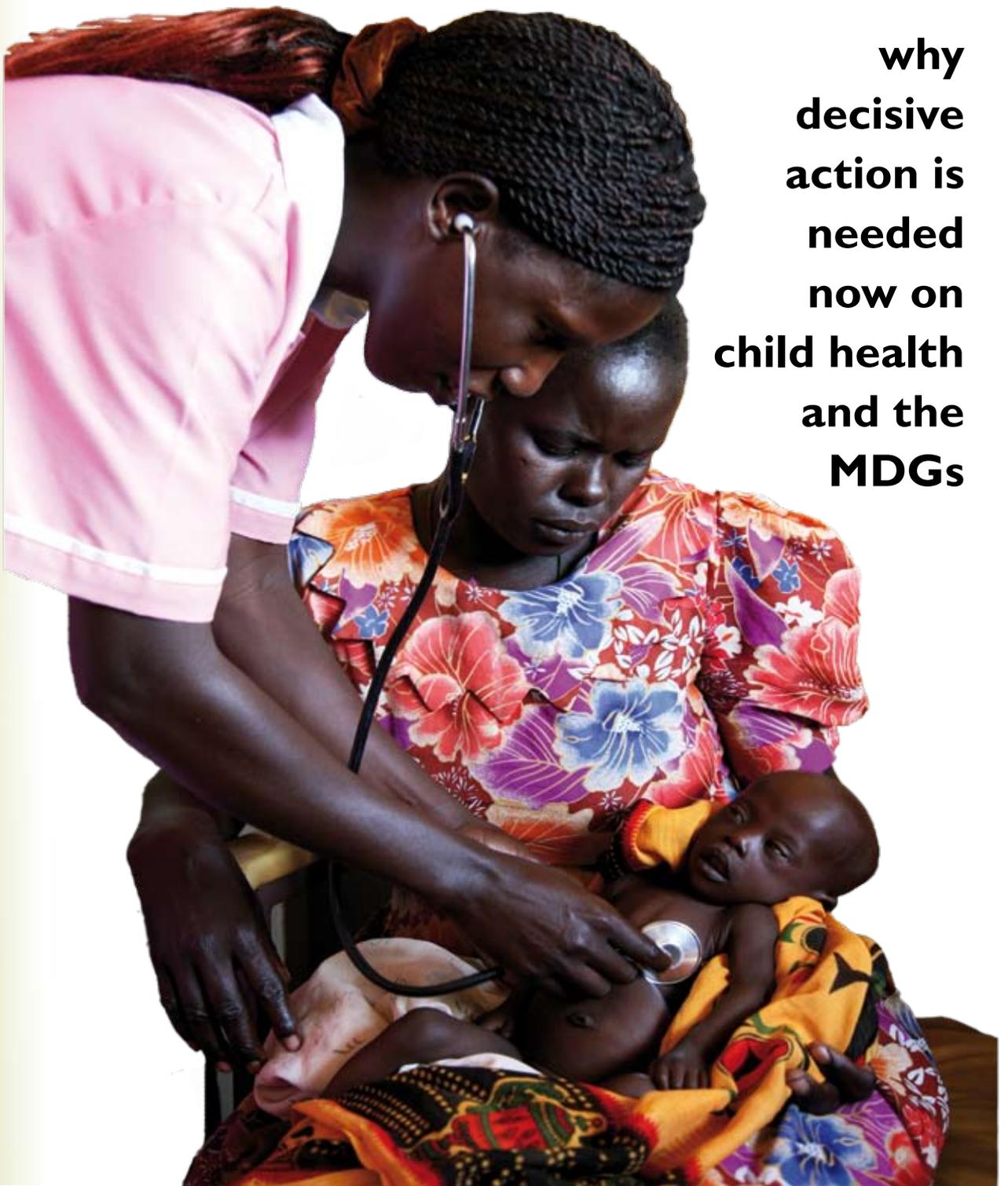


Last chance for the world to live up to its promises?

why
decisive
action is
needed
now on
child health
and the
MDGs



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Last chance for the world to live up to its promises?
why decisive action is needed now on child health and the MDGs

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A midwife at the Tubur Health Centre, Uganda, examines tiny four-month-old Enyedu, who has malaria. His mother walked for two hours to reach the centre, and looks exhausted from fatigue and worry. This is her second visit in a month for Enyedu, who has suffered malaria since birth and weighs only 2.8 kilograms.

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a World Vision policy briefing

World Vision is a Christian relief, development and advocacy organisation dedicated to working with children, families and 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.

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introduction

With just seven years to go before the target date of 2015, the world is dismally off-track on reaching the Millennium Development Goals of tackling hunger, poor health, death and illiteracy among the hundreds of millions of children and adults who live in poverty. As political, business, faith and civil society leaders gather in New York for the UN High-Level Event to take stock of the eight MDGs, they are confronted by a stark choice.

If they accept responsibility for the inadequate progress towards the goals, and agree to replicate and scale up the successes, there is a genuine possibility of fulfilling the promises made to the world's poorest people in 2000.

If they ignore the call to action, the goals are unlikely to be reached, running the risk that millions of people will be denied an opportunity to escape poverty. Put simply, the next twelve months, beginning with September's meeting in New York, are decisive for the international community to pass its own test of resolve on global poverty, hunger and disease.

Nowhere is the world's resolve more urgently required than in health. Major challenges remain, especially in Africa, for all the MDGs, but in the area of health there is little cause for encouragement. On current trends, Africa, the Middle East and South Asia all will fail to achieve the goal of reducing by two thirds deaths among children under the age of five. While there has been a slight reduction in child mortality over the last few years, 9.2 million child deaths a year remains unacceptably high.¹ Additionally, deaths from pregnancy and pregnancy-related causes remain commonplace in the world's poorest communities. There has

been less than one tenth of the progress needed to reach the goal of cutting maternal mortality by three quarters by 2015.

The potential threat of not meeting the MDG goes beyond loss of credibility for the international community. It points to the urgent need to remedy a gross violation of the most basic rights – to clean water, adequate food, basic health care – that currently leads to more than nine million children, and half a million, women dying annually from easily preventable causes. Acting on this situation is a moral imperative, with each death representing an unacceptable loss of human potential. But if the moral case doesn't convince, the instrumental arguments for action should. The MDGs are inter-linked: without improvements in the health of the world's poorest people, wider development of their societies and economies will not be sustainable. And in an increasingly inter-connected world, the effects of poverty and ill health no longer stop at borders.

As one of the world's largest development NGOs, World Vision has a particular responsibility to contribute to the MDGs, both through our programmes and through our advocacy alongside people in poverty. Our work with thousands of the world's poorest communities, focused on the well-being of millions of the most vulnerable and marginalised children, demonstrates to us that progress towards cutting under-five mortality is a barometer of overall improvements in human well-being.

When world leaders gather in New York on 25 September, they must learn from the current state of progress towards the health MDGs, and take concrete steps in the coming months to get the world back on track. Without these steps, progress on the wider poverty agenda will be jeopardised.

Now is the window of opportunity to ensure that 2015 will be remembered as the year the world lived up to its promise to the world's poorest and most vulnerable people.

This short briefing paper considers child health in the context of the three health-focused MDGs, identifies concrete steps needed in the coming months to put the MDGs back on track, and summarises World Vision's own efforts to contribute to their achievement.

1. UNICEF (2008), "Releasing declining numbers for child mortality, UNICEF calls for increased efforts to save children's lives", Press release, 12 September 2008, http://www.unicef.org/media/media_45607.html

2. World Health Organization (1978), "Primary health care: Report of the International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978", Health for All series, no. 1

Box 1 Health and the MDGs

In 2000, the world's governments pledged to achieve eight Millennium Development Goals. Of these, three are focused on health:

MDG 4 Reduce child mortality - reduce by two thirds, between 1990 and 2015, the under-five mortality rate

MDG 5 Improve maternal health - reduce by three quarters, between 1990 and 2015, the maternal mortality rate

MDG 6 Combat HIV and AIDS, malaria and other diseases - halt and begin to reverse, by 2015, the spread of HIV and AIDS and the incidence of malaria and other major diseases

The other MDGs, for example halving extreme poverty and hunger, and achieving universal primary education by 2015, all have a major bearing on the realisation of the health-focused goals, and vice versa (see Box 2).

The health MDGs also need to be understood in the context of the Declaration on Primary Health Care, which was adopted by the international community in Alma Ata in 1978. This declaration called for:

“essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally available to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination”²

The global context in which the Alma Ata Declaration was adopted was a very different one, but 30 years on, a comprehensive and evidence-based approach to health care is urgently needed as part of a wider effort to reduce child and maternal mortality.

MDG 4

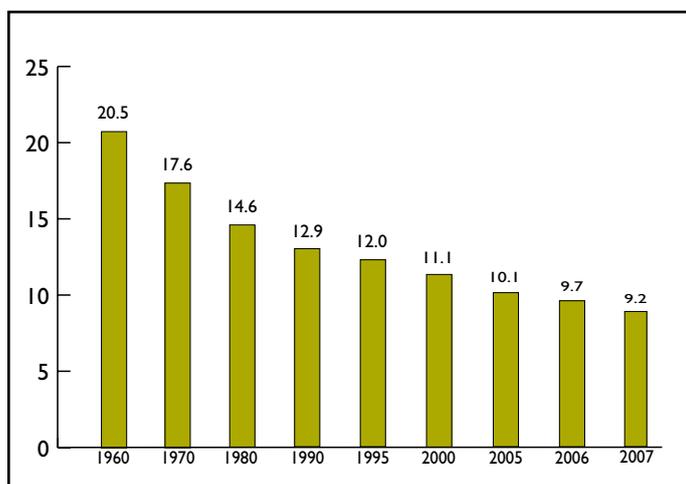
reduce child mortality

Target: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

Viewed from a long-term perspective, the drop in child mortality has been dramatic. Even 30 years ago, one in four children died before the age of five. Today that number has dropped to below one in ten. This progress is cause for guarded optimism: it demonstrates that marked improvements in child survival are feasible, and offers important policy lessons to countries that continue to lag behind on MDG 4.

At the same time, there is cause for major concern. Progress in cutting child deaths has recently slowed, and 62 countries are off-track. Africa is at the centre of the challenge: as a whole, the region has reduced child mortality at an average annual rate of just 1% a year since 1990, while half of the countries in the region have witnessed either no change or deterioration in their child mortality rates.³ Africa is not alone: on current trends, South Asia and the Middle East, also will fail to meet their overall MDG 4 targets.

Figure 1 Total deaths of children under five (in millions)⁴



The major causes of child death – neo-natal complications, diarrhea, malaria and respiratory illness – are well understood, and the means of tackling them are well established. Getting MDG 4 back on track can be achieved through simple and affordable interventions: it is estimated that over 60% of the 9.2 million child deaths each year can be prevented through 23 well-proven responses, which include exclusive breastfeeding, prevention of mother-to-child transmission of HIV, immunisation, micro-nutrients, oral rehydration therapy for diarrhea, effective and timely treatment for pneumonia, and malaria prevention and treatment (including bed nets and anti-malaria drugs).⁵

In particular, there is an urgent need to invest more resources in improving health systems at national and local levels to address child mortality. Currently, only about half of under-fives with suspected pneumonia in the developing world are taken to appropriate health providers; this proportion has not changed significantly since 2000, indicating a lack of clear progress in tackling the number one cause of death among small children. A combined lack of funding and political will means that almost 200 million children world-wide continue to go without any access to basic health care. This is despite the fact that relatively modest sums could achieve dramatic results: it is estimated that a comprehensive set of interventions to achieve MDG 4 would cost an additional US\$5.6 billion dollars annually – equivalent to one day's health spending in the United States.⁶ Failure to make these investments and to improve on current trends would mean sealing the fate of the 4.3 million children who would die in 2015 alone; many of them could be saved if world leaders act now to ensure that MDG 4 is met. Getting back on track towards Goal 4 requires a clear understanding of the barriers to better health among specific hard-to-reach groups, and tailored strategies to overcome

Table 1 Summary of regional progress towards Goal 4⁷

Region	Child mortality rate 1990 (per 1000 live births)	Child mortality rate 2006 (per 1000 live births)	Annual rate of reduction 1990–2006 (average %)	Required annual rate of reduction from 2007 to reach Goal 4	Progress towards Goal 4
Sub-Saharan Africa	187	160	1.0	10.5	Off-track
Middle East & North Africa	79	46	3.4	6.2	Off-track
South Asia	123	83	2.5	7.8	Off-track
East Asia & Pacific	55	29	4.0	5.1	On-track
Latin America & Caribbean	55	27	4.4	4.3	On-track
CEE/CIS	53	27	4.2	4.7	On-track
Developing countries total	103	79	1.6	9.4	Off-track
Industrialised countries total	10	6			

these barriers. One particularly marginalised group is disabled children: the UK’s Department for International Development has estimated that under-five mortality rates for disabled children in low-income countries are as high as 80%, compared to overall rates below 20%. In many instances this reflects widespread discrimination against children with disabilities, who can be denied food, standard immunisations and access to care. Given that an estimated 10% of children in the world’s poorest countries are disabled, any efforts to cut child mortality will be slowed substantially unless the health needs of children with disabilities are treated as a priority.

The right interventions already have led to the reduction in child deaths world-wide; they have resulted in countries such as the Maldives, Timor-Leste, Turkey, Peru and Vietnam reducing child deaths by over two thirds since 1990, and achieving Goal 4 nine years before 2015. Even in some of the poorest countries in sub-Saharan Africa – including Malawi, Eritrea, Mozambique and Ethiopia – under-five mortality rates have been cut by 40% or more since 1990. In short, it is clear that MDG 4 is achievable. What is required is the political will to achieve it.

3. UNICEF, *State of the world’s children 2008*

4. UNICEF Strategic Information Section; UNICEF *Childinfo* database

5. Jones G et al. (2003), “How many child deaths can we prevent this year?”, *Lancet* (362), pp 65–71; Darmstadt G et al. (2005), “Evidence-based, cost-effective interventions: How many newborn babies can we save?”, *Lancet* (365)

6. Stenberg K et al. (2007), “A financial road map to scaling up essential health interventions in 75 countries”, *Bulletin of the World Health Organization*, 85 (4)

7. UNICEF, *State of the world’s children 2008*, p 7

8. United Nations Secretary General’s remarks to UN General Assembly, 18 July 2008, <http://un.org/News/Press/docs/2008/sgsm11707.doc.htm>

9. UNICEF, *State of the world’s children 2008*

10. UNICEF, “Frequently used numbers for nutrition”, http://www.unicef.org/media/media_45490.html and “Low birthweight”, http://www.unicef.org/progressforchildren/2007n6/index_41508.htm, accessed September 2008

11. Copenhagen Consensus, <http://www.copenhagenconsensus.com>

Box 2 Hunger and the health MDGs

The first of the MDGs commits governments to work to halve the proportion of people suffering from hunger, and from extreme poverty, by 2015. Progress towards this goal is an important end in itself, but it is also closely linked to reductions in child and maternal death, and tackling HIV and AIDS. At a time of rising food prices, the implications are potentially grave. As UN Secretary-General Ban Ki-Moon has warned, “high food prices threaten to undo the gains achieved so far in fighting hunger and malnutrition.”⁸

The recent rise in malnutrition in some of the countries worst affected by the food price crisis could have far-reaching consequences for child health and survival. Young children’s cognitive and physical development can be irreparably damaged by under-nutrition, which continues to be the underlying cause in up to half of all child deaths.⁹ Since more than one third of all child deaths occur during the first 28 days of life, good nutrition for mothers and infants is a critical factor in meeting MDGs 4 and 5. Yet at present, UNICEF estimates that some 20 million children annually are born underweight (less than 2,500 grams).¹⁰

A malnourished child is twice as likely as a well-nourished child to die from the main killer illnesses of malaria, pneumonia and diarrhea. Bearing this in mind, child nutrition ranks as one of the soundest investments a developing country can make. Both vitamin A and zinc protect immunity and lower mortality; vitamin A also prevents blindness, while zinc supports normal growth and contributes to prevention and treatment of diarrhea. Iodised salt, meanwhile, can tackle iodine deficiency, which is the world’s greatest single cause of preventable brain damage, as well as a major factor in neonatal deaths, stillbirths and miscarriages.

Indeed, one recent economic survey calculated that returns on micro-nutrient programmes for children rated above those on trade liberalisation, malaria prevention, and water and sanitation.¹¹

MDG 5

improve maternal health

Target: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Half a million women each year die during pregnancy or childbirth, meaning that motherhood is associated with the leading causes of death in developing countries.¹² The toll is even heavier than this figure suggests: an estimated 20 million more women suffer debilitating, long-term effects from pregnancy-related complications. Yet the vast majority of maternal deaths and disabilities could be prevented with appropriate primary health services before, during and after pregnancy.¹³

Part of the problem in tracking progress on MDG 5 is that there are no detailed internationally comparable time trends. This highlights the urgent need for investment in better quality data. The best comparable figures are for 2005 and are summarised in Table 2.

The Countdown to 2015 Monitoring Group for maternal, newborn and child survival classifies levels of maternal mortality of 300 or more as “high”.¹⁴ On this basis, half

of all developing countries have high levels of maternal mortality: 43 of the 48 countries in sub-Saharan Africa have high rates, as do six of the nine countries in South Asia. However, reducing these rates is clearly possible in relatively poorly-resourced countries, as Sri Lanka demonstrates with its maternal mortality rate of just 58.¹⁶ The World Bank has estimated that proven and low-cost interventions would be able to prevent around 74% of maternal deaths; this could save the lives of 370,000 women each year.¹⁷

Given the affordability of basic ante- and post-natal health care, the current lack of progress is doubly unacceptable: the estimated reduction in maternal deaths between 1990 and 2005 represents less than one tenth of what is needed to achieve MDG 5.¹⁸

What this lack of progress means is that a woman in sub-Saharan Africa has a one in 22 chance of dying in pregnancy or childbirth, compared to a one in 3,800 risk for a woman in a developed country – the largest discrepancy of any health indicator.¹⁹ In some countries in Africa, such as

Table 2 Summary of regional progress towards Goal 5¹⁵

Region	Maternal mortality rate 2005 (per 100,000 live births)	Lifetime risk of maternal death (one in every ... women)
Sub-Saharan Africa	920	22
Middle East & North Africa	210	140
South Asia	500	59
East Asia & Pacific	150	350
Latin America & Caribbean	130	280
CEE/CIS	46	1,300
Developing countries total	450	76
Industrialised countries total	8	8,000

Zimbabwe and Malawi, maternal deaths are actually on the rise, due to a combination of high HIV prevalence and deteriorating health provision.

It is no coincidence that the two regions with the highest maternal mortality rates – sub-Saharan Africa and South Asia – also have the lowest number of births attended by skilled attendants.²⁰ Experience shows that skilled birth attendants, emergency obstetric care and family planning services, backed up by a functioning health system, can avert almost all maternal mortality – especially where it is complemented by improvements in women’s literacy and by longer spacing between births. Yet in rural areas, especially, women often lack access to these services. Of 57 developing countries surveyed between 1996 and 2005, on average 81% of urban women gave birth assisted by a birth attendant, but the figure was just 49% for rural women.²¹

Maternal health matters not only for women, but also for children: at least 20% of disease in children under the age of five is related to poor maternal health and nutrition, while children left motherless are ten times more likely than other children to die within two years of their mother’s death.²² Again, this underscores the importance of pursuing all of the MDGs together, as part of a continuum of care to improve health and well-being for all.

12. United Nations, *Millennium Development Goals report 2007*

13. UNICEF, <http://www.unicef.org/mdg/maternal.html>

14. Countdown to 2015 (2008), *Tracking progress in maternal, newborn and child survival: The 2008 report*

15. UNICEF *Childinfo* database

16. United Nations, *Millennium Indicators* database (accessed 20 August 2008)

17. Wagstaff A & Claeson M (2004), *The Millennium Development Goals for health: Rising to the challenge*

18. World Bank, *Global monitoring report 2008*

19. United Nations (2008), General Assembly thematic debate on the Millennium Development Goals, *Background paper: Health*

20. United Nations, *Millennium Development Goals report 2007*

21. United Nations, *Millennium Development Goals report 2007*

22. UNICEF, <http://www.unicef.org/mdg/maternal.html>

23. UNICEF, “Progress towards the drinking water target”, <http://www.unicef.org/wes/mdgreport/progress.php>; *Country, regional and global estimates on water and sanitation*, http://www.unicef.org/wes/mdgreport/who_unicef_WESestimate.pdf

Box 3 India’s Integrated Child Development Services as a response to MDGs 4 and 5

According to the recent UNICEF report on the Millennium Development Goals, it is a “fundamental truth” that unless India and China significantly improve their record on MDG achievement, the world will certainly fail to meet the targets.

In India, access to water in rural areas has exceeded the MDG target,²³ while some of the indicators linked to the MDGs 4 and 5 have not been met.

The maternal mortality rate is still three times higher than the MDG target, and the infant mortality rate is more than double the target.

These rates remain high despite the fact that India has had the largest programme in the world to address infant and maternal mortality: the Integrated Child Development Scheme (ICDS).

ICDS meets the needs of children under the age of six years with an integrated package of services supplementary nutrition, health care and pre-school education, and is extended to adolescent girls, pregnant women and nursing mothers.

The strong performance in proper implementation of ICDS in states such as Tamil Nadu stands in stark contrast to the almost non-existent services elsewhere, except in some pockets of Bihar and Uttar Pradesh.

World Vision’s child survival project in the latter state has shown that child survival and nutrition can be addressed effectively by strengthening ICDS.

The need of the hour is “universalising with quality” of ICDS, and the only way to achieve this is to drastically increase the budget allocation for the scheme.

MDG 6

combat HIV & AIDS, malaria and other diseases

Target: Halt and begin to reverse, by 2015, the spread of HIV and AIDS and the incidence of malaria and other major diseases

HIV and AIDS

The pandemic of HIV and AIDS is a development challenge as much as a health issue: where it is established, it poses profound threats to wider economic and social stability. Bridging current gaps in access to prevention, treatment and care for people with HIV and AIDS is therefore an urgent necessity for progress on all of the MDGs.

Given the pivotal role that an effective response to AIDS will play in achieving the MDGs, it is a major concern that, despite the overall drop in infection rates, 2.5 million people were infected with HIV in 2007, while two million died of AIDS and its complications.²⁴ Indeed, for every person added to the treatment programmes, two new people became infected with HIV.²⁵

The epicentre of this challenge is sub-Saharan Africa, where 90% of all pediatric HIV infections occur and where HIV is often a major cause of high child and maternal mortality. The region's governments need to significantly increase coverage of services that prevent new infections, and find ways of caring for the millions of children infected and affected by HIV and AIDS.

Despite recent improvements in the global response to HIV and AIDS, particularly the expansion of anti-retroviral treatment, the two million children world-wide living with HIV continue to miss out. Children are only one third as likely as adults to receive anti-retroviral treatment, despite the fact that half of all children born with HIV will die before their second birthday.²⁶ With such high mortality among infants with HIV, preventing infections – 90% of these the result of mother-to-child transmission – is imperative.

Over the past few years there has been an encouraging expansion of services to prevent mothers infecting their children – during pregnancy and childbirth, and through breastfeeding. Just four years ago, fewer than one in ten pregnant HIV-positive women had access to “prevention of mother-to-child transmission” (PMTCT) services. The proportion increased to 34% in 2007.

However, this means that almost two thirds of HIV-positive pregnant women still do not have access to comprehensive services to prevent transmission, including anti-retroviral treatment, and more than one thousand children are newly infected with HIV every day. Greater attention must be given urgently to the follow-up of children born to HIV-positive mothers, especially in situations where coverage of PMTCT services remains low. Early diagnosis of HIV in children literally means the difference between life and death.

The pandemic's impact on children reaches beyond those who are infected. Almost 12 million children in sub-Saharan Africa alone have lost one or both parents to AIDS, and millions more children have been made vulnerable. Children orphaned or made vulnerable by HIV and AIDS face a wide range of problems: they are less likely to attend school, are more likely to be forced early into the world of work. They are also more likely to fall ill, and are at greater risk of exploitation and abuse.

Efforts must intensify to ensure that these children, as well as other marginalised groups such as children and adults with disabilities, are explicitly included in strategies to arrest and reverse the spread of HIV and AIDS.

Malaria

Malaria is one of the foremost global health challenges, resulting in nearly one million deaths a year, almost 85% of them among children.²⁷ According to the World Health Organisation, malaria is the fourth leading cause of death for children under five world-wide, and a leading cause of death for children in sub-Saharan Africa.²⁸ With more than 2,000 children dying each day from the disease, achieving MDG 4 depends on effective strategies to roll back malaria.

In recent years, malaria has climbed back onto the international agenda, partly as a result of initiatives from prominent advocates such as Jeffrey Sachs, Bill and Melinda Gates, and US presidents, and increased funding has followed. However, on a global scale evidence is still lacking that malaria is being stopped, or that morbidity and mortality rates are being reversed. Moreover, funding still lags well behind what is needed to ensure universal, comprehensive coverage of anti-malaria interventions. With around 250 million²⁹ clinical cases of malaria each year, the MDG 6 malaria target is clearly off-track.

Recognising the magnitude of the problem, African leaders meeting in Abuja in 2000 committed to halving child mortality from malaria by 2010. But while there has been an increase in prevention and control measures, currently only 5% of children under five in sub-Saharan Africa sleep under an insecticide-treated net.³⁰ Given that universal bed net coverage could potentially reduce child deaths in sub-Saharan Africa by 20%, this is one area where further investment is needed urgently.³¹ Other interventions with proven benefits include rapid diagnostic testing and treatment, “intermittent presumptive treatment” (a course of low-dose anti-malaria drugs for at-risk pregnant mothers and infants), and indoor spraying. These efforts should be accompanied by steps to eliminate malaria from regions where the disease is less widespread or is seasonal, and measures to control transmission in high-burden regions. These initiatives should either be integrated with or linked closely to the National Malaria Control Plan in each country, and should be targeted at the household level.

Inadequate official funding is one major obstacle to progress in these areas. It is estimated that \$3.5 billion to \$4.5 billion is required annually to prevent and control malaria.³² Yet global funding to support anti-malaria efforts averaged only

\$1 billion annually between 2002 and 2007 – considerably below what is required to achieve MDG 6.³⁴ A significant increase in funding is required urgently, both from public and private donors, and from those countries in Africa currently failing to meet the promise of providing 15% of their overall budget for health.

24. UNAIDS (2007), *AIDS epidemic update*, p 1

25. UNAIDS (2008), *Report on the global AIDS epidemic*, p 15

26. UNAIDS (2008), *Report on the global AIDS epidemic*, p 139

27. World Health Organization, *World malaria report 2008*, <http://www.who.int/malaria/wmr2008/>

28. World Health Organization, *World health report 2004 and 2005*; UNICEF & Roll Back Malaria Partnership (2007), *Malaria and children*

29. World Health Organization, *World malaria report 2008*

30. United Nations, *Millennium Development Goals report 2007*

31. Phillips-Howard P et al. (Centers for Disease Control and Prevention et al.) (2003), “Efficacy of permethrin-treated bed nets in the prevention of mortality in young children in an area of high perennial malaria transmission in western Kenya”, *American Journal of Tropical Medicine and Hygiene*, 68 (Suppl. 4)

32. Kiszewski A et al. (2007), “Estimated global resources needed to attain international malaria control goals”, *Bulletin of the World Health Organization*, 85 (8)

33. *Public Library of Science Medicine*, 5(7), 2008 pp 1–11

what is needed by 2010 to put the health MDGs back on track

In September 1978, world leaders met in the then-Soviet resort of Alma Ata and signed a historic declaration that recognised the right to health for all, and aimed at providing universal health care by the year 2000. This goal was missed by a huge margin: as world leaders gather in 2008 to review progress on the MDGs, the right to basic health care continues to be neglected.

With seven years to go before the MDG target date of 2015, the world risks repeating history as tragedy, by failing to achieve the targets it set for itself. Failure would be unconscionable, because we have the technical and financial resources needed to address child health-related MDGs.

High-burden countries

If the 62 countries that are currently off-track for meeting the MDG 4 and MDG 5 targets are to achieve the Goals by 2015, urgent action is required. Based on the experience of other countries, they need to ensure that community- and district-level maternal, neo-natal and child health services have a high priority in comprehensive national health strategies, by the end of 2009 at the latest. They must base these strategies on evidence of effective interventions.

In addition to this, high-burden countries should:

- allocate at least 15% of government budgets to health by the end of 2010;
- provide detailed reports to their parliaments from 2009, and each year thereafter, on progress in improving health and incorporating indicators of maternal and child health as key measures of health system performance;
- develop costed strategies to ensure that all women and children have access to essential health services by 2011

and that cost is not a barrier to accessing treatment; and

- set up and adequately resource national health monitoring systems that include birth and death registration.

Donor governments

Donor governments have made repeated statements on the unacceptability of current levels of maternal, newborn and child mortality and morbidity. Numerous commitments to tackling the issue have also been made, including the G8 commitment to work towards 2.3 health workers per thousand, and the European Union commitment to providing an additional 8 billion Euros and 35 million more attended births by 2010. The donor community has also recognised the need to co-ordinate responses to health and many are acting increasingly on this through the International Health Partnership.

However, at least a doubling of effort is needed now in order to deliver the Goals by 2015. The total aid for health systems (excluding the HIV and AIDS response) needs to increase to at least US\$15 billion annually by 2010, if MDGs 4 and 5 are to be met.

Donors should contribute to this figure on the basis of their share of OECD donor gross national income (GNI), and should:

- co-ordinate their health support to countries through the International Health Partnership by the end of 2010;
- support strategies that ensure that cost is not a barrier to women and children accessing essential health services by 2011; and
- work to ensure that all developing country governments have effective and comprehensive child and maternal health monitoring systems by 2010.

Multilateral organisations

Multilateral organisations should:

- provide a detailed annual report and organise an annual high-level meeting on maternal, newborn and child health progress in all high-mortality countries from 2009;
- support the development and implementation of strategies that ensure that all women and children have full access to essential health by 2011, and that cost is not a barrier to access or treatment;
- ensure that all developing-country governments have effective and comprehensive child and maternal health monitoring systems by 2010; and
- call for maternal, newborn and child mortality statistics to be used as a key indicator of health system performance.

Private sector companies

The private sector has a vital role to play in addressing the health-related MDGs, particularly in societies where governments are weak. As well as generating economic growth, contributing to the revenue base and increasing household incomes, the private sector can have a significant impact by directly addressing social problems using its skills, expertise and resources. World Vision calls on private sector companies to:

- develop strategies by 2009 to use their resources and technical expertise to contribute to the reduction of maternal, newborn and child death in high-mortality countries;
- launch at least one significant initiative to improve maternal, newborn and child health by 2010;
- actively work to inform their staff and their families about key maternal, newborn and child health messages in all high-mortality countries in which they work; and
- work with the health sector to develop and implement sponsorship programmes for the training of health workers.

Civil society organisations

Millions of dollars have been channelled through civil society organisations to ensure that they are able to assist, encourage and pressure governments to meet their commitment to the MDGs. Civil society organisations need

to play their part fully in ensuring that governments honour their commitments to the health-related MDGs. This requires civil society organisations to mobilise their resources on health and also to effectively engage and represent their communities. Recognising the historical opportunity now present to address maternal, newborn and child health, civil society organisations to:

- allocate at least 10% of resources to achieving improved maternal, neo-natal and child health by 2010; and
- actively support the communities within which they work to access relevant health services and to hold governments accountable for the quality of these services.

34. For details see: World Vision International (2008), *A matter of life or death: How 18 million children are relying on the G8 to keep its promises*

World Vision's contribution to the health MDGs

World Vision believes that good health is fundamental to breaking the cycle of child poverty and risk and is a fundamental element of children's well-being. Recognising this, we've put community-based maternal and child health at the core of our global health strategy, and are investing heavily in efforts to achieve MDGs 4, 5 and 6. In 2008, World Vision is investing approximately \$150 million in cash towards addressing health in our programme areas to help achieve the MDGs, in particular MDGs 4 and 5, and we are investing an additional \$300 million in in-kind contributions for medications and health products.

Our work reaches 100 million people in 97 developing countries. In most of the communities where we work, ill health is a major concern, and both a cause and a consequence of people's poverty and marginalisation. At the same time, the challenges to achieving the health related MDGs in many countries are clear: simple and cost-effective interventions that could dramatically reduce child mortality by over 60% are not being widely implemented. Safe water and sanitation, adequate nutrition and sustainable livelihoods are all key elements in improving child survival. So too is effective and accessible basic health care.

Yet in many countries where we work, national capacity for delivering this health care is limited by weak administrative capacity, misplaced spending priorities and under-funding. World Vision's presence in the poorest and most marginalised communities enables us to reach people who are missed by current government interventions. We aim to integrate our health and nutrition work with education, water, sanitation, food security and child protection to build on the synergies between the MDGs, and we focus our efforts on the leading causes of child death – malnutrition and diseases including diarrhea, malaria and HIV – largely through household- and community-based interventions. We do not believe in setting up parallel programmes, but work with government and private sector partners to ensure that these community-level activities contribute to the achievement of national plans and goals.

In the long term, improvements in health will come about not just through our interventions, but through people demanding their right to quality health care and participating fully in decisions that affect their lives. Thus, World Vision seeks to empower communities to understand and advocate for their needs and rights. Improving the health of a population should be a continuous, inclusive process, from prevention and promotion of healthy behaviour to treatment and support in a functioning health system.

Box 4 Nutrition as part of an integrated approach to maternal and child health: the MICAH programme

The Micro-nutrient and Health (MICAH) programme was a large-scale initiative implemented in five countries (Ethiopia, Ghana, Malawi, Tanzania and Senegal) between 1996 and 2006 to address micro-nutrient malnutrition which affects around one third of the global population.

Women and children are most vulnerable to micro-nutrient deficiencies, which are a major cause of under-five mortality. The programme reduced vitamin A, iron and iodine deficiencies among children and women through advocacy and community-based interventions promoting improved diets, measures to help parents provide nutritious food for their children, fortification of staple foods and provision of micro-nutrient supplements, and targeting of diseases that affect micro-nutrient status.

The project contributed to a significant reduction in overall malnutrition in all five countries, with chronic malnutrition falling from 45% to 31% on average.

Nutrition

World Vision has a long history of combating child malnutrition in a diverse set of circumstances, ranging from emergency situations where acute malnutrition may be widespread to contexts of poverty where longer-term interventions are required.

World Vision works in some 80 countries in emergency contexts to provide nutrition through programmes such as general food distributions, food-for-work and specialised feeding programmes for treating severely malnourished children. We are extending aspects of our emergency food and nutrition work into stronger prevention programmes, recognising that preventing under-nutrition is a key contributor to increasing child survival and well-being.

An example of World Vision's effort to do this over the longer term is the MICAH project (see Box 4) which focuses on reducing hidden hunger (micro-nutrient deficiencies) by integrating nutrition with child and maternal health, water and sanitation, and food security.

Its focus on micro-nutrients recognises that nutrition-rich foods are particularly important to children's normal growth and development, and decreased susceptibility to disease and death.

World Vision is supporting innovative, behaviour-centred approaches to addressing nutrition, which not only have improved health outcomes for children but have empowered women in the community. For example, Peru's Positive Deviance programme disseminates lessons from local success stories of good nutrition in the home. The programmes use the "positive deviance"³⁵ approach to promote solutions from within poor communities.

Child mortality

The 'continuum of care' from before pregnancy through early childhood is critical to increasing child survival. World Vision is implementing community-level child survival projects in close collaboration with local health systems and community development workers. India's Ballia Rural Integrated Child Survival (BRICS) project is a case in point: World Vision is increasing immunisation coverage, addressing food security and providing family planning services.

World Vision recognises that water and sanitation have a crucial role to play in reducing early deaths: poor sanitation and hygiene and unsafe water account for 88% of cases of diarrhea, which in turn leads to 1.5 million deaths each year. World Vision is addressing the need for safe water in partnerships with communities, through projects such as the West Africa Water Initiative (see Box 5).

Box 5 Building a healthy environment for children: water and sanitation in West Africa

The West Africa Water Initiative (WAWI) started in 2002 and is a public-private partnership to supply drinkable water from sustainable local sources, improve sanitation and hygiene, and improve water resources management in Ghana, Mali and Niger – all countries that face widespread water shortages and inadequate access to safe water.

The number of child deaths in these countries is high and often linked to water-related diseases. The project is supporting community efforts to drill wells, training pump maintenance volunteers, and training and mobilising people for latrine construction.

By the end of 2008, the World Vision component of WAWI will have provided safe water to 192,000 Ghanaians, 104,000 Malians and 70,000 Nigeriens.

Box 6 Reducing maternal mortality: rural health system strengthening in Afghanistan

Since 2001, World Vision has worked in communities in western Afghanistan to improve food security, education and health. Afghanistan's maternal and infant mortality rates are among the highest in the world due to a complex range of factors, including poverty, lack of education, 30 years of war and instability, the low status of women and girls, malnutrition, and lack of access to health services. World Vision is educating mothers on how to avoid malnutrition and also training professional midwives at the Institute of Health Services in Herat in a two-year programme. They will then return to their rural communities, the overwhelming majority of which have never before been served by a professional midwife.

Between 2004 and 2006, the number of births attended by a skilled midwife doubled to 23%. Altogether, more than 1.5 million women and newborns have benefited from access to professional midwives as a result of World Vision's programme.

Maternal mortality

World Vision is training and equipping midwives to carry out life-saving interventions in several countries. Our training programme in Afghanistan (see Box 6) is one that has provided skilled midwives in rural communities. Socio-economic status is a powerful predictor of maternal death, while malnutrition increases the risks during pregnancy and delivery, and is a factor in one fifth of all maternal deaths.

The poorest women are heavily affected by absence of, or poor-quality, family planning: where appropriate services exist, they can prevent up to a quarter of maternal deaths. Helping women to understand contraception and make timely decisions about birth spacing is an important component of maternal health that can be delivered at the household level. World Vision birth spacing programmes, involving community leaders and locally recruited health workers, have been effective in delivering broad maternal health education in some of the poorest parts of India, where child mortality rates are very high.

As with other health interventions, successful family planning depends on tailored provision for marginalised groups. The experience of disabled women is a case in point. Limited access to public health information can place their general health at risk, as well as making them vulnerable to unwanted pregnancies or HIV infection, and health care providers can fail to accommodate their special needs.³⁶

35. <http://www.positivedeviance.org/pdf/fieldguide.pdf>

36. See, for example: Sweeney J (2004), *Double exposure: Disability and HIV & AIDS in sub-Saharan Africa*, Advantage Africa

HIV and AIDS

World Vision has been involved closely in addressing the HIV pandemic, particularly at the community level, for almost two decades. Today, World Vision is responding to HIV and AIDS in hard-to-reach communities in more than 60 countries, contributing \$107.3 million in 2008 for prevention efforts, care and advocacy.

Through our HIV and AIDS Hope Initiative, World Vision has developed models of community-based care that can be taken to scale by governments and donors. These models include Community Care Coalitions, that strengthen community-based support for orphans, children living with or affected by HIV, and other vulnerable children and their households; Faith-Based Organisation Mobilisation, aimed at equipping churches and other faith communities to respond to the needs of people affected by HIV and AIDS; and life-skills training to enable children and young people aged 5–24 years to develop the knowledge, attitudes and skills needed to avoid HIV.

In 2007 alone as part of the World Vision-supported Hope Initiative, some 59,000 volunteer care-givers provided care to 843,000 orphans and vulnerable children and 69,000 chronically ill adults. Taking these initiatives to scale poses challenges, but one example of this happening is the RAPIDS project in Zambia (see Box 7), a multi-partner response led by World Vision.

Box 7 **Scaling up community-based HIV and AIDS programming: the RAPIDS programme in Zambia**

Reaching HIV/AIDS- Affected People with Integrated Development and Support (RAPIDS) is a consortium of six partner NGOs, of which World Vision is the lead. It aims to systematically scale up successful models of home-based care, support for orphans and vulnerable children, and youth livelihoods and life-skills programmes.

RAPIDS collaborates with government and national civil-society coalitions to improve policies concerning HIV and AIDS and orphans and vulnerable children (OVC), and to establish public–private partnerships to tackle HIV.

RAPIDS joined an existing societal response to the overwhelming challenge of addressing disease burden at the household level by training, equipping and organising 16,000 care-givers who care for 230,000 orphans and vulnerable children, 44,000 people living with HIV or AIDS and 63,000 youth. RAPIDS works in 52 of the 72 districts in Zambia.

37. The World Vision HIV and AIDS Hope Initiative categorises vulnerable children as children whose parents are chronically ill; who are living in households that have taken in orphans; who have physical or intellectual disabilities; and any other children the community identifies as vulnerable.

conclusion

Thirty years ago, world leaders gathered in the Soviet resort of Alma Ata and signed a historic declaration that promised to deliver health for all by the year 2000. Thirty years on and despite the great progress made to achieve universal access to primary health care, governments have failed to meet their promise.

Now, with seven years to go before the 2015 deadline for meeting the Millennium Development Goals, we remain seriously off-track on some of the goals – notably those concerning children's health: MDGs 4, 5 and 6. We are now at high risk of not heeding lessons learned from Alma Ata, and of following the trail of broken promises. Without urgent action to get the MDGs back on track in the coming months, starting at the 2008 UN High-Level Event, world leaders have little chance of meeting their commitments to ending poverty and will have missed an historic opportunity to shape the course of this generation.

We have the remedies to meet these goals. We are now looking for the political will and leadership to end once and for all the afflictions that are claiming the lives of millions of innocent children and mothers the world over.

Let us ensure that we don't follow in the footsteps of the previous generation of world leaders, and let us ensure that this generation will step up to the mark and meet its own commitments to maternal, newborn and child health.

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