

CHILD SURVIVAL
AN OPPORTUNITY FOR DRAMATIC SUCCESS

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EXECUTIVE SUMMARY

The Accelerated Health Program has had a major impact on the child survival and development revolution in Pakistan. If the country continues the momentum, chooses the right strategies, invests its health resources wisely, and manages them efficiently, it should be possible by the end of the 7th Five Year Plan to reduce further infant and child mortality by at least 25% and thereby eliminate an additional 170,000 deaths now occurring each year.

USAID believes that progress in child survival would have enormous developmental impact by enhancing the vitality and productivity of the country's population. We are therefore prepared to collaborate on a major scale and propose that a joint GOP-USAID team of experts be established to prepare a child survival project. This paper suggests several policy measures to promote child survival. Three of the most important are:

1. Reorientation of Health Services with Greater Priority to Preventive Health

GOP planning documents and public statements give high priority to preventive health; however budgets, deployment of personnel, orientation of medical education, and the incentive structure of the public service strongly favor clinical and curative medicine. The massive expansion of the rural health infrastructure now being considered by the GOP may be an inefficient use of resources unless it is accompanied by policy changes and management improvements in the current system.

Emphasis should be given to immunization, oral rehydration therapy, child spacing, rational drug policies, efficient health information systems, effective supervision of personnel with accountability, development of community level health workers and provision of incentives to attract doctors into preventive health careers.

2. Strengthening Medical Education for Child Survival

To train doctors to address effectively the priority health problems of Pakistan, the GOP should consider: (a) making pediatrics a separate examination subject with pediatricians as examiners; (b) including extensive field practicums in community medicine; (c) teaching practical management practices; and, (d) modernizing educational methodology.

3. A Sharper Institutional Focus on Children

Many GOP Ministries deal with children; however, there is no overall institutional focus on the problems of children, nor is there an effective mechanism to mobilize the level of political support and resources required for a major public and private sector effort to improve child survival and development.

The GOP should consider establishing new institutions to develop national policies, mobilize resources, conduct research and training and administer a grants program of child survival activities for NGOs, other private sector institutions, government organizations, and local bodies.

(END SUMMARY)

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I. PROBLEM

The most comprehensive measure of child survival is the infant mortality rate. Estimates of the rate in Pakistan range from 90 to 120 infant (0-11 months) deaths per 1000 live births. The World Bank estimate for 1984 was 116. Its estimate for child mortality (12-60 months) was 64 deaths per 1000 live births, meaning 18% of Pakistan's children died before age five.

The child survival situation in Pakistan does not compare favorably with that of neighboring countries. Using World Bank estimates for 1984:

	<u>Infant & Child Mortality</u>	<u>Decrease since 1964</u>
Pakistan	180	26%
India	134	45%
China	44	67%
Sri Lanka	45	48%
Bangladesh	196	21%

In this paper we assume that by 1987 infant mortality declined to 104 and child mortality to 56. This means that for every 1000 babies born, 160 do not survive to age five. The principal child killers are diarrheal disease, neonatal tetanus, measles and acute respiratory infections. Malnutrition is a complicating factor.

II. RECENT PROGRESS

The launching of the Accelerated Health Program in 1983 was a turning point for child survival in Pakistan. If the momentum continues, the years from 1983 to 1993 could become the decade of child survival and place Pakistan in the company of countries like China, Sri Lanka, Costa Rica and parts of India which are demonstrating rapid and spectacular improvements in child survival and health.

The success of the Accelerated Health Program was due to:

- a correct analysis of the public health problems of the country,
- selection of appropriate strategies using simple but effective interventions targeted at the priority problems,
- firm Government commitment to provide the necessary finances and personnel,
- adequate attention to management, supervision and evaluation in program implementation.

Through this program full immunization coverage of one to two year old children has grown from under five percent in 1982 to 69 percent in 1987. Another achievement of the program is widespread knowledge of oral rehydration therapy and significant levels of use to protect against death from diarrheal dehydration. Over 25,000 dais (traditional midwives), who provide basic health services at the village level, were also trained.

These activities have certainly had a measurable impact on child survival. Unfortunately, due to the inadequacy of the health information system, it is impossible to document this hidden success story. One estimate is that 75,000 children's lives are now being saved each year because of the Accelerated Health Program whose cost was only 60 crore rupees over four years.

III. OBJECTIVE

The Accelerated Health Program has probably resulted in a 10-15% reduction in child mortality to date. We believe that an achievable objective between now and the end of the 7th Five Year Plan in 1993 is a further reduction of 25%, meaning the elimination of an additional 170,000 unnecessary deaths now occurring annually. If the constraints are properly addressed and sufficient resources provided and adequately managed, the proposed 25% target could be exceeded.

IV. INITIATIVES FOR CHILD SURVIVAL

A. Consolidating the Gains: Institutionalizing the Accelerated Health Program

The remarkable achievements of the immunization program and the progress in oral rehydration therapy for diarrheal disease were the result of strong federal commitment and funding and strong technical and managerial leadership from the National Institute of Health. The Government's intention is that these programs should be integrated into the ongoing programs of the provincial health departments. If, however, provincial constraints such as inadequate funding, insufficient preventive health manpower, management problems or competition from other higher priority programs such as hospital services are allowed to interfere, these lifesaving interventions will not reach the target population. For example, Baluchistan has made very little progress so far. Another danger is that achievements to date could be eroded as happened temporarily in the Punjab after integration of the immunization program in 1985.

It is essential that the Government proceed with integration gradually, after the respective provinces convincingly demonstrate their ability to sustain child survival activities. This will mean continued federal financial support and technical and management direction from the National Institute of Health for some time. Senior policy levels in Islamabad should give unequivocal signals that these programs should receive the highest priority.

B. Reorientation of Health Services with Greater Priority to Preventive Health

In Pakistan as in the United States there is greater public expenditure for curative services than for preventive programs. However, the overall health and well-being of a population is enhanced much more by disease prevention than it is by doctors, hospitals, sophisticated equipment and drugs.

Although Government funding for preventive programs has increased in recent years, it needs to increase a lot more. Further, Pakistan needs to find a way to attract doctors and other leaders into public health programs. Very few doctors are interested in managing programs in primary health care, malaria, and TB because it is so much more lucrative to hold a clinical job with opportunities for private practice. The non-practicing allowance is not sufficiently attractive. Some new incentives and a career track are required to attract doctors to public health.

Formal surveys confirm the common observation that rural health centers and basic health units are seriously underutilized. Although the health needs are great, the low demand for services (10-15 patients a day at a BHU) is perhaps explained by the low quality of service, attitudes of the doctors and staff, the shortage of drugs, and overall shortcomings in management, supervision and discipline. Proposals presently under consideration for a massive expansion of the rural health infrastructure, without major improvements in the present system, would seem to be a misplacement of priorities. Without policy changes and better strategies to improve the output of the existing system, investment in expansion may prove to be an enormous waste of resources. More inpatient beds in underutilized rural health centers cannot meet the basic needs of the population.

Reorientation of the existing system should focus on disease prevention and the promotion of sound health practices in the community. Doctors would be much more effective and productive if medical education were reformed to give higher priority to public health, to community orientation, to pediatrics and to management. Without better management and supervision, the output of the rural health system will remain low. Decentralization of administrative authority to lower levels might enhance the accountability of medical officers. Greater incentives are necessary to attract doctors into rural service and preventive health jobs. Since most people requiring health care do not go to Government facilities, the Government should develop effective methods to reach the population with needed health information and services. One approach is strong outreach teams delivering primary health care services to the village level. Another approach emphasized in the World Health Organization model calls for recruiting and training health workers from the community to provide health education and a permanent village link to the government facilities. Effective schemes for outreach services and community level health workers result in more efficient utilization of the entire health infrastructure.

A major shortcoming in planning the most effective use of resources and evaluating ongoing programs is the ineffective health information system. The Government has recognized the problem and should now take action to develop a simple functional system, perhaps using microcomputers.

C. Strengthening Medical Education for Child Survival

Much of the knowledge and skills imparted to an M.B.B.S. student does not focus on the priority health problems of Pakistan. 42% of the population are under 15 years of age, yet pediatrics is given low status. 70% of the population are rural, yet primary health care and community medicine are given even lower status. Many doctors will be required to be in charge of health facilities and supervise teams of health workers, yet they are not given training in management and personnel. Modern teaching methods are not widely used. The written curriculum as approved by the Pakistan Medical and Dental Council is not the main problem. It is the quality and the orientation of the actual teaching and examination procedures.

To persuade students to give more attention to pediatrics, the subject should be given a separate examination paper with pediatricians on the examining boards. Many countries have adopted this policy. It has considerable support in Pakistan, but the PMDC and the medical colleges have not acted. Similarly, although included in the curriculum, the stress placed on community medicine and all subjects related to disease prevention and public health should be increased and given highest priority. The current predominance of clinicians on the PMDC and in medical colleges should be balanced by a greater role for public health physicians.

D. In-Service Training of Doctors, Paramedicals, Chemists, Homeopaths, Hakims, Dais, etc.

The technologies and strategies for improving child survival and health are evolving rapidly; doctors and other health personnel become quickly out of date. One important reason why health care providers often fail to use the most effective means to assure child survival and health is that they have never been trained in these methods. In addition, doctors see their role as the limited one of examining patients and prescribing drugs. Their potential as health educators of families and communities is overlooked.

What is needed is a massive retraining and updating program of short courses, seminars and workshops. The concept of continuing education, perhaps as a condition for continued registration by the professional bodies, should be considered. Some short courses are conducted now. To reach the tens of thousands involved in health care, however, it will take a much larger effort, systematically planned and institutionalized to assure permanence. Since Government surveys show that most people do not go to government facilities for health care, the training program must also include private sector health workers.

E. Child Spacing

Population planning and family welfare have been a public issue since the 1950s, mainly because of concern for the long term implications of rapid population growth. Efforts so far have largely been failures, probably because of frequent shifts in strategy and adverse social conditions such as low participation in education, high infant mortality and the low status of women. Countries that have made some progress, like India, Indonesia, and now Bangladesh, have had visible and forceful leadership at the highest political levels advocating population and family planning programs.

It is not widely appreciated that too many births, births at a young age and closely spaced births are dangerous for child survival and development as well as for the health of mothers. The Pakistan Fertility Survey of 1975 showed that when successive births were less than 18 months apart, the infant mortality rate was over 200. With a birth interval of three years, it was only 75. It was calculated that if adequate birth spacing were practiced in Pakistan, infant mortality would decline by over 10%.

If the importance of child spacing to health were understood by the medical profession, perhaps there would not be so much Ministry of Health indifference and footdragging on implementing the September 1985 ECNEC decision to provide family planning services at all health facilities. To date that GOP decision is in effect being ignored by one of its own ministries. Since implementation of the ECNEC decision would quadruple the current number of public family welfare outlets, the Government should focus on this as a high priority and assure that federal and provincial health leaders are committed to child spacing as a health measure. In-service training of health personnel is also needed.

F. Communications and Mass Media

The experience of the Accelerated Health Program shows the crucial importance of a communications strategy that provides needed information to the population to obtain their cooperation. Parents have heard about immunizations and oral rehydration therapy and want these benefits for their children. These messages must be frequently and continuously reinforced. The mass media can also promote hygiene, proper infant nutrition including breastfeeding, child spacing and child care. In Egypt's highly successful diarrhea control program, the mass media convinced families that diarrhea was dangerous and that children with diarrhea should be brought to a health center. It resulted in a reduction in infant mortality and increased use of health facilities.

Because of the high cost of the media, the use of these powerful tools has been restricted. An approach used in many countries is to provide free media time for child survival programming. For a cause so universally popular as children, and with so great a potential for impact, free media time or sufficient budget to purchase time would be a sound investment in the future of Pakistan.

G. A Sharper Institutional Focus on Children

Many Ministries such as Health, Education, and Labor are responsible for various aspects of the survival and welfare of children. Pakistan does not have, however, a successful institutional focus on children to bring to the government and the public the whole range of problems of children and to mobilize public and private resources and energies to solve them. India, China and other countries have successfully established innovative institutional arrangements that do not compete with the line departments but rather complement and reinforce their efforts.

Pakistan should consider establishing such institutions. One model would be a high level commission or board chaired by the President or Prime Minister to develop national policies for children, mobilize political support and resources for child survival, and coordinate public and private programs for children.

There could also be an institution with a permanent staff that would act as secretariat to the commission, conduct research and training, and administer a grants program to support child survival projects of NGOs and other private sector organizations. The grants could also supplement resources of public institutions wishing to expand their activities in support of children. Such a children's institute could execute the as yet unimplemented government policy to support NGO primary health care initiatives. If non-ADP funds were made available to selective public institutions, it would attract new attention to child survival. Local government bodies might also be recipients.

Establishing such institutions would be a demonstration of government concern for the welfare of the people and particularly of children. To be successful, however, the secretariat would have to have a high degree of autonomy and flexibility with sufficient staff, funds and authority.

V. USAID COOPERATION IN CHILD SURVIVAL

USAID believes that at the present stage of Pakistan's development, the investment with the highest potential for improved health, and the greatest probability of success, is child survival. Appropriately targeted interventions, properly managed with firm Government commitment could in a short time yield dramatic gains in reducing mortality and increasing life expectancy. Since most health care is provided by the private sector, the initiatives should not be limited to Government programs. With proper guidance and support, private health personnel, NGOs, traditional healers, and the commercial sector could play a major role. USAID is prepared to collaborate in a child survival and health program larger than any previous USAID health projects in Pakistan. We propose that we jointly establish a team of Pakistani and USAID experts to design a project this year for implementation from 1988 to 1993. The planning should be coordinated with UNICEF, W.H.O., and other interested donors.

Corresponding to the initiatives proposed in Section IV above, assistance from USAID might include:

- a. Support for strengthening and institutionalizing the Accelerated Health Program activities of immunizations, oral rehydration therapy and other child survival measures.
- b. Support for policy and program initiatives that would focus additional resources on preventive health. Technical and financial support for developing an effective health information system.
- c. Financial grants, training, commodities, and technical collaboration to support policy changes to improve medical education, especially relating to child survival.
- d. Financial support, training materials, etc. for a major program to retrain and update the knowledge and skills of doctors, paramedical personnel, dais, chemists, traditional healers and other health care providers.
- e. Financial support, training assistance and commodities to strengthen the contribution of the Health Departments to child health through child spacing.
- f. Technical support, audience research, materials and funding for an effective communications program, particularly drawing on the expertise of the private sector.
- g. Financial support for the establishment and initial operating costs of new child survival institutions, especially if given sufficient authority and autonomy to function effectively, and funding for a grants program for NGOs, other private sector organizations, and official bodies.