Ending Preventable Child Deaths Globally: Lessons From Togo's Integrated Primary Care Model

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Despite decades of global progress, millions of children still die each year from preventable and treatable conditions.[1–3] Deaths in children younger than age 5 years persist largely because of inequities in access to quality primary care, especially in low-resource settings.[4,5] Under age 5 years mortality (U5M) remains highest in countries where health systems face structural challenges and where poverty and weaker health system infrastructure continue to restrict access to essential services, reflecting a stark equity divide between poor and rich regions.[6–8] Without urgent action, it is projected that nearly one-third of countries will fail to meet the 2030 target for the United Nations Sustainable Development Goal (SDG) 3.2, which is focused on the reduction of U5M.[9] As pediatricians and child health advocates, we are uniquely positioned to champion models that are grounded in evidence and designed to be scalable, cost-efficient, and sustainable.[10] In this issue of *Pediatrics*, Fiori and colleagues present the effectiveness of the implementation of an integrated primary care program (IPCP) across 4 districts in Togo, demonstrating how strategic investments in integrated, community-based primary care can accelerate progress in reducing child deaths.[11]

Recent evidence shows that child health programs are most effective in reducing preventable U5M when they are decentralized, integrated, implemented across multiple levels of the health care cascade, and tailored to local contexts.[7,8,12] Fiori and colleagues' study adds to this body of work by providing real-world data at scale, implemented across multiple rural districts in Togo.[11] Using a stepped-wedge cluster randomized design, the IPCP was evaluated through a pragmatic approach that measured adoption and outcomes. The evaluation incorporated household surveys, health facility assessments, and implementation science frameworks to monitor both uptake and outcomes. The program achieved a 29% reduction in U5M rates, from 64.5 to 45.5 deaths per 1000 live births, within just a few years.[11] With an annual average implementation cost of $10.28 per person per year, this model was cost effective compared with facility-only models when directed at high-burden populations. By addressing social determinants of health and closing equity gaps through community health worker deployment, strong supervision, and sustained financing, the program achieved measurable, population-level impact and showed potential for long-term sustainability.[11,13]

These results echo findings from evaluations of Integrated Management of Childhood Illness and Integrated Community Case Management, which have shown improvements on quality and mortality proxies, especially when case management and timely care-seeking are strengthened.[5] The study's approach aligns closely with broader evidence that suggests that key enablers of integrated primary care strategies, optimized implementation strategies, caregiver trust and engagement, and strong community health systems improve child survival and quality of care in low- and middle-income countries.[12]

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One notable feature of the IPCP was its emphasis on caregiver trust and community engagement.[11] Interviews with frontline workers and families emphasized the value of building relationships and ensuring that services felt responsive, respectful, and reliable.[11] These insights resonate with pediatricians worldwide: families are more likely to engage with care when they feel heard. This kind of community-centered approach supports initial uptake, encourages consistent use of services, and helps build lasting confidence in the health system.

Although the IPCP demonstrated promising gains in child survival and system readiness, several design and measurement considerations should be kept in mind while interpreting the results. The study used a stepped-wedge cluster randomized design, which allowed for temporal comparisons but included only 4 clusters, potentially limiting statistical power. The intervention was implemented as a bundled package, making it difficult to isolate the effects of individual components, and fidelity varied across sites. Some indicators relied on self-reported data, and cost estimates did not include household-level expenses. Finally, the study was conducted during the COVID-19 pandemic, which may have influenced both implementation and outcomes.

The IPCP offers valuable, real-world evidence that integrated primary care can improve child survival in low-resource settings. Its impact reflects key principles of Universal Health Coverage, with primary health care investments acting as a foundational strategy by bringing services closer to families, strengthening quality and continuity of care, fostering trust in health systems, and addressing health system gaps through community-based delivery.[14,15]

For pediatricians and global child health champions, an IPCP offers a practical model for advancing SDG 3.2: ending preventable deaths of children younger than age 5 years. Using an implementation science approach, this study shares actionable insights that can be translated into policy and practice at scale. Scaling these approaches will require sustained investment, strong local partnerships, and a commitment to equity in service delivery. As pediatricians, we are part of a global movement to end preventable deaths of children younger than age 5 years, and this work reminds us that our clinical expertise, advocacy, and leadership are essential to shaping health systems that reach every child, no matter where they live.

ABBREVIATIONS

IPCP: integrated primary care program
SDG 3.2: Sustainable Development Goal 3.2
U5M: under age 5 years mortality

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