 Symposium : Strategies for child care

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Health for all by 2000—myth or reality

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A young Ethiopian girl was asked “What do you want to be when you grow up?” “Alive”, she replied. This sums up the situation of child health and survival in India too, and with 14 years to go for achieving the target of Health for All (HFA 2000) the situation is not exactly rosy.

For infants and young children the risk of dying is very closely related to the environment in which they live. While the baby is in his mother’s womb, the health and nutrition of the mother, her age and the number of children she has had and the interval between them, care during pregnancy—all have profound influence on his survival and optimum growth. Inadequate care during delivery further enhances the hazards both to the mother and the baby.

Level of mortality

Of 1,000 children born in India, about 110 die during the first year, 40 more die during the second year, 25 in the third year and 10-15 in the fourth and the fifth year. In other words, almost one-fifth children die before they are five years old. Of those that die in the first year, about half die in the first month, about half of that in the first week and half again of that on the first day. The causes of death too are fairly well known. Almost 1.5 million die of diarrhoeal diseases, 1.5-2 million die of acute respiratory infections and about 1.3 million die of diseases preventable by immunisation, mainly neonatal tetanus and measles. Malnutrition is a major cause of death, mortality doubling for each lower category of nutritional status. Malnutrition contributes to infectious diseases and infections in turn increase energy demands and decrease food absorption. The problems are compounded by anorexia and cultural practices that limit the amount of food during illness.

Less than 100 years ago infant mortality rate (IMR) in Europe and North America was as high as it is in developing countries now. In New York city in 1900 for example, IMR was 140 per 1000. The main causes of death were exactly the same as in the developing world today.
Over the next 50 years, IMR dropped from 140 to around 30. In India, IMR declined from 200 in 1901 to 129 in 1970, and is now estimated to be 105. In contrast, general mortality has declined much faster. Public health measures and control of communicable diseases have much more effect on general mortality than on infant mortality. Rural-urban differences in IMR have persisted through the years. Besides there are vast inter-state variations. Female deaths are more than males resulting in an excess of males over females. The sex ratio declined from 972 females to 1000 males in 1901 to 935 in 1981.

Infant deaths within the first week or month are caused mostly by maternal and delivery related factors such as extremes of age, a short birth interval, multiparity, malnutrition and hard physical work. All these result in a low birth weight baby whose chances of dying are three to four times that of a better weight baby. Most of the deliveries take place at home under unhygienic conditions and assisted by untrained persons or by family members, resulting in a high death rate due to problems of delivery and infections, the prominent among them being neonatal tetanus. Two-thirds of all first week deaths have been assessed as preventable.

The causes of death are known and the technologies also are known yet it is ironic that the impact of the various health strategies and a vast infrastructure on lowering mortality has been insignificant.

Health is not just a medical matter, but several social, psychological, behavioural and economic factors have their impact on it. The health status and survival is related to literacy of the mother and her status within her home and society. Education increases the utilisation of health services and creates a demand for more. Education delays the age of marriage and of the first conception, thereby giving a better chance to the mother and the child.

To summarise, the risk of death is related to income; neglect of rural programme and urban poor; mother's lack of schooling; mother being very young; low birth weight which is due to maternal undernutrition, lack of antenatal care and repeated pregnancies; poor housing, poor sanitation and water supply; curtailment of breast feeding and delayed and inadequate supplementary feeding; and non-availability of services for children and mothers.

Strategies

The adoption of the primary health care (PHC) by WHO in 1978 as a strategy for HFA 2000 did not happen suddenly but was a result of a growing awareness of the health problems of the developing countries. By 1960s it was clear that although some countries had grown fast, the gains had been confined to a few, to the detriment of the many. The failure of vertical massive family planning programmes led to a trend against vertical family planning services and towards integrated services for the mother and child and the emphasis shifted to concern about family welfare, lessening maternal mortality and improving the health and survival of children.

Some of the important health indicators suggested by WHO are:

1. Safe water in the home or within 15 minutes walking distance and adequate sanitary facilities.
2. Immunisation against diphtheria, tetanus, whooping cough, measles, poliomyelitis and tuberculosis.