

# The Demise of Primary Health Care and the Rise of the Child Survival Revolution

## From Comprehensive to Selective Primary Health Care

For reasons we have discussed, the Alma Ata formulation of Primary Health Care came under attack almost from its inception. This attack came even from within the public health sector itself. As early as 1979, before the debt crisis and structural adjustment programs were used as arguments against it (see Part 4), Julia A. Walsh and Kenneth S. Warren of the Rockefeller Foundation argued that the comprehensive version of Primary Health Care (Comprehensive Primary Health Care, or CPHC) formulated in the Alma Ata Declaration was too costly and unrealistic.<sup>20</sup> If health statistics were to be improved, they argued, high risk groups must be “targeted” with carefully selected, cost-effective interventions. This new, more narrow approach became known as Selective Primary Health Care (SPHC).

ical interventions, determined not by communities but by international health experts. Thus Selective, Primary Health Care was quickly embraced by national governments, ministries of health, and many of the larger, mainstream international organizations.

Governments that cater to a privileged minority—with vested interests in preserving the inequities of the status quo—had been especially reticent to implement the comprehensive Alma Ata version of Primary Health Care. While no one quite dared say publicly that the Alma Ata model of PHC was subversive, almost from the time of its conception there were choruses of important voices proclaiming that it would not, could not, and did not work. These were the same governments and voices that were so quick to support Selective Primary Health Care.

## Another Setback to Comprehensive Primary Health Care: the Global Recession of the 1980s

As we will discuss in greater detail in Part 3, the 1980s brought a combination of global recession, suffocating foreign debt, devastating adjustment policies, escalating military spending, worsening poverty, and massive environmental destruction, each exacerbating the others in a vicious cycle. The underdeveloped countries, and in particular their poorest citizens, were especially hard hit—so much so that UNICEF

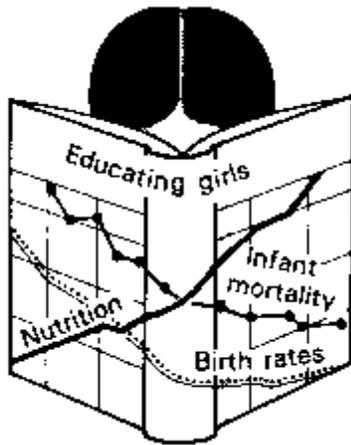
dubbed the 1980s the “decade of despair.”<sup>21</sup> In *The State of the World’s Children, 1989*, UNICEF reported that:

- In much of Africa and Latin America, average incomes fell by 10% to 25% during the 1980s. Hardest hit were families who, even before the fall in income, did not earn enough to adequately feed their children.<sup>22</sup> The number of malnourished children increased in many countries.<sup>23</sup>



This new approach stripped PHC of many of its key concepts. The emphasis on overall social and economic development was removed, as was the need to include all other sectors that related to health in the focus of the programs. Furthermore the keystone of involving communities in the planning, implementation, and control of PHC no longer existed. This selective, politically sanitized (and thus unthreatening) version of PHC was thus reduced to a few high priority technolog-

- In the poorest 37 countries, public spending per capita on health was reduced by 50%.<sup>24</sup>
- In these 37 countries, spending on education dropped by 25%.<sup>25</sup> And in almost half of the 103 countries reviewed, the proportion of six- to eleven-year-olds (especially girls) enrolled in primary school fell.<sup>26</sup> This has special significance for health, as the average level of female education is often correlated with child mortality.



Confronted by these escalating obstacles to the goal of Health for All, in the early 1980s UNICEF faced some difficult decisions. One of the hardest was whether to promote Comprehensive or Selective Primary Health Care. Should UNICEF continue its uphill battle for a broad, empowering approach, as advocated at Alma Ata? Or should it ride with the conservative winds of the decade by endorsing the more selective approach that could more easily win support from powerful governments, institutions, and funding sources? This was a difficult and a crucial choice.

Painfully, UNICEF began to back away from its advocacy of a comprehensive, equity-oriented approach to health care. Rather than renewing its 1970s call for a more just international economic order, expressed in the Alma Ata Declaration, UNICEF began to speak of the “opposing force ... affecting the world’s children—the continuing economic recession” as if the socially regressive policies imposed on poor countries were an inescapable force of nature.<sup>27</sup> UNICEF’s refusal to “question the need for adjustment policies leading to a restoration of economic growth,”<sup>28</sup> was tantamount to accepting inequity and poverty as unalterable facts of life.

\*In some Third World countries, cutbacks in spending on health and education have been even more drastic. For example, in 1991 Peru spent roughly \$12 per capita on health and education, one-fourth what it had spent a decade before—and half the amount it was spending on debt payments to Western banks.

By accepting the thesis that the global conditions increasing inequity and poverty could not be corrected, it became easier to argue that the Alma Ata goal of “health for all” was unrealistic. Clearly, “complete physical, mental, and social well-being” was out of the question for the growing millions of people living in dire poverty. And even the medical goal of “absence of disease and infirmity” was unattainable given the mandated cutbacks in health services and increasing levels of hunger and poverty.

Since *health for all* was no longer a viable goal, UNICEF opted for *survival of children*.

### The Child Survival Revolution: An adjustment policy for health

In 1983 UNICEF announced that it was adopting a new strategy designed to achieve a “revolution in child survival and development” at a cost that poor countries could afford.<sup>29</sup> Falling clearly within the paradigm of Selective Primary Health Care, the Child Survival Revolution was presented as a streamlined, cheaper, more feasible version of Primary Health Care designed to shelter children from the impact of deteriorating economic conditions. Aimed principally at children under five years old, its goal was to cut Third World mortality of young children in half by the year 2000.<sup>30</sup> To this end, it prioritized four important health interventions, together bearing the acronym “GOBI:”

- Growth monitoring;
- Oral rehydration therapy;
- Breastfeeding; and
- Immunization.

In response to concerns that GOBI might be too selective, UNICEF the following year recommended an expanded version, “GOBI-FFF,” adding Family planning, Food supplements, and Female education. Although the response to the limited version of GOBI had been enthusiastic, the expanded version of GOBI-FFF made little headway among health ministries and donors. In fact, in actual practice GOBI was often trimmed further. Many nations limited their major child survival campaigns to Oral Rehydration Therapy and Immunization, which UNICEF began to call the “twin engines” of the Child Survival Revolution. Some countries even put most of their resources into one of these “engines” while neglecting the other.

At face value, UNICEF's argument for GOBI appears compelling. It has been summed up by Ben Wisner, a strong critic of GOBI, in four steps:

- 1) Financial and human resources for primary health care in poor countries are scarce and growing scarcer due to the persisting international economic crisis;
- 2) Simple, low-cost, widely accessible technologies for saving children's lives exist;
- 3) A method for popularizing these technologies at low cost (i.e., "social marketing") also exists;
- 4) Therefore, GOBI should be implemented as a priority now.<sup>31</sup>

If funding and government support are used as the determining indicators, the Child Survival Revolution can be seen as an almost instant success. Business-friendly governments in both hemispheres which had shown little support for Comprehensive PHC welcomed GOBI enthusiastically. USAID and the World Bank both pledged major financial support; the Holy See (the headquarters of the Catholic church) and Rotary International also jumped on the bandwagon. By the mid 1980s virtually every underdeveloped country had launched a campaign promoting some or all of the GOBI interventions.

However, not everyone has been happy with the Child Survival Revolution. GOBI has been criticized for giving high priority to a few selected health interventions. Indisputably, immunization and oral rehydration therapy are effective, low-cost interventions that can help to save many children's lives, if sometimes only temporarily. Many social activists and community health workers, however, argued that the shift from Comprehensive to Selective Primary Health Care and GOBI was a way for governments and health professionals to avoid dealing with the social and political causes of poor health, and thus to preserve the inequities of the status quo. As one author noted, "The effect of this [sort of] promotion of SPHC under the PHC umbrella is to keep health interventions firmly within medical control and to detract from the need for long-term social, economic and political change."<sup>32</sup>

UNICEF has received some strong criticism for its silent acceptance of government imposed "adjustment policies" (see page 83) and its self resignation to narrow approaches to health care. George Kent, author of *The Politics of Children's Survival*, notes:

Such resignation is not the only possible response. Even while adapting to an economic squeeze by developing low-cost health care techniques, it is possible to resist and fight that squeeze. Instead of asking only how citizens

and public health workers can adapt, one can also ask how they might become vigorous advocates of their cause, cultivating a power base of their own and making their demands felt.<sup>33</sup>

Because it represents a compromise away from the potentially more empowering Comprehensive Primary Health Care to a more limited and conservative Selective Primary Health Care, some critics have called the Child Survival Revolution "the revolution that isn't."<sup>34</sup> One thing is certain: UNICEF's endorsement of Selective Primary Health Care via the Child Survival Revolution represented a major policy shift with profound political implications.

UNICEF's defense to this criticism is to insist that the Child Survival Revolution is compatible with Comprehensive Primary Health Care, suggesting it represents the leading edge of PHC. However, Child Survival measures have too often been implemented in the manner of the medical care given by the doctor in *Rakku's Story*, with predictable results: the treatment was successful (or successfully implemented) but the patient died. Because the measures of the Child Survival Revolution do not adequately combat the underlying social causes that contribute to children's deaths, they are much less "life-effective" than they would be if posited in a more comprehensive strategy. In its writings, UNICEF continues to address societal causes of poor health, but the actual health measures it promotes carefully avoid them. This may put UNICEF in a position of lower political risk. But what of the children?

We believe that the health measures included in the Child Survival initiative could do more to save children's lives. But for this to happen, these priority health measures need to be implemented in a comprehensive, empowering way. When it is controlled by consumers, health work can be an important component of, and even a leading edge for, social development and change. Indeed, this is one of the central points of this book. But the process is not as simple as UNICEF suggests. There are as many approaches to health interventions as there are to development.

As with development strategies, health interventions are never politically neutral: they can promote self-reliance and empowerment or they can foster dependency and passivity. They can support either a just or an unjust form of governance. They can pave the way for an equitable social order or they can bolster an inequitable and despotic one. Health planners must be careful to formulate and implement interventions in ways that facilitate progressive social change rather than obstruct it. UNICEF's unwillingness (or inability) to embrace the political dimension of health interventions is largely responsible for the inadequate and often unsustainable results of its various child survival strategies.