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## **An analysis of the donors' effort to immunize Africa's children: progress or missed opportunities?**

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Foreign aid substantially influences the health services provided for Africans. While international organizations and donors<sup>1</sup> may evaluate their projects, the long term effects of their assistance on establishing sustainable programs and affordable delivery systems receives little attention. Once a project reaches its predetermined endpoint, donors move on and design new projects and start new initiatives. The consequences of the previous time limited infusion of resources remains unknown, particularly for Africa, the continent with the weakest infrastructure, the greatest disease burden for children, and the most donor driven projects.

My public health career began in Africa in 1972 with the Smallpox Eradication Programme, a global initiative which eradicated a disease from the planet. My views have evolved, not only from over 25 years experience working with national immunization programmes in Africa and Asia, but also from long-term associations with colleagues and friends in ministries of health, NGOs, and donor and international organizations. I offer the following perspective as one example of a donors' developmental process, the EPI (Expanded Programme on Immunization), perhaps the greatest global concentration of financial and human resources into any single health initiative.

### **History**

In 1977 WHO launched the Expanded Programme on Immunization initiative to immunize the world's children against six vaccine preventable diseases: measles, polio, diphtheria, pertussis, tetanus, and tuberculosis. As a result, many countries with undeveloped health care services began improving the skills of health workers to provide safe and effective immunizations, and establishing the logistics systems and management structures needed for maintaining immunization services.

To accelerate progress, by the mid 1980's many donors began pouring their resources for health, and Primary Health Care (PHC), into EPI to achieve a global objective set by WHO and UNICEF: 80% global immunization coverage for infants with the EPI vaccines by the year 1990. UNICEF's UCI (Universal Childhood Immunization) initiative rapidly supplied refrigerators, vaccination equipment, and vaccines; funds for training health workers and mobilizing countries; and, in some countries, supplemental payments for health workers giving immunizations. In 1991, WHO and UNICEF announced that their global objective had been achieved, truly a remarkable achievement.(1) Reported global immunization coverage for BCG, polio, DPT, and measles immunizations increased from less than five percent in 1977 to 80% by December 1990. Like all information however, this reported global figure depended on the presentation of the data. For example, China, with 21% of the world's population, more than twice the population of Sub-Saharan Africa, and high immunization coverage, skewed the global figure upward.(2) Also, many countries had to use out dated and unreliable census data for reporting their immunization coverage. The accuracy of this global statistic was never seriously considered. The 1990 global statistic masked the reality in many African countries.

Shortly after announcing the achievement of UCI, donors began redirecting their attention and funds away from immunization and into other initiatives, such as Integrated Management of Childhood Illnesses (IMCI), health reform, or district projects. Today, at the beginning of this new century, many countries in Africa still remain below the global immunization target of 1990. In 1998 only one of 21 countries in Sub-Saharan Africa which reported immunization coverage data to WHO managed to achieve the 80% global coverage target for more than one vaccine. None were able to sustain coverage of 80% or better for 3 consecutive years between 1995 and 1998 (WHO/V&B/99.17). Despite this wide spread deficiency in immunization coverage, WHO's global "EPI" agenda now presents even greater challenges. Besides the ever daunting task of achieving and sustaining 80% immunization coverage for all of the traditional EPI vaccines, today's global EPI mandate includes: reducing measles morbidity by 90% and measles mortality by 95%, eliminating neonatal tetanus, and eradicating polio (WHO/AFRO/GAG/93). Immunization programmes are also expected to provide more vaccines, such as hepatitis B vaccine. In addition to this technical agenda, the centralized EPI programmes built through donor funds during the 1980's now need to adjust to the current government and donor trends of decentralization and health reform. Also, governments are expected to pay for the vaccines provided by donors during the previous two decades. Besides

this global immunization agenda, many African countries must implement programs against diseases presenting even graver consequences than the vaccine preventable diseases, such as malaria and HIV/AIDS.

### **Progress or Missed Opportunities?**

While governments and donors made tremendous progress immunizing millions of children, regrettably, the 1990 global coverage initiative missed opportunities to build more affordable health services. Instead of working toward integrated and affordable systems with country specific and local strategies to deliver health services, donors poured their money into a single intervention, immunization, and a purely technological approach for PHC. Their 80% global immunization coverage objective took precedence over sustainability and efficiency, and neglected other health needs and services.

Donors and international organizations still promote immunization, or EPI, as simply a technical and financial effort using vertical systems and highly selective assistance. This exclusive approach by the international community may achieve short term and measurable results, but not sustainable progress. While some international experts advocate that global initiatives are the only means for attracting donor funds, they fail to recognize that technology and donor money alone cannot overcome the greater obstacles confronting government health services: deficient government budgets, inadequate communication and transportation systems, poorly educated communities, unpaid government health workers, and lack of national and local ownership from globally driven approaches.

Initiatives like EPI provide a convenient mode of operation for donors. A donor county representative once mentioned to me that she liked EPI because “it was the only project that you can measure.” In addition to readily providing statistical evidence of activity using coverage rates, EPI provides a relatively easy and visible way for donors to disperse and account for large amounts of money. Bulk international purchases like vaccines, refrigerators, and motorcycles, and large scale centrally controlled training and “social mobilization” activities ease the bureaucratic burden of preparing budgets and accounting to headquarters. To the uninformed bureaucrat, politician, or taxpayer; dollars, equipment, vaccines, and workshops certainly appear as the adequate humanitarian response.

Despite good intentions, donor support actually blocks the establishment of sustainable health services. Affordable delivery systems and efficient program management cannot be achieved through global objectives, external funding, and free equipment. Because donor money drives EPI, many programme managers view “planning” as simply preparing spread sheets for requesting money from donors. Managers struggle with one crisis after the other: answering globally generated budget requests, receiving large and sometimes unscheduled international shipments of equipment and supplies, finding more and more storage space, and completing reports for donors. Fulfilling bureaucratic requests from donors prevails over preparing for the long haul.

What business could survive using the free spending concept which donors applied to EPI without first establishing efficient supply, distribution, and maintenance systems, and without assuring a continuous demand for the product? Instead of affordable systems, high-cost and vertical mechanisms were put in place using excessive external funding only to achieve the donors’ time limited objective. The donors’ EPI selective process excluded other health care programs that would have provided a coordinated and less costly approach. Local health teams and communities were not involved with determining how to effectively establish and maintain their immunization and other health care services, the critical foundation for sustainability. Donors with their relatively short term projects, time limited objective, selective “pots” of money, and desire for quick and visible results, simply didn’t even consider longer term, less visible, nontechnical approaches, such as self determination or cost efficient management.

After two decades, EPI, the vertical program has now become a vertical initiative. WHO and some donors, now direct large sums of money, their experts, and national immunization programmes at another global goal, eradicating polio. Certainly, eradicating polio is a laudable goal. No one, of course, wants to see a child disabled for life due to a vaccine preventable disease. But, the donors’ approach on implementing this singular initiative with an even more narrow focus of resources, not only further undermines PHC, but



also erodes fragile foundations for immunization and other health care services. While eradicating polio will be a noteworthy scientific achievement, we must ask, have we achieved our goal when a child who has received 10, or even more, doses of oral polio vaccine dies from measles, dehydration, or malaria; or must grow up malnourished, without parents because of the AIDS pandemic, or in urban squalor, without hope?

Disease eradication, like a global immunization coverage objective, serves the donors well. It's highly visible, measurable, and short lived. The global eradication strategy involves national mass immunization campaigns which take place during only a few days of the year. These donor funded campaigns provide a carnival-like atmosphere. Banners with organizations' logos fly; T-shirts and caps are given away; celebrities make appearances. Big media events provide visible evidence of action by governments and donors. Annual events are much easier to implement than confronting the systemic problems, the mundane and unnoticed tasks of providing quality health services day in and day out. Eliminating a disease from the planet makes a simple statement which appeals to the North's fast paced, hi-tech culture. A scientific achievement diverts us from the more complex reality: the declining quality of life for millions in poverty, the environmental degradation, and the failures our development projects.

Proponents of disease eradication sell eradication as a means for attracting money from donors, strengthening health care systems, ultimately saving money, and a stated priority by MOH's. However, if you go break through the surface of this global rhetoric, polio eradication means, saving the more wealthy countries millions of dollars from vaccine costs. For the United States at least, this vaccine cost savings argument lacks substance. Eradicating smallpox certainly has not financially impacted any cost savings on the health care system in the USA. Even today, the United States government is fearful of destroying its remaining stock of the smallpox virus for fear of the virus being reintroduced by international terrorism. There is still disagreement among scientists on whether or not polio immunization can be stopped, even in the absence of clinical poliomyelitis.

Africa and the rest of the world officially endorsed the eradication of polio by the year 2000 at the World Health Assembly in 1988. However, high level MOH officials disassociated from program management and field operations must make such agreements during highly visible international meetings. One African MOH official nicely put this pressure tactic into perspective during one of WHO's first polio eradication planning meetings in eastern Africa a decade ago. When some national EPI programme managers seriously questioned if polio eradication really was a priority for their country, one WHO facilitator responded, "... but your Ministers agreed to it!" The MOH participant replied privately, "Yes, we know what they [the MOH officials] said, but we also know what they were thinking when they said it." No one can afford to appear out of step in front of an international audience or risk losing foreign aid. In Africa, with the catastrophic consequences of AIDS, malaria, malnutrition, and war, it is unconceivable that health officials would mention eradicating a low incidence and non fatal disease as their priority, if ever asked before the decision had been predetermined by the North, or in a more democratic setting.

Like UCI, "eradication" provides a convenient and highly visible means for donors to disperse their money. As one example, donors once again sent large numbers of refrigerators to African countries in parallel with conducting mass polio immunization, even though effective equipment inventory and maintenance systems are still not in place. Some donors reason that, surely the refrigerators which they donated during the UCI era of the late eighties must need replacement. Yet today, when you visit African EPI programs, many still site an inadequate cold chain as one of their biggest problems. Some international experts maintain that the EPI refrigerators need to be replaced to conform with the international ban on chloroflourocarbons (cfc's). This simplistic "throw away" mentality only further undermines sustainability, and could even over time do more harm to the environment. If let to decay in the graveyards of donor vehicles, these stock piles of "used" refrigerators and cold storage equipment could in fact even add to the damage of the earth's ozone.

While global rhetoric portrays the disease eradication initiative as a means for strengthening EPI, and PHC is no longer even mentioned, you need only attend a WHO EPI managers meeting or a national immunization coordination committee meeting in an African country to see that the agenda focuses almost entirely



on a single disease. Observation of the daily routine of national immunization programs also reveals a disturbing trend. EPI managers in many countries must devote many months preparing for the annual national immunization campaign. In one country, even the routine monitoring of immunization coverage stopped for over six months because staff had to devote all of their time preparing for the annual national immunization campaign. One program manager told me "... they are killing us." while in another country the EPI manager said, "... [our program] is dying." From this global initiative, the overload created by overpaid experts on underpaid government health workers only to conform to a global strategy and objective, not only diverts management from routine work, but also erodes morale. While polio eradication appears finite, the diversion from establishing more effective routine services is devastating to fragile infrastructures.

Proponents claim that disease eradication strengthens health services by strengthening systems. However, actions do not support the rhetoric. For example, for building disease surveillance systems EPI programmes now focus nearly entirely on a rare syndrome, Acute Flaccid Paralysis (AFP), WHO's marker for eradicating polio. WHO's indicators on the level of development of disease surveillance systems center on reported AFP cases and stool specimens collected, not on local application of information to control diseases. Simple logic and a few days in the field will show that a sustainable, practical, and integrated disease surveillance system cannot be developed using an event which most health workers will never even see, and which is neither important to them or to the community. In two African countries with great logistics problems which I know, donors have provided new pick up trucks to districts, but these vehicles are restricted only for the surveillance of this rare syndrome and polio eradication. So, while measles epidemics affect hundreds of thousands of children, national immunization programs and EPI surveillance officers are encouraged and supported to direct their energies on developing a system that detects a syndrome which annually affects only one out of one hundred thousand children under the age of 15 years, only to prove to the North that they have achieved a global goal.

Donor funding patterns accurately reveal a disturbing trend. In some African countries the amount of money provided by donors for an annual four day mass immunization campaign and for selective disease surveillance are greatly disproportional to the funds given and required to maintain immunization services through out the year. Donor money for global initiatives also spreads horizontally, to NGO's, donor funded projects, international organizations, and consultants. Organizational empires grow; careers flourish. Global initiatives support, global organizations.

Sadly, the short term success of the mass polio immunization campaigns in Africa may ultimately result in the demise of EPI. Already, before effective and sustainable routine health services are in place in many African countries, some international experts talk about global measles eradication. Eradicating measles calls for even larger scale, more complex, and more expensive mass immunization campaigns. Under certain circumstances mass measles immunization may be warranted, such as: refugee populations, natural disasters, or in countries such as those in Latin America which can maintain high immunization coverage. However, imposing mass measles immunization campaigns in countries with weak health care systems will cause unrepairable harm. Mass immunization alone can neither effectively control nor eliminate measles. Even worse, health worker morale and the credibility of immunization services will decline further when donors lose interest in the mass immunizations campaign approach, move on to other trends, and subsequently the deadly measles cycle resumes because of the continuing, inadequate health services.

Giving millions of injections during hectic mass measles immunization campaigns before ensuring injection safety and appropriate waste disposal would be unconscionable in the North. Yet international experts who advocate global measles eradication promote mass injections in countries without adequate supervision, without biological waste disposal policies and systems, and with high prevalence of HIV or hepatitis B virus. Like many other problems they face, international experts apply technology to ensure injection safety. Although autodestruct syringes and disposal boxes are available, a brief visit to a few health facilities will show that technology alone does not overcome problems resulting from poorly paid, inadequately trained, unsupervised health workers, and undependable logistics systems which cannot continuously provide enough needles and syringes. The nice shiny sharps disposal boxes, which donors occasionally provide in very limited quantities, are sometimes valued more as a decoration than part of injection safety.



Even if used correctly, few governments will be able to continuously finance adequate supplies of this technologically appropriate disposable injection equipment after the donors no longer provide them.

I do not fault those involved in polio eradication, nor am I against eradicating polio. I only use polio eradication as an example of the methods donors employ to achieve their goals which, although well intended, actually obstruct the advancement of health services. Some implementing global initiatives realize that their organization's tactics are wrong, but feel powerless to challenge the system. Several international advisors have expressed dissatisfaction to me over the disruption of routine immunization and other health care services because of the national polio immunization campaigns. Some in the international community lament that global initiatives are the only way to attract donor support, re-activate national programmes, and achieve results. Such logic, however, only underscores the lack of awareness and creativity in the international community. No matter how laudable the goal, time limited and concentrated external support does not revive, strengthen, or "jump start." Instead, this narrow top down approach only extends and temporarily postpones the damage from the previous decades of unsustainable, vertical, technological solutions.

After UCI and other donor trends such as decentralization and health sector reform emerged, some donors finally began to realize the importance of sustainability. Although, no global organization will admit any blame for EPI's unsustainable condition. Donors tend to view "sustainability" primarily as an issue of withdrawing their financial support. For example, some donors use the percent of vaccine costs assumed by governments as one of their indicators of sustainability. Remarkably, they selected vaccines, the most efficient and probably least damaging contribution by the donors, as their mechanism for getting governments to assume the high costs of running the immunizations programmes designed by the donors. Vaccines usually require international purchasing from corporations based in the industrialized countries. Yet now, donors compel financially strapped governments to use their limited budgets for importing vaccines. Other financial indicators of sustainability could have been used, such as government contributions for maintenance systems, or better pay for government health workers.

Today, donors enthusiastically report that many countries are increasing their contributions for vaccine costs. Yet it doesn't require too much research or intuition to ask, "if government budgets for health are declining or below minimum requirements, then where is this government money for vaccines coming from?" The answer is simple. You divert from other health programme budgets and continue to under-pay government health workers to purchase vaccines in order to please the donors.

After developing centralized "EPI" structures during the previous decades, donor's now concentrate on decentralizing them. Still, donors pursue the quick fix; infusing their money into limited geographical areas through district projects and on people with little managerial or financial experience. Donors, and NGOs as well, carve out their territories with district projects, producing an array of resources, systems, and services. Today, the donors' intervention selective process for PHC has degraded even further, from programme specific to geographically limited.

### **What can we do?**

Global organizations recognize the health problems, particularly those which they can describe using statistics. Ironically however, the solutions which they impose to solve these problems undermine their own efforts. Instead of analyzing their own history, development and international organizations disassociate from their past and proceed with new global initiatives. If donors made a critical review of their "EPI" process over the past two decades, they could make tremendous improvements on their approaches, and, ultimately, promote quality and more sustainable health services. Not the traditional project review by technical experts, but an independent and critical analysis by those who can look beyond immunization coverage and refrigerators, and envision other solutions besides a time limited global statistic or focusing on eradicating a single disease. Instead of the government programme, reviewers should look at the donors and international organizations, and their effects on the management and sustainability of health services. They should be able to envision coordinated donor input, community approaches, use of local resources, and the priorities of countries and communities. Knowledge of the successes and failures of the donors' EPI process can then be applied to educate the international community on planning and implementing



more effective assistance. A critical analysis of the global EPI process will even help the global organizations achieve their objectives.

Including the poorer countries from the beginning when formulating global health strategies and goals provides another more appropriate means for building effective and efficient health care services. Regrettably, some international decision makers fear that MOH officials and health workers with real experience will interfere with their organizational needs by not accepting the priorities of the Americans or the Europeans. The Africans might propose national health priorities and broader solutions. Priorities and solutions which do not conform to the limited frame of donor projects, or which may not contribute to the sustainability of global organizations. Some how, the needs and the views of the South must be considered democratically by the North.

Global decision makers can easily proceed with their global initiatives because their funding sources are unaware of the issues. At the international level, the experts are far removed from countries and even further removed from those paying their salaries, the taxpayers. Likewise, politicians can allocate foreign aid inappropriately because their constituents are unaware and consequently unconcerned. In the USA the major issue for the average taxpayer concerning foreign aid centers on whether or not, or how much money should be given, not how it should be applied. Global experts, by focusing only on a technical and a geopolitical agenda, keep their ultimate funding source, the tax payer, ignorant of the social and economic issues, local priorities, and alternative solutions. An uninformed public enables the global experts to sell their narrow concepts as the only solution.

No doubt, donor driven initiatives have contributed to preventing death, illness, and disability. EPI, UCI, and eradication have achieved objectives and established structures, although selective and unsustainable. However, without ever attempting to consistently support community focused and more cost efficient approaches, we cannot conclude that this selective concentration of external resources and global objectives are the only, or the most effective means for achieving results. Although less visible, less expensive, and perhaps less sophisticated, there are many examples of effective local efforts initiated without high input from donors, { which are being presented during this Assembly }. Unfortunately, smaller scale efforts do not attract attention like the well funded bilateral and multilateral donor projects. Many nongovernment organizations lack resources to adequately inform the global community about their successful approaches. Greater and coordinated effort is needed by the NGOs to more widely publicize their work through the international media, such as the internet, and through increased access to global audiences and donor funding sources by being included on the agenda of international conferences.

Providing appropriate assistance for building more effective and sustainable health care for Africa first requires changing the concepts and practices of the donors and international organizations. Changing the concepts of long established and well funded bureaucracies from global, to people and community focused, presents a daunting challenge. To do this, we must increase our efforts and publicity on: evaluating the evaluators and reforming the reformers. A sincere and independent analysis of the "EPI" process could be the first such step. We also must increase awareness among people in the North on the needs and the fragile infrastructures in the poorer countries, and on alternative solutions. Like the original ideals for Primary Health Care declared in 1978, redirecting the donors from global to more affordable and local initiatives, provides the long term, yet very challenging solution.

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<sup>1</sup> In this paper/presentation the term "donor" implies both bilateral and multilateral organizations.

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