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Written statement* submitted by World Vision International, a non-governmental organization in general consultative status

The Secretary-General has received the following written statement which is circulated in accordance with Economic and Social Council resolution 1996/31.

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* This written statement is issued, unedited, in the language(s) received from the submitting non-governmental organization(s).

Preventable child deaths and realising the child's right to health

Introduction

The Convention on the Rights of the Child (CRC) explicitly affirms the *'right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health'*.[1] States Parties have committed to ensure that no child is deprived the right of access to health-care services. Furthermore, signatories have an obligation to take appropriate measures to reduce infant and child mortality.[2]

Despite this commitment, millions of children continue to die each year in violation of this right. In 2011, 6.9 million children died before reaching their fifth birthday, around 70 per cent within the first year of life.[3] In children aged 2 months to five years, pneumonia, diarrhoea and malaria are the most common causes of mortality globally. Forty-three per cent of child deaths occur in the first month of life from complications of pre-term birth, intra-partum complications, birth asphyxia and neonatal sepsis or meningitis. For the world to reach Millennium Development Goal (MDG) 4 to reduce child mortality before the 2015 deadline, accelerated efforts to address these preventable deaths are paramount.

This submission highlights various approaches identified by World Vision to tackle the major causes of under-five mortality, which are intrinsically linked to the obligations of States Parties under Article 24 of the CRC.

Overcoming preventable child deaths and fulfilling the child's right to health

The essential new born and child health interventions to promote the highest standard of health and prevent and treat the major causes of death are failing to reach the poorest, most vulnerable and needy children and families. We know why and where children are dying and we know the interventions needed to reduce child mortality. Accelerating the reduction in under-five mortality before the deadline of the MDGs is possible by expanding effective preventive and curative interventions targeting the main causes of neonatal, infant and child deaths and those most vulnerable.

Provision of essential new born and child health interventions in neglected areas to combat disease and malnutrition

States Parties to the CRC have committed to ensure universal coverage and access to health services for all children. Evidence-based, affordable, and simple packages of new born and child health services are recommended and should be used i.e. the Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, New born and Child Health.[4] World Vision's maternal and child health approach is founded on evidence-based and cost-effective preventive and treatment practices targeting pregnant women and mothers and

[1] Convention on the Rights of the Child, Article 24.1.
[2] Convention on the Rights of the Child, Article 24.2(a).
[3] UN Inter-Agency Group for Child Mortality Estimation (2012). Levels and Trends in Child Mortality, Report 2012, UNICEF, New York.
[4] The Partnership for Maternal, Newborn and Child Health (2011). A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health, PMNCH, Geneva.

children under age two. States should make all essential medicines on the WHO Model List of Essential Medicines for Children accessible and affordable.[5]

However, there are glaring gaps in the coverage of some interventions for the most marginalised communities. For example, greater attention is needed around care in the post-natal period - the 2012 *Countdown to 2015* report, commissioned by the UN Commission on Information and Accountability for Women's and Children's Health, revealed that an early postnatal visit (within two days of birth) is given to only one in three mothers and babies.[6] Few children receive the appropriate treatment for diarrhoea (Oral Rehydration Solution and zinc) with no real progress shown in the past decade, and less than a third of children with suspected pneumonia receive antibiotics. The recent recommendations of the UN Commission on Life-Saving Commodities for Women and Children provide guidance to increase access to 13 essential health commodities – interventions to treat pneumonia and diarrhoea are at the front of overlooked commodities.[7]

Measures ensuring a clean and healthy home environment, including safe water, hygiene, sanitation practices, clean household energy, alongside access to treatment and health services are critical in preventing diarrhoea and pneumonia. Yet access to improved sanitation facilities is lacking for nearly half the population in developing regions.

Universality, equity and reaching the poorest children

The burden of child mortality remains in the families on the lowest incomes and in the most remote and rural areas. Under-five deaths are increasingly concentrated in sub-Saharan Africa and Southern Asia. The majority of the world's poor now live in middle-income countries where the bulk of child deaths are concentrated. Fragile contexts have seen least progress and in some cases have seen increases in child mortality, with up to half of all infant deaths globally.

The most deprived and marginalised communities are often forgotten when national development plans are made and resourced. For example, across 54 low-income countries, birth in a health facility is more than twice as likely for a richer family compared to a poorer family.[8] Growing disparities in child survival means that concerted efforts are required to extend health services to the most vulnerable children where the greatest inequities exist. Prioritising services for the most marginalised has been shown to be more effective and cost-effective than mainstream approaches to health care provision.[9]

Bring services closer to home through primary health care and invest in families and communities

The development of high-quality, well-resourced health facilities is vital for building strong national health systems. However, many of the factors that contribute to child health operate at the household and community level, and many of the major threats to health can

[5] World Health Organisation (2011). WHO Model List of Essential Medicines for Children, 3rd List updated March 2011, WHO, Geneva.

[6] World Health Organisation and United Nations Children's Fund (2012). Countdown to 2015: Building a Future for Women and Children, The 2012 Report, Washington DC.

[7] UN Every Woman Every Child (2012). UN Commission on Life-Saving Commodities for Women and Children Commissioners' Report, September, United Nations, New York.

[8] World Health Organisation and United Nations Children's Fund (2012). Countdown to 2015: Building a Future for Women and Children, The 2012 Report, Washington DC.

[9] Carrera et al (2012). Equity in Child Survival, Health and Nutrition 2, The comparative cost-effectiveness of an equity-focused approach to child survival, health and nutrition: a modelling approach, The Lancet, published online September 20, 2012.

either be prevented by informed individuals and communities (including through adequate nutrition, hygiene, and appropriate care-seeking behaviours when a child falls ill), or treated by community members with some health training (diarrhoea treatment, administration of antibiotics for pneumonia, and care of low-birth-weight babies). Access to commodities and quality health facilities must be scaled up with measures that encourage the poorest and most remote families to seek and use essential services, promote improved practices and behaviours, and advocate for the empowerment of men, women and children to fully participate in decisions that affect the health of their families.

Where high mortality rates, weak formal health systems, inequitable coverage of care, and remote communities are excluded from the formal system by distance, cost, or lack of knowledge and education, there are significant opportunities to strengthen care closer to home, and reduce mortality rates. The recent Lancet series on Equity in Child Survival, Health and Nutrition[10] affirms the notion that engaging communities in understanding and participating in their own health care, and particularly targeting children who are most in need through an equity-focused approach, holds potential to further accelerate the global efforts to reduce child deaths. An estimated 63 per cent of child deaths could be averted if interventions known to be effective were successfully delivered when and where they are needed.[11] Almost 40 per cent of new born deaths could be prevented with community interventions.[12] Pneumonia and diarrhoea, regarded as diseases of poverty, are closely associated with poor home environments, under-nutrition, and lack of access to essential community-based healthcare. There are many synergies between the interventions required to tackle these diseases, and countries should focus on implementing the recommendations in the forthcoming *'Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea'* due to be published in April 2013.

Lack of clarity about the community's role has resulted in limited support for community activities or services or for targeted strengthening of community actors. Ultimately, progress on child survival will depend on more deliberate partnerships for health at the community level.

Local level monitoring and accountability

National estimates of child mortality and coverage of essential health interventions can mask important inequities within countries. In some contexts, Health Management Information Systems stop at the lowest facility level (such as an aid post or health centre) without collecting health activity or vital statistics from the household or community level, such as stillbirths, new born or child deaths which occurred at home. Families and communities can play an essential role in surveillance and reporting of health activities, including verbal autopsies.

Accountability includes holding governments and donors to account for pledges they have made including the MDG targets and specific commitments under the UN Secretary General's Global Strategy for Women's and Children's Health.[13] Recent efforts to improve

[10] www.thelancet.com, published online September 20, 2012, see Online/Series http://dx.doi.org/10.1016/S0140-6736(12)61423-8, and http://dx.doi.org/10.1016/S0140-6736(12)61378-6.

[11] Jones, G., R. W. Steketee, R. E. Black, Z. A. Bhutta & S. S. Morris (2003). How many child deaths can we prevent this year? The Lancet, 362, pp. 65–71.

[12] Save the Children (2012). A Decade of Change for Newborn Survival: Changing the Trajectory for Our Future, Health Policy and Planning, Supplement 2.

[13] See www.everywomaneverychild.org/ for further details.

accountability include the UN Commission on Information and Accountability for Women's and Children's Health.[14]

For World Vision, accountability spans the local to global levels and includes engaging citizens in the planning, monitoring and review of health services that impact their lives. At the local level, social accountability models such as World Vision's *Citizen Voice and Action* approach offer opportunity to include women and children in the implementation and monitoring of health services in their communities. World Vision has found that as essential services improve, so does the relationship between the government and its citizens. A recent randomised control trial of community-based monitoring in Uganda, similar to World Vision's *Citizen Voice and Action* approach, showed that a reduction in child mortality of 30% was possible through social accountability without the injection of significant new resources.[15]

Recommendations

1. States must progressively remove all barriers to children fully accessing their right to health. Rural, remote and neglected areas must be particularly targeted by a scale-up of evidence-based interventions and measures to address inequities. Efforts to better define high-risk communities must be made, examining how they can be fully included in service provision. Services must be brought closer to home through investing in families and communities and empowering them to participate in local level monitoring and accountability.

2. In countries with high child mortality rates, governments should identify and prioritise the poorest and most vulnerable children and families, and prioritise family and community interventions within national and district health plans and budgets, to ensure they benefit from low-cost, proven interventions against the major child killers.

3. Governments should partner with communities, ensuring the full participation of women and children, caregivers, and faith and civil leaders, and empower them to become active participants in improving their own health, in seeking care when appropriate, and in holding governments accountable for the delivery of quality health care.

4. Donor countries and organisations should support governments of high-burden countries in the development of health plans that give priority to family and community-based interventions, and improve transparency and coordination with other donors to ensure long-term predictable funding for family and community care, as part of full funding for strengthening national health systems.

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[14] Commission on Information and Accountability for Women's and Children's Health (2011) Keeping Promise, Measuring Results - http://www.everywomaneverychild.org/images/content/files/accountability_commission/final_report/Final_EN_Web.pdf.

[15] M. Bjorkman and J. Svensson, "Power to the People: Evidence from a randomised field experiment on community-based monitoring in Uganda", Quarterly Journal of Economics (May 2009, Vol.124, No.2), 735–769.