mostly consisted of facility-based care. Training of local staff started with
nursing schools. Because of the overwhelming workload, male and female nurses were soon running most peripheral services. District
governments in some countries start-
ed clinics and small district hospitals, but in most countries mission hospi-
tals provided 50–80% per cent of hospital beds. Public health focused on
environmental protection, in particular on early efforts to provide safe water and improved sanitation
facilities in urban areas.

Health services in francophone and other European colonies were
uniquely different from those in anglophone countries, since the
latter placed great emphasis on

The Measles Initiative

The Measles Initiative shows how a well resourced, targeted and
managed global vertical initiative can reach scale rapidly and
produce dramatic results. The initiative is a partnership that
groups UNICEF and WHO with other leading international
agencies and prominent private organizations. Launched in
2001, the Measles Initiative adopted the goal set at the UN
General Assembly Special Session on Children in May 2002 to
reduce deaths due to measles among children between 1999–2005. It has been the main sponsor of the mass cam-
paign to boost measles vaccination, which has resulted in
vaccinating more than 217 million children between 2001
and 2005 – mostly in Africa.

The results have exceeded the UN target: measles deaths fell by 60 per cent between 1999–2005. Africa contributed
72 per cent of the absolute reduction in deaths. Estimates concluded that immunization helped avert almost 7.5 million
deaths from the disease.

The reduction in measles deaths reflects support and com-
mitment by the Measles Initiative to boosting immunization
coverage and by national governments to following the
WHO/UNICEF comprehensive strategy for reducing measles
mortality. The strategy consists of four key components: the
Grandes Épidémies programme. In this, separate levels of a national
network focused on a single disease, such as sleeping sickness, lepra-
sis, leprosy and other high-prevalence conditions affecting the capacity
to work. Mass care was provided by mobile units, often generously
equipped with complete travelling facilities. The rationale was that
relating on outreach to treat patients at mass gatherings was more effective
in reaching larger numbers of people than investing in static facilities.
Repetitive cycles of treatment focused on simple curative interventions rather
than on prevention and control.

As in Africa, the early Chinese
hospitals were mainly established by
missions. A national public health
system began in the 1920s with
fights to control the rapidly spread-
ning pneumonic plague in the province
of Manchuria.

An important historical footnote is that the first published case study
of successful community-based pri-
mary health care concerns a project of this period. The project took
place in Ding Xian (formerly Ting
Hsien), about 200 kilometres south
of Beijing. In this province of about
half a million people, health care
was provided by health workers
who were the forerunners of
China’s ‘barefoot doctors’. For a
quarter of a century and for more
than a fifth of the world’s popula-
tion, China had one of the most
equitable health systems ever
designed. This experience provided
important lessons for planning the
1978 International Conference on
Primary Health Care that took
place in Alma-Ata, Union of Soviet
Socialist Republics (now Almaty,
Kazakhstan).

Early in the century, such coun-
tries as Denmark, the Netherlands,
Norway and Sweden managed to
reduce maternal mortality very
quickly. The way in which skilled
attendance at birth was organized
appears to have been the major fac-
tor contributing to these gains. In the
case of these four countries, efforts
focused on providing professional
care close to where women lived,
mainly by enhancing the skills of
community midwives.2

The success of the smallpox eradica-
tion campaign was a key element
informing the design of possibly the
most successful preventive public
health programme in history – the
Expanded Programme on Immuniza-
tion (EPI), launched in 1974. EPI
initially aimed to vaccinate children

The Measles Initiative

- Provide at least one dose of measles vaccine, administered
  at nine months of age or shortly after, through routine
  vaccination coverage of at least 90 per cent of children in
each district and nationally.
- Give all children a second opportunity for measles vaccination.
- Establish effective surveillance.
- Improve clinical management of complicated cases –
  including vitamin A supplementation.

Measles control activities are contributing to health-system
development in several ways – for example, through
promoting safe injection practices, developing enhanced cold
chain capacity for vaccination storage and establishing
the development of a global public health laboratory
network. In addition, vaccination campaigns are often
combined with other essential interventions as
vaccine A supplementation, deworming medicines and
the distribution of insecticide-treated mosquito nets.

A new global goal was set at the World Health Assembly in
May 2005 – to reduce measles deaths by 90 per cent by 2010,

**Global burden of measles deaths**

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Deaths</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Pacific</td>
<td>17,000 (5%)</td>
<td>5%</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>38,000 (11%)</td>
<td>11%</td>
</tr>
<tr>
<td>Americas</td>
<td>&lt;1,000 (&lt;0.15%)</td>
<td>&lt;0.15%</td>
</tr>
<tr>
<td>Africa, 126,000 (37%)</td>
<td></td>
<td>37%</td>
</tr>
<tr>
<td>South-East Asia, 174,000 (57%)</td>
<td></td>
<td>57%</td>
</tr>
<tr>
<td>Europe, &lt;1,000 (&lt;0.15%)</td>
<td></td>
<td>&lt;0.15%</td>
</tr>
</tbody>
</table>

* Regions refer to World Health Organization regions.


**Figure 2.1**

Children under five account for 90 per cent of measles deaths

**Mass disease control campaigns: 1950–1977**

By 1950, the population of the world exceeded 2.5 billion, and
global average life expectancy had risen to 47 years.

The 1950s, 1960s and 1970s wit-
nessed a number of disease control
efforts, often termed ‘mass campaigns’
or ‘disease-focused responses’. These
efforts employed scientifically sound,
epidemiologically proven interventions
through free-standing programmes
designed to combat a specific disease
or condition. Often characterized by
clearly defined goals, they includ-
ed time-delimited targets for either
the reduction or the eradication of
the disease, using a specific technol-
ogy delivered by dedicated health
workers.3

The most successful of these cam-
paigns was the smallpox eradication
initiative, which reported its last
case of human-to-human transmis-
sion in 1977. Other mass campaigns
have been successful in eradicating
or substantially reducing such
illnesses as Guinea worm disease,
trachoma and yaws.

The success of the smallpox eradica-
tion campaign was a key element
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health programme in history – the
Expanded Programme on Immu-
nization (EPI), launched in 1974. EPI
initially aimed to vaccinate children

compared to 2000 data. The target is challenging, and its
attainment will require sustaining the progress made in those
countries that performed well and making large inroads in
countries with high numbers of measles deaths, such as India
and Pakistan. There is some way to go in the fight against
measles – 345,000 people died of the disease in 2005, and
90 per cent of them were children under five. This highly
contagious disease remains an important cause of under-five
deaths, accounting for about 4 per cent of the global burden.
It weakens children’s immunity to other life-threatening dis-
eases and conditions, including pneumonia, diarrhoea and
acute encephalitis, and remains one of the leading causes of
vaccine preventable deaths among children.

The success of efforts to reduce measles in 1999–2005 has
shown what can be done if political will, financial commitment
and sound strategies on the part of international partners and
national governments are implemented to deliver proven,
cost-effective treatments. Provided that this degree of commit-
ment is sustained, there is every reason to believe that the
new target can be met, helping advance progress towards
Millennium Development Goal 4.