public services.

- Structural reforms in return for loans, demanded by the International Monetary Fund and World Bank, forced governments to reduce expenditure even more.

- Many other factors including financial mismanagement further deepened the crisis.

- The World Bank and IMF did little to make the governments understand the impact of adjustment cuts, leaving vulnerable populations unprotected against their impact.

- 41 highly indebted poor countries (mostly in sub-Saharan Africa) spend a yearly average of under $10 per person on health care, 20% below the level needed for the minimum basic package recommended by the World Bank.

- In some countries rural health services were stripped and resources re-routed into urban centres.

- Decentralisation can worsen existing inequalities by reducing the ability of governments to transfer resources between richer and poorer geographical regions.

- District capacities often cannot cope with the responsibilities required by decentralisation due to severe personnel problems, including lack of training and inadequate numbers of nurses and midwives.

- Decentralisation may lead to a reduction in the quality of the care needed to maintain an effective immunisation programme.

- There has been widespread donor negligence in efforts to integrate and decentralise national EPI (extended programme of immunisation) and hand-over to Ministries of Health.

- Essential mass childhood immunisation programmes are threatened by increased risk of HIV and Hepatitis B infection due to use of un-sterile syringes and needles by untrained and unmotivated staff.

*The report calls for:*

- A significant amount of new money to be spent on strengthening health systems in poor countries

- A reappraisal of existing practice away from donor-led, vertical interventions that focus narrowly on tackling diseases such as HIV/AIDS and malaria, while ignoring other major killers such as diarrhoeal diseases.

- The priority for addressing increasing access to HIV/AIDS related drugs (treatment for opportunistic infections, sexually transmitted diseases and anti-retrovirals) must focus on improving health service delivery systems.

- Health spending to reflect national government priorities rather than those of donors.

- Sufficient strengthening of national health systems and policy making and together with administrative structures to support large-scale injections of finance.

- Support for recurrent costs as well as capital expenditures on health in low-income countries. The support should be made available over lengthy periods of time.

- Funding priorities to be based on nationally owned plans, which aim to develop health systems, rather than a series of new vertical programmes, which reflect that of donors. This must include long-term funding for recurrent running costs including staff salaries.

- The global health fund to be fully integrated into nationally owned poverty reduction strategies that are known to effectively address the needs of the most vulnerable in the countries concerned. This might include poverty reduction strategy paper initiatives (PRSPs) in countries in which there is a high degree of participation by national actors and stakeholders (including non-governmental organisations) which are not predominantly donor-led.

- The PRSP process should invest more in human resources to carry through public sector reforms and serve patients better.

- Policy-makers should avoid unnecessarily complicated reforms, which have been shown to have little significant value even in developed countries.

- Governments and the international community should urgently find ways of reducing user charges for health care and shift towards greater risk pooling in health care financing.

- Governments should avoid segmenting the health system by concentrating public resources on the poor and leaving the more wealthy to buy private health services; services for the poor tend to be low quality, as they lack money and serve a constituency which has little influencing power.

**Recommendations for the World Health Assembly**

- The World Health Organisation (WHO) should take up a greater role in monitoring the effects of health system reforms and the effects of government policies outside the health sector where they impact on health.

- For WHO to advocate for health to be seen as a right, not just as an investment in development.

- All joint public private initiatives the WHO enters into must be contractually required to provide evidence on the potential and actual impact of the initiative on the right to health, and adherence to specified WHO guidelines and standards.

- Any programmes involving drug delivery undertaken by the WHO, especially the emerging joint public private initiatives, must contractually aim to strengthen not erode the public sector's capacity to fulfil its duty under international human rights law to ensure access to healthcare for all.

*ONLY THEN WILL THE GOOD INTENTIONS OF WORLD LEADERS HAVE A MEANINGFUL CHANCE OF SUCCESS.*

# The bitterest pill of all: the collapse of Africa's health systems

## Delivering disease prevention in the developing world

World leaders are currently discussing the establishment of a multi-billion dollar package of initiatives aimed at tackling major diseases in poor countries such as HIV/AIDS, TB and malaria. This would be a welcome step forward. However it is important that lessons from the last 30 years are learned before such vast resources are committed.

This report will argue that many of the nations that will be the focus of these initiatives are burdened by failing health systems. Programmes to tackle these important diseases will not be sustainable in the long-run unless effective health services are in place. International aid should therefore support system development and improve the delivery of health services.

The report will also explain how current health sector reforms have exacerbated existing weaknesses within these systems and how the poor (supposedly the key target group in international development policy today) suffer because they are not shielded the costs of health care. The report emphasises the need to invest far greater amounts of money in health services, and especially in health personnel, so that reforms such as decentralisation and integration of services can work better, and so that patients can be properly served. It also points to the need to avoid a "blue-print" attitude to reform and towards the necessity for developing health reforms that suit local needs.

Finally, this report will call for a reappraisal of existing practice, particularly in terms of donor-led, vertical interventions. It will argue that health spending should reflect national priorities rather than those of donors and that policy-making capacity in poor countries be supported.

Only when health systems work on a national level and the structures exist to support large-scale injections of finance will the good intentions of the G8 leaders have a better chance of success than previous initiatives.

## What went wrong?

The twentieth century witnessed unparalleled reductions in child deaths. According to the latest analysis by WHO the rates of decline reached a peak in the late 1970s.

However, since the mid-1980s, the rate of decline has slowed significantly (Ahmad et al., 2000). In 1999 an estimated 10.5 million children died of diseases which were mostly preventable. The slowdown was felt most significantly in sub-Saharan Africa and South East Asia, with some countries even experiencing reversals (i.e. rises) in their child mortality rates. (See Appendix 1).

There are also alarming signs of a deterioration in health system effectiveness over the past decade. Available figures suggest that two key indicators of effectiveness –

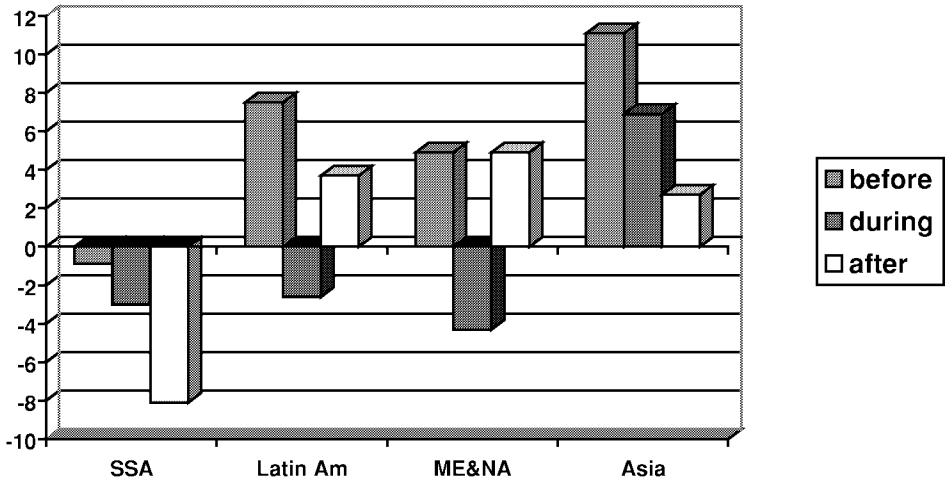
immunisation rates and the proportion of women receiving trained medical assistance at birth – have been declining in many countries in sub-Saharan Africa (see Appendix 1). This deterioration, along with problems caused by economic crisis and the impact of HIV/AIDS, may well be contributing to the mortality crisis in Africa.

Below we examine some of the reasons for health system failure. We argue that important factors include the effects of the economic crisis in the 1980s and economic policy responses to that crisis: both severely undermined social sector spending. We also look at whether health sector reforms in the 1990s have contributed to the crisis. Part of the research which contributed to this document also included consultations with about 50 donor representatives and other stakeholders in the health reform process during field visits in 1999 and 2000 to Kenya, Zambia, Madagascar, Tanzania and Senegal. Their comments are woven into the analysis.

*Economic crisis and austerity*

The widespread problems in health systems in Africa and in many other developing countries have their roots in the economic crisis of the 1980s and the policy reforms which attempted to deal with the crisis. The burden of making large interest payments on debt squeezed out spending on health, education and other public services. Reforms demanded by the International Monetary Fund and World Bank in return for loans which could be used to deal with the crisis included reining in government expenditure even further – a measure which only reinforced the negative impact of the economic crisis (see figure 2 and box 1).

**Figure 2: Growth rate (%) in real per capita social spending in four regions before, during and after structural adjustment, 1980-93**




Source: Data from "Social Dimensions of Adjustment", World Bank 1996

(Key- SSA:Sub-Saharan Africa; Latin Am: Latin America; ME&NA : Middle East and North Africa.)

The severe decline in health service provision during the 1980s was not simply the outcome of adjustment policies but a multiplicity of factors including economic crisis and mismanagement. However, the key point remains that few proactive steps were taken to protect vulnerable populations and basic services

during the 1980s. A senior health advisor in Kenya describes the situation this way:

*I could see the deterioration from the ground since the 1980s, from financial flows, from manpower, from structures and the 9 yards of whatever it takes to provide health care. In 1986 the World Bank and IMF came in with their 'grande design' for government budgets. It meant that the Kenyan government could no longer pretend it could afford the programmes it was supporting. The Bank in typical fashion brought their conditionalities. But it would not discuss how to implement structural adjustment. It wouldn't tell you what to do, what pitfalls to avoid or what would kill you if you made a bad decision. They did nothing, nothing, nothing to make the government understand the impact of adjustment cuts.*

A senior donor official in Southern Africa states that the after-effect of spending cuts applied to basic services in the rural sector is still being felt.

*This may be a policy-induced mortality crisis (in the 1990s). But I would maintain that policies during the 1980s were the culprit. Resources were pulled out of rural support for health services and put in urban centres and left them totally bare and they still haven't recovered. We're in the process of recovery so we're still seeing this marked decline in the health situation.*

Today, the Bank and Fund claim that health expenditures are now rising in adjusting countries and that their policy recommendations ensure that government expenditures in health and other social sectors are not only protected but improved. However, others have argued that improvement is occurring from a very low level and at one-third of the rate in non-African nations - countries such as Mali, Tanzania, Zambia and Zimbabwe were found to have suffered significant cuts in health spending under adjustment (Oxfam, 2000). Recent analysis of health expenditures across 40 highly indebted poor countries (most of which are in sub-Saharan Africa) reveals an average health spend of under $10 per person (BMA, 2000). This is far below the spending level of $60 per capita which the World Health Organisation (WHO) has suggested as a minimum reasonable level of expenditure and even 20%-40% lower than the sum considered necessary to finance the World Bank's basic package of health services.

## Box 1 The impact of expenditure cuts on service provision during the 1980s

What was the impact of public health spending cutbacks? World Bank's "grey cover reports" including *Public Expenditure Review*, *Participatory Poverty Assessment* and *Social Sector Strategy Review* provide a wealth of empirical and qualitative data describing the deterioration in basic services.

- **Zambia:** *The people have nowhere to turn for help. Those* (rural) *buildings which have been historically primary health care centres or district hospitals are often empty shells. Many institution are losing qualified health personnel, are utterly devoid of basic health materials (WB PER 1992).*

- **Madagascar:** *In 1985, the government budget for drugs and supplies decreased to one fifth of its 1977 level and only 10 percent of programmed medical imports were realised. This low level of expenditure only allowed primary health care centres to cover barely 25 percent of patient drug requirements...as a result real value of overall drug consumption in Madagascar declined by 30 percent between 1976-85.*(World Bank, PER 1996)

- **Nigeria:** *…not only were capital investments suspended, resulting in unfinished infrastructure, but recurrent expenditures were drastically reduced to levels that could not support such routine functions as the payment of salaries, supply of essential consumables (drugs and instructional materials), and maintenance of facilities. The result has been a significant decline in the quality of services.* (WB 1996)

- **Niger:** *After 1980... Niger's adjustment to economic crisis may have worsened inequality and poverty – notably the protection of public sector wages and deep cuts in government expenditures on health, education, agriculture, and the infrastructure (especially in rural areas)...the poor have virtually no access to medical care, education, and other social services* (World Bank 1996).

- **Tanzania:** *health system performance suffered because of a lack of training and poor motivation of doctors and health workers, shortage of supplies, breakdown of transportation and inadequate management over a dispersed rural health system. In urban areas the health situation was worse. The quality of hospital care declined dramatically and clinics became increasingly crowded. Some dispensaries in Dar es Salaam, for example, were attempting to cater for over 300,000 people* (World Bank 1991)

- **Senegal:** *there is ample evidence that the adequacy and quality of Senegal health delivery services in the public sector have deteriorated significantly over the last decade: data from 1978-86 show decline in consultations, in clients seen and in hospitalisations, all against a background of increasing population and a reduction in health facilities generally (fixed investment was 27 percent higher in the period 1981-85 than 1986-90)* (World Bank, PER 1993).

- **Cameroon:** *its collapse has been one of the most painful any country has suffered, particularly coming after the extended period of growth over the previous two decades. As a result, the structural poverty which predated the crisis has combined with the rapid impoverishment that has accompanied the economic decline in the 1985-93 period to become a serious problem for Cameroon, one requiring urgent and sustained attention.* (World Bank,1995)

- **Burkina Faso:** *recent studies carried out in some rural areas of the country show that only 10% and 14% of patients with mild and severe diseases respectively made use of the health services. The majority of the cases are dealt with outside the modern health structures. This situation is linked with the distance from health units, to the poor organisation of health activities at the health centres, to the inadequacy of activities to inform and educate the population, to the high cost of care and the non-availability of drugs at the health units"* (WHO/WB,1994)

## Health Sector Reforms

Health sector reforms have come about in part because of a need to contain costs, and also to re-orient health sector objectives to the challenge of demographic and epidemiological transitions, as well as to new diseases such as HIV/AIDS. In any given country, reforms are not occurring in linear fashion only in the health sector and are usually coupled with other processes such as reform of the state, modernisation of the civil service, privatisation of other services and changes in the democratic process – each of which may be at a different stage of progress (Acuna, 1999). In addition, international comparisons of reform policies indicate that local conditions produce different outcomes from similar policies so that generalisations are difficult to make, and lessons-to-be-learned are difficult to discern (McPake and Mills, 2000).

In *Financing Health Services in Developing Countries: an agenda for reform* (World Bank, 1987), the World Bank made its first statement on health reform and recommended increases in fees for health services paid by individuals at the point of delivery (user charges). Decentralisation, privatisation and the development of health insurance was also promoted. These ideas were developed further in the Bank's 1993 World Development Report *Investing in Health*. The World Bank (1999) currently describes the "new environment" of health reform or restructuring as consisting of four components:

- **Integration:** the consolidation of resources across vertical programmes ostensibly to increase efficiency.
- **Decentralisation:** a change in decision-making structures to bring them closer to communities or service-providers at the local level.
- **Attention to systemic constraints:** more time and attention (including analysis, consensus-building and dialogue) committed to resolving issues of sustainability of investments and financing, client and provider incentives, and management and logistics systems.
- Changes in the organisation of **external and internal financing.**

Despite the very evident need for reforms in health systems in these areas, the changes demanded by the World Bank and other donors have often been badly conceived and poorly implemented, giving rise to concerns that the reforms themselves have undermined the provision of effective health care, and therefore contributed to increases in mortality. Perhaps the main problem has been way in

which the international community has taken a "blue-print" approach to health sector reform, with little consideration given to local needs.

Below we examine two areas which give special cause for concern. Firstly, problems caused by the widespread implementation of user charge policies; and secondly, problems with the processes of integration and decentralisation of health services.

## 1. User Charges

Of all the different approaches to financing health care, direct charges for health services paid by individuals usually at the point of delivery, have been the most controversial.

Proponents of user charges including the World Bank (1987; 1993) and UNICEF (through its Bamako Initiative) have argued that they represent a solution to the severe financial difficulties created by the prevailing situation of economic austerity. The principle objective of user charges was to improve sustainability by raising revenue which could then be used to improve the provision of health services. It was felt that fees would increase efficiency by making users more conscious of the quality of care (and therefore demand improved services). User charges were also said to be a way of improving equity by reducing the tendency of the non-poor and urban dwellers to capture the lions share of government public health services.

*Negative effects on utilisation of health services*
The introduction of fees was based on a frequently-stated view from the World Bank that the utilisation of services was relatively unresponsive to its price (see for example World Bank, 1987 and Griffin, 1988). A subsequent study from the Bank (Gertler and van der Gaag, 1990) found however the evidence for this view was both very limited and methodologically flawed. Reassessing the issue, the authors found that demand was, in fact, sensitive to price, and that this sensitivity was greatest for households with lower incomes and for children.

Throughout the 1990s, numerous studies and review articles (Creese and Kutzin 1996; Russell 1996; Creese 1997) have described the decline in utilisation of services following the implementation of user fees and have reached conclusions similar to those of Gertler and van der Gaag. Typical of these is Murray (1996) who, examining the relationship between user fees and access to maternity health services, found that admissions and deliveries in hospitals fell significantly after the introduction of fees, obstetric admissions declined and mortality rate among babies born outside of the hospital (and mortality rates of mothers) increased. Changes in admission patterns have been noted as more high-risk mothers delivered at home and put-off seeking help for as long as possible. The introduction of, or increase in fees, has presented barriers to women requiring timely access to maternity care and has put women's health at greater risk.

There is some evidence to suggest that while fees may reduce utilisation for a given level of quality, this effect may be partly or wholly offset if the proceeds are used to finance an improvement in the quality of services (e.g. Litvack and Bodart, 1992).

However, studies which have registered this effect have often been one-off pilot experiments, benefiting from large infusions of donor funds as well as attracting skilled personnel from other institutions. As a result, they would probably not be sustainable across the whole health system.

In many low-income countries, service provision is so poor and incomes are so low that ordinary people can not be persuaded to use services even when improvements are made. Lucas and Haddon (1998) evaluated the impact of Nigeria's Bamako Initiative (BI) on health services and their utilisation. Before BI health provision was "close to breakdown" with low utilisation; after BI there was no substantial or sustained improvement. It failed for two reasons: the high cost of the services and a decline in people's incomes. The cost of the numerous licit and illicit charges discouraged use of facilities and no facility reported exemptions for the poor and vulnerable. The researchers concluded that "This study visit (in 1998) has again found, as in 1996, that relatively few people are using public health facilities... It seems evident that public services remain marginal to the lives of many Nigerians... Whilst some people are able to afford the services of qualified practitioners, a serious concern is that many are now going without any care, even for quite serious conditions, and relying on self-care using inappropriate or low quality medications obtained from shops, public markets and hawkers".

There is a serious lack of research on the long-term effects of paying user charges. According to Lucas and Numagaba (1999) "even if utilisation is maintained, it is essential to know if this is being achieved by reductions in other aspects of well-being, for example, by asset sales, or reduced expenditure on food and education or by individual sacrifices.... If this is the case, there are liable to be serious implications for the longer-run health and welfare of such households." Furthermore, there is a serious lack of knowledge about the differential impacts of user charges on different members of the household and even different economic and geographical groups, and little attention has been paid to how the degree of utilisation (for example delays in seeking treatment, under-dosing and non-completion of treatment) may be affected by the introduction of fees. These discrepancies in research are likely to result in an under-statement of the negative effects of user charges on utilisation (Woodward, 1997).

*Exemptions for the poor don't work*

In an international survey of health service user fees and exemption policies in 26 low-income countries, Russell and Gilson (1997) assessed whether there were exemptions to protect the poor. They found that "policies to promote health service access for disadvantaged groups did not exist in many countries" and that in any case exemptions for the poor were extremely difficult to implement. Worryingly, exemption-monitoring systems were rare.

*Perverse impacts*

User charges were intended to improve efficiency by reducing the frivolous use of services, following the principle that "when a service costs money people will think twice about using it" (Shaw and Griffin, 1995). However, this misses the point with regard to health utilisation by the poor, as frequently the travel and time costs of

attending clinic are so high that there is unlikely to be any unnecessary utilisation (frivolous use) to discourage through fees (Gilson, 1997).

Fees may also reduce the quality (and increase the cost) of the services provided by creating incentives for health workers to over-prescribe or use more expensive health services. In China it was found that fees schedules affect the behaviour of under-paid health workers who were over-charging and over-providing the more expensive (and more profitable) higher levels of health care, thus creating distortions in the market (Liu, 2000). Data from Swaziland suggest that the introduction of user fees did not increase the appropriate use of services by patients either: consultations for preventive reasons and certain serious diseases declined more than consultation for some minor illnesses (Nolan, 1995).

*Mixed ability to raise revenue*

The ability of user fees to provide a significant boost to health care expenditures is also open to question. Creese (1997) found that as a percentage of total government spending on health, income from user fees remains at less than 5% in most African countries (although this seems to be higher in Asia). In fact user fee systems can be costly to run and administration may soak up to 40-60% of any revenues raised (van der Meer, 1998).

There is evidence however that at the local level user charges can provide a significant proportion of the running cost of facilities. In Dakar, Senegal (which has had some form of cost recovery since the 1970s), hospitals and clinics charge very large fees and are intrinsically dependent on these revenues (see UNICEF, 1998). At Mukumi Health Centre (see box 3), a mission facility in Tanzania, inpatient, outpatient and card fees account for 67 percent of revenues. In Madagascar, which has had informal user fees since the economic crisis worsened in the late 1980s, facilities which cannot collect revenues are closing.

It is partly because of the need for user fees to sustain health care at the local level that so many parts of the health and development community have failed to reflect adequately on the impact of user charges on the poor. Box 2 shows both the strength of support amongst some donors for user charges, whilst others are increasingly uncomfortable about their negative impacts.

**Box 2 What Donors are Saying about User Fees and Exemptions**

Most donors seem to accept cost recovery as policy. It is not an issue under review, nor on the agenda at donor meetings. One donor states:

*We know that ours is the right policy. We see that districts are not getting support from government. They don't put up the dollars. We need contribution from beneficiaries. If you use services you must pay. Health services must be sustainable and generate income.*

Another donor states:

*We want to raise user fees. We have done an important study which shows women can afford the pill. Under the category "discretionary spending", they spend money on hairdresser, clothes, lottery, harambe etc. It is an important study because we want to raise fees and it shows they can pay for it without too much trouble, even the poorest. They can go to the hairdresser every 6 months rather than every 3 months.*

Many health systems appear dependent upon beneficiary contributions to finance healthcare, especially in Franco-phone Africa. One UN agency official states:

*In Senegal you have to pay for health services. If we eliminated user fees the social cost would be even greater because the health service delivery system depends on these fees - services would decline. There is nothing to discus- it's a fait accompli.*

However, many donors are also expressing deep concern about user fees' impact on vulnerable populations, children, the poor, the geographically isolated and other vulnerable groups. A UN country representative in Madagascar states that "I was shocked by user fees. Here, people in Antananarivo are told straight to their face that if they cannot pay they must be refused treatment. These rules are strictly applied".

For reasons of equity and public health, cost recovery was to include exemptions to protect those who could not pay. In Zambia, Tanzania and Kenya this was official government policy although there is very little evidence that it has been effectively applied. In Madagascar and Senegal, there are no official exemptions. In rural Madagascar mothers are even asked to pay for cotton swabs when their children are immunised.

In Zambia, a senior donor official said:

*I think we have made a series of mistakes which have been absolutely disastrous. There were exemptions for user fees but districts don't know what they are. Some districts are asking for money and some are not. But it's all because the districts don't know the exemptions. They were so strapped for cash last year that if you wanted services you would be charged.*

**Box 3 The impact of user charges on the children of Mukumi**

Health service indicators show large reductions in access to effective health care and stagnating levels of childhood mortality in rural Tanzania during the period 1992-96. Most observers are expecting that Tanzanian demographic and health survey (DHS) 2000 will reveal further deterioration. Consultations with Dr. Loes Schelamkamp, Medical Officer-in-Charge at the Mukumi Health Centre (which is widely perceived as a well-run mission facility) reveal a very disturbing phenomenon - but one which may be confronting many service providers in Tanzania. Children are arriving at Mukumi in an extremely weakened condition, with very low haemoglobin levels and more than half are dying within 48 hours. User fees appear to be dissuading mothers from seeking timely treatment for their children; consequently, utilisation rates are declining and CFRs are rising - especially among the poor. So conspicuously ill are the children that Schalemkamp conducted investigations to find out what is happening. For many mothers, taking their children to a health facility when they are sick is not an affordable coping strategy. Says Schelamkamp,

*Things are in a real mess at the under-five clinic. If you look at the re-attendance figures for 1996, 1997 and 1998 for our catchment area you see a decline from 14,000 to 11,000. This is due partly to the rain and partly user fees; user fees are quite high.*

*We don't get the poorest people here; we have very poor we know, but overall they don't come to the Centre...even though our fees are Ts300 versus Ts500 in government facilities. We did a small (utilisation) study which showed travels costs are Ts600 one-way. We reviewed 380 records of which only 88 were children; you can see mothers are not bringing their children when they are sick. They wait until they are very sick and then they come. About 23% of total are under-fives. Then you look at percentage of children who were ill (50%). We aren't getting the very poor. In the first 24 hours 33% die and in first 48 hours, 53% die.*

She reports that the number of children seriously ill - simply exhausted - is very alarming; they are dying from malaria and anaemia.

*I did this study because I was worried about the number of blood transfusions. The number of blood transfusion goes up since 1996. I've tested all children for haemoglobin at end of December and early January. The distribution shows that nearly all (samples) are below 10. We give transfusions below 5. We have already had 500 blood transfusions. Its been going up and up. They come in gasping for air. We don't have an official blood bank.*

## 2. Integration and decentralisation

Attempts to integrate and decentralise health services have also caused access problems during the last decade. Throughout the 1980s, many priority health programmes were donor-funded, "vertical", separate from the MoH and more or less controlled by donors who paid for supplies, training, operations and recurrent costs. They included immunisation, TB, leprosy, nutrition and numerous child survival programmes. However, vertical programmes have increasingly been perceived to have hindered the development of effective health systems: they often duplicated existing activities; distracted health personnel who had to focus on the immediate

outcomes of individual projects rather than the long-term development of systems; and they were only sustainable as long as donor priorities stayed the same and funds continued to flow. They have led to the fragmentation of health systems and to a lack of attention to the causes of ill-health which exist outside the health sector.

From the beginning of the 1990s, some parts of the donor community started to recognise the distortions that vertical programming was causing, and attempted to integrate some of the vertical programmes. This shift took place in parallel to an effort to decentralise health services in order to make them more responsive to local communities.

**Box 4 Decentralisation**

Decentralisation as term is used very loosely to cover a number of different forms of decision-making structures, including delegation of powers and devolution.

There are various arguments for the adoption of decentralised forms of structure and decision-making.

- It is argued that decentralisation away from the central or national level brings decision-making closer to the communities served. As such it accords with the principle of community participation.
- It brings decision-making closer to the field-level providers of services and hence may make it more appropriate.
- It is argued that there is greater potential for multi-sectoral and multiagency collaboration at the lower service delivery levels than through centrally controlled structures.
- It has been suggested that decentralisation may enhance the ability to tap into new forms of finance-generation.
- It is suggested that by breaking down the large monolithic structures typical of many national service ministries, decentralisation may lead to greater efficiency in service provision.

Source: Green (1999)

Numerous studies have assessed efforts to decentralise and integrate services in developing countries, and a series of problems have been identified. Chief amongst these is under-funding of both the integration and decentralisation processes. Part of the problem is that integration of services has been seen purely in terms of increasing the cost-effectiveness of programmes by merging them. However, the short-term financial costs of integration may be high and the process may throw up administrative, logistical and political difficulties which impede progress. One key donor in East Africa told us:

*"We made a critical error with integration. In terms of resources it has to be additive support. We cannot piggyback one programme on top of another. Each program has to come with its own money. We say integration is a means to improve cost effectiveness (but) the approach*

*was wrong; who was going to pay? We need additional money. We want to combine EPI with other programmes but without twice as much money. It's absolutely ludicrous."*

Decentralisation of services has also suffered from severe under-funding. However, even if resources are available, district capacities are often too low to meet the responsibilities implied by decentralisation. Organisation and management structures are seldom adequate and poor financial management systems may lead to misuse of funds. Decentralisation can also exacerbate existing inequalities by reducing the ability of governments to transfer resources between richer and poorer geographical regions. A World Bank official in Senegal told us that *"The reform policies and strategies are clear – they look very "good" but implementation is very difficult. There are severe personnel problems with lack of training, nurses and midwives. Even if it started now it could not have enough capacity build-up to meet its needs in 2007."*

One method of assessing the efficiency of reform efforts to integrate and decentralise is by analysis of immunisation programmes. WHO (1999, 2000) reports that decentralisation of health services has led to a reduction in the quality of care needed to maintain an effective immunisation programme. WHO (1998) states that health reform's decentralisation policies have lead to the neglect of "issues of quality of service and the need for technical support for peripheral staff". Decentralisation is associated with the following: "deficient quality of immunisation service management in some areas; poorly or untrained staff; unsuitable or dangerous injection and sterilisation practices; inadequate supervision at district and health centre levels and poor communication between health workers and mothers ...in many health centres, immunisations are delivered by untrained and unmotivated staff who receive neither adequate support nor supervision, resulting often in sub-standard injection, sterilisation and communication practices." (WHO 1998)

There are a variety of perspectives on the declines in immunisation coverage rates described in the appendix of this report. According to some donors, these reversals were anticipated and are acceptable. For example, the lead advisor on health reform to a Minister of Health states:

*We have been to the moon and we can't go the moon every year. We know we can reach ambitious immunisation targets through concentrated activity. What we had earlier was artificial improvement. It's a question of true development. I was in charge of EPI 1987-90 in eight countries in Africa. We had a large amount of money for EPI. We used to have resources, training and supervision and vaccines were free. It was artificial. Today we have realistic results reflecting the level of development of the countries.*

Other donors assign responsibility of declining coverage rates to Ministries of Health. They argue that it's time these countries "grew up" and took some responsibility - its up to the State to understand the importance of EPI and make vaccination a priority. They say that the numerous problems relating to supervision, transportation, training and management reflect Governments' failure to prioritise and invest appropriately in EPI. Frequently, funds intended for the district do not get there and if they do, the district may have other issues they

wish to address. Governments are, in some instances, reducing resources for EPI.

On the other hand, some donors do not find these reversals necessary or acceptable. They argue rather, that they reflect widespread donor negligence in efforts to integrate and decentralise EPI and hand-over to MOH. A donor in Kenya says:

*We handed over EPI to Government of Kenya. They took it over but didn't come through and meet their responsibility. The result was neither an integrated nor vertical programme. The management functions to decide rational use of resources were not in place. I would call the result confusion. There was never a plan, or strategy. Maybe the pace, maybe the suddenness was too much. This is our fault. I strongly suspect that recurrent cost and availability of funds for supervisory systems were the first to be cut. They were the nerve centres and they were destroyed. We were naive. We should have expected this would happen. We should have known. Our eyes were closed and we went straight into it. Lets be frank, we didn't even have a follow-up to see what they did.*

The integration of immunisation (and other basic health care services) was poorly conceived. Another donor in Tanzania says:

*There was no thinking in terms of transition strategies by the reformers. They thought they could do things over night like switching a key. Inside EPI people were very concerned. They could see what was happening and where integration was going to lead. There was insufficient money and attention devoted to the integrated system. Indicators were affected. What about appropriate levels of transport, information systems, training, maintenance programmes and supervision? They are under-funded and of poor quality. They didn't put real dollars and attention to get that system off the ground.*

**It is inevitable that these negative trends in the capacity of health sectors will be affecting childhood morbidity and mortality. Underfunding and problems caused by ineffective reforms are two of the key problems the international community needs to address.**

**Current proposals from the international community**

During the African Summit on HIV/AIDS, Tuberculosis, and Other Infectious Diseases, the UN Secretary-General, Kofi Annan, called for the creation of a 'Global Health Fund' to be incorporated into the Declaration being prepared for the UN General Assembly Special Session on HIV/AIDS in June. US$7-10 billion will be allocated to combat the spread of HIV/AIDS, TB and malaria.

It is essential that the global health fund:

- Intrinsically supports the strengthening of existing health systems as an essential element in its promotion of greater access to effective appropriate health care. This means that long-term recurrent costs (such as salaries) should be included.

- Recognises the pressure on national governments and local NGOs to show results quickly. The impacts of this pressure may lead to greater fragmentation, rather than integration of healthcare systems. Governments are likely to find it easier and quicker to establish a healthcare programme with one specific focus (e.g. TB or malaria or HIV/AIDS), rather than trying to develop an integrated healthcare system.

- Is balanced in terms of recognising health system development priorities. In addition to possible fragmentation of the health systems, there is a concern that much of this global fund will be spent on the most easily recognisable outputs – i.e. drugs.

- Should not be used solely to provide medical treatments. It is equally important that the responses to the epidemic continue to address the whole continuum of care – from prevention to care & support of children affected by HIV/AIDS. In addition to this it is necessary to recognise the importance of addressing socio-economic factors that can affect the course of the epidemic (e.g. reducing stigma and discrimination, ensuring children have adequate access to information on HIV and behavioural change interventions etc.).

- Is integrated into existing responses by governments and donors to improve the situation of the poorest countries. As such the global health fund should be fully integrated into nationally owned poverty reduction strategies which are known to effectively address the needs of the most vulnerable in the countries concerned. This might include poverty reduction strategy paper initiatives (PRSPs) in countries in which there is a high degree of participation by national actors and stakeholders (including non-governmental organisations) and are not predominantly donor-led. Such strategies would help to ensure that responses supported by the global health fund reduce the likelihood of system fragmentation and contribute to the long-term sustainability of health systems. A culture of participation and civil society consultation should be further developed to allow for greater ownership of planning and resource disbursement and use.

## Recommendations

### Turning back the trend

There is no doubt that health sectors in low-income countries need large injections of cash simply in order to provide a minimal level of health care. However, Save the Children UK has raised important questions in the past about whether cash-strapped economies can absorb large amounts of donor investment (LaFond, 1995).

Even relatively small donor investments can lead to unbearable recurrent commitments for national governments, so it is absolutely crucial to make sure that investment, should promote, not undermine self-reliance. A global health fund should:

- Support recurrent costs as well as capital expenditure on health in low-income countries. The support should be made available over a long period of time – even as much as 20 to 50 years.
- Be based on nationally-owned plans which aim to develop health systems, rather than a series of new vertical programmes which reflect donor priorities.

Attempts to address health system problems should be made within nationally owned poverty reduction strategies that are known to effectively address the needs of the most vulnerable in the countries concerned. This might include poverty reduction strategy paper initiatives (PRSPs) in countries in which there is a high degree of participation by national actors and stakeholders (including non-governmental organisations) and that are not predominantly donor-led.

The PRSP process could be helpful in a number of ways:

- It attempts to culture local ownership of policies, and thus complements the Sector Wide Approach in the health sector
- It potentially helps to co-ordinate different areas of development, allowing a focus on the broader determinants of disease.
- It could help bring civil society voices from the health field to the policy-making table.

However, PRSPs also need to address some of the important policy problems that have arisen during the process of health sector reform and which we have reviewed above:

- Efforts at integration and decentralisation of health services, both of which are potentially important steps, have sometimes been disastrous. Reforms have concentrated on improvement of financial and management systems to the exclusion of health service delivery. They have also been exceedingly complex and difficult to implement. Macro-economic adjustment has often led to a decline in public sector wages and employment which in turn has had affected the ability of health systems and central and local government to implement

- decentralisation and integration measures. It would thus be important for a PRSP process to address personnel problems by investing more in human resources in order to carry through public sector reforms and serve patients better. As the Director General of the World Health Organisation, Dr Gro-Harlem Brundtland has said "it does not matter how good the structure is – as long as you can't afford to pay your doctors and nurses and fill the shelves with essential medicines and vaccines, a health system will not be performing at a reasonable level."
- Governments and international institutions still recklessly allow the widespread existence of user charges, despite evidence of their negative impact on the poor. The PRSP process should concentrate on finding ways of reducing user charges at all levels of the health system, and shift towards greater risk-pooling in health care financing. The shift towards using public sector resources to serve the poor and allowing higher income groups to buy private health care should be halted, as this will segment the health system and create a two-tier service. It will also allow the development of private insurance markets which will be more difficult to mould into a broader social insurance scheme in the future.

*Achieving better health for all*

Policy-makers in the health sector are increasingly being told to implement evidence-based health care reforms. In fact, there is plenty of existing evidence to demonstrate how health status in low-income countries can be raised from the lessons learned by countries which have achieved a high level of health outcomes despite being poor – this is information which could be useful when policy-makers are constructing their Poverty Reduction Strategy Papers. The high achievers are an ideologically, geographically and demographically diverse group of countries such as China, Sri Lanka, Barbados, Malaysia, Costa Rica and the Indian state of Kerala. According to one recent study these countries were implementing the vision of comprehensive primary health care outlined in the Alma-Ata declaration even before the declaration was written (Mehrotra and Jolly, 1998). In particular they paid attention to system-building and intersectoral action for health. The role of public action in demanding health services and better living conditions was also crucial for their success (for more specific lessons from the high-performing countries, see Box 5 below). The apparent shift by WHO (WHO, 2000) away from a comprehensive primary health care approach is regrettable, given its past successes.

**Box 5 The high performers: how did they do it?**

Lessons from low-income countries which have achieved high levels of life expectancy and lower levels of child mortality show the need for the building of health systems and intersectoral action to tackle disease. Common policies measures include:

- Provision of universal services (as opposed to targeted services) for all, paid out of government revenues, with resources allocated towards the lower end of the pyramid. There is little evidence of user charges being levied at the primary level.
- Higher spending on health, more equitably distributed.
- Strong incentives, which should be used to deploy health personnel to rural/poor areas.
- Emphasis on training nurses and village health workers/community health workers/primary health midwives.
- Comprehensive and widespread maternal and child health services at the primary level. Increasing the proportion of births attended by trained health personnel and good postnatal follow-up visits. Effective and timely referral systems (i.e. links from primary level to other parts of the system).
- Excellent immunisation services.
- Private sector in supportive and complementary role, but not substituting for public services.
- Education (particularly of girls) is hugely important for increasing the demand for and accountability of health services.
- Provision of a nutritional floor can be important – nutritionists recommend targeted subsidies aimed at households facing food insecurity and the very young child (6 months to 3 years).
- Improved water and sanitation.

(Mehrotra and Jolly, 1998)

*HIV/AIDS*

The priority for addressing increasing appropriate and affordable access to HIV-related drugs should focus, first and foremost, on improving health service delivery systems as a prerequisite for effective ARVs (anti-retroviral) drug treatment. Even then, priority should still be given to appropriate HIV/STD prevention services and the treatment of opportunistic infections within primary health care settings.

However, as well as ARVs, it is also essential to ensure that all people (including children) living with HIV/AIDs have universal access to simple antibiotics, pain killers, clean water and adequate nutrition, to assure them a minimum standard of quality of life.

*The role of WHO in Joint Public Private Initiatives (JPPIs)*

In relation to effective and sustainable health systems underpinning all other priorities, it is evident that many of the proposed strategic priorities of WHO involve the development of joint public-private partnerships, with increased potential for conflicts of interest and dilution of accountability presented by these initiatives.

The WHO's collaboration with the private sector is only justified as a means of better pursuing the protection and promotion of the human right to health. Given that the WHO and the for-profit sector ultimately have different missions, it is important that there are mechanisms to ensure that any conflict of interests is avoided in such collaborations.

The WHO has recently produced a number of guidelines of particular relevance to public private initiatives - on Drug Donations, on Preferential Pricing and Donations of Single Source Pharmaceuticals, and on Working with the Private Sector to achieve Health Outcomes. These go some way towards highlighting the standards required. But whatever the merits or faults of the finer details of these guidelines, their value rests in their implementation. Yet none of them provide the tools for monitoring adherence.

The most obvious way of holding these initiatives to account for their adherence to these guidelines is to contractually require it. The existing standards of the WHO must therefore be safeguarded by means of a written and publicly available contract between the parties involved in public private initiatives.

Every contract should state that the primary objective of the initiative is the fulfilment of people's right to health. How to ensure that the pursuit of this objective is equitable, ethical and effective is the subject of a number of excellent guidelines and codes that the WHO has developed over the years – such as the WHO's framework on access to essential drugs, the Ethical Criteria for Medicinal Drug Promotion, and the International Code of Marketing of Breast milk Substitutes. The basic contract of joint public private initiatives should specifically require coherence with and adherence to all relevant WHO frameworks.

One might expect such requirements to be part of the WHO's Guidelines on Working with the Private Sector. But at present, these merely state that commercial enterprises working with the WHO "will be expected to conform to WHO public health policies" in a few loosely defined areas. No system to assess compliance with these standards is defined, nor is a channel for third parties to report on non-adherence to these standards identified. There is simply one line at the end which states that "the application and impact of these guidelines shall be periodically reviewed." Needless to say, there is no process for rectifying a situation where standards are being abused.

We therefore recommend that:

- All joint public private initiatives the WHO enters into must be contractually required to provide evidence on the potential and actual impact of the initiative on the right to health, and adherence to specified WHO guidelines and standards;
- Impact analysis is disaggregated by gender and age to ensure positive net benefit to women and children.
- The WHO ensures there is a mechanism that enables independent observers to assess the impact of the initiative according to its stated objectives and standards and requires the Board of the initiative to respond to such assessments. A report of this process should be sent to the Assembly annually.

No doubt there are resource implications in setting up such systems. However, with the growing interest among civil society observers of the impact of public private initiatives both on the livelihoods of the poor and on the integrity of the UN bodies, the tools of transparency and public accountability are essential to ensure that the standards which the WHO represents are maintained and indeed furthered.

Many of the joint public private initiatives emerging are based on donations or preferential pricing arrangements. Concerns have been raised about how sustainable these can be if commitments are limited. There are also important questions about the effects of such programmes on public sector capacity, particularly if they set up parallel delivery systems.

The UN Economic and Social Council states that it is the state that has the primary obligation to protect the right to health of its children and citizens. Therefore:

- Any programmes involving drug delivery undertaken by the WHO, especially the emerging joint public private initiatives, must contractually aim to strengthen not erode the public sector's capacity to fulfil its duty under international human rights law to ensure access to healthcare for all.

## Conclusions

The health of people in sub-Saharan Africa is currently a disaster. Health systems are not responding adequately. We propose a five point agenda for action.

- Large-scale, long-term recurrent support for whole health sectors from the international community. Vertical "disease-specific" approaches should be avoided.

- Health sector reforms should be made more responsive to local needs – blueprint approaches will not work. There needs to be better funding and management of health sector reforms such as integration and decentralisation.

- Greater emphasis should be placed on bettering the conditions and training of people working in the health sector.

- Governments and international donors should shift away from charging patients at the point of delivery, and move towards greater risk-pooling in the financing of health care.

- Donors should weave their support for the health sector into the Poverty Reduction Strategy Paper process in order to avoid duplication of activities, help establish local control over health sector priorities, and encourage greater intersectoral action for health. The international community should also support the development not only of health systems, but also of policy-making capacity, a vital measure to ensure the long-term viability of health systems in Africa.

# Appendix 1

## Childhood mortality in the 1990s

Analysis by Medact and Save the Children UK on Demographic and Health Survey data from 22 countries in Latin America, Asia and sub-Saharan Africa illustrates the problem. It shows that "total" infant and child mortality rates increased in 8 countries. National aggregate data may however disguise important sub-national trends. In fact, in our sample, when background characteristics were taken into account (place of residence, level of education and service utilisation), there were rises in 21 countries.

Table 1 Childhood mortality, by residence, education and MCH utilisation in selected countries

| | | | Residence | | | | Highest level of education | | | | | | MCH |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total | | Urban | | Rural | | None | | Primary | | Secondary | | None |
| | IMR | U5 | IMR | U5 | IMR | U5 | IMR | U5 | IMR | U5 | IMR | U5 | IMR |
| Kenya | + | + | + | + | + | + | + | + | + | + | + | + | + |
| Madgr | | | + | | | | | | + | | | | + |
| Tanz | | | | | | | + | + | | | | | + |
| Ugand | | | | | | | | | | | | | + |
| Zimbw | | | + | + | | | | | + | | + | + | |
| Zambi a | + | + | + | + | + | + | + | + | + | + | + | + | |
| B.Fas o | + | + | | | + | + | | + | + | + | + | + | + |
| Camer | + | + | | | + | + | | | + | + | + | + | + |
| Ghana | | | | | | | | | + | + | + | + | |
| Mali | + | | | | + | | + | | + | + | + | + | + |
| Niger | + | | | | + | | + | | | + | + | + | |
| Seneg | | | | | | | | | | | | + | |
| Togo | | | | | | | | | | | + | | + |
| Bangl a | | | | | | | | | | | + | + | + |
| Indone | | | | | | | | | | | | | + |
| Philipp | | | | | | | + | | | | | | + |
| Dom. R | + | | + | + | | | + | + | | | + | + | |
| Guatm | | | | | | | | | | | + | + | |
| Bolivia | | | | | | | | | | | | | + |
| Brazil | | | | | | | | | | | | + | + |
| Colum | + | + | | | + | + | | | + | + | + | + | + |
| Peru | | | | | | | | | | | | | |

Many factors will account for this rise. Deteriorating economic circumstances for the poor and widening inequalities will have played a major role. In Africa, average per capita incomes are now lower than they were at the end of the 1960s (World Bank, 2000).

There is also growing evidence of the contribution of HIV/AIDS to the current slowdown. The most recent research (U.S. Bureau of the Census, 1999; Adetunji, 2000) describes the relationship between annual percentage change in

adult HIV prevalence and annual percentage change in under-five mortality (in the years between DHS surveys). Consistent with previous research (Nsemukila, 1996, Hanmer and White 1998, Timeus 1998), it shows that the epidemic is obviously contributing to the rise in childhood mortality, especially in countries with low mortality and high adult HIV prevalence rates.

However it also suggests other important factors are contributing to mortality change. The important message is that HIV can only account for a proportion of changes in childhood mortality rates in most countries, and that other socio-economic or health system factors also play a part. It should also be remembered that HIV/AIDS has itself been increasing as result of greater poverty and vulnerability, particularly where these factors force people into migration for work or prostitution (UNRISD/UNAIDS, 2000).

**Indicators of health system effectiveness**

There is a scarcity of data with which to evaluate changes in access to effective health service provision, especially in low-income countries. Traditional indicators such as percentage of the population with access to safe water and sanitation, a health facility or, the number of beds, nurses or doctors per 1,000 population, tend to be unreliable given that many public services have not been maintained, and personnel are frequently untrained, unsupervised and unmotivated and, buildings and equipment are often unusable.

However, two notable exceptions are immunisation coverage rates and delivery assistance at birth.

The percentage of children aged under one year who are fully immunised for diphtheria, pertussis and typhoid (DPT3), measles, polio and BCG and the percentage of pregnant women who receive two doses of the anti-tetanus vaccine (TT2) are an important set of access indicators. WHO finds that "the effectiveness of immunisation services is an excellent indicator of the effectiveness of the health systems" and coverage rates a good indicator of the "degree of efficiency of a particular reform process" (WHO 1999a, 1999b) because the components needed to support a decentralised immunisation programme (supervision, training, transport, logistics etc.) are also requirements for the efficient operations of other basic services.

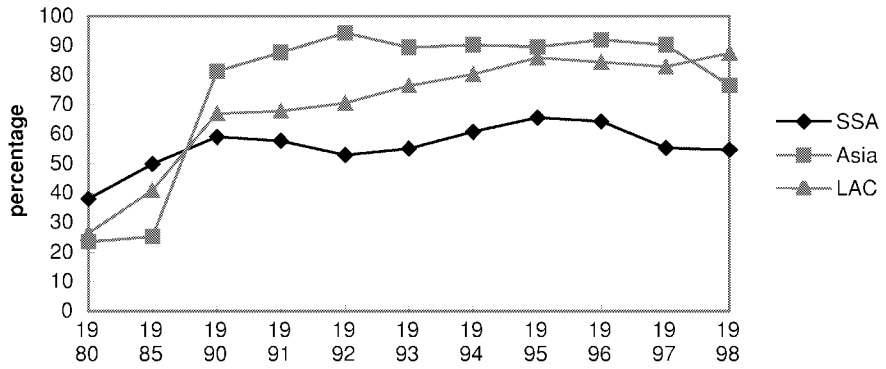
In addition, when compared with other commonly used indicators and classified by 1995 level of under-five mortality categories, births attended by trained medical personnel is a very "useful statistic" (Bloom *et al* 2000). A recent World Bank study (Peters et al 1999) found the relationship between supervised deliveries and infant mortality to be highly significant. A further reason for using this indicator is that, with the implementation of cost recovery, assistance at delivery became an important charged item at health facilities; for many underpaid health workers, it was intrinsic to their incomes.

*Immunisation*

After large advances in childhood immunisation coverage rates in the 1980s, WHO surveillance systems show stagnation or reversals throughout the 1990s in many developing countries. Figure 2, below, which charts coverage rates for the 22 selected countries (categorised by region), shows overall that coverage rates have been declining since 1995 in sub-Saharan Africa and since 1996 in Asia. Latin American and Caribbean countries performed somewhat better with 3 of 7 countries (Bolivia, Guatemala and Brazil) peaking in 1998. However, many observers question these Latin America data. Bolivia's National Health Surveys, for example, show that coverage rates have been falling since 1996 and that DPT coverage was actually 46 not 94 percent in 1998 as reported by WHO. Similarly, DHS surveys show that on average DPT coverage rates in Bolivia, Guatemala, Columbia and Peru were overestimated by about 15 percentage points by WHO surveillance[1].

**Figure 2**

**DPT coverage rates in selected countries**




Another sign that most of the delivery systems are severely flawed is that 18 of the 22 countries represented have a high BCG-DPT drop-out rate, which is generally considered a good indicator of the quality of immunisation services. This means that the caregiver has contacted the health system to obtain an anti-tuberculosis shot but did not return for DPT3 either because she did not know it was necessary or was not satisfied with the service.

*Medical assistance at birth*

Data from second and third round DHS surveys in 22 countries on the percentage of women receiving trained delivery assistance at birth (five years before survey) show declines at the national level in 15 countries and improvements in 7. Only in 5 countries were there improvements in urban, rural and total percentages (See table 1 below).

[1] According to DHS, in 1998, Bolivia was 48.6% not 94%; in 1995, Columbia was 77.4 not 86%; in 1996 Peru was 77% not 99%; in 1999 Guatemala was 70.4 compared with 90% reported in 1999; in 1996, Brazil was 80.8% not 75%.

**Table 1**
**Change in percentage of women receiving trained medical assistance at birth five years before survey in 22 DHS-survey countries, nationally and by residence**

| | Medically-assisted births | | |
|---|---|---|---|
| | Urban | Rural | Total |
| Kenya 1998 | - | - | - |
| Madagascar 1997 | - | - | - |
| Tanzania 1996 | - | - | - |
| Uganda 1995 | - | - | - |
| Burkina Faso 1999 | - | - | - |
| Cameroon 1998 | - | - | - |
| Ghana 1998 | - | | |
| Mali 1996 | | | |
| Niger 1998 | - | | |
| Senegal 1997 | - | | - |
| Togo 1998 | | | |
| Zambia 1996 | - | - | - |
| Zimbabwe 1994 | - | - | - |
| Bangladesh 1997 | - | - | - |
| Indonesia 1997 | | | |
| Philippines 1998 | - | - | - |
| Bolivia 1998 | - | | - |
| Brazil 1996 | - | - | - |
| Colombia 1995 | - | | - |
| Peru 1996 | - | - | - |
| Dom.Rep 1996 | | | |
| Guatemala 1999 | | | |

This trend, together with changes in immunisation coverage rates, are in contrast with progress made in the development of simple medical technologies in most regions of the world in previous decades. This suggests that increased vulnerability and changes in access to effective basic health care may be important factors explaining changes in childhood survival.

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