the sharp fall in the global under-five mortality rate, from 115 per 1,000 live births in 1980 to 93 in 1990 – a reduction of 19 per cent over the course of the decade.

**Focusing on integrated, sector-wide approaches and health systems: 1990s**

Despite the gains of selective primary health care, by the late 1980s, health systems in many developing countries were under severe stress. Population growth, the debt crisis in many Latin American and sub-Saharan African countries, and political and economic transition in the former Soviet Union and Central and Eastern Europe were but three of the contributing factors.

In response, a number of countries embarked on efforts to reform deteriorating, under-resourced health systems, raise their effectiveness, efficiency and financial viability, and increase their equity. The **Bahmako Initiative**

One such approach used by many countries was the Bahmako Initiative, which was launched in 1987 at the World Health Organization meeting of African health ministers in Bamako, Mali. This strategy focused on increasing access to primary health care and meeting basic community needs in sub-Saharan Africa by delivering an integrated minimum health-care package through health centres. A strong emphasis was placed on access to drugs and regular contact between health-care providers and communities. (See Panel, page 36, for further details on the Bamako Initiative.)

**Integration**

The emphasis on integrating essential services that was a central feature of the Bahmako Initiative was to become the driving force of approaches in the 1990s. Integrated approaches sought to combine the merits of selective primary care and primary health care. Like selective approaches, they placed a strong emphasis on providing a core group of cost-effective solutions in a timely way to address specific health challenges; like primary health care, they also focused attention on community participation, intersectoral collaboration and integration in the general health-delivery system.

A long-standing example of the greater emphasis on integration during the 1990s is IMCI, the Integrated Management of Childhood Illness. Developed in 1992 by UNICEF and WHO, and employed in more than 100 countries since then, IMCI adopts a broad, cross-cutting approach to case management of childhood illness, acknowledging that there is usually more than one contributing cause. Indeed, in many cases, sick children exhibit overlapping symptoms of disease, complicating efforts to arrive at a single diagnosis even in communities with adequate first-level examination facilities, let alone those with more challenging circumstances.

IMCI strategies have three primary components, each of which requires adaptation to the country context:

- **Improving health worker performance:** This involves training health workers to assess symptoms of diseases, correct mapping of illness to treatment, and provision of appropriate treatment to children and information to the caregivers.
- **Improving community and family practices:** The final component is often referred to as Community Integrated Management of

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**National immunization days and child health days**

National immunization days (NID) originated as one-day mass polio vaccination campaigns across the developing world. NIDs, which still take place in many countries, are supplementary and do not replace routine immunization. Their original aim was to prevent the spread of polio by immunizing all children under the age of five, regardless of their previous polio vaccination history.

The concept of setting aside a day for mass interventions on child health is not new. Successful trials of days took place in the 1980s in such places as Burkina Faso, Colombia and Turkey. More recently, active civil wars have been halted to provide days of tranquility that allow children to be safely vaccinated in such countries as Angola, Sierra Leone and Somalia. Mass vaccinations allow for economies of scale, as skilled professionals can supervise a cadre of volunteers, especially for oral polio vaccine, which does not require a needle and syringe.

Child health days have expanded the scope of interventions beyond polio immunization to include vitamin A supplementation, and in the case of Zimbabwe, distribution of insecticide-treated mosquito nets and other immunizations. Other countries that conduct similar events include Nepal and Nigeria.

Nepal's national vitamin A programme is particularly noteworthy because it employs an existing network of female community health volunteers to deliver the supplements. The programme is found to be highly cost-effective, with a per child death averted estimated at US$337–$397, whilst the cost per disability-adjusted life year (DALY) gained was approximately US$11–$12. The programme was steadily expanded, from the original 32 priority districts to cover all 76 districts, in annual increments of 8–10 districts over an eight-year period. Expansion was assisted by using national immunization days to advance coverage.

Integrating the delivery of a range of interventions in a single location and at a single point in time, child health days are efficient for both households and health service providers. Related concepts, such as the child health weeks, are enhancing the opportunities to immunize all children under the age of five, regardless of their previous polio vaccination history. Other countries also conduct similar interventions.

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**Health sector financing: Sector-wide approaches and the Heavily Indebted Poor Countries Initiative**

During the 1990s, concerns escalated about the potential predominance of vertical approaches, which tend to create and utilize managerial, operational and logistical structures separate from those of the national health system to address disease control. These concerns contributed to the development of a new mode of health financing: sector-wide approaches (SWAps). Under SWAps, the major funding contributions for the health sector support a single plan for sector policy, strategy and expenditure backed by government leadership. Common approaches to health service delivery are adopted across the sector, and government procedures increasingly control the disbursement and accounting of funds.

SWAps were created for several purposes: to address the limitations of project-based forms of donor assistance, ensure that overall health reform goals were met, reduce large transaction costs for countries and establish genuine partnerships between donors and countries in which both had rights and responsibilities. SWAps are a dynamic process rather than an end point, and they display considerable variation across countries. SWAps have led to greater dialogue and trust, a sharper focus on a select number of key sector priorities and closer links between policy and implementation. However, constraints include an overemphasis on planning and the development of procedures; limited civil society participation; weak performance management; and a slow shift from emphasizing donor coordination to considering service improvement and results.

At the end of the 1990s, in the context of the Heavily Indebted Poor Countries Initiative implemented by the International Monetary Fund and the World Bank, the focus on the health sector and financing reform in many low-income countries broadened to include Poverty Reduction Strategy Papers (PRSPs). Medium-term expenditure frameworks, the multi-annual public planning instruments associated with PRSPs, are used to plan future budget requirements for public services and to assess the resource implications of policy changes and new programmes.