Comments on: Child mortality trends and determinants – policy implications for child survival in India.

This short paper covers a lot of ground, allowing an even shorter commentary a great deal of freedom to pick and choose topics to discuss. I'd like to make just one point and draw out implications from it for actionable policies to reduce child mortality.

The one point is: "there is a world of difference between the proximate causes of a child's death and policies that can influence these proximate causes". Examples of proximate causes are "low birth weight", "unattended delivery" (or, more accurately, the problem that an attendant might notice and be able to do something about), or even "immunization". Their contribution to child survival is not in doubt. However, the proximate cause is an endogenous consequence of (mostly) household decisions – and within this, often of the mothers within the household – possibly helped by a medical professional. Household decisions are the consequence of family conditions and constraints (e.g., being poor). Service provider availability and quality are consequences of their own decisions, themselves based on their motivation and to some extent, (less than you might think), their knowledge.

Public policy is several steps away from either of these decisions. Policy makers cannot and do not directly control them and policy impact can only be assessed on the degree to which the decisions can be influenced. The most important message from Mariam's paper is that a key principle for a successful child mortality reduction strategy

requires "…a shift in focus from 'what to do' to '…how to do it"'. "What to do" usually refers to the proximate causes. "How to do it" gets to the heart of what government actions will truly change the behavior of households and service providers. My main criticism of the paper is that it does not apply this dictum consistently and falls back on the easier recommendations of either more emphasis on proximate causes (e.g., a package of home-based neonatal care) or on leaps of faith that public spending will somehow translate into the right outcomes (e.g. "…the way the government spending is allocated across programs makes a difference to its impact on the MDG #4"). For the record, the study leading to the latter conclusion in fact showed no such impact of government spending on health outcomes in India (World Bank 2003).

Why doesn't pursuing these "policies" translate into outcomes in the poorest states? The paper rightly emphasizes the importance of making progress in the largest, poorest and, therefore, sickest states if overall national progress is to be achieved. This is uncontroversial. In fact it is a matter of simple arithmetic. But there are many weak links between the Government of India or the international community deciding to attack child mortality and getting the, well-known, proximate causes accomplished in, say, Bihar or Uttar Pradesh. The World Development Report 2004 "Making Services Work for Poor People" puts the blame squarely on the lack of accountability – of policy makers to citizens (especially poor citizens) and of service providers to policy makers. The second is easier to describe.

Let's assume that the state governments responsible for improving services in the poorest districts actively want to succeed at this task. What would keep them from doing so? The WDR commissioned research on absenteeism as measured by surprise visits to public primary health centers in every major state in India (Chaudhury et al 2004). The average for the country was around 40% and in Bihar it reached just under 60%. It is hard to see how simply putting more money into public programs is going to translate into better outcomes in this circumstance. The reasons for such high figures are not hard to determine. Medical providers – even paraprofessionals – are relatively well educated, often urban bred, and want their children to be educated (and urban bred) as well. This is natural. As Mariam's paper notes, studies in Andhra Pradesh indicate that there are a lot of factors that contribute to job satisfaction. Many of these ("tools and materials to use skills fully on the job") are difficult to maintain in rural areas. Not too surprising that there is absenteeism in locations with low morale.

Other analyses also indicate (though this research is much less well developed) that even when professionals in public facilities are present, the advice given, especially in poor areas, is often not very good – and not any better when done in the public sector than the much-maligned private sector (Das and Hammer 2004). Again, no wonder that intentions of policymakers may not make much difference to real people.

But there is a further issue of accountability that the WDR raises: it is not a foregone conclusion that governments are intent upon improving the health status of poor people. If public action is to contribute to achieving the MDG goals (or, in India, the even

more ambitious goals of the 10th plan), policy makers be held accountable for their achievement. Whether state governments are as committed, and in whose hands most policies that would achieve them lie, is a matter of debate.

What can practically and seriously (in contrast to rhetorically) be done to improve child mortality in India? I don't really know but the WDR suggests a few possibilities. First, consistent with the paper, regular measurement of the goals at a small enough geographical unit that someone could feel accountable for them would help. District level death rates are known only at census years. Second, these numbers need to be publicized. There is no guarantee that officials will feel responsible for improving results simply because they are published in the newspapers. But it is possible. Further, the decision of how best to reduce these rates would be made with the specific features of the district in mind. It might be sanitation; it might be immunization; it might be ante-natal nutritional supplementation; it might be any number of things that only someone on the ground and with the motivation to find out could possibly know. In this way the "right" policy can be made to endogenously evolve as circumstances require.

Higher level governments – the GoI for the states, the state governments for districts, etc. – can help with this search for appropriate, context specific, policies by providing help in finding out what works. This may require careful evaluation of policy initiatives – the actions of policy-makers and not of the proximate causes – that can save children's lives.