Child Mortality

Looking Beyond Patterns and Determinants to Politics and Institutions

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Ammunition for the Policy Maker

I apply a single test to Anil Deolalikar's paper while writing my critique – what a policy maker would take away from it. I believe that its greatest contribution is that it disaggregates patterns of child and infant mortality at the state level; and lower down to regions within states. That four states – UP, MP, Bihar and Rajasthan - together account for slightly more than half the infant deaths in the country is a very telling statistic. It tells the policy maker first, that the problem can be isolated, that reducing child mortality in these states alone will make a large difference to the national picture and that within these states, policy makers should concentrate on districts.

To be fair to policy analysis in India, there would be few policy makers at the state level who would not know that the problem is acute in specific districts and few district officers who would not this down to the Primary Health Center (PHC) or the Gram Panchayat level. What they would be less confident of would be to focus on those districts alone. Deolalikar's paper provides the empirical basis for policy makers to trust their knowledge and provide additional resources (mot merely in monetary terms) to the most vulnerable districts, even if criticized for leaving out the better performing ones.

The second important piece of ammunition for the policy maker is to know rates of change at the state level. Thus, it comes as a surprise that Karnataka had the slowest, while Bihar had one of the fastest declines in IMR in the period 1981-2000; and it is not as if Bihar started from such a low base that decline could be achieved with minimal inputs. Bihar in fact, has the same levels as Gujarat (IMR of 62) in 2000 and the same rate of change in the 20 year period.

But how is the ammunition to be used?

Deolalikar's analysis also shows that increased public spending is associated with better child mortality outcomes for the poorer states. My main criticism of the paper is based on the policy conclusion it draws from the empirical analysis. It is too simplistic to recommend that first, public spending in the poor states should be increased and second, that poor states should be brought on par with non-poor states through a mix of interventions. He does emphasize that the quality of the spending is important, but what he gives virtually no pointers to is **how to increase public spending** on health in the poorest states. If the paper had included an institutional and political economy focus in addition to the empirical analysis, the conclusions may have been different, since in policy circles it is well-known that there is no dearth of financial resources or technical competence to develop interventions to reduce child mortality in the high mortality states. Figures of allocated resources juxtaposed with monies actually spent in health show that

the poorest states consistently tend to spend less than their allocated resources[1]. The key issue is that the states that perform worst on child mortality and have the lowest public spending on health are also the ones with low institutional capacity at multiple levels, lack of priority to health, often lack of direction on how to proceed and have low articulation of demand (voice) by citizens. It is these issues of governance and political economy that inhibit both greater spending and better outcomes.

***Why has it been so difficult to place child mortality on the policy agenda and get good results*?**

While it is relatively easier to control epidemics and respond to crises like famine, or even to immunize targeted children, it is more difficult to maintain a concerted level of public action required to reduce child mortality and contain chronic malnutrition[2]. Addressing issues of governance and political economy and galvanizing different levels of the polity and bureaucracy into action is also far more difficult than increasing outlays and applying more state of the art protocols. The efforts have to be at several different levels; and motivated leadership, inter-sectoral coordination, coherent agenda setting and better incentive structures are key determinants of success.

The structure if Indian federalism also has a part to play in the way policies are implemented. The Constitution has identified public health as a state subject (but related issues of "population control and family planning" belong to the concurrent list and can be legislated by both the states and the central government). Thus, while the central government cannot set the priorities for the states, it can influence policy through "centrally sponsored schemes". However, the implementation of these schemes is within the purview of the state governments and the centre has little or no influence here, especially if the ruling parties at the state and central levels are political opponents[3]. The fact is that effective implementation of programs that reduce malnutrition or child mortality are seldom on the agenda of state governments in the poor states. This is increasingly in contrast to education, which has over the years become a key rallying point for a diverse group of actors from parents to politicians and lobbyists[4]. In a recent article on the Maharashtra Assembly elections, Kalpana Sharma[5] points out that even after recent child deaths, this issue (and other pressing development issues) is not on the election agenda, as political parties squabble over turf.

The comparatively peripheral place that child mortality as an agenda (as opposed to a menu of interventions such as immunization, nutrition etc.) occupies is due to a variety of

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[1] See Annexure 2.8.5 Tenth Five Year Plan, page 149.
[2] See Sen, 1995.
[3] Two related programs that have a direct bearing on child mortality are the Reproductive and Child Health program and the Integrated Child Development Services (ICDS) and one each has its own programmatic and implementation barriers that prevent child mortality from being on the agenda. That discussion is not the subject of this critique.
[4] There are several reasons why education related interventions have succeeded more than child mortality related ones, but that is outside the purview of this discussion.
[5] "An election too close to call", The Hindu, Sunday, Oct 03, 2004, accessed from http://www.hindu.com/2004/10/03/stories/2004100301461400.htm

reasons. First, households whose children are at highest risk of dying in the first year are those that have the weakest voice. Deolalikar shows us that child mortality is concentrated, not merely in some states, but in some districts and within districts, in certain households (in particular, among Scheduled Tribes, remote rural communities, and migrants, among other vulnerable groups). More often than not, these households cannot assert their demand for services that would improve child health and in many cases child mortality is not even a priority for them, while other more basic issues like employment, food security and curative treatment facilities for earning adults are.

In states with large tribal populations there have been frequent public outcries over what are called "malnutrition deaths". Usually these child deaths cluster around periods of seasonal stress like drought when household food supplies are low and employment dries up (as in Rajasthan), or during the monsoon (as in Maharashtra) when remote communities are rendered incommunicado. Public interest law suits have been filed on behalf of families that lose their children, and state governments have been repeatedly directed by the courts to take steps to remedy the situation. Governments have undoubtedly become more vigilant on this issue than they were before, but solutions that are devised in response to crises are largely piecemeal and unsustainable. For instance, during an emergency large scale medical personnel is deployed to the vulnerable areas, but the issue of absenteeism of doctors is endemic in rural and especially tribal areas. So, after the crisis blows over, it is business as usual.

Second, policy to reduce child mortality has historically competed with the overarching national and local focus on fertility control, which is in turn part of a broader rhetoric that developing countries have historically bought into – one that blames "over-population" for a host of development ills[6]. The connection that mortality decline can and does, lead to fertility decline is seldom made. Thus, the health machinery in the rural areas functions most effectively to implement the family planning program; then to implement other vertical programs to control malaria, tuberculosis and leprosy. The vertical program that has a direct bearing on child mortality is the immunization program but in the worst performing states, even immunization rates are very low.

Third, the policy agenda on child mortality has been excessively medicalized by the technical bureaucracy. When child mortality is framed in medical terms only and broader cross-sectoral links are not articulated effectively at the policy level, there is a tendency to see only limited responsibility of the state in the reduction of mortality. If for instance, the children of migrant workers who leave their villages with their parents in the lean season and return at the time of sowing or harvesting, have no health surveillance and their family food banks are empty, leading to large numbers of child deaths, these are blamed on migration patterns. Similarly, cultural explanations detrimental to tribal lifestyles are often advanced to justify large scale deaths in tribal communities[7].

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[6] There is prolific demographic literature on the politics of the fertility control paradigm.

[7] See Govt. of Maharashtra and UNICEF. (date not indicated). *Women and Children in Dharni: a Case Study of villages after fifteen years of ICDS*. Bombay.

Beyond patterns and determinants to an understanding of what works and how

In spite of the many political challenges, there have been a number of very successful initiatives both in the non-governmental and the governmental sector to address the issue in a multi-sectoral manner. The answer lies to a large part in local action and local accountability. For instance, when local level officers have been held accountable for child mortality or malnutrition as a preventive step (most often when a neighboring district has had a crisis, or a district officer has taken personal interest) then the entire district machinery has been galvanized into action. There is little documentation of such initiatives in the public sphere. The best known interventions are small scale and in the non-governmental arena. While extremely important, they are often so small and resource intensive, that scaling up becomes the real challenge, and when attempted, it fails, making the problem seem more intractable than it is. Interventions made by local governments (district officers and Zilla Parishads) on the other hand, are large enough in scale that they can be replicated, but these need to be documented, analyzed and built upon as well. It is important to address questions such as - who has ultimate responsibility for the reduction of child mortality? How are outcomes measured (or targets set)? Can a "lens of child mortality" be applied to health (and other) programs?

Second, the role of civil society and its effective partnership with government is probably one of the most important determinants of success. Yes, decentralization is important, but it is as important to link local structures of governance to broader social movements such as right to food, right to employment and right to information. In many cases, these movement do make the links between their agenda and malnutrition, but often these relationships are fraught with conflict and distrust. Greater understanding is needed of how such partnerships can be successful.

Finally, it is a truism to assert the importance of communities in several aspects of development. This truism is however, most applicable to fertility and mortality – both household level phenomena whose outcomes are based on household level decision making. The most successful experiments in reducing child mortality are those that rely on community ownership and partnership. However, it is sometimes difficult to tell if demand for child health at the community level is robust. If not, is it disguised as demand for public employment, food security, access to roads? These are some of the connections that any analysis of the "how" to reduce child mortality must do.