
ADOPTING A CHILD-CENTRED APPROACH: INTEGRATION FOR MAXIMISING IMPACT ON CHILD HEALTH



This paper builds on recent developments in integrated approaches to child health programming. It aims to highlight innovative examples and provide policy recommendations for national governments and development partners.¹

Recommendations

- * Promote good child health outcomes by supporting national systems to deliver integrated child health programmes at all levels.
- * Promote country-led rather than donor-driven strategies to strengthen ownership and implement child health programmes that focus on local needs and priorities.
- * Integrate child health approaches and interventions to tackle both morbidity and mortality.
- * Support the evaluation and documentation of integrated approaches to improve effectiveness, efficiency and results.
- * Create and support frameworks and aid structures that encourage and incentivise integrated approaches to child health.
- * Ensure the inclusion of a health goal in the post-2015 framework that promotes cross-sectoral collaboration to achieve child health targets, recognising that good health is a universal human right to which everyone is entitled.

Introduction

As the development community prepares for the final push towards meeting the Millennium Development Goals (MDGs), while also entering into a process of defining future global development goals post-2015, it is important that lessons are learnt on the successes, and shortfalls, in tackling global health challenges.

The MDGs helped generate important political momentum around health, at global and national levels. Important achievements have been made in addressing issues such as HIV/AIDS and malaria. However, the adoption of separate targets on, among others, nutrition, water and sanitation led to a fragmented response to public health challenges, while other important areas such as neglected tropical diseases lacked attention and funding. This lack of a comprehensive approach to health at the global level has contributed to fragmented approaches at the national level, both in government planning processes and the way in which aid funds are channelled. Fragile and conflict-affected states provide stark examples of where government policy is often led by donor funding, meaning that priorities are not set by an evaluation of needs, but by the specific funds set up by donors. Consequently, opportunities have been lost to strengthen health systems and respond to the underlying burden of disease across the various social and environmental determinants of health.

There have been examples where vertical approaches have exacerbated fragmentation within the healthcare system, created complex and expensive health aid structures, and drawn healthcare staff away from primary healthcare provision into disease-specific programmes, although in certain cases vertical approaches have proven to be effective and have achieved noteworthy successes. The accountability structure of the MDGs, which focused on global and national averages, meant that unequal progress between groups and individuals, within the hardest to reach populations across and within countries, was insufficiently addressed. A case in point is the global MDG drinking water target, which was met in 2010 as a result of progress in East Asia, while 783 million people remain without access to water and 2.5 billion people are without access to sanitation. Consequently, the majority of child deaths are still caused by infectious causes (for example diarrhoea), and related factors such as undernutrition.

At the same time, health systems need to prevent morbidity as well as mortality. In terms of child health, this means focusing on the life of a child, not just its survival. Unseen morbidity burdens, due to diseases like schistosomiasis, conditions such as stunting and lack of access to broader health services like those that promote good eye health, can impair a child's development and create barriers to accessing crucial services such as education. The current global health architecture does not incentivise approaches that address morbidity and mortality in a joined up way.

Moving towards ‘integrated’ approaches

In the past few years, there has been increased recognition of the need for enhanced cross-sector collaboration for health, as well as more ‘integrated’ approaches that go beyond collaboration to deliver key interventions more efficiently and effectively. Various definitions of integration are used by different sectors (for example with specific disease communities and in different sectors). Generally speaking, however, integrated approaches deliver a range of interventions that address multiple needs through collaboration within and across a variety of sectors and diseases and with participation of all relevant stakeholders to achieve common goals through national systems. Such approaches go beyond the remits of the healthcare system to comprehensively respond to the burden and causes of disease.

The increased focus on integration is driven by the recognition that all too often the potential impact of one set of interventions is undermined by the lack of interventions in other areas. For example, children are repeatedly dewormed without adequately addressing the lack of sanitation and hygiene responsible for continuous reinfection. In most countries, the institutional response to health needs rarely reflects the ways in which poverty, health, nutrition, gender, education and other issues interrelate in people’s lives. Further to the need for better integration across sectors, alignment is also necessary within the health system itself, which is all too often characterised by a fragmented approach to health

(for example, separate and non-aligned child health (Integrated Management of Childhood Illnesses) and immunization (Expanded Programme for Immunisation) programmes). Opportunities for integration also cut across different spheres, and should explore the role of families and communities in supporting integration at the local level, where issues and factors affecting health ultimately converge, to provide maximum impact.



¹ This paper follows on from the publication by Action Against Hunger, Action for Global Health, End Water Poverty, PATH, Tearfund and WaterAid, 2011: *Join up, scale up – how integration can defeat disease and poverty*. <http://www.actionforglobalhealth.eu/blog/?p=1388>

² See WHO/UNICEF, June 2012: Joint Statement, *Integrated Community Case Management*. http://www.unicef.org/health/files/ICCM_Joint_Statement_2012.pdf

THE PATIENT-CENTRED APPROACH

An approach that focuses on the users of healthcare services, rather than the interventions that healthcare services should deliver, provides a fertile ground for integration. In reality, families seeking to meet their health needs often have to attend different clinics and programmes to access the services they need, but may face multiple barriers, such as time, resources and physical distance. Health facilities and programmes should provide prevention and treatment services that address the

essentials of reproductive health, safe child birth, infant care, and child health. The ‘continuum of care’ for women and children recognises the importance of integration through the delivery of essential services in one location, as well as the linking of services from the home through all levels of the health system (e.g. access to water and sanitation at home and in schools and healthcare facilities). Another example of integration for child health is the integrated community

case management (ICCM) strategy developed by WHO and UNICEF, addressing childhood malaria, pneumonia and diarrhoea together.² By training community health workers to diagnose and treat appropriately at the community level and ensuring a continuous supply of rapid diagnostic tests and treatment commodities, the programme has helped reduce under-five mortality. In South Sudan this has been extended to include tackling malnutrition as well (see box on page 4).

Integrating prevention and treatment

BRIDGING ACROSS THE SECTORAL DIVIDE

Often primary health care and public health care interventions are implemented independently of each other, and by different agencies. Consequently, the impact of these interventions is not optimised. This divergence can be seen in the marginalisation of the role of water, sanitation and hygiene (WASH) in health, despite their critical importance for health. The importance of WASH goes beyond the well-known links with diarrhoea mortality, affecting broader areas such as nutrition and stunting,⁴ as well as for less fatal but debilitating infections such as trachoma and soil-transmitted helminthes.⁵ Despite this recognition, and the repeated mention of WASH in policy documents and international commitments, this link is rarely acted upon at the programmatic level. This is also the case within the water sector, as infrastructure programmes are at times planned, implemented and monitored without health considerations in mind. Although there has been a movement towards integrating the curative aspects of healthcare to improve cost-effectiveness (such as through the ICCM, and joint administration of preventive chemotherapy for certain neglected tropical diseases) factors ‘external’ to healthcare such as environmental health and individual sanitation and hygiene behaviours are inadequately addressed within health programmes. New integrated programmes acknowledge the complementarity between different health interventions in order to establish a better link between disease prevention and treatment. For example:

- * Cambodia’s Ministry of Health established an integrated programme on prevention and treatment of diarrhoea and pneumonia in the Baray-Suntuk Operational district of the Kampong Thom province, while currently strengthening its national policy. This included delivering key inputs for treatment of diarrhoea and pneumonia alongside the promotion of WASH and breastfeeding. The updated policy generated sustained national commitment, while the district-level demonstration pilot simultaneously provided an opportunity to put the revised policy into practice and monitor and evaluate the outcome.⁶
- * In Nepal, the new IMCI strategic plan includes ‘hygiene’ as one of its integral components in order to prevent infections such as diarrhoea and pneumonia. This represents a strong strategic shift for IMCI implementation in Nepal, although the exact manner in which hygiene promotion will be delivered through IMCI is yet to be fully agreed.

³ Cf. also Malaria Consortium, 2013: Project Brief, *Addressing emergency nutritional needs in young children*. <http://www.malariaconsortium.org/resources/publications/192/south-sudan-addressing-emergency-nutritional-needs-in-young-children>

⁴ London School of Hygiene and Tropical Medicine, SHARE and WaterAid, 2013: *Under-nutrition and water, sanitation and hygiene*. <http://www.wateraid.org/~/media/Publications/Undernutrition-and-WASH.ashx>

⁵ The NTDs NGDO Network and WaterAid, 2012: *WASH: the silent weapon against NTDs - Working together to achieve prevention, control and elimination*. http://www.wateraid.org/~/media/Publications/wash_the_silent_weapon_against_ntds.ashx

⁶ PATH, 2013: *Tackling pneumonia and diarrhoeal disease through program and policy coordination - A case study of PATH’s integrated approach in Cambodia*. http://www.path.org/publications/files/ER_app_edd_cambodia_cs.pdf

INTEGRATING THE TREATMENT OF SEVERE ACUTE MALNUTRITION AND INFECTIOUS DISEASE: AN EXAMPLE FROM SOUTH SUDAN³

Children who are malnourished are at greater risk of illness because their immunity is lowered. At the same time children with an infectious disease are often more at risk of becoming malnourished. This ‘vicious circle’ means that it makes sense to adopt an integrated approach to treatment.

In South Sudan, Malaria Consortium, in partnership with the Ministry of Health, has integrated the treatment of severe acute malnutrition (SAM) and the most common childhood diseases – malaria, pneumonia and diarrhoea. Community drug distributors have

been recruited to work in their own community to assess cases of malaria, pneumonia and diarrhoea in infants and children under five years of age and prescribe the necessary drugs for treatment. The distributors are also responsible for detecting cases of severe acute malnutrition in households. Children found to have SAM are referred to a nearby outpatient therapeutic programme for treatment, or to a stabilisation centre, if the case involves medical complications. They are treated using the therapeutic feeding method, but

also receive the appropriate treatment for malaria, pneumonia and diarrhoea.

This approach offers a more cost-effective way of diagnosing and treating different diseases and conditions than handling them separately. Crucially, it also means that more cases get detected and therefore more lives are saved. By bringing treatment to the community, more people have access to health care treatment, while the stress on the already overburdened health system is reduced.

Akek Akol Maehol with two year old
Aweng Atuer Garang, MUAC test



What needs to happen?

1. There is an urgent need to implement integrated approaches to child health, while maintaining a focus on scaling up. At the same time, emerging examples of successful integration should be evaluated and documented, to better understand how an integrated approach can improve effectiveness, efficiency and value for money, as well as achievement of outputs and health outcomes. This need for evaluation should not, however, result in delayed implementation.

The continued process of learning from integration successes should not be isolated, but must feed into international discussions and processes, including *A Promise Renewed*, the *Zero Hunger Challenge/Scale Up Nutrition* and *Every Woman Every Child*. Lessons are of particular value to the debate around the post-2015 targets, including current discussions on Universal Health Coverage. These should inform the interpretation and implementation of goals such as those recommended by the High Level Panel on the post-2015 framework, and can inform the design of targets and indicators, as well as approaches such as Universal Health Coverage, that incorporate promotion, prevention, treatments and rehabilitation.⁷

Particular emphasis should be placed on the ability of these approaches to improve the **health outcomes of children** (rather than simply counting outputs and indicators such as number of mosquito nets, text books, soap and latrine slabs distributed); a focus is needed on the impact of health programmes on overall reductions in child mortality and morbidity. Such outcome measures should not replace but be used alongside standard progress measures such as access to key life-saving interventions.

The relative long-term, sustainable **value for money** of integrated approaches compared with vertical programming should be assessed, to inform the adoption of such approaches by aid agencies and national governments. The apparent lack of hard evidence on value for money of integration can lead to reduced willingness among donors and governments alike to implement integrated programmes that go beyond existing programme remits and funding streams. This in turn can lead to even less evidence. A review by the UK Department for International Development (DFID) on its WASH portfolio⁸ recommended exploiting ‘the potential for efficiency gains through improved integration of WASH and health programmes to achieve health impacts’ as a way to optimise value for money (p 8), arguing that efficiency gains may be achieved through ‘better integration of WASH with other DFID interventions such as health, nutrition and education in order to maximise potential synergies between them’ (p 77). This approach has been reinforced recently by the Global Action Plan on Pneumonia and Diarrhoea (GAPPD),⁹ which argues that since the determinants for pneumonia and diarrhoea are often the same, the preventive strategies and delivery platforms are also similar.

Promotion of the relevant interventions together should therefore be encouraged to achieve maximum benefit.



⁷ Action for Global Health: Civil Society Call to Action on Universal Health Coverage. <http://www.actionforglobalhealth.eu/index.php?id=303>

⁸ UK Department for International Development, March 2012: *Water, Sanitation and Hygiene Portfolio Review*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214187/DFID_20WASH_20Portfolio_20Review.pdf

2. Development partners (bilateral, multilateral and NGO) should help create incentives to integrated approaches in the way they disburse funds, measure results, and influence global and national policies. To facilitate integration, development partners should aim to create the right incentives and frameworks.

Successful adoption and scale up of integrated approaches to child health requires a clear signal from high-level decision makers that such approaches are desirable, and preferable. This also requires a change in aid policy, to enable countries to initiate and roll out programmes that build health systems that respond to countries' specific context and disease burden.

Health aid should therefore be made more flexible in terms of channels and time frames, to respond to country priorities and fund multi-sectoral approaches whose success is measured in terms of long-term improvements in health. Where possible, systems for monitoring and evaluating the health impact of donor and multilateral funds need to be integrated into existing national systems, in order to prevent the duplication of work, but also as a way to strengthen national health information systems. Furthermore, strengthening existing information systems is necessary to ensure high-quality data, which is critical in understanding health needs and ensure prioritisation of interventions based on burden of disease.

This flexibility should extend to programme design, allowing for an approach that goes beyond basic service delivery inputs and outputs to include elements such as behaviour change and creation of demand for health

and other services such as sanitation. For example, GAPPD provides a useful framework for a comprehensive approach to tackle two major killers together by integrating protection, prevention and curative aspects, while the SAFE (Surgery, Antibiotics, Facial cleanliness, and Environmental improvement) strategy¹⁰ for the elimination of blinding trachoma brings together four curative and preventive interventions under a common objective. The strategy acts as a useful intersectoral coordination platform; further, several donors have recently committed to tackling trachoma through full SAFE implementation, instead of funding one curative or preventive aspect.



IN ORDER TO ACHIEVE GOOD CHILD HEALTH OUTCOMES WE RECOMMEND THAT DONORS AND NATIONAL GOVERNMENTS SHOULD:

- * Promote good child health outcomes by supporting national systems to deliver integrated child health programmes at all levels.
- * Promote country-led rather than donor-driven strategies to strengthen ownership and implement child health programmes that focus on local needs and priorities.
- * Integrate child health approaches and interventions to tackle both morbidity and mortality.
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- * Ensure the inclusion of a health goal in the post-2015 framework that promotes cross-sectoral collaboration to achieve child health targets, recognising that good health is a universal human right to which everyone is entitled.

⁹ UNICEF and WHO, 2013: *Ending Preventable Child Deaths from Pneumonia and Diarrhoea by 2025 - The Integrated Global Action Plan for Pneumonia and Diarrhoea (GAPPD)*. http://apps.who.int/iris/bitstream/10665/79200/1/9789241505239_eng.pdf

¹⁰ Sightsavers and WaterAid, 2013: *WASHing away blinding trachoma*. http://www.sightsavers.org/blogs/insights/helen_hamilton/19621_J0552_Trachoma%20Policy%20Brief%20v%205.pdf



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