

Moving from vertical to integrated child health programmes: experiences from a multi-country assessment of the Child Health Days approach in Africa

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Introduction

Child Health Days (CHDs) are currently used in many African countries as the preferred approach to reach children twice a year with selected low-cost, high-impact health products and services, such as Vitamin A supplements (VAS), deworming tablets, insecticide-treated bed-nets, and catch-up immunizations. CHDs emerged in the early 2000s in response to weakening health systems, to ensure that the selected basic services could be provided with the broadest coverage possible. This delivery mechanism has proved highly effective, despite being introduced at a time when vertical programming was becoming unpopular. Evidence from middle-income countries (Mexico, Thailand and Brazil) has shown that this type of 'vertical' programming does not undermine general health system strengthening [synonymous in this article with 'horizontal' integrated services]. However, little information is available on the relationship between CHDs and the performance of general health services in lower-income countries. Therefore, the authors of the present study conducted an assessment of CHDs in Eastern and Southern Africa to examine empirical evidence concerning the impact of ("vertical") CHDs and their possible effects on the ability of ("horizontal") general health services to provide key child survival interventions.

Methodology

The assessment team purposively selected six countries (Ethiopia, Madagascar, Tanzania, Uganda, Zambia, Zimbabwe) that reflected a broad range of health system functioning, and two districts within each country that demonstrated high and low performance. All levels of facilities involved in the provision of interventions were included in the assessment. Key informants representing national-level Ministry of Health staff, development partners, district health workers and child caregivers were interviewed. The semi-structured interviews focused on issues of program management, capacity building, supplies, health information systems and communication and advocacy. All authors reviewed the interview transcripts for recurring themes and reached general agreement on the interpretation of the data, using the interpretive approach methodology (Pope et al 2000; this methodology is further elaborated in the full reports compiled and disseminated through UNICEF). The investigators also summarized selected health indicators reported in the DHS and other surveys for the period 1997-2007 to determine how these changed in relation to implementation of CHDs in the respective countries.

Results

The CHD programs were implemented nationally and integrated into health sector plans in all countries except Ethiopia, where the program was operational in slightly more than half the health districts. The authors elaborated on five of the most important themes that they discovered concerning the implementation and impact of CHDs: 1) CHD program management, 2) human resources, 3) effect on other child survival interventions, 4) effect on primary health care (PHC) services; and 5)

supplies. Positive benefits of CHDs that they noted were enhanced capacity building in supervisory skills and health worker performance, improved coordination between health facilities and communities, increased coverage rates for most child survival interventions, and raised awareness and perceived importance of child survival programs. However, it was also found that the implementation of CHDs suffers from common problems, such as: a lack of a clear chain of command of responsibilities among health staff at various levels, limited planning capacity at the district level, diversion of staff members from other PHC activities, distortions of pay scales due to incentives paid to health workers during CHDs and the secondary disincentive for them to conduct routine activities, and duplication of information and supply systems. The authors also highlighted the lack of progress in the areas of exclusive breastfeeding and deliveries attended by skilled birth attendants, although it is not clear why they would have expected CHDs to produce an impact on these particular feeding behaviors or health services.

Conclusions

The authors concluded that CHDs should be continued in areas where health systems are weakest, but should be merged into the routine health care delivery system in areas where health systems are better staffed and equipped, for example in urban areas. Recommendations for improving CHDs in the meantime include integrating CHD data into routine Health Management Information Systems, providing support for districts to plan and budget for CHDs, streamlining the routine and CHD supply systems and revisiting the incentive system for health care workers.

*NNA Editors comments:

The assessment of CHDs in Eastern and Southern Africa described in this paper is particularly valuable because of the dearth of information on the implementation and impact of these programs in this sub-region. The observed increase in coverage of VAS with CHDs is consistent with the experience reported elsewhere in Africa (Aguayo *et al*, 2007). The recommendations for improving CHD delivery and programming described in the present paper should be considered in various country programs, as applicable. However, the authors' conclusion that CHDs should be phased into routine health services as these services become better staffed and equipped seems to contradict the observations they cited from middle income countries, where CHDs seem to increase delivery of selected child survival interventions without undermining routine health service delivery. Thus, the authors appear to have neglected the results of their own review or they started their analysis with a pre-conceived assumption that CHDs should be viewed only as a short term solution for providing these important interventions. In fact, of the 6 countries assessed there was no mention of any deliberate political effort to shift away from the CHD approach, which still provides the most viable coverage strategy in the post-NIDs era for countries with poorly functioning health systems.

Even with strong health systems employing adequate staff, it is uncommon for children to attend health facilities for preventive interventions after the age of 18 months, when most EPI schedules drop off. Thus, these older children would not routinely receive necessary interventions like VAS and deworming unless a special effort were undertaken to motivate their participation in these routine service delivery efforts. Moreover, if healthy children would attend fixed facilities twice yearly for

preventive services, this would likely overwhelm even the most well-equipped health systems. In a country like Tanzania, for example, that would mean 60 million additional health visits per year, requiring staff to receive, register, and process children to receive the various child survival interventions continuously. In addition to managing this greater influx of clients, the facilities would need to manage a more complicated continuous supply chain.

Because of the efficiency in the CHD method for delivering specific preventive child survival interventions that are required at just a few contact points a year to a large number of children, there is no reason to believe this delivery method cannot become the routine strategy for delivering such interventions. Even with stronger health systems in place, many countries in Latin America and Asia continue to employ a combined vertical and horizontal approach (sometimes referred to as a 'diagonal approach') for reducing child mortality and morbidity (Sepulveda, 2006). Notably, both the March, 2009 Global Alliance for Vitamin A (GAVA) pan-Africa meeting and the July, 2009 Assembly of Health Ministers of the Economic Community of West African States (ECOWAS) have called for institutionalization of CHDs.

Finally, we believe that the authors inappropriately link the lack of progress in exclusive breastfeeding and skilled birth attendant deliveries to the implementation of CHDs. There is no evidence for a causal relationship, and there is no reason to expect that a complex behavior change intervention, like promotion of exclusive breast feeding, or provision of skilled obstetric services should be either enhanced or undermined by CHDs. Although the authors argue that stagnation in these indicators may have resulted from the diversion of staff to attend to Child Health Days, it seems very unlikely that the few days devoted to CHDs would have a major impact on the delivery of these other services if appropriate programs were already in place.

Citations

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