7

Barriers to access to child health care
Barriers to access to child health care

A number of financial and non-financial barriers may delay or prevent poor households from seeking health care for their sick infants and children. Such barriers include geographical access or distance; financial barriers; sociocultural, language and ethnicity-related barriers; and lack of knowledge and awareness, which can together lead to low demand for and use of services, particularly by the poor. Each of these is briefly discussed below.

7.1 Geographical distance

Distance and long travel times to health facilities remain key barriers to access in many rural communities in the Region. A study of demand for antenatal care among pregnant women in Cebu, in the Philippines, found that health care services were less accessible for rural than urban women. The study showed that rural women faced significantly longer travel times than women living in urban areas and that the travel costs in rural areas were almost double those in urban areas. Similarly, a 1996 household survey in Papua New Guinea found that travel time to the nearest aid post (nursing station/clinic) ranged from 67 minutes in Papua/ South Coast to 28 minutes in New Guinea Island.

The coverage of cost-effective child health interventions in the developing countries of the Region is very low, and this typically disadvantages children in poorer and more marginalized areas. In Cambodia, only 38% of the rural poor population was reached by measles immunization in 2000. In comparison, the average coverage rate was 63% among the rural non-poor and 66% among the urban non-poor Cambodian population during the same year. Urban-rural disparities in the coverage of measles vaccination are also evident in Viet Nam, and significant rural-urban differences are also found in the number of children fully immunized before the age of one year in the Philippines. Evidence points to similar inequalities in the coverage of child health interventions among marginalized populations. For example, a UNICEF baseline survey in Viet Nam revealed that the coverage of measles vaccination was significantly lower in the Northern Upland provinces, with the gap in coverage between the Kinh majority and ethnic minorities ranging from 27-49 percentage points. Analysis from Cambodia indicates that the reasons that certain areas and populations are underserved with immunization services are predominantly socioeconomic, including distance from the health facility, ethnic status, poverty and low education.

7.2 Financial barriers

Even where health care services are available, the cost of seeking care may delay or prevent poor households from accessing them. The cost of seeking care may be thought of as comprising direct costs (such as user fees), indirect costs (such as costs
for transportation) and opportunity costs (such as lost wages). Such costs weigh more heavily upon poor households than non-poor. A survey from the Philippines, for example, reports that the poor pay less than the non-poor in absolute amounts, with the rich spending, on average, 10 times more on health care than the poor. However, mean health expenditure comprises a higher share of household expenditure for the poor (7%) than for the rich (5%).\(^{162}\) In Northern Mindanao, Caraga and the Autonomous Region for Muslim Mindanao, all in the southern Philippines, more than 80% of women cited lack of money for treatment of illness as the most serious problem in obtaining health services.\(^{163}\) A case study in a northern district of Viet Nam found the cost of transportation alone to be equivalent to one-third of monthly expenditure in the locality.\(^{164}\) The opportunity cost of seeking health care is likewise relatively higher for poorer than wealthier households. This is because the poor often earn income directly from their labour. Caring for sick children may divert the labour and time of poor parents away from income-generating activities, thereby reducing household income.

Insurance can provide financial protection in times of ill health. However, in the Philippines and Viet Nam, as in other countries, the poor are underrepresented in insurance coverage.\(^{165}\) In the Philippines, only 11.3% of members of the Philippine Health Insurance Corporation (PHIC) are poor.\(^{166}\) Lacking insurance and savings, poor households must often borrow money at high rates of interest or sell productive assets to cover the cost of seeking care. For example, a study in Cambodia estimated that as much as 40% of new landlessness may be due to the costs of health care.

In many societies, women are the primary caregivers for children. Yet, this role is sometimes constrained by the additional financial constraints women may face when seeking care. An analysis of the urban component of the 1998 China National Health Survey data shows that a significantly smaller percentage of women (41.9%) than men (46.3%) were covered under the Government Insurance Scheme or the Labour Insurance Scheme. The study suggests that this is because women in China are less likely to be employed in the formal sector, more likely to be laid-off and less likely to be rehired than men.\(^{168}\) Across countries, women often have less control over the allocation of household assets, such as income and household time, than men.\(^{169}\) This arises from their generally lower intrahousehold bargaining power relative to that of their male partners. The ability of women to make decisions benefiting their health and that of their children may thus be curtailed. For example, although higher household income has been found to increase the likelihood of women receiving antenatal care and skilled assistance during delivery,\(^{170}\) evidence from Indonesia shows that use of health care services, as measured by antenatal visits and visits during the first trimester of pregnancy, is less common among women who have relatively little control over household resources.\(^{171}\) Further, the time that women are able to devote to seeking health care for themselves and their children is often constrained by the heavy demands placed on their time by their multiple productive and reproductive roles.
7.3 Sociocultural, language and ethnicity-related barriers

Besides women’s unique financial barriers, various other gender-related barriers may likewise constrain women in seeking health care for themselves and their children. Their male partners’ dominance or lack of support and prejudice affect women’s and children’s access to health and other community services. A study conducted in Diandong County in rural China, for example, found that 45% to 55% of women respondents required their husbands’ permission to go to the market, clinic or natal village. In addition, poor women have been found to be particularly sensitive to the behaviour of health staff and may not access formal services when they perceive health care providers as disrespectful and insensitive to their needs.

Ethnic minorities and other marginalized groups may face particular barriers when seeking health care in the Region. A study from Viet Nam that was published in 2002 observed that ethnic minorities use health care facilities less often (24%) than the majority ethnic group (34%). It is suggested that this is because of their limited knowledge of the majority language and the high cost of transportation. Other studies explain that health care providers may be unresponsive to or may not understand the needs of ethnic minorities.

7.4 Lack of knowledge and awareness

The generally lower levels of health-related knowledge and awareness among poor and marginalized groups may result in low demand for health care services. To realize the benefits of seeking care for sick children, caregivers must know where and when to seek appropriate health care. Delays in seeking health care have been estimated to contribute up to 70% of child deaths.

However, health information may not reach poor and marginalized populations for a variety of reasons, including physical distance to health centres and limited outreach in many areas. Low levels of education and linguistic or cultural barriers may likewise make health information or other health-related information, education and communication (IEC) inaccessible. This may be especially true for ethnic minorities, who often live in rural and remote areas and face unique cultural and linguistic barriers. Women’s typically lower levels of literacy may likewise place many forms of health information, such as print media, beyond their reach, while restrictions on their mobility may limit their exposure to new health-related ideas and practices.

7.5 Inequalities in quality of care

Even when children from poor families are successful in accessing health care facilities, they often receive lower quality care than their non-poor counterparts, as the quality of care extended by health facilities serving poor and marginalized populations is typically lower than of those serving non-poor populations. Facilities serving poor communities are less likely to have well trained staff or to be stocked with
appropriate drugs and equipment than facilities located in better-off communities. Poor households in Viet Nam explain that the low quality of services deters them from seeking care in public facilities, although 97% of communes have a health centre.\textsuperscript{179} In the Philippines, satisfaction with the quality of care in public health facilities was found to be lowest for primary health care facilities, which typically serve poor populations. In such facilities, diagnosis was described as poor, thus necessitating repeated visits, and medicine and supplies were reported as often being out of stock, especially in rural areas. Primary health care staff were perceived as lacking in medical and people skills, waiting times were long, schedules very inconvenient and facilities rundown.\textsuperscript{180}

Low quality health care contributes to the lower survival rates among poor children. For example, a prospective systematic review of consecutive deaths in children over a 24-month period (April 1998-March 2000) in a rural hospital in the Eastern Highland Province of Papua New Guinea suggests that a lack of skilled maternal care was a factor in 39.6% of all neonatal deaths.\textsuperscript{181} Demand for child health interventions is thus constrained by the actual or perceived low quality of the health care system in general, and of child health interventions in particular.
Ill health among children leads to greater poverty
Ill health among children leads to greater poverty

8.1 Poorer child health leads to greater poverty in that generation

For the poor, the link between poverty and ill health is clear: ill health leads to greater poverty and good health is key to ensuring higher productivity and increased income. The consequences of ill health are a key reason for impoverishment among many of the poor. For example, serious disease has forced 15% of households to the brink of poverty or into poverty in Mongolia. Impoverishment arises because the cost of seeking medical treatment weighs more heavily on the poor than the non-poor, as briefly discussed above. The impact can be especially severe if poor households are forced to sell productive assets, such as land or livestock, or to remove their children from school. Various estimates suggest illness as a primary cause of impoverishment among 20%-50% of households living below the poverty line in rural China. Poverty can also be measured by the change in the poverty head count, i.e., the proportion of the population in poverty. In Viet Nam, which has a food-based poverty line, overall spending on health care added approximately 4.4% to the poverty head count in 1993 and 3.4% in 1998. More specifically, case studies from Lao Cai, a province in northern Viet Nam, suggest the impoverishing effects on households of seeking health care for their children.

Morbidity and mortality in childhood may reduce household income by compelling parents, more frequently mothers, to substitute income-generating activities with caring for their sick child. Limited assets and access to resources force poor households to rely mainly on their labour for their livelihood. A decrease in productivity or time away from work can thus result directly in a reduction in household income. Besides, illness and undernutrition in childhood are increasingly associated with lower productivity in the longer term. Poorer health outcomes and limited educational attainment together result in lower levels of human capital, which has been shown to be the basis of an individual’s economic productivity. Undernutrition, micronutrient deficiencies and illness in childhood have been found to impair cognitive development, school attendance and learning capabilities. In Cebu, in the Philippines, children who were stunted at the age of two years were observed to have significantly lower test scores than their peers. Within the study population, stunted children tended to start school later, and by age eleven, they were three times more likely to have dropped out of school, 1.8 times more likely to have repeated a grade and 1.2 times more likely to have been absent in the month before the interview than their peers. Poor health (or disability) was the main reason cited for school dropout, followed by economic constraints.

Households in countries that experience high infant mortality rates tend to have bigger families. Having more children can lower the ability of families to adequately invest in the health and education of each child.

8.2 Poorer child health leads to greater poverty in the next generation

The effects of poor child health also spill over into the next generation. Adults who survive undernutrition and illness during childhood are physically and intellectually
less productive than adults who were well nourished as children. Across developing countries, studies have shown that adult height is strongly and positively correlated with adult earnings. In the Philippines, studies of agricultural workers report that adults who are stunted due to poor childhood nutrition are less productive and earn lower wages than adults of average height. Further, adults who were undernourished as children are likely to suffer higher levels of chronic illness and disability than their better nourished counterparts. Reduced productivity and fewer hours spent working result in lower individual labour income. At the national level, poor population health depresses the returns on investments in business and infrastructure. This arises from absenteeism and high employee turnover, resulting in increased hiring, for example.

Coupled with the long-term costs of reduced household investments in children, the aggregated social costs of poor child health are staggeringly high. The high cost of poor child health to countries is confirmed by a UNICEF study of economic growth in 49 countries from 1990 to 2001. The study found that countries with a baseline of low infant mortality and income poverty in 1980 achieved the highest rates of economic growth within the decade. Conversely, countries with high levels of infant mortality and/or high levels of income poverty in 1980 experienced a decade of economic decline.
The importance of tackling inequalities in child health
The importance of tackling inequalities in child health

As the discussion above shows, although the Western Pacific Region has realized impressive gains in child health outcomes, inequalities in the survival prospects between children living in less and more advantaged households persist and even appear to be growing in some cases. This suggests that, although many cost-effective child health interventions are being implemented in the Region, their coverage is still low, particularly among the poor. Renewed efforts are therefore required to address poverty and inequality in child health.

There are at least three main arguments for increased efforts in tackling inequalities in child health: efficiency, equity and human rights.

Recent estimates from the World Bank reveal that only 17% of the population in the East Asia and Pacific region resides in countries that are on track towards reaching the MDG 4 target for child mortality reduction. Pro-poor child health interventions that aim to tackle the major causes of disease and death suffered by poor children may provide a more efficient means of reducing the average burden of child mortality in countries. Efforts aimed at eliminating inequalities in child health may thus be an effective means of meeting MDG 4. For example, estimates suggest that achieving MDG 4 in Viet Nam may be challenging because of the slow rate of decline in child mortality among the poorer income quintiles. Addressing the various factors affecting higher child mortality among the poor in Viet Nam may also mean taking steps to attain the other MDGs. Collectively, such efforts can result in more rapid progress towards achieving the MDG 4 target for child mortality reduction. Besides, there are linkages between improved child health outcomes and poverty reduction at the household, community and national levels. A recent study from the Philippines estimates that a US$ 1.00 investment in an early childhood nutrition programme would yield at least a 43% return in higher income and better educational outcomes among the beneficiaries of the programme. This is linked with preventing the perpetuation of intergenerational poverty.

Equity constitutes another strong rationale for addressing the needs of the poor in child health programmes more effectively. Inequalities in child health outcomes are increasingly thought to amount to inequities, which are deemed to be avoidable and thus unfair or unjust. Inequities in child health are understood to reflect underlying inequities in the distribution of wealth, resources and social privilege in society, rather than individual choice or behaviour. Efforts are therefore required to tackle inequities in the burden of morbidity and mortality among poor children.

Finally, there is a compelling human rights rationale for developing and implementing more pro-poor child health policies, strategies and programmes. The right to the
highest attainable standard of physical and mental health, or the right to health, is rooted in the Universal Declaration of Human Rights and in WHO’s Constitution and is further supported by the Convention on the Rights of the Child, which recognizes every child’s right to health and health care. Article 24 of the Convention obliges ratifying parties to “pursue full implementation of this right and, in particular, [to] take appropriate measures… to diminish infant and child mortality.” The Convention and its monitoring mechanisms can potentially promote the accountability of stakeholders for improving child health. To date, every country in the world is party to at least one human rights treaty that addresses health-related rights. A human-rights-based approach to child health requires that services must be accessible, affordable, appropriate and of good quality for all.
Addressing inequalities in child health
Addressing inequalities in child health

Cost-effective technical interventions exist for many of the major causes of childhood morbidity and mortality. A recent analysis of child health interventions concluded that at least one level-one curative or preventive intervention that is appropriate for delivery in low-income settings exists for each of the main causes of child mortality, except for birth asphyxia. Further, if level 1 (sufficient evidence of effect) or level 2 (limited evidence) interventions were universally available, 63% of child deaths could be prevented. However, experience suggests that interventions or programmes alone will not bring significant gains. More than technical interventions, what seems to be missing are adequate resources, political commitment and appropriate health systems to ensure that these interventions reach the poor and achieve acceptable coverage levels that can lead to significant reductions in child mortality.

Evidence on effective and efficient strategies to deliver those interventions to poor and underserved communities and households is slim. However, the evidence base is slowly being augmented and refined through various pro-poor delivery strategies that are emerging and being piloted in communities around the world, including the Western Pacific Region. Similarly, lessons on methods to stimulate demand for child health interventions among poor and marginalized communities are slowly being learnt. Based on such experience, the discussion below seeks to identify possible approaches to reducing inequalities in child mortality. It aims to build on successful experiences gathered from diverse countries throughout the Region and to suggest some possible ways forward.

There are two broad strategies that may be followed to address inequalities in child survival. While distinct, the strategies may complement one another in important ways if approached simultaneously. Such synergies may result in greater opportunities, support and resources for tackling inequalities in child health. The two broad strategies are outlined below.

10.1 Mainstream child health and survival in national and international poverty-reduction strategies

Improved health in childhood is increasingly viewed as a cornerstone of human development and poverty reduction. Safeguarding health early in life has been shown to be a key element in building human capital, increasing productivity and enhancing economic growth. Better child health likewise moves towards protecting households against the impoverishing costs of seeking health care, in both the short and longer term. There is growing international support for increased investment in child health interventions as an effective poverty-reduction strategy. This is clear from the increasing recognition of the importance of the MDGs, and also from the recommendations of the Commission on Macroeconomics and Health. By affording a central place to child survival, the MDGs highlight the interrelationship between child health, poverty and development: improved child health is a vital aspect and effective means of tackling poverty. The Commission on Macroeconomics and Health has called attention to the powerful linkages between health beginning in childhood, and economic development. Building on that concept, child health needs to be promoted as central to human development and poverty reduction.
Integrated Management of Childhood Illness (IMCI) is a strategy for improving child health and development through the combined delivery of essential child health interventions. However, financial investments to address the constraints to effective implementation of IMCI have been inadequate. Mounting evidence on the association between improved child health outcomes and poverty reduction may likewise be harnessed to advocate for new and increased resources for child survival interventions. Various examples of such global initiatives already exist. More resources for child health are being made available through EPI and the Global Alliance for Vaccines and Immunization (GAVI). Roll Back Malaria, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the 3 x 5 Initiative may also lead to improved funding for child health initiatives within the broader framework for tackling infectious diseases, specifically AIDS and malaria. The Bellagio Study Group on Child Survival explains, however, that although these health initiatives have increased funding for interventions to reduce child mortality, they have done so solely in a disease-specific context. Greater advocacy is thus required to focus new and increased resources towards a more coordinated and comprehensive approach to child survival and maternal health interventions that includes health systems strengthening.

Efforts to enhance the allocation of resources towards child health interventions are likewise required at the country level. The ongoing Poverty Reduction Strategy Papers (PRSP) process was anticipated to be an effective vehicle for increasing the allocation of government resources towards the health sector. However, recent desk review of 21 final PRSP, undertaken by WHO, concludes that PRSP are unlikely to result in large increases in resources available for health. The review finds that even the more optimistic assessments of the level of health funding that may be made available through the PRSP process fall short of those advocated by the Commission on Macroeconomics and Health (see Box 1). Another assessment suggests that very few PRSPs completed to date contain a strong health component supported by resource allocation across sectors that would increase the probability of realizing improved child health outcomes.

While increased resources can improve child survival interventions delivered within the health sector, a cross-sectoral response is also required to address the multiple determinants of child health that lie beyond the health sector. Such cross-sectoral strategies aim to reduce the exposure of poor children to the risks of ill health. Improvements in child health thus also depend on cross-sectoral collaboration on a range of strategies, including eliminating inequalities...
in income, educational attainment and nutritional status; ensuring access to water and sanitation and safe and adequate housing; developing appropriate agricultural policy; improving the status of women; and promoting social protection for vulnerable populations.

The PRSP process potentially provides an arena for such a cross-sectoral approach. Effective cross-sectoral partnerships may also be developed at the community level (see Box 2).

Recognizing that social disadvantage strongly influences health, WHO recently launched the Commission on Social Determinants of Health. Here, WHO defines social determinants of health as all “factors influencing health that are shaped by people’s different positions in society.” The Commission will gather evidence on the pathways through which social determinants lead to ill health and health policies and interventions to successfully address those social determinants.

### 10.2 Ensure a focus on poverty and equity in child health interventions

Inequalities in child survival are not the result of a lack of technological solutions. Rather, poor children continue to suffer because cost-effective child health interventions fail to reach them. It has been estimated that taking existing child health interventions to scale can result in a two-thirds reduction in child mortality, ensuring achievement of the MDG 4 target for child mortality reduction.

Significantly insufficient investments and other factors described in the previous section have prevented child health interventions from reaching children in poor households and communities. Within the basket of effective child survival interventions, however, some have been more successful in reaching poor children than others. A World Bank analysis using DHS data from over 40 countries, for example, suggests that greater progress has been made in reaching poor children through professionally delivered interventions (skilled birth attendance, treatment of common childhood illnesses) than through home-delivered interventions (breastfeeding and timely complementary feeding). Evidence suggesting that IMCI has led to improved equality in child survival has recently become available through the IMCI Multi-country Evaluation on its cost effectiveness and impact. IMCI-based care, for example, offers an opportunity to reduce out-of-pocket payments among the rural population of Southern Tanzania, mainly through more rational use of antibiotics. This has led to improvements in child health that did not occur at the expense of equity.

Child health policy and programme goals and targets are generally formulated in terms of maximizing health gains among children within a given population in the aggregate.

---

**Box 2: Microcredit in Bangladesh**

Since 1978, approximately half of the villages in the Matlab district of Bangladesh have been served by the maternal and child health and family planning (MCH-FP) project of the International Center for Diarrhoeal Disease Research, Bangladesh (ICDDR,B). In 1992, BRAC (formerly the Bangladesh Rural Advancement Committee) launched a women-focused development project targeting very poor women in a number of villages covered by MCH-FP. In the following decade, a study recorded a larger decline in the mortality rate among infants whose mothers participated in the BRAC project compared with infants of non-participating women with similar socioeconomic backgrounds. The study suggests that the BRAC inputs, including savings, credit, skills development, leadership roles and social awareness, led to greater self-confidence and the ability to allocate resources more effectively among participants. These may have positively impacted the many determinants of child survival.

Source: Bhuiya A., Chowdhury M. 2002
For example, the average IMR or U5MR are commonly used indicators. Since achievements are traced at the aggregate level, it is theoretically possible that those goals may be achieved with little or no improvement in the health of poor children. Such concern has been expressed regarding the MDG for child health, which requires a reduction in the U5MR by two-thirds between 1990 and 2015. Reformulating child health goals to specifically recognize the need to improve the health of children from poor and marginalized households can help ensure that measurable progress will simultaneously be made among those populations. Such goals also provide the framework for pro-poor child health service delivery strategies. When reformulating child health goals, effort is required to ensure that the terms ‘poverty’ and ‘poor children’ are clearly defined and understood to refer to specific groups, such as income-poor households, urban slum populations, rural communities or ethnic minorities, as appropriate within the given local or country context.

When combined with case studies of successful child health service delivery strategies, the evidence begins to suggest possible means of increasing the accessibility of child health interventions for the poor. Inequalities in the burden of childhood disease may be tackled by ensuring that the poor are able to benefit at least proportionately from health sector resources allocated to child survival interventions. This may be achieved by prioritizing innovative child survival interventions that aim to improve the accessibility of health care for poor children. Few, if any of the examples of child health service delivery strategies outlined below have been taken to scale and the quality and quantity of evidence available to evaluate them is variable. However, they suggest some ways forward (see Box 3).

**Box 3: Preventive interventions in selected low-income countries**

Using data from the Integrated Management of Childhood Illness (IMCI) Multi-Country Evaluation (MCE) baseline surveys in Bangladesh, Northeast Brazil and Tanzania, a recent study investigates the distribution of key preventive interventions among children under five years of age. Specifically, the study seeks to assess whether preventive child survival interventions were concentrated among some children at the expense of others. The coverage of six preventive interventions was considered: having received one dose of BCG vaccine, three doses of DTP, and one dose of measles vaccine; having slept under a mosquito net on the night preceding the survey (except in Brazil, where there was a lack of information on the coverage of mosquito nets); having taken one capsule of vitamin A in the preceding six months; and having received nutrition counselling or growth monitoring interventions. Households were ranked according to a country-specific asset index.

The results show that at least five interventions reached 7% of children in Tanzania, 16% in Bangladesh and 13% in Brazil. The proportion of children failing to receive any intervention was 13% in Tanzania and 2% in Bangladesh, while in Brazil every child received at least one intervention. A clear association between the number of interventions children received and their household socioeconomic status was observed in Tanzania and Bangladesh, while a weaker association was found between socioeconomic status and access to child health interventions in Brazil, which might be explained by the near universal coverage of many interventions in that country.

The paper hypothesizes that mediocre coverage levels with several interventions delivered simultaneously may result in increasing inequalities. The study questions whether the strategy of delivering a few child health interventions at high coverage is a better goal than seeking to deliver several interventions simultaneously, which may achieve only low coverage.

a. **Prioritize underserved areas in resource allocation**

In general, low coverage of child health interventions among poor or marginalized population groups is observed in many countries in the Region. Children residing in urban areas and in better-off households are often more successful in accessing care than children living in rural areas or in poor households. The resulting inequalities in access to child health services may perpetuate inequalities in child survival. Redirecting resource allocation for child survival interventions towards underserved populations and remote and isolated communities may thus benefit poor children. A population or needs-based formula may be employed to reallocate child health resources towards rural or otherwise underserved areas. Child health services may also be expanded into underserved areas by offering financial incentives to nongovernmental organizations (NGOs) or private providers. Services by NGOs in particular may be more accessible for the poor and more likely to serve rural or remote populations (see Box 4).

b. **Invest in primary health care**

Evidence suggests that the poor benefit more from public spending on primary health care than from total public health spending. In the 2003 Human Development Report, the United Nations Development Programme (UNDP) reports that, in countries where the poorest 20% of the population benefits from more than 25% of

---

**Box 4: Contracting nongovernmental organizations to deliver child health interventions in Cambodia**

Based on recent evidence from Cambodia, contracting NGOs to deliver primary health care services may be an effective and equitable means of increasing the coverage of child health interventions in rural areas.

Beginning in 1998, two contracting models were assessed in Cambodia: contracting-out and contracting-in. For contracted-out districts, the contracted NGOs had complete responsibility for the delivery of specified services, employed health care staff directly and had full management control. In contrast, contracted-in NGOs provided management support to health staff retained by the Government, which also provided for recurring costs. The contracted districts received a budget supplement of approximately US$ 0.25 per capita, the allocation and management of which fell to the contracted NGOs (within government rules and regulations). The control districts received a comparable budget supplement. Three operational districts were contracted-in, two operational districts were contracted-out and four served as control districts.

The results of an evaluation in 2001 show that, within 2.5 years, the contracted districts performed significantly better than the control districts. For example, the use of antenatal care increased by 401.5% in the contracted-out districts, 233.3% in the contracted-in districts and 160.1% in the control districts. Further, the evaluation shows that poor households benefited disproportionately in the contracted districts, where much of the increased utilization of health care services was a result of increased uptake among the poor.

Immunization coverage increased in all nine districts and inequalities in coverage between children in poor and non-poor households appeared to have decreased. The likelihood of being fully vaccinated was found to be lowest among children from the poorest 50% of households overall, although children in the contracted districts fared better than children in the control districts. Among children from the poorest 50% of households, 59% of those in the contracted districts were immunized by the time of the evaluation, compared with 47.8% of those in the government-run districts. The contracted districts thus appear to have achieved greater success in targeting children from poor households than the control districts.

Source: Bhushan I., Keller S., Schwartz B. 2002; Schwartz J., Bhushan I. 2004
public spending on primary health care, fewer than 70 per 1000 children die before the age of five years. Conversely, in countries where the poorest 20% receive less than 15% of public spending on primary health care, the under-five mortality rate is above 140. In many countries, the costs associated with seeking health care are lower when accessing primary care than higher levels of care. Thus improving the quality and coverage of child health services located in primary health care through greater resource allocation may be an effective means of enhancing the accessibility of health care services for the poor (see Box 5).

IMCI builds on this approach by enhancing the capacity of health workers who manage childhood illnesses in primary health care facilities and strengthening health systems to support implementation.

c. Reduce financial barriers

The cost of seeking health care for sick children may be more than poor households can bear. Methods to reduce that cost may therefore improve the accessibility of health care services for poor children. The WHO-UNICEF Regional Child Survival Strategy recommends that the direct costs of seeking care and user fees should be reduced through tax-based systems, social health insurance, private health insurance (including community-based health insurance) or mixes of these. Insurance, in particular, can offer protection to poor households against catastrophic health care costs, as it separates payments from utilization (see Box 6). Extending insurance to poor and vulnerable populations may thus improve the coverage of health care services for poor children. Community health insurance schemes offer such a possibility. However, evidence suggests that community-based health insurance schemes tend to miss the very poorest among the population, who subsist from day to day, because premiums are often required to be paid in advance.

d. Prioritize health conditions affecting poor children

Poor children suffer a disproportionate burden of morbidity and mortality. An estimated 70% of child deaths are caused by pneumonia, diarrhoea, measles, malaria and undernutrition. Allocating resources towards interventions targeting those conditions is thought to benefit children from poor households. Various examples of this strategy exist, including EPI, GAVI and IMCI.

The IMCI approach combines a number of complementary essential child survival interventions at the health facility, community and referral levels to address the conditions responsible for the majority of child deaths in developing countries. Evidence from the IMCI Multi-country Evaluation shows that IMCI training leads to improved quality of care among primary health care workers managing children.
For example, the evaluation carried out in Tanzania shows that IMCI training was associated with significantly better case management than existing training approaches.

**e. Target service delivery towards poor populations**

Child health service delivery strategies should aim to efficiently and equitably allocate resources in ways that benefit poor children. However, this does not always happen. For example, although diarrhoea and ARI are diseases of poverty and interventions are available, children with those conditions from better-off households are more likely to be taken to a trained health care provider than those from poor households. On the other hand, poor children who are sick may not be taken for care or may be taken to facilities with untrained health personnel or limited resources. The aforementioned interventions should be delivered through various pro-poor strategies to increase the accessibility of health services for poor children. Targeting poor children and tailoring service delivery to meet the needs of poor households are moves towards increasing the accessibility of child survival interventions.

Interventions may be targeted at poor children directly, through means testing, or indirectly, on the basis of some characteristic, such as geographical location or membership of a vulnerable group, including ethnic minorities, street children or landless farming households. Given that inequalities in access persist between urban and rural areas, with rural areas generally poorer than urban areas, expanding child survival interventions into rural and remote areas can improve accessibility for poor children. Regular outreach and deployment of mobile teams in underserved, remote or mountainous areas may also improve the accessibility of child health interventions.

**Box 6: Reducing financial barriers to child health interventions in Yunnan Province, China**

A voucher system may be an effective method of protecting poor households from the impoverishing cost of seeking health care. A poverty alleviation fund established in Yunnan Province in China through a World Bank-supported maternal and child health project appears to have increased the utilization of health services among poor households.

The fund was used to subsidize health care costs for the poorest 5% of households in the project area. Beneficiaries were identified through a participatory process, using criteria developed by local councils. Pregnant women from the identified households were then given vouchers that could be used to obtain ante- and post-natal care, delivery attendance and medical treatment for common childhood illnesses. The poverty alleviation fund reimbursed health facilities for the cost of services obtained by poor women through the vouchers.

Preliminary results reveal that the voucher system had a significant impact on the usage of health care services by poor households. For example, among poor households in Nanhua, the proportion of children with diarrhoea receiving treatment increased from 67.3% in the year before the introduction of the voucher system to 81.1% in the year following its introduction. During that period, the proportion of non-poor children with diarrhoea receiving treatment increased from 77.2% to 82.5%. While the proportion of children from non-poor households in Huize, a control area, increased from 75.0% to 77.4% during the same period, the increase among poor households was marginal (63.1% to 64.1%). Thus, reducing the direct cost of health services in the project areas seems to have contributed to improved health-seeking behaviour among poor households.

by bringing care closer to poor households. The coverage of child health interventions may also be expanded through networks of community health workers or local organizations. Service delivery needs to be tailored to reach underserved populations, such as the children of urban poor households, migrants and landless labourers. Such strategies may be undertaken in collaboration with NGOs and private practitioners (see Box 7).

f. **Promote information, education and communication**

Appropriate IEC strategies may increase knowledge and awareness to change behaviour among poor households on key family and community practices, such as exclusive breastfeeding, appropriate complementary feeding and improved hygiene. Enhanced awareness and understanding of childhood illnesses and where and when to seek preventive and curative services can likewise lead to greater demand for health care services. However, low levels of education and literacy, together with limited access to standard modes of mass communication (radio, television) in some communities, may place much of traditional IEC beyond the reach of poor families. Distance, as well as cultural and

---

**Box 7: Outreach strategies can improve the accessibility of child health interventions for the poor**

There are various examples of delivery strategies that are being implemented in the Region to increase access to child health services for poor households. The Primary Health Care Project in the Lao People’s Democratic Republic outlined above, for example, has mobile outreach clinics that visit remote villages every three months. The mobile clinics offer vaccinations, family planning services, antenatal care, and health education for malaria and diarrhoea prevention in particular. In Papua New Guinea, Save the Children Australia and New Zealand are implementing the East Sepik Women’s and Children’s Health Project. The project has trained and supported a network of women volunteers who provide health care to their communities in five districts where other health services are mostly absent. A second Save the Children project in Papua New Guinea seeks to increase vaccine coverage in remote areas of the Lufa district in the Eastern Highlands. The Health Services and Faith Mission project uses foot patrols to deliver immunization services to 18 villages.


---

**Box 8: Behavioural change in Viet Nam**

In 1993, Save the Children US implemented a poverty-alleviation and nutrition project (PANP) in ten rural communities in Thanh Hoa Province in Viet Nam. The project included four components: community registration; growth monitoring and promotion; positive deviation inquiry; and a nutritional education and rehabilitation programme. Village members and project staff used the positive deviation inquiry approach to identify families which had an older child who had received better nutrition through a previous PANP intervention and a younger child who had not participated. The control group of families had two children, neither of which had received a nutrition intervention. Such an approach is seen to be effective because it identifies behaviour changes in the project group that are affordable, acceptable and likely to be sustainable. Families in the project group were then interviewed and observed to identify feeding and child care practices that could account for the better nutritional status of their children. Findings from the positive deviation inquiry approach formed the content of the nutritional education and rehabilitation programme, which aimed to rehabilitate malnourished children and teach caregivers to sustain improvements.

The long-term impact of the project was assessed in 1998 and 1999. The results of the two surveys show that, in the four communities covered, the nutritional status of children who had participated in the PANP and their younger siblings was better than that among children in a control commune. Feeding, hygiene and health-seeking practices were also observed to be better among mothers in the four communities covered by the project than in the control district. For example, more mothers in the project communities were found to be breast-feeding (41%) in 1998 than mothers in the comparison community (20%). The success of the poverty-alleviation and nutrition project in improving the nutritional status of children has resulted in its replication in communities across the country.

linguistic barriers, may also prevent IEC messages from reaching poor communities, such as ethnic minorities. Focused efforts are thus required to ensure that the strategies, methods and messages used are tailored to ensure accessibility for the poor. This may include materials designed for low literacy levels or messages that are culturally appropriate and delivered in local languages. IEC may be combined with outreach or other activities to support behavioural change among the target population (see Box 8).

**g. Improve system responsiveness**

In many areas, mobilizing demand for child survival interventions through IEC activities may be ineffective if the actual or perceived quality of general health care services is low. Efforts are therefore required to improve the responsiveness and quality of health care services in general and of health workers who manage child health in particular (see Box 9). For example, monetary and non-monetary performance-based incentives may be used to improve the quality of health care providers. Beyond improving the general quality of services provided, efforts to enhance responsiveness may include improving staff attitudes and communication skills, decreasing waiting times, and increasing confidentiality, to name a few. In particular, efforts should be made to increase the awareness, sensitivity and skills of health care providers in dealing with poor and marginalized communities, to ensure that all clients, especially the poor, are treated with dignity and respect. For example, providers who speak local languages and understand the culture and customs of minority groups may be more responsive to their needs, thereby increasing demand for health care services among those communities.

**h. Ensure appropriate monitoring and evaluation**

A key constraint in addressing inequities in child health is the general lack of disaggregated data and information at the national and subnational levels. Disaggregated data are required to analyse inequalities in childhood morbidity and mortality, and in access to child health services, by various socioeconomic indicators. Such an analysis provides the basis for targeting the delivery of interventions to poor or otherwise marginalized children. To meet this need, child health data that are collected within the health sector need to be disaggregated and analysed by gender, urban-rural location, ethnicity, income level of household, region or province, or whatever other indicators of social exclusion may be practically feasible. Where possible, recording the level of

### Box 9: Improved case management in two districts of Tanzania

A health facility survey was conducted in 2000 to assess the quality of case management and health system support indicators in four districts in Tanzania. Two of the districts had been implementing IMCI since 1997, while the other two had not yet adopted the IMCI strategy. Using data from the survey on the quality of care and health facility support for children between two months and four years of age, a recent study reports that children in the IMCI districts appear to have been receiving better case management than those in the areas without IMCI. More specifically, nearly all the indicators assessed suggest that children in the IMCI area were receiving more thorough assessments, were more likely to be correctly classified, and were more likely to receive appropriate treatment than children in the comparison districts. For example, 95% of children in the IMCI districts were checked for cough, diarrhoea and fever, compared with only 36% of children in the non-IMCI districts. Similarly, significantly more children in the IMCI areas (75%) were correctly treated for pneumonia than in the areas without IMCI (40%). Counselling and communication skills were reported to be better among IMCI-trained health workers than among health workers who had not been trained in IMCI. Concerning parental knowledge, higher levels of correct knowledge about how to care for their sick children were reported among caregivers in the IMCI areas than among caregivers in the areas without IMCI.

educational, occupational or socioeconomic status of children’s households allows for a more comprehensive analysis. The data may be supplemented by case studies to identify various financial and non-financial barriers poor children may face when accessing health care. Disaggregated data may also be used to monitor changes over time and progress towards meeting pro-poor child survival goals. Along with better quality disaggregated information, it is important to move towards greater community participation in the monitoring and evaluation process. Such participation can potentially improve accountability and promote the empowerment of communities.
Conclusion
Conclusion

The persistent and growing inequalities in child survival that are witnessed throughout the Region demand renewed commitment and concerted action for child health. Increased efforts are required to ensure that child survival interventions reach poor and vulnerable children. Such efforts may be guided by the experience of various countries across the Region and beyond on health service delivery strategies that have proven to be effective in benefiting poor households. While much of that experience has been built through small-scale context-specific interventions, it suggests some ways forward. The evidence base for pro-poor health service delivery strategies may be augmented through the collection and analysis of disaggregated child health data and more rigorous evaluation of child health service delivery strategies being implemented in the Region. Greater commitment to effective, equitable and sustainable child health service delivery strategies will mean a concrete move towards meeting the Millennium Development Goal for child mortality reduction.
References


REFERENCES


Mackintosh U, Marsh D, Schroeder D. Sustained positive deviant childcare practices and their


Vega J. *Presentation on Commission on Social Determinants of Health*. 89th Consultation of WHO Representatives and Country Liaison Officers, Manila, World Health Organization, Regional Office for the Western Pacific, 2004 (PowerPoint presentation).


Victora C. *et al*. Co-coverage of child survival intervention in Tanzania, Bangladesh and Brazil.


World Health Organization Regional Office for the Western Pacific. *Health Indicators,* 2004. (http://www.wpro.who.int/hin/default.asp)


Endnotes


6 Ibid.

7 The World Bank uses the World Bank Atlas method to classify countries according to their GNI per capita. Countries with GNI of US$ 765 or less are classified as low-income countries, while those with a GNI of US$ 766-1035 are classified lower-middle income countries. For more information please see: http://www.worldbank.org/data/countryclass/countryclass.html

8 United Nations Development Programme (http://hdr.undp.org/statistics/data/indic/indic_8_1_1.html)

9 Op cit. Ref 5


19 Ibid.


30 Ibid.

31 National Health Survey 2000-2001 (http://www.wpro.who.int/sites/nut/data)


36 *Op cit.* Ref 24.

37 King S, Mascie-Taylor C. *Nutritional status of...


46 World Health Organization Regional Office for the Western Pacific. Child and Adolescent Health and Development Focus. Nutritional status by country [http://www.wpro.who.int/themes_focuses/theme2/ focus2/themes2_focus2data.asp]


48 Op cit. Ref. 23.


50 Op cit. Ref 23.


52 CAH/EIP CHERG estimates *Op cit*. Ref. 5


55 *Op cit*. Ref. 23.


59 The IMR in Ho Chi Minh City is 10.5 per 1000 live births and is 82.6% in Kon Tum, which is situated in the mountainous central region and which ranks among the poorest provinces in Viet Nam. In: *Millennium development goals: bringing the MDGs closer to the people*. Hanoi, United Nations Country Team Viet Nam, 2002. [http://www.undp.org/vn/undp/ docs/2002/mdg02/]


64 *Op cit*. Ref 54.


72 *Op cit*. Ref 64.


74 *Op cit*. Ref. 51.

75 *Op cit*. Ref 22.


81 *Op cit*. Ref. 29.


83 *Op cit*. Ref 22.

84 *Op cit*. Ref 47.

85 *Op cit*. Ref 34. Using data from 1992-93, Glewwe et al. note that the highest rate of stunting was in the Northern Uplands and Central Highlands, areas with the lowest average per capita expenditure, and was least common in the Southeast Region around Ho Chi Minh City.


90 *Op cit*. Ref 81.

91 *Op cit*. Ref 74. The authors define infant mortality as death during the first year of life and child mortality as death between the first and fifth birthdays.

92 The authors explain, however, that there is an insignificant association between household income and infant mortality.

93 *Op cit*. Ref. 10.

null
those children grow into in South Asia.


22 Op cit. Ref 143.


27 Op cit. Ref 112.


29 Claeson M et al. In: *Op cit. Ref 123.* The authors also considered policies that aim to achieve universal access to basic sanitation, use of clean cooking fuels and universal female primary education.


32 For example, the authors explain that estimates suggest that if men and women in South Asia had the same status, the under-three child underweight rate would drop by and estimated 13 percentage points. *Op cit. Ref 157.

33 Wong E et al. *Accessibility, quality of care and prenatal care use in the Philippines*. *Social Science and Medicine*, 1987, 24 (11): 927-944. This study analyses the results of a random sample of 3327 rural and urban women who gave birth between 1 May 1983 and 30 April 1984 in 33 sample barangays, combined with the results of a survey of public and private health facilities in those 33 barangays.


37 Op cit. Ref 53.


39 Op cit. Ref 123.

40 Op cit. Ref 51.


43 Op cit. Ref 51.


46 Op cit. Ref 141.


51 Op cit. Ref 15.

52 Op cit. Ref 164.


54 Op cit. Ref 146.


56 Op cit. Ref 63.

57 Op cit. Ref 123.


59 Op cit. Ref 16.


63 Swedish Mountain Rural Development Programme in partnership with Lao CAI province, the World Bank and the Department for International Development of the United Kingdom. Lao Cai - a participatory


189 Op cit. Ref 123.

190 Op cit. Ref 17.


197 Op cit. Ref 17.


200 Op cit. Ref 61.

201 Op cit. Ref 18.


204 A level-one intervention is defined as "sufficient evidence of effect: the working group for the paper believed that a causal relationship had been established between the intervention and reductions in cause-specific mortality among children younger than 5 years in developing countries." Jones G et al. Child survival II: How many child deaths can we prevent this year? The Lancet, 2003, 362: 65-71.

205 Op cit. Ref 74


215 Ibid.

216 Op cit. Ref 112.

