Global Future

Number 2, **2009**

A WORLD VISION JOURNAL OF HUMAN DEVELOPMENT

THIS EDITION

Child health: generating the will

FEATURING

Bob McMullan

Australian Parliamentary Secretary for International Development Assistance

Flavia Bustreo

Partnership for Maternal, Newborn and Child Health

Lawrence Gostin

Melbourne, Sydney and Georgetown Universities

Henry Perry

Future Generations

contents

Number 2, **2009**

Letter
from the editors

Dear Readers,

Please turn to page 9 for an important announcement that affects your subscription to *Global Future*.

If you wish to keep your link with World Vision's policy publications, we invite you to contact us at **global_future@wvi.org** notifying us of your e-mail address, by 30 September 2009.

Sincerely,

Heather and Marina (Editors)

what next?

in number 3, 2009

Meeting the twin challenges of poverty and climate change

Two of the greatest challenges of our age are poverty and climate change. They cannot be solved separately since each contributes to the other. The solutions to one must not exacerbate the other.

Our great challenge then is to ensure that developing countries are helped to eradicate poverty at the same time as we rein in climate change and prevent its most serious potential impacts.

This edition of Global Future *explores both the challenges of and the intertwined solutions to climate change and poverty.*

front cover image: *Parents and care-givers attend a child care workshop in Mali, a country with a high under-five mortality rate. The "Nutrition Hut" activities teach participants about correct care and nutrition practices for their children.*
photo: *Justin Douglass/World Vision*

facing page background image: *Koulouwa Ali took her three-year-old son to one of World Vision's 51 Community-Based Therapeutic Care clinics in Niger, after he had a fever that sent him into convulsions, followed by diarrhea and vomiting. At the clinic, volunteers and a government-paid nurse treat children for malnutrition and other illnesses, give them free medicine and nutritious food, and teach mothers to care for their children at home.*
photo: *Jon Warren/ World Vision*

Global Future is published by World Vision International to encourage debate and discussion on development issues.

World Vision

Publisher: Dean R Hirsch, **Editors:** Marina Mafani and Heather Elliott, **Contributing correspondents:** Denise Allen, Jan Butter, Cheryl Freeman, Ruthi Hoffman Hanchett, Joe Muwonge, Kirsty Nowlan, Jennifer Philpot-Nissen, Rachel Samuel, Frank Smith. ***All opinions expressed in Global Future are those of the authors and do not represent the opinions of the World Vision organisation.*** Articles may be freely reproduced, with acknowledgement, except where other copyright is indicated. Global Future is distributed to many NGOs and non-profit organisations in developing countries. Donations to support our production and mailing costs are very welcome (US$20 suggested). ***Correspondence and/or donations should be addressed to:*** Global Future, World Vision International, 800 W Chestnut Ave, Monrovia, California 91016-3198 USA Telephone (1) 626-303-8811 Fax (1) 626-301-7786 e-mail: global_future@wvi.org or World Vision, 6 chemin de la Tourelle, 1209 Geneva, Switzerland. Graphic design by Friend Creative (Australia). Printing by Pace Litho (USA).

www.globalfutureonline.org ISSN 0742-1524

Turning our dream to reality

Once upon a time . . . the international community committed to a grand vision of achieving health for all through primary health care, at Alma-Ata in 1978. More than 20 years later, in 2000, world leaders agreed on a new set of ambitious targets for addressing global poverty by 2015 through the Millennium Development Goals (MDGs). This plan included a global commitment to reduce under-five mortality by two thirds (MDG 4) and to improve maternal health (MDG 5). So how are we doing so far to make this dream a reality?

At present, only 16 out of 68 countries with the highest rates of child death are on track to reach this goal.[1] More graphically, 25,000 children are dying each day – yet we have the means to prevent two thirds of these deaths through proven and affordable interventions. As an international community, we are guilty of failing to end this travesty.

This edition of *Global Future* explores the nature of political will and what is required to reverse our failure. Our authors lay out the "why, who, what and how" of the actions needed to realise MDGs 4 and 5 and give us hope that we can quickly get on track.

Lawrence Gostin argues for a Framework Convention on Child Health, to establish a global governance system. Laying out the international and national legal obligations regarding children's right to health will help us to harmonise and co-ordinate the efforts of governments, donors and civil society towards ensuring the basics of what children need to survive and thrive.

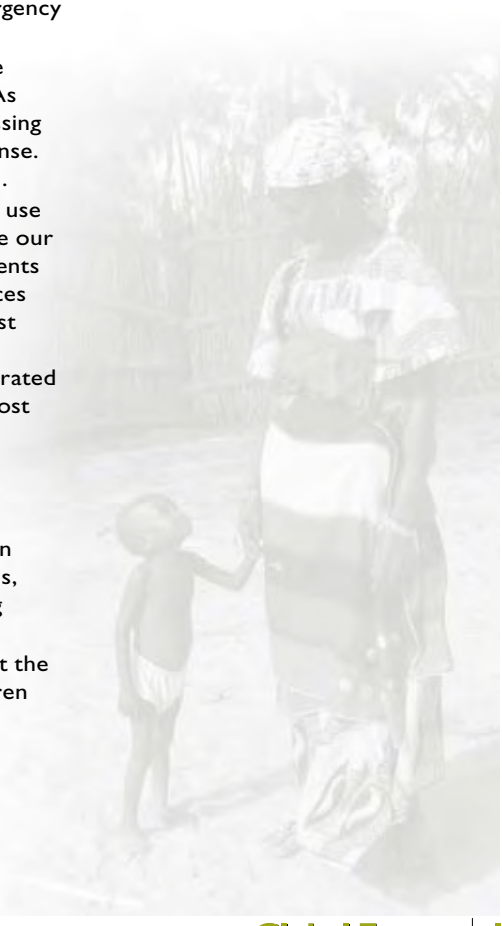
Further, as Rachel Hammonds and Gorik Ooms propose, we need to operate within a new paradigm; we can learn important lessons from AIDS activists who have employed a humanitarian, rather than a developmental, approach to build a global movement towards universal treatment, prevention and care. With 9.2 million children under five years old dying each year, child mortality is already a public health emergency that requires sustained international support and not just domestic self-reliance.

Our goal is realistic. We can avoid millions of preventable child deaths. But we must engage critical stakeholders in innovative partnerships to achieve our goal. As argued by Bob McMullan, Flavia Bustreo and Elizabeth Mason, this involves harnessing international, national, civil society, community and household levels in our response. And, as Gerard Finnigan emphasises, we must adopt a wholly integrated approach.

During this time of economic woe, we need governments with the courage to use new creative funding mechanisms to raise the additional money required to realise our MDG commitments to maternal and child health. We also need national governments to prioritise the health needs of women and children and to channel these resources into basic health and social protection systems that work for the poorest and most marginalised. After all, as both Linda Richter and Henry Perry argue, child health depends greatly on the strength, knowledge and health of care-givers; this is illustrated in the stories of Roma families in Bosnia and Herzegovina – where poverty, the most powerful health determinant, is prevailing – and of Indonesia, where parents have adopted healthier behaviours for themselves and their children.

We can also learn from the success stories that are told from empowered communities: the faith-based groups bringing about social transformation, as explained by Harold Segura and Christo Greyling, and the communities engaging in participative planning, budgeting and monitoring of municipal public health services, as demonstrated in Fortaleza, Brazil. As Barbara Schmid reminds us in her closing reflection, we need to build on the social capital and assets of our communities.

This edition spells out all the elements required to complete our story, so that the dreams that were formed "once upon a time" become the reality today and children achieve fullness of health and life! ■



Ms Martha Newsome is Senior Director for Global Health and HIV&AIDS Hope Initiative, World Vision International.

[1] UNICEF, *Tracking progress in maternal, newborn and child survival*, 2008, p 17 http://www.childinfo.org/files/Countdown2015Publication.pdf

by Henry Perry

Empowering communities and women: Primary Health Care and child survival

We know that simple approaches to child health will save lives; we now need to ensure that strong partnerships support effective community-based interventions, argues Henry Perry.

"I understand the importance of breastfeeding." World Vision's integrated nutrition project in Bangladesh, started in 1999, addresses the health problems of pregnant mothers and malnourished children.
Photo: *Raphael Palma/World Vision*

In 2000, world leaders came together at the United Nations Headquarters in New York to adopt the UN Millennium Declaration. Committing to a new global partnership to reduce extreme poverty, they set out a series of time-bound targets, with a deadline of 2015, that have become known as the Millennium Development Goals (MDGs).

MDG 4 calls for a two-thirds reduction in the mortality rates of children in their first five years of life, based on the 1990 rates.[1] There are 68 countries in which 97% of the annual deaths of under-five children take place; at present, only 16 are on track to reach MDG 4.[2] We have now passed the half-way point between the Declaration and the year for reaching these goals. Why are we so far behind on child health?

Simple approaches save lives

Although the number of children dying each year around the world has fallen from 18.9 million in 1960 to 9.2 million in 2007,[3] the great majority of these deaths are from readily preventable or treatable conditions such as pneumonia, diarrhea, malnutrition, measles, and neo-natal infections and tetanus.

In the 68 priority countries, the coverage of key interventions for improving child survival shows that much progress can be made through simple approaches (see Figure 1).

Immunisation and vitamin A supplementation reach at least 78% of mothers and children in these countries. But only one third are receiving appropriate treatment for the two leading killers of children: pneumonia and diarrhea.

If all mothers practised exclusive breastfeeding during the first six months of life, we would be able to prevent the deaths of 1.5 million children each year.[4] However, only 28% of mothers do this.[5]

Exclusive breastfeeding is the single most important preventive intervention against child mortality,[6] providing optimal nutrition during early infancy and protection from diarrhea-causing pathogens in food and liquids to which the infant would otherwise be exposed. And the other benefits of breastfeeding are numerous and significant as well: prevention of hypothermia in the infant, empowering women, reducing household expenses, and many more. Promoting appropriate complementary feeding, by frequently providing nutritious foods at six months of age, can prevent another 6% of child deaths.[7]

Improving the quality of water, handwashing and sanitation can each prevent the number of cases of diarrhea by one third.[8] Diarrhea treatment by mothers using oral rehydration fluids is life-saving. So is the early treatment of childhood pneumonia (which can be diagnosed by simply counting the number of breaths per minute) by properly trained and supervised community health workers administering oral antibiotics costing only pennies.[9] Home-based neo-natal care, in which community health workers educate pregnant women and assist them in the care of their newborn, can reduce neo-natal mortality by one third or more.[10]

Treatment close to home

We are learning that community-based programmes, that reach every household with health education and that provide services as close to the home as possible, are the key to high levels of coverage with proven child survival interventions and to having maximum impact on reducing under-five mortality. Many organisations around the world are helping to empower communities to be able to provide these key services themselves and to link communities with existing health services.

Government health programmes often focus on facility-based curative services and give little emphasis to community partnerships and empowerment

Empowering communities and women to adopt healthier behaviours for themselves and their children, teaching mothers about the symptoms of childhood illness that indicate the need for treatment by a trained health worker and about the importance of obtaining preventive services such as immunisations, will save the lives of

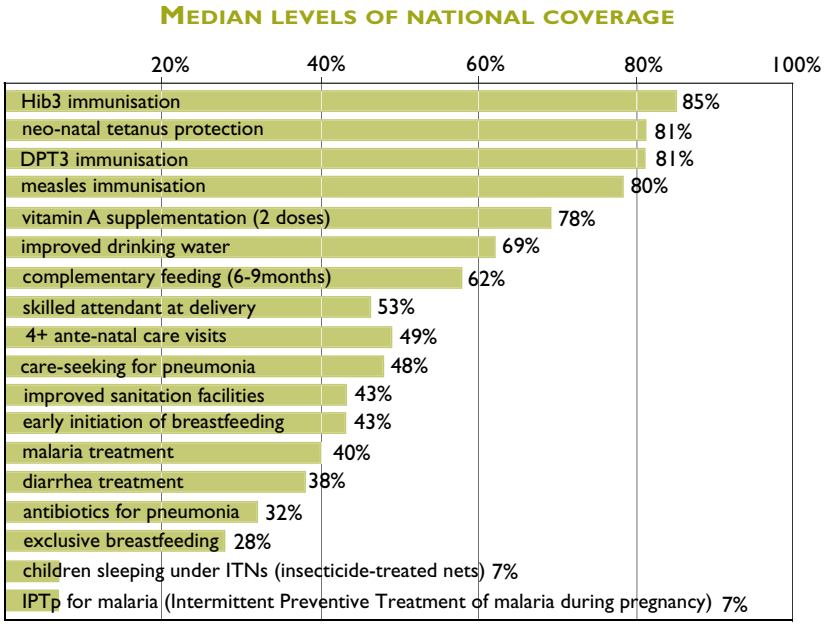


Figure 1. *Median national coverage levels for selected "Countdown to 2015" indicators and approaches across the 68 priority countries, most recent estimate.*
Source: *UNICEF,* Tracking progress in maternal, newborn and child survival, *2008*

children who otherwise would die. Training and supervising community health workers to be able to diagnose and treat childhood pneumonia, malaria and severe dehydration from diarrhea will also save lives, by bringing effective treatment closer to home.

ENGAGEMENT, EMPOWERMENT

For decades, many non-governmental organisations all around the world have been engaged in these community-based child survival programmes that have saved the lives of thousands and thousands of children.

Unfortunately, community-based approaches that focus on community empowerment and women's empowerment have not always been embraced by formal government health programmes, which often remain focused on facility-based curative services.

Ministries of health in most countries have not been able to develop programmes that encourage strong community collaboration. However, UNICEF, the World Health Organization, the World Bank and other leading development organisations are now coming to the realisation that stronger partnerships with communities – partnerships that engage communities as a valued resource rather than as a target for health programmes – are needed in order to reach MDG 4, especially in the poorest countries with the highest under-five mortality rates.

Formation of participatory groups in which women can obtain practical and sound advice, and in which women can learn from and support each other, is perhaps one of the most effective strategies that we know for implementing these simple child survival interventions. The effectiveness of this strategy for reducing under-five mortality is now well-documented.[11]

One of my friends once remarked that the greatest injustice in the world is the "lottery" of **where** a child is born. Millions of children have suffered the injustice of being born into poverty without access to basic health care services and have died from an avoidable cause. We must not forget them, nor our collective responsibility as a global family for their deaths. But we cannot undo the past. Instead, we must redouble our efforts on behalf of those who have suffered and who will suffer this injustice of being born into poverty. We must do all we can on their behalf.

We must work hard to implement what we know works. And we must increase efforts to support those that have the expertise and the capacity to build partnerships between governments, communities and ministries of health that will strengthen community-based primary health programmes. ■

Dr Henry Perry is Carl Taylor Professor of Equity and Empowerment, Future Generations.

[1] United Nations, *Resolution adopted by the General Assembly: 55/2 United Nations Millennium Declaration*, 2000

[2] UNICEF, *Tracking progress in maternal, newborn and child survival*, 2008, p 17, http://www.childinfo.org/files/Countdown2015Publication.pdf

[3] UNICEF, *ibid.*; OB Ahmad, AD Lopez, M Inoue, "The decline in child mortality: A reappraisal", *Bulletin of the World Health Organization*, 78(10), 2000, pp 1175–91

[4] UNICEF, "Infant and young child feeding", see http://www.unicef.org/nutrition/index_breastfeeding.html

[5] UNICEF, *Tracking progress in maternal, newborn and child survival*, *op. cit.*

[6] N Bhandari, *et al.*, "Mainstreaming nutrition into maternal and child health programmes: Scaling up of exclusive breastfeeding", *Maternal & Child Nutrition*, 4 Suppl 1, April 2008, pp 5–23

[7] G Jones, *et al.*, "How many child deaths can we prevent this year?", *The Lancet*, 362(9377), 5 July 2003, pp 65–71

[8] BF Arnold, JM Colford Jr, "Treating water with chlorine at point-of-use to improve water quality and reduce child diarrhea in developing countries", *American Journal of Tropical Medicine and Hygiene*, 76(2), 2007, pp 354–64; RI Ejemot, *et al.*, "Hand washing for preventing diarrhea", Wiley, 2008, see http://www.ehproject.org/PDF/ehkm/ejemot2008-handwashing_review.pdf ; L Fewtrell, *et al.*, "Water, sanitation, and hygiene interventions to reduce diarrhoea in less developed countries", *The Lancet Infectious Diseases*, 5(1), January 2005, pp 42–52

[9] S Sazawal, RE Black, "Effect of pneumonia case management on mortality in neonates, infants, and preschool children: A meta-analysis of community-based trials", *The Lancet Infectious Diseases*, 3(9), September 2003, pp 547–56

[10] AT Bang, *et al.*, "Home-based neonatal care: Summary and applications of the field trial in rural Gadchiroli, India (1993 to 2003)", *Journal of Perinatology*, 25 Suppl 1, March 2005, S108–22; AH Baqui, *et al.*, "Effect of community-based newborn-care intervention package implemented through two service-delivery strategies in Sylhet district, Bangladesh: A cluster-randomised controlled trial", *The Lancet*, 371(9628), June 2008, pp 1936–44

[11] DS Manandhar, *et al.*, "Effect of a participatory intervention with women's groups on birth outcomes in Nepal: Cluster-randomised controlled trial", *The Lancet*, 364(9438), September 2004, pp 970–9; A Edward *et al.*, "Examining the evidence of under-five mortality reduction in a community-based programme in Gaza, Mozambique", *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 101(8), August 2007, pp 814–22

New and creative approaches to health funding

The global financial crisis highlights the need to remain committed to ending global poverty, and forces us to explore new channels of funding for health, says Bob McMullan.

Australian Parliamentary Secretary for International Development Assistance, Bob McMullan, meets a newborn baby and his mother at a birthing clinic in West Lombok, Indonesia.
***Photo:** Josh Estey*

If the global financial crisis continues, the World Bank estimates that an extra 200,000 to 400,000 children will die.[1] That's up to 400,000 **more** than those already dying.

The purpose of the Australian Government's aid programme is to stop those children from being ill or hungry in the first place. Despite the domestic priorities and downward pressure on the 2009 Budget, we increased our commitment to improving child and maternal health to A$595 million (US$489 million)[2] over four years and our overall aid commitment to 0.34% of gross national income (GNI) in 2009–10. We remain committed to increasing spending on international development assistance to 0.5% of GNI by 2015–16.

We know that meeting Millennium Development Goals 4 and 5 (child and maternal health) is critical to the lives of thousands in our region, and critical to meeting the primary goal of ending global poverty. That is why Goals 4 and 5 are a particular priority of mine, and of the Prime Minister, who helped launch a A$250 million United Nations plan for child and maternal health in 2008.

The gap between the standard of child and maternal health in Australia and in some areas of our region is stark: the infant mortality rate per 1,000 births in Australia is less than five; in East Timor it's 41.[3] While the size of that gap is daunting, we must not be deterred from helping to close it. Almost two thirds of neo-natal deaths that occur each year are because of poor maternal health and hygiene and deficiencies in health services, and the vast majority are preventable.[4] The World Health Organization says 80% of maternal deaths could be prevented or avoided through affordable means, even in resource-poor countries.[5]

Closing the gap on health will be difficult, and expensive. If all developed countries increased their aid budgets to 0.7% of GNI, we would raise an extra US$42 billion for MDGs 4 and 5 – and we'd still be around $7 billion short.

New funding channels

This means we need to explore new ways to raise the funding to meet the child and maternal health goals. Australia has been actively involved in looking for new sources and channels of funding.

I was pleased to represent Australia at the 2009 meetings of the High Level Taskforce for Innovative International Financing for Health Systems, co-chaired by the UK's Prime Minister, Gordon Brown, and the President of the World Bank, Robert Zoellick. One Taskforce working group developed 100 innovative funding options, and reduced them to a few priority options. Of these, there are two the Australian Government is examining closely.

The first is the International Financing Facility for Immunisation (IFFIm). While immunisation has a good impact on health outcomes in the long term, it is expensive to pay for upfront. The IFFIm allows countries to borrow now, spend early to get the maximum advantage from immunisation, and spread the repayment cost over time.

Another option we are looking at is the Advance Market Commitment (AMC). The AMC is designed to overcome the fact that drug companies cannot get a sufficient return on their drugs if they are developed mainly for diseases afflicting poor people who have no capacity to pay for them. The AMC works by giving drug companies a guarantee in advance that if they develop such a drug it will be bought at a reasonable price by aid donors.

Our part in a global plan

As part of the International Health Partnership, we join a global plan for developed countries to help improve the health systems of developing countries.

The Government knows that in this time of financial turmoil, our development assistance to our poorest neighbours is more important than ever. We are determined that we will not take our eye off the challenge of ending global poverty. ■

The Honourable Bob McMullan MP is Parliamentary Secretary for International Development Assistance, Australia.

[1] The World Bank, "Crisis hitting poor hard in developing world, World Bank says", *News release no: 2009/220/EXC*, 12 February 2009

[2] The exchange rate for the US dollar (0.8213) is based on the WM/Reuters Australian Dollar Fix at 4.00 pm (Sydney) on 17 August 2009, see http://www.rba.gov.au, cited 18 August 2009.

[3] CIA, "Country comparison: Infant mortality rate", *The world factbook*, 2009

[4] A Joint WHO/UNFPA/UNICEF/World Bank Statement, *Reduction of maternal mortality*, World Health Organization, 1999, p 18

[5] World Health Organization, *Beyond the numbers: Reviewing maternal deaths and complications to make pregnancy safer*, 2004, p 5

Investing in maternal and child health: more important than ever

Faced with a global economic crisis, strategic partnerships can offer the investment, protection and empowerment needed to save the lives of millions of women and children, argues Flavia Bustreo.

We are facing a severe economic downturn and the health of mothers and children are likely to be most affected. Now, more than ever, it is critical to protect investments in maternal, newborn and child health in order to preserve recent gains in health outcomes, to continue to build on these achievements, and to sustain them into the future.

The Partnership for Maternal, Newborn and Child Health is ideally placed to mobilise a broad range of constituencies during this economic crisis. The Partnership's initiatives aim to reach key stakeholders – investment bankers, parliamentarians and families – who can protect mothers and children through (respectively) budgetary decisions, important legislation, and a galvanised community-based demand for basic health services.

A case for finance

At the recent annual meeting of the Asian Development Bank (which brought together more than 3,500 development and investment bankers), partners and governments of the region launched the report *Investing in maternal, newborn and child health: The case for Asia and the Pacific*,[1] which shows how governments can protect the poor, strengthen fragile health systems, and invest in long-term social and economic growth, as well as social and political stability.

Even at this early stage of the economic crisis, it is evident that international development assistance will be significantly reduced. But the investment case for Asia and the Pacific recommends practical steps for accelerating progress, including intervention packages. The study also identifies a set of "best buys" that take account of local problems, priorities and costs; specific "best buys" will vary from country to country, and will change over time.[2] Detailed estimates show that an additional US$10 billion is needed to provide a "core package" – increased access to "best buys" plus additional resources, such as drugs – by 2015, to contribute to the achievement of Millennium Development Goals 4 and 5 in the region.[3]

These findings and the improved tools for prioritisation are useful when advocating for increased donor investment. The Asia–Pacific investment case approach also will be applied in Africa and Latin America/Caribbean, aimed at contributing to higher coverage of interventions in high-mortality countries.

Many factors contribute to poor health outcomes, including poverty and illiteracy. Domestic expenditure on essential health care is an important part of successful programmes. Yet investment is often inadequate, fragmented and poorly aligned with incentives. Increased and more predictable international development assistance will strengthen economies and improve health for women and children.

Reaching law-makers

Effective financing depends, in great measure, on actions taken by parliaments. Advocacy efforts that target parliamentarians can yield enormous benefits by ensuring that investments in maternal, newborn and child health are at the appropriate level and are maintained during a crisis.

The 120th Inter-Parliamentary Union (IPU), a global gathering of parliaments of 154 countries, took place in Addis Ababa in April 2009. At a Partnership-sponsored IPU special session, the partners of "Countdown to 2015" – a movement which tracks key indicators of maternal and child health in 68 countries – asked some 1,200 parliamentarians to create and approve legislation designed to protect millions of lives. Dr Tedros Adhanom Ghebreyesus, Ethiopia's Minister of Health and Co-Chair of the Partnership, called upon parliamentarians to:[4]

- represent the voices of women and children;
- create and accelerate legislation to ensure universal access to care;
- oversee government accountability;
- provide adequate budgets for national health policies and programmes; and
- advocate nationally and internationally for the MDGs.

Maternal and child health issues are coming to the forefront of IPU discussions. Already agreements have been reached with the hosts of 2010's IPU Assembly in Thailand to organise a half-day session to review key actions taken by parliamentarians.

Empowering communities

Education and community mobilisation – and the empowerment of women – are key factors in determining, for example, how and when a pregnant woman will seek ante-natal care, or a young mother will seek care for a sick child.

To this end, the Partnership, together with White Ribbon Alliance's "Know Your Entitlements" campaign, is sponsoring an advocacy drive in the state of Orissa, India, which has a high burden of poor maternal and child health. This includes messages of positive health behaviours through media spots supporting community mobilisation and capacity building. Impacts are being monitored and plans are under discussion to expand the initiative to other states in India.

The health-seeking behaviours and practices of families and communities influence health outcomes and are especially critical during times of economic crisis or special need. ■

Dr Flavia Bustreo is Director for the Partnership for Maternal, Newborn and Child Health Secretariat in Geneva.

[1] Maternal, Newborn and Child Health Network for Asia and the Pacific, *Investing in maternal, newborn and child health: The case for Asia and the Pacific*, World Health Organization, 2009, http://www.who.int/pmnch/topics/investinginhealth.pdf [2] *ibid.*, pp 10–12 [3] *ibid.*
[4] T A Ghebreyesus, *Special Session on maternal, newborn & child health 120th IPU Assembly*, 7 April 2009, see http://www.who.int/pmnch/media/press_materials/pr/2009/20090407tedrospeech.pdf

by Rachel Hammonds and Gorik Ooms

Global solidarity for health

In order to achieve the health-related MDGs, we must look to successful examples; AIDS activists refused to respond to the HIV crisis as anything less than a public health emergency and therefore have made great progress, argue Rachel Hammonds and Gorik Ooms.

On World AIDS Day each year in Uganda, many people have marched to raise awareness, and to call for more funding and commitment to stop AIDS.
Photo: *Simon R Mugenyi/World Vision*

In September 2008, governments, international organisations, civil society and businesses recommitted themselves to achieving the Millennium Development Goals (MDGs).[1] But the latest review on progress towards meeting the MDGs shows that the world is failing in two key areas: reducing child mortality (MDG 4) and improving maternal health (MDG 5) in the developing world, and in particular in sub-Saharan Africa.[2] In contrast, there has been world-wide progress in combating HIV, malaria and other diseases (MDG 6): we have seen a promising start in the fight against AIDS, with improvements in the prevention of HIV and significant increases in the number of people on anti-retroviral treatment (ART).

Why are maternal and child health lagging behind while access to HIV treatment is expanding? Logically we would expect a high-cost intervention, like the long-term provision of ART, to be harder to fund. Perhaps, more importantly, we need to ask: why is access to ART improving and what can we learn from this so that we can realise all health-related MDGs?

While there are myriad reasons for poor progress in maternal and child health,[3] we believe there is one particular area of work by AIDS activists to build upon to help achieve health for all people – namely, harnessing the power of global solidarity to strengthen global health systems.

Two paradigms

Global solidarity is the "motivating force" for global action in two main areas: international development and humanitarian relief. Each operates within its own paradigm, and the consequences of adopting one approach over the other is one reason why we see progress in the fight against HIV and AIDS, but little progress in maternal and child health.

When a natural disaster or war affects a population, emergency humanitarian organisations such as the International Red Cross and Red Crescent Movement or Médecins Sans Frontières (MSF) respond. They appeal to global solidarity in their requests for funds and their work responds to the urgent desire that most people feel to "do something" to help those they see suffering. Their emergency operations are typically of short duration and are unconstrained by questions of sustainability (whether the national government will be able to replicate their work once they're gone). Whether the quality of and access to health care are better in a region affected by war than in a neighbouring region that is peaceful does not affect the nature of their operations; they aim to provide the best possible care to those people they are helping.

On the other hand, international development organisations, such as the World Bank, are also motivated by global solidarity but they are focused on sustainable interventions that lead to self-sufficiency. They want to see an exit plan. Development practitioners focus on improving health or education for all within a country over a limited time and consider the long-term sustainability of an intervention a key factor in project goal setting, design, implementation and assessment.

Efforts to improve maternal and child health fall within the international development paradigm and are funded by international donors within the framework of a country's overall development plan. Typically, in terms of scale and duration, they are unambitious; recipients know that donors focus on self-sustainability (when the project can be handed over to national authorities and when donor assistance can end) and experience shows that an overly ambitious project will be deemed unsustainable and will not receive funding. Structural change – like creating a functioning, accessible, quality health care system, which takes a long time – is often overlooked even if it may be the only way of achieving lasting improvements in health or education.

AIDS activism

In contrast, the fight against HIV has been conducted within the emergency/humanitarian relief paradigm. The approach adopted by AIDS activists – and their ability to remain outside the development paradigm, often termed "AIDS exceptionalism" – is at the root of their success. We believe that their

activism can serve as an example of the radical new approach to global health that is needed to achieve the MDGs.

In the mid-1980s, when AIDS was beginning to decimate gay communities in the United States, thousands of Americans acted. They marched, lobbied politicians and pushed pharmaceutical companies to develop a cure. Many activists called upon the world to respond to this public health emergency, not through coercive repressive methods but by arguing that respecting the human rights of all would help slow the spread of HIV and affirm the dignity of those living with the disease.

When ART was first introduced, HIV was claiming African lives at an enormous rate and spreading throughout the population, but the cost of the treatment put it out of the hands of people in the developing world. AIDS activists world-wide understood what it was like to be marginalised, stigmatised and discriminated against and were ready to fight for access to treatment for all.

In South Africa, a country with over 5.5 million people who are HIV-positive,[4] Treatment Action Campaign (TAC) is a civil society force that fights for "a unified quality health care system which provides equal access to HIV prevention and treatment services for all people".[5] Since 1998, TAC has taken the government to court to obtain universal access to life-saving treatment and has pressured pharmaceutical companies, using advocacy and the legal system, to win access to lower cost generic drugs.

Solidarity through funding

The Global Fund to fight AIDS, Tuberculosis and Malaria has been the lead actor in rolling out ART in developing countries hit hard by the AIDS crisis. The Global Fund's executive director explains how the organisation has abandoned international development norms: "The Global Fund has helped to change the development paradigm by introducing a new concept of sustainability. One that is not based solely on achieving domestic self-reliance but on sustained international support as well."[6] This suggests a new path to global health that is based on the normative belief that there are global responsibilities for global health rights, and that it is therefore no longer necessary to aim for national self-sufficiency.

Re-thinking the world's approach to global health was also included in a proposal by the High Level Taskforce on Innovative International Financing for Health Systems, whose Working Group 2 suggested that the Global Fund and GAVI[7] act "as a conduit for additional resources for health systems and achieving MDG 4, 5 and 6".[8] Such a change would lead to increased funding, more donor co-ordination and longer time horizons for recipient countries toward building and strengthening health systems.

We must move beyond the developmental self-sufficiency concept and treat this as an emergency

Moving forward

Attracted by the idea of autonomous communities and countries being able to finance health care themselves, without relying on donors' whims, we can easily fool ourselves and only aim for low-cost interventions, for example training traditional birth attendants in order to have a positive impact on maternal mortality.[9] But while these interventions may keep us going, hoping there will be some progress, we must ensure that they are integrated into functioning health systems.

In the fight against AIDS, we did not have such choices; it was either letting people die, or aiming for costly ART therapy. This forced AIDS activists to abandon the old development concept of sustainability and to aim for a combination of sustained domestic funding and sustained global solidarity that included funding.

Today, the Declaration of Solidarity for a Unified Movement for the Right to Health[10] draws on the principles and achievements accomplished by the AIDS movement, and calls for an expanded and re-invigorated movement of health for all. The Partners In Health organisation calls upon health activists, including those working on primary health care and the social determinants of health, to join forces for the Right to Health.

Strengthening health systems in the developing world is key to lowering child and maternal mortality rates and an integral part of achieving the MDGs. Moving beyond the self-sufficiency concept that is part of most development work is crucial. The approach of the past few decades – applying incremental solutions to this crisis – has proved ineffective. The current situation is an emergency and should have be treated as such long ago. ■

Ms Rachel Hammonds is a licensed attorney specialising in the right to health, development and children's rights and is currently a consultant to the Belgium-based Hélène De Beir Foundation. Dr Gorik Ooms is a human rights lawyer and until recently, the executive director of Médecins Sans Frontières, Belgium; in 2008, he joined the Department of Public Health at the Institute of Tropical Medicine in Antwerp, Belgium.

[1] High level Event, UN Headquarters, New York, 25 September 2008, see http://www.un.org/millenniumgoals/2008highlevel/

[2] World Bank, "Progress on the MDGs: September 2008 update", *Global monitoring report*, 2008, see http://web.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTGLOBALMONITOR/EXTGLOMONREP2008/0,,contentMDK:21901842~menuPK:4738069~pagePK:64168445~piPK:64168309~theSitePK:4738057,00.html

[3] Gender-based discrimination is the driving factor behind the violation of women's human rights including the rights to health, food, education and civil and political rights. The promotion of gender equality, MDG 3 is fundamental to achieving all of the MDGs.

[4] UNICEF statistics: South Africa, see http://www.unicef.org/infobycountry/southafrica_statistics.html

[5] Treatment Action Campaign, see http://www.tac.org.za/community/about

[6] M Kazatchkine, *Closing speech at the XVII International AIDS Conference in Mexico*, Global Fund to fight AIDS, Tuberculosis and Malaria, Geneva, 2008, see http://www.theglobalfund.org/en/pressreleases/?pr=pr_080811

[7] GAVI Alliance, formerly known as the Global Alliance for Vaccines and Immunization

[8] Taskforce for Innovative International Financing for Health Systems, Working Group 2, *Raising and channelling funds: Progress report to Taskforce*, 13 March 2009, http://www.internationalhealthpartnership.net/pdf/IHP%20Update%2013/Taskforce/london%20meeting/new/Working%20Group%202%20First%20Report%20090311.pdf

[9] J Replogle, "Training traditional birth attendants in Guatemala", *The Lancet*, Vol. 369, 2007, p 177, see http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)60090-7/fulltext?_eventId=login

[10] See http://act.pih.org/page/s/declaration

Working with governments and partners to improve child health

We know which interventions will save the lives of children; now we need to scale up these interventions through strengthened health systems to reach our goals, argues Elizabeth Mason.

The number of children dying around the world every year has gone down over the past decade, and some countries have made tremendous strides towards achieving the fourth Millennium Development Goal (MDG 4) of reducing under-five mortality by two thirds, from the 1990 rate, by 2015.

The rate of improvement has been uneven between and within countries, however, and around nine million children under five are still dying every year. Most of these deaths are caused by conditions such as pneumonia, diarrhea, malaria, malnutrition and AIDS, which can be prevented and treated with effective and affordable interventions that are already available.

Achieving MDG 4 will require engagement and commitment at all levels (community, district, national and international) and by all stakeholders (governments, donors, non-governmental organisations, United Nations agencies, etc.) to reach all children with the care they need.

A strong footing

Generating the scientific evidence for effective policy recommendations, norms and standards, building capacity for their implementation, and gathering data to monitor progress and allow for better planning, are among the key areas for promoting joint action. The World Health Organization's Department of Child and Adolescent Health and Development (CAH) is making significant contributions at global, regional and country levels in all these areas.

The fact that we now know which interventions effectively reduce under-five mortality is a result of research that, to a large extent, has been supported and guided by WHO. CAH continually provides policy-makers with evidence-based recommendations for policies, norms, standards and guidelines. These are generated through research designed for practical application and to have the greatest impact on child survival. For example, CAH recently supported a study involving 2,000 children in Pakistan which showed that in low-income countries with appropriately trained community health workers it is just as effective to treat severe pneumonia at home as it is in hospitals.[1] The implications of this study are huge, and the findings are expected to significantly change the way pneumonia is managed in developing countries with low access to health facilities.

Dialogue and action

But the evidence is not enough. It needs to be supported by advocacy for policy change and building capacity for implementation. As new evidence arises, WHO engages in policy dialogue with ministries of health and other stakeholders on how best to formulate policies and deliver strategies for child survival that are effective and tailored to epidemiological and country-specific situations.

Through its regional and country offices, WHO supports the implementation of those strategies and CAH offers tools for capacity building, ranging from programme management training on how to scale up coverage of key interventions for child survival, to training of community health workers in caring for sick children.

Fundamental to all these efforts is the strengthening of health systems, addressing all components from financing and human resources to creating demand for services at community level.

International efforts need to be complemented by national and sub-national data

"Countdown to 2015" is a multi-partner initiative tracking progress towards achieving the MDGs for maternal and child health. It is a forum for parliamentarians and policy-makers from national governments to engage with leading global health experts in addressing key issues for reducing maternal, newborn and child mortality. WHO has been a lead partner in this initiative from its inception, and contributes specifically to tracking health policy and systems indicators.

However, the international efforts in monitoring progress need to be complemented by national and sub-national collection, use and analysis of data for better planning and implementation.

CAH has recently developed a Short Programme Review tool to help countries use existing data to review their newborn and child health programmes, which also addresses issues related to the right of all children to health. In-country experience from the use of the review tool has shown it to be an effective way of involving a broad range of national stakeholders in joint action for child health. ■

Dr Elizabeth Mason is Director of the Department of Child and Adolescent Health and Development (CAH), for the World Health Organization.

[1] World Health Organization, *Progress report 2008 – highlights: Child and adolescent health and development*, p 7, http://whqlibdoc.who.int/publications/2009/9789241597968_eng.pdf

Special announcement

Global Future suspending production in 2010

Dear Readers,

We regret to advise that *Global Future* will suspend production from the end of 2009. We apologise for any inconvenience that this may cause.

We thank you for your readership of *Global Future* and for your interest in the issues that affect people living in poverty. If you do not hold an electronic subscription, please send us your e-mail address so that we can keep you informed of future developments.

We welcome any comments or queries you may have. Please contact us via e-mail to global_future@wvi.org, or via the 'contact us' link at www.globalfutureonline.org.

sincerely,
Marina and Heather
The *Global Future* editorial team

Building community will through performance monitoring

BRAZIL

"The Brazilian public health system is universal, integrated and decentralised. The entire population has access to services including preventive actions and medical care. Administration of the system is carried out at the municipal, state and federal levels. By law, citizens can participate in the control of the government administration through Health Councils, the agencies responsible for controlling the policies that are implemented.

Although modern in concept, the Brazilian public health system lacks sound investment to ensure that it services the most vulnerable communities. In many regions, the structures are precarious and the public health budget is insufficient to guarantee the rights fixed by law. In these cases, it is necessary to have resolute, organised political action at the community level to influence the decisions of the government.

Applied by World Vision Brazil since 2005, Community-Based Performance Monitoring (CBPM) has become an effective instrument of community articulation to influence the public health system. CBPM offers local groups from World Vision Area Development Projects (ADPs) a mechanism to monitor the services they use and to propose improvements. The CBPM methodology includes periods of training (capacity building in areas related to the public policies that are being monitored), mobilisation and articulation within the communities.

CAREFUL ANALYSIS AND A PLAN OF ACTION

One community that has benefited from CBPM is situated in Fortaleza, in the north-east region of Brazil. With about 2.5 million inhabitants, Fortaleza has various problems caused by social inequalities and poor income distribution. Health, basic sanitation and security are better in middle- and upper-class areas, whereas in the outskirts of the city there are inadequate health centres, a lack of schools and, very often, no sewerage system or rubbish collection.

In order to improve the situation in the outskirts of Fortaleza, World Vision and the local organisations that are part of Pantanal ADP decided to monitor two health centres that serve the region. More than 200 community members served by these health centres joined the CBPM process. They held meetings to discuss the local situation and evaluate the factors that hindered an improvement in health services. Through this process of social mobilisation, the communities diagnosed the services they had access to and the quality of the facilities offered to the public.

Service providers, including the manager of one of the health centres, also joined the dialogue. This process led to a co-ordinated plan of action proposing improvements in both the facilities and the service delivery of the health centres.

Suggested improvements ranged from the cleaning of the facilities to a "more human" relationship in the delivery of services by the health centre staff. The action plan also suggested that doctors and staff who did not work properly be replaced, and proposed better working conditions for staff.

The recommendations were handed in to the Municipal Secretariat of Health, which has committed to solving the most urgent issues and working together with the community to improve service delivery.

AN INFORMED CONTRIBUTION

As part of the community training, the CBPM methodology in Fortaleza has enabled communities to provide a critical view of their reality, as well as to present feasible proposals based on the characteristics of their city and the available resources for each area of intervention.

In the attempt to increase community influence on the policies, to change the unfair systems and structures, the CBPM methodology was applied to the existing Participative Budgeting model of Fortaleza City Council. Through this budgetary process – whereby the local government

"whatever is improved in our community means improvement for my family as well"

consults the community to ascertain their investment priorities – it was also possible for the community to have some control over the implementation of their proposed actions.

Ensuring accountability

Following the successful CBPM experience of Pantanal ADP, some other ADPs from Fortaleza – along with local organisations, churches and other non-governmental organisations that work there – have formed the REAJAN network to strengthen community-based monitoring of the city's services and public policies.

REAJAN was the starting point of an interesting movement to monitor proposed changes. The "Participative Budgeting Caravan" is a community group, led by the CBPM facilitators, that regularly visits local centres to gather evidence (photos, films and testimonies) to monitor progress on each proposed action.

The REAJAN network has become a reference in the monitoring of services and public policies, mainly related to health and education. It has gained increasing support and acceptance from the community, as well as the respect of the local authorities. This network produces regular reports that are transformed into proposals and handed in to the Municipal Secretariat of Health.

Since 2007, the organisations that are part of the Pantanal ADP and the Ipaumirim ADP have been invited to take part in the Municipal Health Council of Fortaleza, to contribute to the decision-making process around the health policies in their areas."

Reported by Ms Maria Carolina Silva, Advocacy Adviser, World Vision Brazil, and photographed by World Vision Brazil. Community-Based Performance Monitoring is now referred to as Citizen Voice and Action (CVA).

Albaniza's story

Albaniza Dantas has lived in the Jangurussu region of Brazil since 1996. She arrived there with her husband when she was pregnant with their third child. At that time, the population was just over 65,000 there, yet there was no public transport nor schools with proper facilities, and there were only three health centres, all far from her home.

"The children weren't properly vaccinated as there weren't any qualified nurses in the health clinics," Albaniza explains. "The difficulties were the same for everybody here."

Over the past 12 years, Albaniza has seen her district grow – there are now 100,000 inhabitants, but their problems also have increased. Public transport is very poor – there is only one bus route to serve the community. The school facilities are reasonable, but the education is of low quality. And violence is still a major cause of death for boys under 18.

In 2005, Albaniza was hired as a community spokesperson. She explains that, with CBPM, people's perception of their community has changed: "We realised the capacity we have to identify our problems and to know what works and what doesn't work. We can make proposals and demand the guarantee of our rights from the public authorities, checking if they are administering their resources well."

Today Albaniza is a health agent hired by Fortaleza City Hall. She is part of a team of 10 health agents who work in the district; before CBPM, there were only four. Among their achievements, they are building a new health unit, there are more doctors, and a Family Health Programme team visits the homes of people suffering from diabetes and high blood pressure.

Albeniza's motivation is to serve many people, not only her family. "Obviously I want my children to live in a better place, with less violence, more schools, more health services and more education. My family is part of this community. Whatever is improved in our community means improvement for them as well."

"Next year I'm going to graduate from college, where I study Social Service. What I learn here I take to the classroom, and what I learn there I bring here. Everything in life has to do with the exchange of knowledge and experiences."

life

UND THE GLOBE

Community-based intervention helping to save babies' lives

INDONESIA

*"**Mrs Karuniharsih** is a mother and housewife, and her husband has a job in a small orders printing business. This family lives in a modest room, measuring just three metres by three metres, in a village of the Tegalsari sub-district in Surabaya, in the East Java province of Indonesia.*

*The couple's fourth child, son **Arif Aliansyah**, was born in May 2009, weighing 3.2 kilograms and measuring 50 centimetres in length. It was a dramatic birth.*

PREPARED FOR A SUDDEN ARRIVAL

Towards the end of her pregnancy, Mrs Karuniharsih joined World Vision Indonesia's Pregnant and Lactating Mothers Support Group, known as Pos Bumil, in Surabaya City. The group teaches pregnant women and new mothers about important health and nutrition practices for pregnancy, lactation and childhood. There, Mrs Karuniharsih learnt about taking good care of herself and her baby during pregnancy, the importance of an early initiation of breastfeeding and also about the benefits of exclusive breastfeeding.

*When it came time for Mrs Karuniharsih to deliver her son, she sent for the midwife. Unfortunately, the baby arrived earlier than the midwife could! Accompanied only by her neighbour, all Mrs Karuniharsih could think of was to ensure her baby was safe. She remembered the explanation on early initiation of breastfeeding from **Mrs Mudji Astuti**, one of the Pos Bumil facilitators.*

So, she asked her neighbour to dry the newborn, whose umbilical cord was not yet cut, and to put him on her breast. The neighbour was very nervous but Mrs Karuniharsih encouraged her, saying "It's alright, Mrs Mudji explained to me that this is safe and can save my baby." Finally, her neighbour put the newborn on Mrs Karuniharsih's breast and he remained there until the midwife arrived one hour later. "My baby was so calm. He did not cry when he was on my breast – just after the midwife picked him up and cut his umbilical cord."

Mrs Karuniharsih stressed how grateful she was that Mudji taught her about breastfeeding in the Pos Bumil sessions, and that her knowledge contributed greatly to a healthy start in life for her baby boy. Even now, she provides only breastmilk to Alif because she now knows that exclusive breastfeeding is the best for baby until he is six months old.

Mudji, who is also a nurse in a private hospital in Surabaya, remarked on how much she appreciated this experience and how it touched her heart. "At the hospital, I seldom find situations like this one. But when I work in the community, I gain experience and understanding of how meaningful my work is for the poor people I serve, and I am so proud to be a Pos Bumil facilitator."

Pos Bumil has helped to increase the number of mothers delivering in a healthier and safer environment, accompanied by health personnel. Around 75% of pregnant mothers who took part in the programme had at least four ante-natal care visits and as many as 79% of pregnant mothers gained at least 10.5kgs in pregnancy. Pos Bumil also improved mothers' awareness of the importance of breastfeeding for the growth of their babies.

***Yurlina**, another participant, delivered her second child in 2007. With the knowledge she gained from the programme, this young mother had the courage to refuse infant formula when it was offered to her newborn; she was determined to give her child only breastmilk up to six months of age.*

"After learning from the Pos Bumil, I know how to breastfeed correctly, how I should position the baby, the benefits of breastmilk, and that the first milk is very, very important and should not be thrown away," says Yurlina. "Since he was born until now, my son hasn't caught any disease. He's very healthy and very active. I can save money as well from not having to buy milk. And it's so practical – I don't have to prepare the milk, the bottle and the hot water."

Global

VOICES OF LIFE FROM ARO

Recognising the need for partnership

World Vision Indonesia has been implementing health and nutrition programmes in Surabaya since 2004. Initially, programmes fell under a special project named FAST UP (Food Aid Supporting Transformation for Urban Population), funded by USAID. An evaluation of the FAST UP project showed a significant improvement in health and nutrition practices. The best practices of the programme were later integrated into World Vision's Surabaya Area Development Programme (ADP), located in the city's sub-districts.

The success of Pos Bumil and other World Vision health programmes has built a high level of trust and confidence from our partners, including the government of Surabaya. As such, the programme continues to gain support, partners and work volunteers because they see the positive results of efforts from World Vision and the community.

However, this success is a result of several key factors that create a willingness from all partners to invest in maternal and child health.

The Surabaya City Government realised that the problems in the community were so great that the government would not be able to tackle them alone; they, too, need partners to do that.

There is also continuous and dynamic communication between the city government and World Vision on the programme's development, ideas and innovations. Thus, the government gains more understanding about the work of World Vision and, more importantly, greater understanding of actual problems experienced at community level.

Finally, seeing evidence of organisational consistency, accountability and capacity to implement community-based health and nutrition programmes has led to greater enthusiasm and optimism from the partners.

Transformational development is a joint effort – the result of partnership between the community, World Vision, government and others with the same goal: a better life for children. Generating good political will is possible once each partner realises that we need each other, that we must communicate on a continuous basis, and that there is success that we can celebrate together. A success as sweet as the survival of Mrs Karuniharsih's baby boy."

Reported by Ms Agnes Wulandari, Urban Manager of Surabaya, World Vision Indonesia and by Ms Esther Indriani, Maternal Child Health and Nutrition Specialist, for the World Vision Asia Pacific Regional Office, with World Vision Indonesia

[1] UNICEF, *State of the world's children: Maternal and newborn health*, 2008, p 155, http://www.unicef.org/sowc09/docs/SOWC09-FullReport-EN.pdf [2] *ibid*, p 119
[3] *ibid*., p 123 [4] *ibid*., p 147

"I know that the first milk is very, very important"

Indonesia in 2007 had an under-five mortality rate of 31 deaths per 1,000 births – a 66% reduction on the country's 1990 rate.[1] But over half of the current under-five deaths occur in a the first month of life (the neo-natal mortality rate is 17).[2]

Forty percent of children under six months of age are exclusively breastfed, and 75% of children are breastfed with complementary food between the ages of six and nine months.[3]

A key to child survival may be found in the care and support that is provided in the birth and early care of a child. While 72% of Indonesian deliveries involve a skilled attendant, only 40% take place in a health facility or institution.[4]

life
UND THE GLOBE

Photos

Left *– Mrs Karuniharsih and her son Arif Aliansyah when he was 40 days old*
Photo: *World Vision Indonesia*
Above *– Yurlina maintained exclusive breastfeeding for her son for six months and feels the benefits*
Photo: *Johnson Tobing/World Vision*

Systems strengthening to care for the most vulnerable

Bosnia and Herzegovina

While on a journey towards democracy and equality over the past 15 years, Balkan countries are yet to achieve social justice. This is especially true when it comes to marginalised communities like Roma, an ethnic minority group living throughout Europe with no country in the world where they are the majority population.

Bosnia and Herzegovina (BiH) was declared a newly independent country in 1992. The seeds of hope for economic prosperity and security were planted throughout the country, including for the people of Visoko, a city with a significant Roma population that lives with scarce economic resources. But a draining war in 1993–95 led to marginalisation, low employment and education rates, a lack of housing, poor access to health care services and health insurance, and a lack of government policies to support Roma.[1]

The situation in BiH highlights the dual challenge of, on the one hand, generating community will when working with a very disempowered and vulnerable group and, on the other hand, generating political will for a minority group that risks being simply overlooked.

"Survival, inequities, social determinants of health

Slow physical growth and poor emotional support are known to have life-long effects: increasing the risks to a person's health and reducing physical, cognitive and emotional functioning in adulthood. Likewise, poor social and economic circumstances affect health throughout life, structuring lifestyle choices and producing health outcomes.[2] It is hard to judge which comes first for Roma – the risk factors or the social determinants – but the causal pathway seems to run both ways.

The traditional Roma culture embraces pregnancy and early childhood as the most important foundation for adult health. One Visoko resident, 27-year-old ***Selvedina****, says, "We want better lives for our children. Children are the essence of our life. We want them to be educated, to eat well and not smoke or drink, to refrain from sex at an early age and to be healthy. This is what any mother would want for her children, right?"*

Education is considered a predisposing determinant of health, but around half of the Roma population have not completed primary school[3] and only 30–35% of children are estimated to be enrolled.[4] Poverty, the most powerful health determinant, is prevailing. A 2008 World Vision BiH survey shows that, although optimistic, around half of the Roma population consider their living conditions now much worse than fifteen years ago. One in five survey participants claimed their children are engaged in paid labour, including begging.

"Numbing the pain"

People's lifestyles and the conditions in which they live and work strongly influence their health. The World Vision research suggests that spending on legal drugs is significant; alcohol and cigarettes appeared in the list of top ten expenditures. For 50% of the Roma surveyed, spending on tobacco equalled that of medicine. Sadly, illicit drug use has been called "the new disease for Roma youth".

"Our men turn to alcohol to numb the pain of the harsh reality of our kids' lives. Then, of course, alcohol dependence leads to lack of employment," says ***Sevala****, 38. "Drugs are used mostly by men, but we smoke and drink regularly – so do our children as soon as they are given the opportunity."*

Children begging in the street and adults and children using illicit drugs are responses to social breakdown and are an important factor in worsening inequalities in health, education and social status.

Little understanding of health systems

Although the country has committed to the Millennium Development Goals, it is difficult to measure BiH's progress towards the health-related MDGs (4, 5 and 6) for Roma. World Vision's 2008 survey reveals a major inequity in access to health. Only around 30% of Roma in BiH have health insurance, and most have it through an unemployment bureau; those who do have insurance rarely claim their right to health.

"I delivered at home," Sevala tells us. "My kids never had birth certificates and I doubt they will ever

Photos

Left *– "I love school very much and I really want to finish it. Without school I would become nothing," says this 10-year-old Roma boy. Sadly, the trend among Roma is the other way.*
Right *– A World Vision educator talking with a group of young Roma girls*
Photos: *John Schenk/World Vision*

Global

VOICES OF LIFE FROM ARO

"children are the essence of our life"

have health insurance. When they get sick, we try home care that we learned from our grandmothers. When they're very sick and we have no choice but to take them to hospital, we spend all our savings."

In general, the concept of public health is vague, with the post-communist system of Primary Health Care (PHC) skewed towards curative health. There is significant confusion in the community, especially among Roma, about the purpose of the health system. At the community and family level, preventive health care is absent and has no policy support (apart from an expanded vaccination programme, which has low coverage among Roma).

Health care: a right and not a privilege

Countries often have pockets of vulnerable sub-populations who do not access the health services available to the majority; Roma are an example of this situation. Such inequities can be alleviated by the simultaneous strengthening of health and community systems. No health promotion and behaviour change initiatives can succeed if the contributing social factors are left unchanged.

For Roma people to participate fully in the social, economic and cultural life of their countries relies on improved access to education so that people from Roma communities are able to become doctors, nurses and so on. And promoting awareness within Roma communities of their health rights and of services available to them render them less likely to face insecurity, exclusion and deprivation.[5]

World Vision has partnered with 20 Roma associations and non-governmental organisation networks throughout BiH. As a pro-active bridge between the Roma grassroots communities and BiH governments, we are advocating for inclusion and improved quality of life for the Roma, an enabling policy environment, a rights-based approach for basic health services, and the fostering of family and community coping mechanisms. Our work aims to change attitudes and practices so that Roma are more able to care for their own health and believe in their right to primary health care.

Health promotion and disease prevention are now being prioritised in the Decade of Roma Inclusion Action Plan 2005–2015, a political commitment by European governments to improve conditions for Roma. The revitalisation of primary health care is possible only with the parallel strengthening of health and community systems. This is the only sustainable solution to improve access to health across transitional Eurasia – not only for Roma but for all people who are poor, marginalised and disenfranchised." ■

Reported by Ms Marina Adamyan, Director of Health and HIV&AIDS, World Vision Middle East/Eastern Europe Regional Office, with Mr Albert Pancic, HIV&AIDS Advisor, World Vision Middle East/Eastern Europe Regional Office and Ms Maja Grujic, Project Manager, World Vision Bosnia Herzegovina

**** To protect the privacy of individuals, names have been changed and photos do not disclose identities or locations.***

[1] World Vision BiH and Ministry For Human Rights in BiH, *Action plan of Bosnia and Herzegovina for addressing Roma issues in the field of employment, housing and health care*, 2009

[2] D Raphael, "Social determinants of health: Present status, unanswered questions and future directions", *Int J Health Serv* 2006, 36(4), pp 651–77

[3] The 2008 survey conducted by World Vision BiH in partnership with the European Union as part of the "Advance human rights of Roma minority in BiH" project shows that the Roma population in BiH generally has a low level of education.

[4] Up to 80% of Roma children in Bosnia and Herzegovina do not attend school, see UNICEF, *Breaking the cycle of exclusion: Roma children in south east Europe*, 2007, p 50 http://www.unicef.org/ceecis/070305-Subregional_Study_Roma_Children.pdf

[5] The Roma right for and access to health is in line with the "International covenant on economic, social and cultural rights", "European social charter", "European health for all policy and targets", and "Resolution on the health policy for all citizens of BiH". It is also a condition for BiH joining the "Decade of Roma Inclusion 2005–2015" in 2008.

life

UND THE GLOBE

by Lawrence Gostin

Global governance: harnessing political will

Lawrence Gostin explains how a legal Framework Convention on Child Health would advance global governance and harness political will to meet the basic health needs of children.

I have campaigned for the international community to adopt a Framework Convention on Global Health (FCGH) to dramatically improve the health of the world's most disadvantaged populations.[1] This mechanism to advance global governance and harness political will could also extend to a more focused Framework Convention on Child Health. International conventions are far from perfect, but they can help drive an international consensus around an important global problem, set priorities, and harness the energies of multiple stakeholders in driving progress towards meeting basic survival needs for child health.

Rich countries should care about the world's least healthy people out of self-interest – to prevent the spread of infectious diseases across borders and to project the values of health and democracy (global health diplomacy). More importantly, rich countries should care about the world's poor as a humanitarian imperative and because ethically it is the right thing to do.

Two of the three health Millennium Development Goals (MDGs 4 and 5) focus on maternal and child health – the subject of World Health Day 2005, which launched the Partnership for Maternal, Newborn and Child Health. However, MDGs 4 and 5 lag behind other Goals. A major reason for this poor performance is that the international community has focused on the wrong priorities and has exhibited an unprincipled, undisciplined and unco-ordinated approach to global health assistance.

More than 700 people from the Maier and Barum villages of Papua New Guinea have access to clean water with the completion of new water wells in rural areas.
Photo: *Pamela Sitko/World Vision*

International efforts have been unprincipled, undisciplined and unco-ordinated

As the World Health Organization (WHO) has noted, the international health landscape is increasingly crowded and complex; more international actors are working in health than in any other sector. Global health activities overlap, are fragmented, and do not align with country priorities and capacities. Moreover, global health funding and interventions are skewed toward emotional, high-visibility events (e.g. the Asian tsunami), diseases that capture the public's imagination (e.g. AIDS), and diseases with the potential for rapid global transmission (e.g. SARS and pandemic influenza). Instead, what is truly needed is an approach that meets basic survival and focuses on creating and sustaining effective health systems.

The framework

To alleviate these seemingly intractable problems, the international community could adopt a Framework Convention on Child Health (FCCH). A FCCH would represent an historical shift in global health, with a broadly imagined global health governance regime.

It would incorporate a bottom-up strategy substantively focused on:

- co-ordinating fragmented activities;
- aligning global health efforts with country priorities;
- building capacity, so that all countries have enduring and effective health systems;
- setting priorities, so that international assistance is directed to meeting basic survival needs; and
- ongoing scientific evaluation

A continuum of care

Although there has been a 27% decline in child deaths since 1990, 9.2 million children aged under five years died in 2007; 37% of these deaths occurred in the first week or month of life. Additionally, more than 500,000 prospective mothers die of preventable causes each year.

WHO data show that maternal, infant, and child survival increase with the density of health workers in a country. The United Nations Children's Fund (UNICEF) highlights the importance of a supportive environment for mothers and newborns, establishing a continuum of care.

and monitoring of progress toward meeting clear, well-defined goals.

A FCCH would seek to harmonise the fragmented activities of international actors, ranging from governments (e.g. the United States' PEPFAR), public–private partnerships (e.g. the Global Fund and GAVI) and non-governmental organisations, to donors (e.g. the Gates Foundation and the Clinton Global Initiative). It would establish forums to allow global actors to meet and rationalise activities.

An international convention can be an effective way to build political consensus around clear actionable goals; it offers a platform for dialogue around shared responsibilities and international co-operation; and it maps a clear, defined path toward health goals and possible development of additional legal instruments – such as optional protocols and treaties around the right to health.

A clear focus

More importantly, the FCCH idea would focus international attention precisely on what children need to improve health and well-being. This "basic needs" approach would include prioritising primary care, maternal and infant care, childhood vaccinations, sanitation and hygiene, clean water, nutritious foods, and pest abatement.

These focused interventions would reduce vaccine-preventable diseases, diarrheal disease and vector-borne diseases such as malaria – all of which are leading causes of child ill-health and mortality. It would ensure access to health care for pregnant women, young mothers, infants and children, so that disease could be prevented and treated cost-effectively. It would also ensure potable water for drinking and hygiene, so that children are well hydrated and protected from water-borne pathogens. Similarly, it would focus on ensuring adequate amounts of nutritious foods to prevent malnutrition. These are the basics, which are exactly what children need to survive and thrive.

If the global community does not accept fair terms of co-operation on child health soon, there is every reason to believe that affluent states, philanthropists and celebrities simply will move on to another cause. And when they do, the vicious cycle of poverty and endemic disease among the world's least healthy children will continue unabated. That is a consequence that no one should be willing to tolerate. ■

Professor Lawrence O Gostin is the Miegunyah Distinguished Visiting Fellow at the University of Melbourne; Visiting Professor of Global Health, University of Sydney; and holds the O'Neill Chair of Global Health Law, Georgetown University Law Center.

[1] L Gostin, "Why rich countries should care about the world's least healthy people", *JAMA*, 298, 4 July 2007, pp 89–92; L Gostin, "Meeting the survival needs of the world's least healthy people: A proposed model for global health governance", *JAMA*, 298, 11 July 2007, pp 225–228

Do you know?

- Universal coverage of existing interventions can prevent 63% of under-five child deaths – including an estimated 55% of neo-natal deaths – and nutrition interventions can cut under-five mortality by 25%. (G Jones *et al.*, "How many child deaths can we prevent this year?", *The Lancet*, Vol 362, 5 July 2003, pp 65–70)
- The 1978 Alma-Ata Declaration defined primary health care as key to achieving health for all. (*Declaration of Alma-Ata*, International Conference on Primary Health Care, Alma-Ata, USSR, September 1978, http://www.who.int/publications/almaata_declaration_en.pdf)
- There are 68 countries in which 97% of the annual deaths of under-five children take place; at present, only 16 are on track to reach MDG 4. (UNICEF, *Tracking progress in maternal, newborn and child survival*, 2008, p 17, http://www.childinfo.org/files/Countdown2015Publication.pdf)
- The Paris Declaration, endorsed in 2005, is an international agreement by which over 100 ministers, heads of agencies and other senior officials committed to continue increasing efforts in harmonising, aligning and managing aid. (see http://www.oecd.org/dataoecd/11/41/34428351.pdf)
- Pneumonia is the largest single killer of children under five years old around the world. In 2008, a major study supported by the World Health Organization's Department of Child and Adolescent Health (CAH) showed that treating children with severe pneumonia at home is just as effective as treating them in hospitals. The trial, conducted in Pakistan, involved more than 2,000 children with severe pneumonia who received either injectable antibiotics in hospital or oral antibiotics at home. This study confirmed the findings of three other trials at sites in Africa, Asia, Europe and Latin America, which showed that oral antibiotics were just as effective as injectable antibiotics in treating hospitalised children with severe pneumonia. (World Health Organization, *Progress report 2008 – highlights: Child and adolescent health and development*, p 7, http://whqlibdoc.who.int/publications/2009/9789241597968_eng.pdf)

Faith communities must unite for child health

Faith communities are a powerful force for progress in maternal and child health, especially when unified, say Harold Segura and Christo Greyling.

Religious communities and their leaders are key actors in processes of social influence, co-ordination and concentration that aim to achieve comprehensive decent living conditions. British Prime Minister Gordon Brown acknowledged this fact in a 2008 letter to Pope Benedict XVI in which he invited him to back a "global coalition to ensure that we live up to the pledges we made back in 2000" to achieve the Millennium Development Goals.[1]

Faith-based communities are important not just for the ethical and moral content that they contribute to building a fairer world, but also for the force of their public influence when they make social justice commitments.

This is obvious if we consider efforts to promote children's health. We cannot talk about building a safer, fairer, more equitable world without recognising the urgency of children's health care.

UNIFIED EFFORT

Many international organisations expend enormous efforts to develop strategies to improve child health.

In 2007 the World Health Organization (WHO), as part of its efforts to offer broader care to children, published the first internationally agreed-upon classification code for evaluating the health of children and adolescents in the context of their development phase and of their environment.[2] This is a praiseworthy effort to understand the connections between children's health and influences such as social politics, environmental factors and educational support in their lives.

And for more than 30 years, WHO and UNICEF have been sponsoring the International Conference on Primary Health Care; the 1978 Alma-Ata Declaration defined primary health care as key to achieving health for all.[3]

Joint co-operation alliances of various forms are engaged with organisations, governments and the international community. Together with these efforts are those made by civil society, which includes faith-based groups such as religious movements, religious humanitarian aid organisations and churches.

Faith-based groups are motivated to act as agents of transformation for the poorest and most vulnerable of people

Mobilisation of faith-based organisations is effective when a co-ordinated, united work strategy is added to their values of ssocial responsibility and passion for justice. Models like this have emerged, primarily in recent decades, when so many efforts at ecumenism with social implications have been implemented world-wide.

WORKING MODELS

The crisis the world faces due to HIV and AIDS managed to bring the faith community together in one voice, as rarely seen before in history.

The Ecumenical Advocacy Alliance (EAA), of which World Vision is an active member, has campaigned on HIV and AIDS over the past eight years, including advocating on children's health rights.[4] With over 100 participating members – a broad range from large international organisations such as the World Council of Churches and Caritas Internationalis, to churches and local and national groups – EAA provides a vehicle for Christians from various denominations to have a shared voice on issues that are important to improving maternal and child health.

Through this combined effort many faith-based groups are raising awareness, lobbying governments and businesses, and collaborating with organisations such as the UNAIDS Programme Coordinating Board and the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria, which influence key decisions affecting the lives of millions around the world.

The Viva network is another group that offers a model of collaboration to care for vulnerable children.[5] Working with more than 8,000 projects through 40 Christian networks, Viva maps existing efforts, connects people and projects, provides practical support through training and resources, and mobilises faith communities.

At the 2008 World AIDS Conference in Mexico, Peter Piot, the retiring Executive of UNAIDS, acknowledged the important role of faith leaders of all religions, saying: "When I started this job I saw religion as one of the biggest obstacles to our work…but I have seen great examples of treatment and care from the religious community, and lately prevention."[6]

Not only is this true ecumenically, but also in inter-faith efforts. World Vision is using Channels of Hope (CoH) in partnership with the Christian AIDS Bureau of Southern Africa (CABSA) to mobilise and equip faith communities to respond to HIV and AIDS. The materials have been adapted to speak to multiple contexts and denominations, including the Catholic Church and Muslim leaders. At a recent training session of CoH facilitators in Istanbul in February 2009, one participant said: "I must honestly say that I had many doubts before this training. But now I am convinced this is the way to go.

This approach of Channels of Hope allows people from both faiths to address a common issue. It creates an environment where they can share the common principles while respecting the differences. What I like is the fact that it did not try to make the faiths all the same, but built respect for one another."

The social passion of religious groups must be accompanied by a keen awareness of the need to make room for unity, to include the most diverse expressions of faith and to work together harmoniously.

INSPIRED TO ACT

As the saying goes, "the greater the illness the bigger the pill". Improving child health requires effort on the part of as many actors as possible. These are actions associated with commitments of joint responsibility, without detracting from the undeniable role that must be played by governments.

Over the past four years (2004–2008), Channels of Hope has mobilised some 9,200 workshops which reached over 231,000 church leaders. During 2008, more than half of the 78,000 community members who volunteered as home visitors to care for orphans and vulnerable children and/or the chronically ill were from churches and faith communities.

Faith-based organisations are motivated to act as agents of transformation and to mobilise models of alternative living at the service of the poorest and most vulnerable of people. Such great social transformation aspires to "another possible world". This input is opportune in an era characterised by a deep moral crisis.[7] It is an indispensable offering for the international development community to recover its ethical dimension and to reach the vast sectors of marginalised humanity. ■

Mr Harold Segura is Global Church Relations Director for World Vision International. The Reverend Christo Greyling is Global Advisor on HIV/AIDS & Church/FBO Partnerships for World Vision International.

[1] Zenit, *British Prime Minister's letter to Benedict XVI: "We are falling short on the commitments we made"*, May 2008, see http://www.zenit.org/article-23147?l=english

[2] World Health Organization, *International classification of functioning, disability and health for children and youth (ICF-CY)*, 2007

[3] *Declaration of Alma-Ata*, International Conference on Primary Health Care, Alma-Ata, USSR, September 1978, http://www.who.int/publications/almaata_declaration_en.pdf

[4] See http://www.e-alliance.ch/en/s/hivaids/accessmeds/children/

[5] See http://www.viva.org

[6] See R Hill, C Finlay, *Report, Church of Scotland HIV/AIDS Project Group*, May 2009, see http://www.churchofscotland.org.uk/generalassembly/downloads/gareports09hivaids.pdf

[7] J Prats i Catalá, "Instituciones y desarrollo en América Latina ¿un rol para la ética?" ["Institutions and development in Latin America: A role for ethics?"], in B Kliksberg (ed.), *Ética y desarrollo. La relación marginada* [*Ethics and development: The marginalized relationship*], Editorial El Ateneo, 2002

Pastor Asaph John Serugga of Uganda, a graduate of the World Vision Channels of Hope training for faith leaders, passes on what he has learned to members of his church.
Photo: *Nigel Marsh/World Vision*

by Linda Richter

Love and care in the context of state-provided social protection

Care-givers need support from the state so that they can provide the love and care that a child requires to survive and thrive, argues Linda Richter.

Parental love and care are the most important elements of child survival, health and well-being. In situations where no health care or sanitation exists, the children who survive and thrive are those whose care-givers watch over them and respond to the listless look of a sick child with tenderness and available remedies.

Even when health care is available, a child's survival depends on attentive care-givers: their reaction to early warning signs; their ability and willingness to allocate scarce resources for transport to the clinic and the costs of medicine; their conscientiousness in following prescriptions; and their follow-up if the child's condition deteriorates.

But poverty and other conditions of disadvantage and hardship make it very difficult for parents to play this role. State provision does not always explicitly incorporate the important role of parents and other primary care-givers in the survival, health and development of young children, but social protection can safeguard families' capacity to care and provide for children. Provisions such as secure minimum income through social security transfers, subsidised staple foods or vouchers, free schooling and health care are examples of state support for family capacity.

The vulnerability of care

Parenting is fundamentally driven by two powerful bio-psycho-social systems. The first is the universal developmental trajectory of young children. Even under extremely difficult conditions, children develop an attachment to care-givers, attune to their language and acquire the social and cognitive skills valued in their environment. Developmental sequencing provides parents with an agenda or roadmap of care needed by a young child. When infants start to reach for objects, they are ready to grasp them; when they start to pull themselves up, they want help to take their first steps.

The second system, interaction, draws parents and children together. Even in their early weeks, babies turn to the voice of their mother and respond to playful talk, a friendly face, a soft touch. Adults – and even older children – find themselves unwittingly interacting with the child to maximise the baby's attention and enjoyment. This interchange alters over time, eventually including play, rituals and talk.

These bio-psycho-social systems have evolved to ensure care of children and to maximise learning within a culture. Yet although these systems are extremely robust, they are vulnerable in several ways.

One is that parenting is essentially a motivational activity, mobilised by the love for a child, by the desire for the child to survive and thrive, and by a mindfulness for the child's health and happiness into the future. Many conditions can interfere with this motivation, most especially the wretchedness of poverty.

Hopelessness, shame and exhaustion can erode parental happiness and interest. Routines for feeding, washing and dressing a young child may become irregular; a cough or a raised temperature may not be noticed as early as it should be; and no-one has much energy for talking to young children, answering their questions and guiding their actions.

Many conditions can interfere with parental love and motivation, most especially the wretchedness of poverty

Just as a child's developmental trajectory signifies the need for specific responses from their environment – a quality referred to as "experience-expectant" – so, too, does the child's development **depend** on this input.

In early development, there are specific windows of maximum learning aptitude for particular abilities. If these opportunities are missed, the child's functioning may be set at a lower level and as a result, the child may expect and draw less from the environment in future interactions. A vicious circle can be established, with loss of attention by a tired and withdrawn parent matched by the lethargy of a neglected and stunted child.

A review published in *The Lancet* in 2007 drew the conclusion that, around the world, more than 200 million children under five years are subject to these conditions, losing the opportunity to reach their full human potential as a result of stunting and poverty.[1]

Access, support, equality

What is to be done about this? One part of the solution lies in expanding access to health systems, and making health care simultaneously more appropriate and community-based to serve the needs of the poorest people.

Improving the education and authority of women so that they have personal and financial resources to act in the best interests of their children, and increasing the support men give to women and children, would also help.

But it is essential that gross inequalities be addressed. States must provide assistance to protect families from the worst effects of destitution.

It is a common misconception, especially in the health sector, that "nothing can be done" or that it takes too long to address poverty. However, the growth of social protection systems in some low- and middle-countries in Latin America and Africa – and where they have been systematically evaluated – demonstrate that regular, even if small, social security payments to the poorest families have benefits for children. Households in receipt of cash transfers, old-age pensions, child grants and other forms of social security, spend more money on food, education and health care for children. Parents and other adults conserve what's left for livelihood and micro-enterprise activities, creating financial stability to support children's care into the future.

It is widely believed that only macro-economic strategies such as economic growth, and especially employment creation, can counter poverty. However, when social protection mechanisms free up even very small amounts of people's time or money from the perpetual grind of survival, they generally use those resources to improve their circumstances: they buy more food, get their health attended to and repair their homes, and they acquire chickens, a wheelbarrow or other means of livelihood to secure a better tomorrow for themselves and their children. It is the actions of the poor, enabled by the state, that overcome poverty at the level of the individual household and child.

Emerging social protection systems herald new hope in social contracts between citizens and the state

These emerging social protection systems, spearheaded by direct income transfers to the poorest people, many of whom are also labour-constrained because they are elderly or sick, are heralding new hope in social contracts between citizens and the state.

In time, if these social protection mechanisms are protected by law and put beyond the manipulation of unscrupulous politicians, they will help to strengthen democracy. Citizens will hold governments to account to pay them.

It is the fondest hope of all parents that their children will grow up healthy, attend school, have gainful employment, start a family and enterprise of their own that brings them some happiness and security. This is best achieved in a state that protects human rights and provides protection from destitution and desperation. ■

Professor Linda Richter is Executive Director of Child Youth Family & Social Development (CYFSD), Human Sciences Research Council, South Africa.

[1] S Grantham-Mcgregor, *et al.*, "Developmental potential in the first 5 years for children in developing countries", *The Lancet*, 369 (9555), January 2007, pp 60–70

Yazjuma'a, an Afghan widow, received four hens and a rooster through World Vision. The eggs they produce are improving the nutrition of her family, and she sells or trades extra eggs with neighbours. It is a small but important improvement in their livelihoods.
Photo: *Mary Kate MacIsaac/World Vision*

by Gerard Finnigan

Integrated programming to address child mortality

If we are to avoid millions of preventable child deaths, there must be a change of culture amongst development agencies and organisations, argues Gerard Finnigan.

Despite the relative success in reducing under-five mortality over the past 20 years,[1] the current trend indicates the world will not achieve its goal of a two-thirds reduction of the 1990 figure by 2015. Indeed, should the trajectory continue on its existing path, the lives of 41 million children will be lost whose deaths could have been prevented.[2]

While a failure of this magnitude will be attributed to multiple causes, it will suggest an inability of the international community to achieve sustainable health solutions in the poorest communities, in spite of 15 years of dedicated effort, widespread application of evidence-based interventions, political support and historic levels of official development assistance (ODA).[3]

Adding greater significance to the magnitude of this failure is the changing climate system, which will increase the vulnerability of 2.8 billion people within 20 years and bring with it more hunger, disease, poverty, lost livelihoods[4] and a risk to development sectors that account for as much as one third of modern-day ODA.[5] Those children at greatest risk live in countries that have seen the least advance in preventing child deaths, including those in sub-Saharan Africa and south Asia,[6] where 82% of all under-five deaths currently occur.[7]

Holistic approaches

Yet there remains great hope. Unlike any other time in our history, now the international community understands the complexity of designing context-specific holistic health programming solutions to prevent child mortality.

Health activities have been compartmentalised and pursued according to individual agenda

Countries with very low *per capita* income have succeeded in reducing mortality and delivered high-coverage health interventions with maximum uptake through outreach or basic health services, including immunisation, family planning, insecticide-treated bed nets and prevention of mother-to-child transmission of HIV.[8] Furthermore, investment in curative services such as obstetrics, will yield significant results but only where primary health care and referral systems exist and are effective.[9]

However, it is programme integration that holds the key to reducing under-five mortality and, importantly, to creating the belief that vulnerability can be rapidly altered and life protected in the face of the changing climate system.

Alignment, inclusion

This is not new a concept. The universal pursuit of the Millennium Development Goals would have hoped to create synergy and alignment in health programming and bind together inter-agency and government activities. Yet, seemingly, health programme activities have been separated and compartmentalised according to issue, and solutions have been developed on the basis of individual agency/organisation/alliance imperatives and agendas. This has amplified the failure to harness the enormous impact potential of leveraging each agency's expertise and experience through an integrated programming approach.

In Ecuador, María Isabel is an expert on onion harvesting and teaches others about a worm that destroys the crops. The training, as part of World Vision's Andean Permaculture Project, helps families have the knowledge to grow crops and provide nutrition for their children all year round. ***Photo:*** *María Valarezo/World Vision*

Such is the realisation of the importance of integrated programming that UNICEF will concentrate its annual US$1.5 billion budget on integrated approaches that target community-level treatment and prevention of malnutrition, pneumonia, diarrhea, malaria and other disorders.[10] This focus goes much deeper than packaging health interventions in one programme, or collaboration with usual stakeholders such as the World Health Organization, the United Nations Population Fund (UNFPA) or the World Bank – it involves active partnership with non-traditional agencies on water and sanitation, HIV and nutrition.[11]

The challenge facing organisations in following this lead is to develop integrated health programming approaches as **standard** practice, rather than as the exception or *ad hoc* opportunity that occurs from time to time. Accepting this challenge requires two fundamental changes. The first is to create a dedicated organisational resource or external facility, responsible for actively finding and promoting integrated programme opportunities. The second is to foster the belief that innovative partnerships for programme delivery are necessary to establish systemic and sustainable advances in child health – not simply through the provision of financial contributions, or medical goods and services, but through bilateral and multilateral agencies, government and non-government organisations and research institutions as partners.

While calls for integrated funding mechanisms might appear well placed, the most effective and pro-active driver of change will be policy asks that promote and direct the prioritisation of donor funding toward existing integrated programme approaches, at increasing increments. Such actions will create the necessary incentive for implementers to rapidly re-engineer partnerships and programmes toward integration. ■

Mr Gerard Finnigan is Manager of Policy and Program Integration for World Vision Australia.

[1] UNICEF, *The state of the world's children 2009: Maternal and newborn health*, 2008

[2] K R Smith, "Challenges for health and climate: Time and morality", 2008, see http://ehs.sph.berkeley.edu/krsmith/publications/2008%20pubs/RMIT%20%20Jul%2008.pdf

[3] OECD, *Mobilizing private investment for development: Policy lessons on the role of ODA*, 2005

[4] U Confalonieri, *et al.*, "Human health. Contribution of Working Group II to the Fourth Assessment Report of the IPCC", M L Parry, *et al.*, *Climate Change 2007: Impacts, Adaptation and Vulnerability, Contribution of Working Group II to the Fourth Assessment Report of the Intergovernmental Panel on Climate Change*, pp 391–431

[5] Global Humanitarian Forum, *Human impact report: Climate change – the anatomy of a silent crisis*, 2009

[6] UNICEF, *Climate change and children: A human security challenge*, 2008

[7] UNDP, *Human development report 2007/2008. Fighting climate change: Human solidarity in a divided world*, 2007

[8] J Hohde, *et al.*, "30 years after Alma-Ata: Has primary health care worked in countries?", *The Lancet*, 372(9642), 8 September 2008, pp 950–961; UNICEF, *Progress for children: A report card on maternal mortality*, 2008

[9] Z A Bhutta, *et al.*, "Interventions to address maternal , newborn and child survival: What difference can integrated primary health care strategies make?", *The Lancet*, 372(9642), 8 September 2008, pp 972–989

[10] E Loaiza, *et al.*, "Child mortality 30 years after the Alma-Ata declaration", *The Lancet*, 372(9642), 8 September 2008, pp 874–876

[11] UNICEF, *Tracking progress in maternal, newborn and child survival*, 2008; E Loaiza, *et al.*, *op. cit.*

Further reference

The Lancet series:

- ***Child survival*** (2003) Examines where and when children are dying, how many child deaths could be prevented, the role of public health and putting knowledge into action for child survival. See: http://www.who.int/child_adolescent_health/documents/lancet_child_survival/en/index.html
- ***Neo-natal survival*** (2005) Provides global estimates of the cause of four million annual neo-natal deaths; evidence-based, cost-effective interventions to reduce this and scale up neo-natal care; and calls on country leaders and donor agencies to uphold their promises. See: http://www.who.int/child_adolescent_health/documents/lancet_neonatal_survival/en/index.html
- ***Maternal survival*** (2006) Focuses on strategies to reduce maternal mortality world-wide by ensuring that women can give birth in a health facility, in the presence of a midwife. http://www.thelancet.com/series/maternal-survival

- ***Building a world fit for children*** (UNICEF, 2003) Outlines declarations of the UN Special Session on Children. http://www.unicef.org/publications/files/pub_build_wffc_en.pdf

- ***Countdown to 2015 – Tracking progress in maternal, newborn and child survival: The 2008 report*** (UNICEF, 2008) Tracks coverage levels for health interventions proven to reduce maternal, newborn and child mortality. http://www.countdown2015mnch.org/reports-publications/2008report

- ***Primary Health Care: Now more than ever*** (World Health Organization, 2008) Argues for a renewal of primary health care. http://www.who.int/whr/2008/whr08_en.pdf

- ***State of the world's children: Child survival*** (UNICEF, 2008) Assesses the state of child survival and primary health care for mothers, newborns and children. http://www.unicef.org/sowc08/report/report.php

- ***The world health report 2000 – Health systems: Improving performance*** (World Health Organization, 2000) Examines and compares aspects of health systems around the world, provides conceptual insights into the complex factors that explain how health systems perform, and offers practical advice on how to assess performance and achieve improvements with available resources. http://www.who.int/whr/2000/en/whr00_en.pdf

This listing is provided for research purposes, and does not imply that World Vision endorses the entire content of external sources.

the Back Pages

...spiritually speaking

Recognising and strengthening our assets

"Now you are the body of Christ, and each one of you is a part of it."[1]

Children touch us in a way that adults don't. Through their vulnerability they awaken in us the responsibility to protect and nurture; through their openness they challenge us to help them find a way into the future; through their being in the moment they remind us of the simplicity and immediacy of life.

So it shouldn't really be a problem to get attention for addressing children's health, to leverage resources to provide for the needs of these so vulnerable members of society. And yet large numbers of children do not have access to even the most basic health services. And still, in spite of considerable improvements, millions of children die every year of utterly preventable causes; millions of lives started, filled with potential, and never fulfilled.

I often stand amazed at what people are willing to take on, to do and even to suffer for their children. They invest huge amounts of time and effort to secure what seems best for their child: the many sleepless nights, the willingness to hold on to a difficult relationship for the sake of the children, even taking on sex work so that the children survive.

How is it that so little of this effort is invested to secure some of the best for other children? What deep gulf here dividing "ours" from "theirs", "my child" from "under-5s", "us" from "them"?

What will it take for a different world to become possible? A world where there are places and communities that signal the rule of God – a God of love and justice – where the separation into "them" and "us" is not so glaring, the discrepancies not so stark, the reality a closer reflection of justice and love?

Bringing new energy to a hopeless situation

I have learned a valuable approach in six years of working in the African Religious Health Assets Programme (ARHAP) – and that is to start with assets. So often we start with what is wrong – of course, millions of children dying every year of preventable causes is something that does draw our attention, and so it should. But an approach that looks at what is present rather than what is missing can bring a new perspective and energy to a seemingly hopeless situation.

Assets are a range of capabilities, skills, resources, links and institutions already present in a context. They carry value and may be leveraged to access greater value. While needs-based approaches often depend on having a deficiency remedied from outside, the asset focus emphasises local agency – the available capacity to do, to act – without denying the important role of outside agencies.

Assets are present even in the most desperate situations and the most needy communities. Bringing people together to identify these assets as they plan a way forward has, in our experience, shifted the dynamic, brought about new energy, and forged new collaborations to address the needs.

Taking stock of our assets

So, what are the assets available to the development community to secure better health outcomes, especially for the well-being of children at the margins of society? Here are a few.

- There is now much evidence of what does and does not work, and much experience to draw on. The significant reduction in child deaths that has been achieved testifies to that. This is an asset to be leveraged.
- Communities of faith are present across the globe, even in the most remote communities, and are connected through their world-wide denominational web. These groups and their facilities always constitute one of the assets local communities can leverage for access to information and resources, and very often to some health service too. It is an asset that has many demands made on it; as a result it is often over-stretched. Here the biblical image of the

one body – and the reality it reminds us of – is important. We are in this together. We cannot separately do it all. Nor do we need to.

- For Christians there is the asset of a challenging and invigorating faith. Gary Gunderson, one of ARHAP's founding members, says, "Faith makes possible adaptive leaps because it is not surprised by surprise; it anticipates that which may not yet have precedent; it enables action beyond data; imagination not entirely captive to existing technique."
- Theology, too, offers assets by helping us make sense of how our faith is realised in this world. Paul Farmer, the medical doctor, anthropologist and health activist, claims that since many diseases make a "preferential option for the poor", churches need to follow God in his preferential option for those on the margins, those affected disproportionately and seriously by ill health. Drawing on the tradition of liberation theology he shows what this could look like: listening to the poor for their view on their position and needs; taking action with them as well as on their behalf; and passing judgment on conditions that result in preventable deaths. He speaks of "pragmatic solidarity" with the poorest of the poor, of standing alongside them and advocating not for just any health services, but for the best.

There is a need to develop the political will to do more, of course, and much has been said on that. But political will starts out of civil will, out of small and growing pockets of people who are not satisfied for things to be as they are, and who see a way forward and demand that it be taken. I have often been encouraged, when I felt overwhelmed by the huge demands facing us, by anthropologist Margaret Mead's bold statement: "Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it is the only thing that ever has." The history of the church over the past two millennia gives ample illustration of this. An asset indeed. ■

Ms Barbara Schmid is Research Co-ordinator for the African Religious Health Assets Programme. The views in this paper, while drawn from her work in ARHAP, are her own.

[1] 1 Corinthians 12:27

[2] See http://www.arhap.uct.ac.za. For asset-based development see J Kretzmann & J McKnight, *Building communities from the inside out: A path toward finding and mobilizing a community's assets*, ACTA Publications, 1993; also SM De Gruchy, "Of agency, assets and appreciation: Seeking some commonalities between theology and development", *Journal of theology for Southern Africa*, 117, 2003, pp 20–39

[3] African Religious Health Assets Programme Framing document, in *Colloquium 2005: Case study focus – Papers and proceedings*, ARHAP, 2005, see http://www.arhap.uct.ac.za/publications.php#colloquiummaterials

[4] P Farmer, *Pathologies of power*, University of California Press, 2003, see particularly "Health, healing and social justice", pp 139–59

World Vision is a Christian relief, development and advocacy organisation dedicated to working with children, families and their communities world-wide to reach their full potential by tackling the causes of poverty and injustice.

As followers of Jesus, World Vision is dedicated to working with the world's most vulnerable people. World Vision serves all people regardless of religion, race, ethnicity or gender.

Children are often most vulnerable to the effects of poverty. World Vision works with each partner community to ensure that children are able to enjoy improved nutrition, health and education. Where children live in especially difficult circumstances, surviving on the streets, suffering in exploitative labour, or exposed to the abuse and trauma of conflict, World Vision works to restore hope and to bring justice.

World Vision recognises that poverty is not inevitable. Our Mission Statement calls us to challenge those unjust structures that constrain the poor in a world of false priorities, gross inequalities and distorted values. World Vision desires that all people be able to reach their God-given potential, and thus works for a world that no longer tolerates poverty.

back cover image:
Chey Somaly, cradling her son, waits for medical counsel in Damnak Chan health centre, Cambodia. As the centre is close to her house, she drives or walks to regular appointments. Now, Somaly and her son are healthy.
photographer:
Sopheak Kong/World Vision

World Vision

Regional Offices

Africa
PO Box 50816
Karen Road, off Ngong Road
Karen, Nairobi
Kenya
Tel. 254.20.883.652 Fax 254.20.883.942

Asia and Pacific
Bangkok Business Centre, 13th Floor
29 Sukhumvit 63 (Soi Ekamai)
Klongton-Nua, Wattana 10110
Thailand
Tel. 66.2.391.6155 Fax 66.2.381.1976

Latin America and Caribbean
Apartado 133-2300 Curridabat
Torres del Campo
Edificio 1, Piso 1
Barrio Tournón
San José
Costa Rica
Tel. 506.257.5151 Fax 506.257.5151

Middle East and Eastern Europe
PO Box 28979
2084 Nicosia
Cyprus
Tel. 357.22.870.277 Fax 357.22.870.204

Global Office
800 West Chestnut Avenue
Monrovia, CA 91016-3198
USA
Tel. 1.626.303.8811 Fax 1.626.301.7786

International Liaison Office
6 chemin de la Tourelle
1209 Geneva
Switzerland
Tel. 41.22.798.4183 Fax 41.22.798.6547

European Union Liaison Office
33 avenue Livingstone
1000 Brussels
Belgium
Tel. 32.2.230.1621 Fax 32.2.280.3426

United Nations Liaison Office
216 East 49th Street, 4th Floor
New York, NY 10017
USA
Tel. 1.212.355.1779 Fax 1.212.355.3018

www.globalfutureonline.org

e-mail: **global_future@wvi.org**

Global Future
A WORLD VISION JOURNAL OF HUMAN DEVELOPMENT