INSTITUTE OF CURRENT WORLD AFFAIRS

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c/o Tourist Mail
U.S. Embassy
01 BP 1712
Abidjan, Ivory Coast

Saving the Children

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Mr. Peter Bird Martin
Institute of Current World Affairs
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Dear Peter,

More than two million black African children under 5 years old will die this year due to diseases we hardly worry about anymore in the States: measles, tuberculosis, diarrheal illnesses, tetanus, whooping cough, diphtheria. The U.S. Agency for International Development (AID) and the Center for Disease Control (CDC) in Atlanta are about to launch a health program for the continent, initially projected to cost $550 million over 10 years, to end this loss of young lives.

Combating Childhood Communicable Diseases (CCCD) grew out of the worldwide smallpox eradication program, which eliminated the last trace of that scourge in 1977 (although success wasn't officially proclaimed until 1979). CDC played a major role in that campaign, and it wanted to bring the administrative and technical skills it had developed to bear on other diseases that afflict people in the poorest parts of the world. It enlisted the support of AID, a project-funding arm of the State Department, but CCCD will be much more than an American aid program. It has the backing of five other Western governments and of the World Health Organization (WHO). It is designed to work cooperatively with existing and future health programs supported by these and other countries and international organizations. It also stresses participation by African governments, with a view toward their eventual take-over of the projects.

International cooperation doesn't come easily, even for a universally approved goal like protecting children's lives. In 1980, when the governments of Belgium, Canada, France, West Germany, the United Kingdom and the U.S. formed a donor-policy coordinating group called Concerted Action for Development in Africa, the U.S. laid out plans for the CDC-AID program. The other countries agreed to it. When they divvied up different areas of development assistance, the U.S. was put in charge of health. That raised a storm of protest in France, which maintains close links with many of its former colonies and prides itself on its scientific and technical assistance programs. Politicians worry about the propaganda benefits that will accrue to the U.S. Of all development programs, health projects have the most direct effect on people and are the most appreciated by

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them. The source of the outcry, however, according to an American health official, was the French pharmaceutical industry, which foresees a massive loss of business to U.S. drug manufacturers. Such fears are not unfounded, for AID policy requires that the projects it funds "buy American".

CCCD will protect children's health in three ways: immunization, diarrhea control and the care and counseling of mothers.

Estimates are that only between 5 and 10 percent of the children born in sub-Saharan Africa receive immunizations against childhood diseases. The World Health Assembly, WHO's governing body made up of representatives from United Nations member countries, has set a goal of making immunizations available to every child in the world by 1990. The target appears to be out of reach, but CCCD planners hope to attain 50 percent coverage in Africa by 1991. That would entail the immunization of more than 8 million newborn infants in that year. Protection would be given against the five major infectious diseases among African children—measles, tuberculosis, tetanus, pertussis (whooping cough) and diphtheria—plus polio.

Measles is the leading cause of death of black African children. Harry Godfrey, a CDC employee working on an immunization program in the Ivory Coast, told me that when he came to the country in 1977 as many as 165 children a month were dying from measles in one Abidjan hospital alone. The immunization program has cut the death toll to less than 150 children a year. The Ivory Coast program is a model for the CCCD plan. Working in three parts of the country, it covers about 30 percent of the population. By moving into two more areas, the program will attain 50 percent coverage by 1982. Godfrey said participation in Abidjan ranges from about 80 percent for the first injections to about 60 percent for the last in the series. Parental failure to have children immunized is not the result of resistance to the program so much as ignorance of its importance or simple carelessness, he said. Participation is better in rural areas, for once village chiefs have been convinced of the need for immunizations, almost everyone accepts them.

Dr. David French, who heads a 20-country program called Strengthening Health Delivery Systems (SHDS), of which the Ivory Coast immunization project is a part, believes that this country will have 80 percent immunization coverage by 1985. No one expects to do away with measles or the other childhood diseases as was done with smallpox. To eliminate measles would probably require providing protection to 90 percent of the world's population, Dr. French said. Vaccination of less than half that percentage was sufficient to break the smallpox cycle and have that disease die out.

Getting the vaccines, which have to be refrigerated, along with the equipment and trained personnel to scattered villages is expensive, and in AID terms it's not "cost-effective". CCCD will establish facilities in population centers and provide services to the surrounding villages, but people in remote areas won't be reached, for the first five years at least. Nor can measle immunization programs ensure protection to every child who participates. Because of differences in natural immunological systems, some children are susceptible to the disease at six months, while others are protected for a year during which time their bodies are unreceptive to the introduced vaccine.

Immunization programs give the measles injection at nine months, allowing a small percentage of children to get the disease before or after the shot.

The second objective of the CCCD program is to help children who are suffering from diarrhea. In developed countries, diarrhea is usually a minor discomfort, but for African babies it is the third leading cause of death. Acute diarrhea results in a severe loss of body fluids. Parents often do not take care to see that this fluid is replaced, nor that the child is getting enough nourishment if the disease has resulted in a loss of appetite. Worse, mothers in many areas withhold food from children with diarrhea. About one child in 10 in the Third World dies before age 5 as a result of diarrhea.

To combat the loss of body fluids in severe diarrhea, CCCD will promote the use of an oral rehydration fluid, containing salts and sugars, which can be given by mothers at home as well as by nurses. Mothers will receive information on proper feeding habits for babies, including breastfeeding for the first two years with suitable weaning foods from about the sixth month. Mothers will be told how to take care of themselves better as well, with an adequate diet, good personal and food hygiene and a decreased work load when pregnant or lactating.

Pregnant women will also receive immunizations against tetanus, protecting mother and child. Tetanus is one of the biggest killers of newborn infants. An English medical student working in Freetown while I was there estimated that 35 percent of the hospitalized babies were suffering from it. The disease is especially rampant in rural areas where a stone or rusty utensil may be used to cut the umbilical cord at birth, and mud or dung (an especially good breeding ground for the tetanus bacteria) may be used to cover wounds.

CCCD may become involved with other diseases, such as malaria, yaws (a debilitating skin disease) or yellow fever, but such projects would depend on individual country needs and willingness to participate. The program's immediate target is to immunize 30 percent of sub-Saharan Africa's newborn population, about 5 million babies, with programs in at least 20 countries by 1986. Planners hope to immunize the same percentage of pregnant women against tetanus by that year, and to provide diarrhea treatment to approximately 10 million children.

The cost of the first five years of the program is put at $150 million. AID's portion of this would be $44 million in regional funds plus an undetermined amount in bilateral aid. Under AID rules, host countries must put up at least 25 percent of the cost of their programs, and a total of at least $6 million is expected from the African governments. The remainder will come from other Western governments and aid organizations. The five-year cost of the immunization project breaks down to an average cost of about $8 to protect a child. Planners have calculated the cost of the diarrhea control at $122 per life saved.

Expanding the program to 50 percent coverage in 1991 will raise the total cost to more than $550 million. The longterm aim of the program is to improve the capacity of the African countries to provide the envisioned level of health care themselves. Training and staff development projects are budgeted to receive $7.4 million over the first five years of the program.

Although the program is scheduled to begin in the fall of

this year, it is still in the planning stage. One of the persons involved in the project is the AID regional health officer for West Africa, George Jones. The name will be familiar to readers close to the Institute of Current World Affairs. Jones studied family development in East Africa from 1969 to 1971 on an institute fellowship. After working in the health field in Colorado and earning a doctorate in medical sociology from the University of Colorado, he returned to Africa in 1976 as an AID health consultant to the Mauritanian government. He spent three years in Niger on a rural health improvement program and came to the AID regional office in Abidjan last October. He lives here with his wife, Carole, and 13-year-old son Gregory. Daughter Tami, 18, is in school in Massachusetts.

Jones has recommended that the program pay more attention to nutrition and family planning. Some critics of health programs in developing countries see mass starvation ahead if better medical care allows population growth to outstrip food production. Ominously, in Africa over the past 20 years food production per capita has declined. Jones would also like to see more staff based in Africa rather than in Atlanta. He says Africans are more receptive to suggestions from aid workers who live in the areas they are trying to help. Although CCCD is still under review, Jones doesn't expect any hitches. The Carter administration earmarked $30 million for the program, and no objections have come from the Reagan administration so far, apparently.

One criticism of the plan came from Dr. French, whose SHDS program will probably be swallowed up by CCCD, for which it has served as a successful pilot project. Although SHDS receives AID funds, the government has no direct administrative control. French feels that AID officials in Washington have interfered with his running of the program. He thinks one motive behind CCCD is to regain AID's authority over the regional health program. French would like to see AID provide money but leave program administration to experts in the field. Such a hope probably is not only unrealistic but would prove unsatisfactory, laying AID open to Congressional criticism of too little supervision over its funds.

Skeptics will always be suspicious of the objectives behind government humanitarianism, and they will cast an especially wary eye on American programs following pronouncements from the Reagan administration about getting a return on the aid dollar. As planned, CCCD seems to have little cynical political motivation or diplomatic stratagems behind it. If it goes through in its present form, Americans may be proud of their government's efforts to save the children of Africa.

Regards,

Bowden

Bowden Quinn

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