

### Technical Working Group 3: Child Health

Chair: Deputy Minister of Public Health.

Chair: We are here to consider the targets on child health. Are they appropriate for Afghanistan? What indicators should we use and do we have the data? The MDGs for health depend on the achievement of other goals, such as poverty, environment and security, as well as on the efforts of the health sector.

In the Health sector, we can consider our activities in 2 spheres: (i) setting standards and developing partnerships and (ii) implementation - MoPH, NGOs etc. Our task is to set these standards today.

Adib Farhadi, ARDS:

The MDGs will be the overarching framework for our National Development Strategy, Medium Term Fiscal Framework and annual budget plans. We need to "Afghanize" the MDGs, i.e. adapt them to the Afghan context. What are the realistic targets within these goals? The ANDS will be the policy for how we will meet these goals. ANDS will be produced in November.

Time is tight for the preparation of the report for the Millennium +5 summit in September, and for the NDS, but this doesn't mean that we won't have the full process of consultation.

Dr Saurabh Sinha, UNDP Technical Advisor:

Overview for the meeting. We will assess the validity of the MDG for child mortality for Afghanistan, review the data, review the targets and adjust them accordingly. The Goal is to reduce by 2/3 between 1990 and 2015, the child mortality rate. Can this be applied to Afghanistan? We have no data from 1990, and this country is only just entering the development phase, post-conflict. Can we still hope to reduce child mortality by 2/3? Let us set some realistic targets for the next 10 yrs.

There are 3 targets and indicators: Under-five Mortality (U5MR), Infant mortality rate (IMR), and immunization against measles.

It is impossible to dispute the validity of the goal, but what do we know about the current state of the problem in Afghanistan? What can be done in the remaining time, can we set interim targets for the ANDS?

Dr Andrew Pinney, Statistician, MRRD and CSO:

Most of our data comes from the Multi-Indicator Cluster Surveys (MICS) 2003. If we use this data, which varies hugely from region to region, we get a U5MR of 99. But there are 8-fold differences across the regions – so is this realistic or an issue of data collection? In Southern areas, Pashtun areas - it is difficult to get access to women, by women researchers. So therefore it might be the case that the men were asked and for various reasons, gave inaccurate answers. There were other methodology problems in the survey questions and therefore we have very low estimates. A

UNICEF assessment of MICS and other data – “Best Estimates” (BE) - concludes that these should not be used as national estimates.

Afghanistan has always been near the top of the world rankings for these stats. If we discount MICS we have to go back to 1970s to find primary data. The State of the World's Children report has modeled U5 and Infant Mortality rates, but not clear how good these are.

MICS 1997 - never officially released. MICS 2000 only looked at the East and may have suffered similar problems.

UNICEF BE produced three scenarios which we might usefully consider. In the Optimistic scenario: As well as war, improved monitoring may have brought improved health. Stagnation to 1997, followed by measles immunization leading to another drop in mortality rates.

Median scenario: 2001 is almost = to 1990 because of war and drought. Some improvement since then, largely because of measles immunization.

Pessimistic: seen as unrealistic.

The Median scenario could be valid in the absence of all other data.

Measles immunisation. In 2003 - 75% coverage, almost no gender disparity. Now (2005) 90%. Afghanistan doing very well compared with Southern Sudan. Likely to have a very positive impact on infant mortality.

Chair:

The statistics have always been a huge challenge for us. The average is hard to find. There are places where the Infant mortality is very low. E.g Nangahar. Despite the war, the NGOs had very good access to border provinces from Pakistan. Skewed direct service delivery by non-state actors. So despite being Pashtun - the data might be right that there is LOW IMR.

What about Afghanistan's baby boom? Lots of marriages and population growth. What do you think about the impact of that? Vaccination programmes have had a great impact. Can we disaggregate by age and see what has been most effective? Nutrition is more important in early childhood, whilst diseases have more impact in infancy.

The scenarios were a very good guide. Lets consider them. Should we use these national averages, or set some regional targets since we have the data?

Katja, MoPH:

Has the re-analysis of MICS 2003 by John Hopkins been helpful?

Andrew: This is on-going. New population data means that we can re-weight the whole sample. There are distinct regional patterns and so this is really important.

WHO: The last proposal says that we could look at this at regional level instead of the national level. Operationally speaking we operate on a regional level, and we allocate resources accordingly. But we are here to prepare a national picture. So lets focus on that.

Ameerah Haq, DSRSG UNAMA:

The purpose of this exercise is to set the national targets. As Adib has shown us, this should lead into the ANDS, but that will need to be informed by regional data to help you prioritise, plan and programme effectively. What are you willing to commit to as a country? Those are the goals we need to arrive at this morning.

Chair: We need to consider HOW to arrive at this target? We can select at random, or can we use some evidence from neighbouring countries and learn from their experiences. Look at Pakistan, as Afghanistan and Pakistan had the same IMR in the 1960s and now so divergent. Pakistan has lowered the mortality rate from 190 to 90. What does this tell us about a realistic target?

Andrew: To look at neighbouring countries might be valid, as long as the socio-economic context is reasonably similar - we might think that this is feasible, in a country where peace and stability prevails.

Linda, UNICEF: 1/3 reduction is a global target and it was over a 25 years. From the CDC study, we calculated IMR and U5R - based on 4 regions, and this coincides with the median scenario from the UNICEF BE.

Ameerah: UNAMA - don't forget that Pakistan has been relatively stable, and receiving lots of development assistance, whilst Afghanistan has been at war and only receiving humanitarian aid. Unrealistic.

Dr Sinha: From the median scenario, a reduction by 2/3 = 140 to 50 and U5MR goes from 230 to 150. Also can reduce proportionately - 140 - 95. U5 from 230 to 195. Is this realistic? Can it be translated into the ANDS.

Chair: lets set challenging targets. Targets energise and focus people. Let's set ourselves a lot of work.

UNICEF, Wahid: Even 1/3 is very challenging and will require a lot of work given where we are.

Ameerah, UNAMA: You will be monitored nationally and be asked to prepare a progress report every 2 years. You have to say if you are likely or unlikely to meet it. My suggestion is that you should go for a realistic target. I know what you mean about the drive and the energy to go for a big target but channel that into achieving a realistic one.

Linda, UNICEF - this is a very complex target with a lot of inter-linked factors. What about something in between - 1/2, because although things are very damaged, we have a lot of donor funding and lots of programmes, so we might be able to accelerate progress.

Chair: Consensus that 2/3 is too much. Options: 1/2 or 1/3? I think 50% is not bad, but I think 1/3 is realistic in ten years. There are so many factors to address.

Linda, UNICEF: Looking at the best estimates, we have already achieved some reduction through the high impact programmes. However, this is the easy bit, so we can expect things to slow a little so 1/3 is most realistic.

UNICEF, USAID, MoPH are agreeing.

UNICEF, Wahid. Measles reduction is not as a result of routine immunisation. This will be difficult to maintain over 10 yrs, as this is an emergency-style campaign approach.

Dr Sinha:

Thanks for the reality check - this all has to come into policies and programmes, so its good that we are thinking about this.

WHO: The country has ANDS with a time schedule. All the Ministries have their own policies, e.g. MoPH 2005-09. This strategy defines key targets e.g. MMR, CMR etc. Lets revisit it, and link the ministry's strategy to MDGs in 3 yr blocks. The Ministry plans are based on reality and resources available etc. Donors think in 3 yr blocks too. Pakistan and Iran did the same thing which makes things quite simple.

IMF: My reaction to the discussion is set both realistic and ambitious targets. Set a realistic target for 2015, but also set a date by which the actual MDG target of 2/3 will be met e.g. 2020 etc.

Katja, MOPH: Might have to revise the MoPH document, as the targets were set according to the MDGs, but now we are talking about making changes. Have increased basic health coverage but now need to focus on increasing the quality.

Dr Sinha: Also think about the impact of population increase.

WHO: Demographics. We need to see the census. What about refugee returns? CSO has different figures again. What are we working with?

Dr Pinney: currently working on a 1979 census with different urban and rural growth rates. We also have access to the household listing survey – a pre-cursor to a full census. Note that the 1979 census was only 60% complete. CSO and UNFPA are working on the new census right now.

CSO Ramzi: 1979 has been used to prepare annual population estimates. Population census will be completed in 2007. Will show numbers over and under age of 18. Also collecting on facilities, eg. health and education. The Household listing survey is complete in all provinces except Kandahar, where 6 districts have not been accessible until now. Teams are going out in a few days to complete the study there. A crude growth rate was calculated on the basis of 1979. Published at national, provincial and district level. Last available = 2004.

Chair: Whatever we decide, this should go into the ANDS and the MoPH strategy.

USAID: How do the suggestions we are making compare to other similar countries?

Chair: Yes, please consider economic and social dimensions when we make comparisons.

MOWA: mothers play a crucial role in child and infant mortality. Their social status (education, wealth) plays a role. Some traditions in Afghanistan have hindered the ability of women to protect their children. The head of household makes decisions which are binding on women. We have to empower women to take decisions for their children's health.

CSO: Must take into consideration the economic, social, cultural practices and status of our people, and access to services. These take time to achieve. I vote for the 1/3 target.

Dr Farhadi: We may also consider what we can achieve in 2020 instead of 2015. 2/3 can be an achievable target over a longer time frame. By 2015, 1/3 may be achievable. The report will go to the President and the Cabinet, who may have their own ideas.

Chair: I hope that once we have invested in infrastructure, we will speed up our service delivery. Can we assume that 2015 - 2020, might be getting 2/3 achieved. What about going for 1/2 reduction in 2015? From my experience in Pakistan, I would say that things are changing very rapidly here and let's be optimistic.

WHO: I agree with the last proposal. We have seen significant increase in service delivery. 50-70% have access to essential services. Findings of MICS show that there has been a significant reduction in child mortality. Let's keep the common global target of 2/3 reduction. We are part of the global community. Even if we fail to meet it, it doesn't matter. Let's set up 10-15 process indicators for the next ten years.

Linda, UNICEF: sticking with 2/3 goal is smart, but even if we go for 2020, we only give ourselves a few extra years. So shouldn't we pick 2028 as our end date?

Chair: We need to be in step with our national development strategy.

Ameerah, UNAMA: 1990 is the baseline, but the Goals were only agreed in 2000. So we're only 5 yrs behind. So 2020 is the right comparative year for Afghanistan. Adib is right that we can say we'll meet the global target, given the rest of the time frame. However, we need to be in step with the rest of the world, so need to have something to say about 2015 accordingly.

Farhadi: want to go to 50% reduction by 2015, and 2/3 by 2020, as the President and Cabinet will want a high target politically.

Chair: We'll probably need to revise the targets constantly as we get better info.

UNICEF: Afghanistan is part of the world community and has subscribed to the MDGs. Of course there are big constraints here - infrastructure and culture etc. First we should accelerate the building of health infrastructure and then on culture. If we work towards a small and achievable target for 2015 it would be wise. Revise in 2015 and set another target then. I support 1/3 by 2015.

Chair: 50% seems to be the majority.

Dr Pinney: But if you choose 50% and then 2/3 - implies that we will have a big stride, and then progress will tail off. But if you choose 1/3 and then 2/3 - implies that you will accelerate progress as time goes on. Which is more likely?

Chair: Yes, at the end in health, it becomes more difficult over time. Progress won't be a straight line, but all jagged. Need to look at the rounded picture - we can improve water and immunisation, but culture takes longer. I think that it will take a lot of effort in the last few years.

Linda: There are some interventions that can reduce IMR quite quickly eg exclusive breast feeding from start. Treatment of pneumonia and diarrhea has been shown in Bangladesh to be v effective.

Chair: consensus = 50% for 2015 and then 2/3 by 2020.

### **Measles Immunization:**

WHO: 60% under 1 yr last year 04. Aim for 75% this year.

Chair: I think it will be more like 60-70%. Waiting for the recorded outbreaks for this harsh winter.

Dr Farhadi: If we are already at 60% we can make it.

Dr Sinha: This is not a target it is an indicator. An increase in immunisation should help you reach the target of a reduction in IMR and U5MR. I think on the basis of where we are today, 100% target might be achievable. There might be a data problem as the data is for 1-2 yr olds and the indicator is supposed to be under 1 yrs.

Chair: Hard to reach 100% even in developed countries. Reaching the last 10% can be extremely tough, especially given the terrain here.

WHO - EPI: 76% in 2003. We did campaigns in 02 and reached 15m children. The lower figures are for the routine programme. This year again we plan the campaigns, but for 2015 we have to think about what can be achieved through the routine.

USAID: Definition is a child with full immunisation - 3 doses of DPT. Who brought in the measles indicator? We should have the 3 doses of DPT. Diptheria, Polio and Tetanus. Should be DPT plus measles.

Chair: good point. Let's discuss. In other countries this is the DPT3. This is a very good proxy.

WHO: This has been selected globally for the MDGs. Measles biggest cause of global U5M.

UNICEF: Yes, the measles is the big killer. But while we are setting these goals we can set other indicators. One of them could be drop out. This will give us assurance that the child that got measles vaccine got DPT 3 also.

WHO: This is the closest related to child mortality.

MOWA: Vaccination culture has increased. My suggestion would be to also select respiratory diseases as an indicator also. In hot seasons, there are prevalent diseases that take the lives of children, but in cold weather the respiratory diseases take the lives.

Chair: other countries have chosen other indicators and we have to keep up with them, otherwise we take many different indicators. This is a global standard.

Dr Farhadi: What is stopping us from saying 100%? Your programmes have been very successful and we expect things to improve, as access gets better.

Chair: I feel that we could do 90% by 2015. This is reasonable. Then we aim to maintain that level, which is also a huge challenge, rather than continuing big campaigns.

Dr Farhadi - yes, may get there before 2015 but maintaining it is also a challenge.

Dr Sinha: Don't forget that the population will increase. This will require lots of effort to keep it up.

WHO: You can reach 90-95% through campaigns but maintaining it through routine is really tough. Assumes access and trained health workers in all districts, depends on the economic and social status of the country. I agree that a 90% target is feasible.

Saurabh: Data collection in the future. MICS will be collected how often and who is involved?

Chair: Afghanistan has a system of health management information system with MoPH, other ministries and UN. This gathers data on the health indicators. Will be routine I hope, but will also do one off surveys from time to time. It is fledgling, and will need support. The census data is critical for other things also.

Dr Sinha: need to keep tracking the data. But the MICS 2003 is the baseline, so we need to have some consistency, to ensure that it remains valid.

Chair: These statistics are very difficult and expensive to measure. Can look at proxy indicators, such as diarrhea rate, fever and dysentery.

WHO: supposed to submit in a common format their vaccination figures annually. Can compare them to other countries.

Chair: I prefer to look more broadly. Poverty is a key indicator of health. Need to include surveying of socio-economic factors in our ANDS. Should be a group of ministries working together to achieve common outcomes for health. I am very pleased that President Karzai has divided the Ministries up under the vice presidents. We had a meeting of those ministries under our VP. ANDS will be good.

Dr Farhadi - We'll come up with an outline, and distribute it for written comments. We'll then make an initial draft to be distributed to all agencies for comment. Then it will be finalised and submitted

to the oversight committee and then on to Cabinet for approval. By first week of Aug all docs must be prepared and translated for submission.

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