World Vision

Who's counting?

9.2 million children – the cost of inaction on child health

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executive summary

9.2 million children – the cost of inaction on child health

Each year, 9.2 million children under the age of five die needlessly. This appalling tragedy must rank as one of the most neglected crises of our time, particularly given the fact that at least six million of these deaths could be averted each year with an investment of $15 billion. While the global economic crisis is squarely on decision makers' radars, the global child survival crisis – which is claiming the life of one child every three seconds – gains little media and public attention, and is routinely ignored by decision makers.

However, a large and growing body of research and on-the-ground experience indicates that comprehensive provision of appropriate health services at the community and district levels will make a very big difference to the lives of poor children and their mothers,

- saving the lives of around six million children each year;[1]
- reducing the number of maternal deaths by around 400,000 each year;[2] and
- allowing much more effective responses to existing infectious diseases such as HIV and AIDS, malaria, and tuberculosis.

This requires an investment in scaling-up of basic health services, and a change in focus to ensure that adequate attention and resources are provided for preventive care. Millennium Development Goals 4, 5 and 6 can be met only if the health needs of families and communities are met. It requires mobilising the resources to bridge the gaps between national health care systems and local health care needs.

These gaps exist in multiple areas, some of which are not traditionally associated with health in the narrow sense: they include child and maternal (mal)nutrition interventions (among them breastfeeding education and provision of micro-nutrients), water and sanitation for hygiene, as well as other forms of disease prevention, immunisation, and access to community-based interventions in case of illness.

Only by recognising the important role of families and communities in identifying and responding to the health care needs of children, and ensuring that they are provided with the quality basic and essential health care services they need, will we see tangible reductions in maternal, newborn and child deaths.

The current economic crisis is seriously affecting many people who are already living in poverty. Yet the severity and extent of the crisis, both for people and for national economies, can be mitigated by a greater investment in preventive health care. Not only do appropriate prevention measures enable people to stay healthy, minimising the need for expensive curative interventions; such measures can bring a six-fold economic return to countries,[3] and can contribute to political and social stability as governments more effectively address citizens' needs.

In this latest campaign briefing, World Vision calls on world leaders attending the World Economic Forum in Davos to pay equal attention to the child mortality crisis that is claiming the life of one child every three seconds, as they have been paying to the global economic crisis.

continued overleaf

Recommendations

Specific actions are needed to reduce maternal and child mortality and ensure that MDGs 4, 5, and 6 are back on track.

Donor nations need to:

1. Allocate at least 10% of their sector-allocable ODA to strengthening community- and district-level health systems,[4] in order to provide universal maternal and child health services and support the scale-up of responses to HIV and other major infectious diseases. Alternatively, donor countries should contribute their fair share[5] of the minimum $15 billion per year in aid required for basic health services by 2010;
2. Accelerate the increase in funding for HIV and AIDS, TB and malaria through the Global Fund, and other mechanisms where appropriate, in order to meet donor countries' commitments to universal HIV prevention, treatment, care and support by 2010 and their commitments to combating other infectious diseases;
3. Work with high-burden countries to assist them in developing comprehensive, adequately funded and workable health plans that focus on effective health systems, with particular focus on delivering an essential package of care through strengthened community and district health interventions;
4. Work in a co-ordinated and transparent manner with other donors, through mechanisms such as the International Health Partnership (IHP), to ensure more effective and long-term support for health in developing countries;
5. Work with the international financial institutions to ensure that they do not unduly influence or impose on developing countries fiscal conditions that hinder the provision of effective basic health services; and
6. Support and adequately fund the World Health Organization (WHO) in its efforts to revitalise the Alma Ata commitments on Public Health Care.

High-burden countries need to:

1. Allocate at least 15% of government budgets to health by the end of 2010;
2. Provide detailed reports to national parliaments from this year, and each year thereafter, on progress in improving health and incorporating indicators of maternal and child health as key measures of health system performance;
3. Develop comprehensive, evidence-based, costed strategies that grant high priority to community- and district-level maternal, neo-natal and child health services;
4. 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
5. Set up and adequately resource national health monitoring systems that include birth and death registration.

Private sector leaders are urged to:

1. Support and collaborate with the World Health Organization in its efforts to revitalise Primary Health Care as a means of addressing the child mortality crisis;
2. Use their resources and technologies, where appropriate, to support the achievement of the Millennium Development Goals on health;
3. Ensure that their employees in all countries are working in conditions conducive to good health, and support their access to effective health services; and
4. Consistently, in policy and practice, support the right to health as a universal human right.

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1. Jones, Steketee, Black et al (2003), "How many child deaths can we prevent this year?", *The Lancet* (vol 362)
2. Ensuring skilled attendance at all births, backed by emergency obstetric care, could achieve a reduction in maternal deaths of at least 75%. For example, Malaysia, Thailand and Sri Lanka all have achieved decreases in maternal mortality of more than 75%. See WHO (2005), *World health report 2005*, p 66
3. World Health Organization (2001), *Macroeconomics and health: Investing in health for economic development*. Report of the Commission on Macroeconomics and Health, Geneva
4. That is, the sum of funding to OECD DAC sector 122 (basic health) and sector 130 (reproductive health) but excluding sub-sector 13040 (STD control including AIDS) should be at least 10% of sector-allocable ODA. Increasing use of general budget support (which cannot be sector-allocated) means that the share of sector-allocable aid, rather than total aid, is a better indicator of support for health systems and basic health care.
5. The fair share should be based on the donor country's share of the total Gross National Income of all OECD donor countries.

introduction

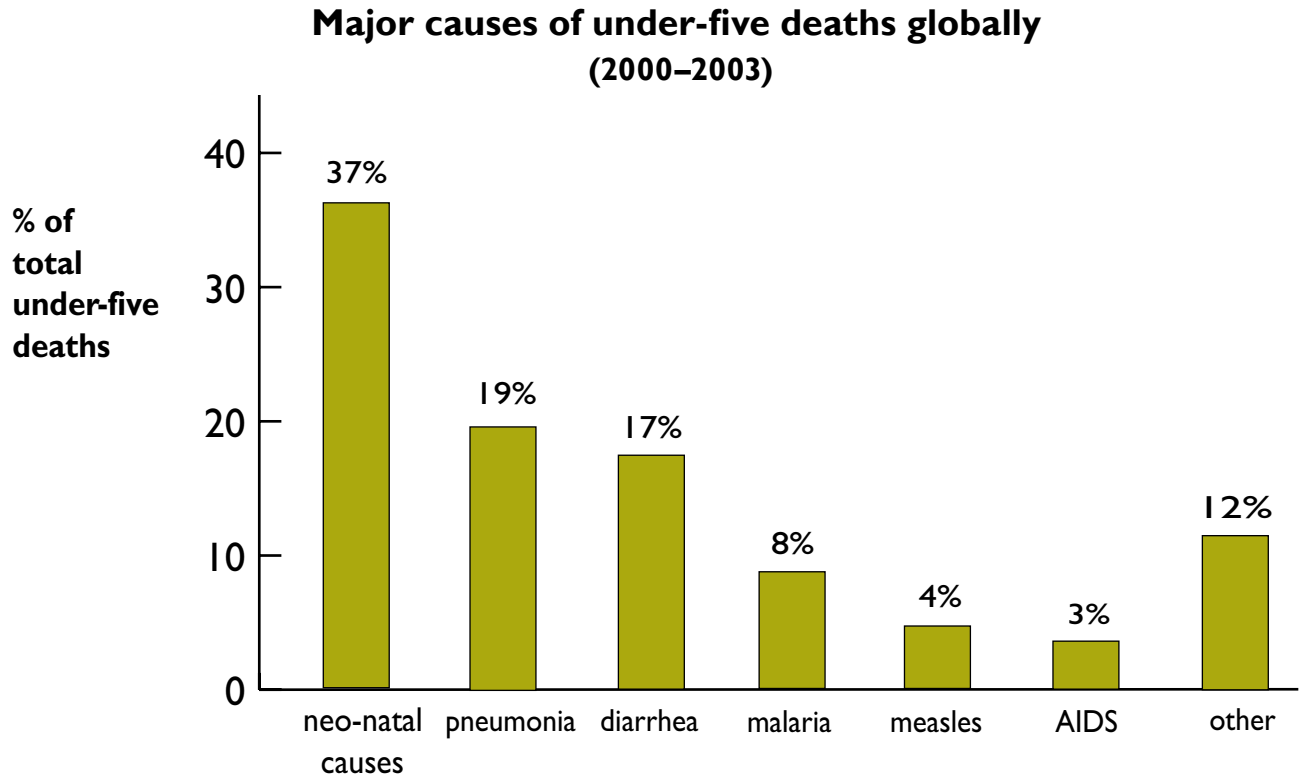
As world leaders meet at the World Economic Forum in Davos between 28 January and 1 February they will discuss, among other things, how to manage the current economic crisis and how to shape the post-crisis agenda. However, they also should focus on another much-neglected crisis that currently is costing the lives of 9.2 million children a year. The global child survival crisis that is claiming the life of one child every three seconds gains little media and public attention, and is routinely ignored by decision makers. This is because the deaths of so many children under the age of five is seen by many as inevitable – the unavoidable effect of poverty that can only be addressed through long-term economic development.

An investment in scaling-up of basic health services can bring a six-fold economic return.[6] Healthy people are more productive and take fewer days off work. Improved life expectancy, better school attendance and lower birth rates (which allow parents to invest more in fewer children) all are likely to spur economic growth. On the flip side, insufficient health investment could slow future growth – iron deficiency alone is estimated to contribute to a loss of 0.6% GDP in developing countries.[7] The impact of the current economic crisis can be mitigated by a greater investment in preventive health care, for three reasons:

- A reduced disease burden means lower emergency spending for health treatments. Currently many governments are spending "pounds on cure" when they could be caring for the health needs of many more citizens by concentrating on "an ounce of prevention".
- Healthy families, even in the poorest households and communities, will be more resilient to withstand this economic crisis. They are less likely to fall victim to catastrophic medical expenditures that push them into deepest poverty. Preventing disease and avoiding expensive drug expenditures could measurably impact those trends into poverty.
- The confidence of people in their government is improved when their priority needs are met – and the health of the child is a top priority for families across the world. The current humanitarian crisis in Zimbabwe offers a stark example. The cholera outbreak, worsened by a failing health system and poor access to safe water, hygiene and sanitation, has triggered protests by the country's health workers,[8] further contributing to the political and social unrest. (Political stability of governments, even more crucial in times of crisis, can only be strengthened by a public that values its government.)

When looking at the causes of child mortality it is easy to buy into the notion that it is inevitable. Of the 9.2 million under-five deaths each year, a significant number (37%) are neo-natal, occurring in the first 28 days of life. A child who survives his or her first 28 days is then most at risk from five main killer diseases: pneumonia (19% of under-five deaths), diarrhea (17%), malaria (8%), measles (4%) and AIDS (3%).[9] *(See chart overleaf)*

Maternal and child under-nutrition is an underlying cause of an estimated 35% of all under-five deaths[10] (3.2 million of the 9.2 million annual child deaths), because it weakens children's ability to fight off diseases and infection. Improved maternal health care in pregnancy and labour could prevent up to 26% of all child deaths (2.4 million children). Clean water and effective hand washing could save the lives of most of the 1.8 million children who die of diarrhea.



***Source:* UNICEF Childinfo database** *http://www.childinfo.org/mortality_progress.html, accessed 14 December 2008*

There are sharp discrepancies in the mortality rates of different countries with very similar poverty levels. Mozambique, one of the poorest countries in the world whose economy is ranked 200th (based on its 2007 per capita GNI), has far better child survival indicators than Angola, ranked at 132. Pakistan, at rank 155, fares worse in terms of child survival than Bangladesh at rank 177, while Tanzania, with the 183rd per capita income, has better child survival than Nigeria at 169th place. This demonstrates that it is possible to achieve significant reductions in child mortality even in resource-limited contexts.

In addition to efforts to address poverty as a whole, what specific health interventions are needed? The *Lancet* series on child health estimates that over 60% of the 9.2 million child deaths each year can be prevented through 23 well-proven responses, most of which are at the family and community level. These include exclusive breastfeeding, prevention of mother-to-child transmission of HIV, immunisation, micro-nutrient supplementation, oral rehydration therapy for diarrhea, effective and timely treatment for pneumonia, and malaria prevention and treatment.[11]

In today's world, far from being simply the outcome of poverty, child mortality is caused by lack of political will, misguided health policy and spending priorities by national governments, and a lack of donor investment in maternal, newborn and child health, particularly at the community level.

6. World Health Organization (2001), *Macroeconomics and health: Investing in health for economic development*. Report of the Commission on Macroeconomics and Health, Geneva
7. World Bank (2008), *Rising food and fuel prices: Addressing the risk to future generations*. Washington DC, 12 October
8. "Zimbabwean police break up protest", *New York Times*, 4 December 2008, http://www.nytimes.com/2008/12/04/world/africa/04zimbabwe.html
9. http://www.unicef.org/sowc08/docs/sowc08.pdf
10. Black R et al (2008), "Maternal and child undernutrition: Global and regional exposures and health consequences", *The Lancet* (vol 371), pp 243–260
11. Jones G et al (2003), "How many child deaths can we prevent this year?", *The Lancet* (vol 362); Darmstadt G et al (2005), "Evidence-based, cost-effective interventions: How many newborn babies can we save?", *The Lancet* (vol 365)

one

the cost of addressing maternal and child health

No single study has comprehensively documented the total cost of basic health services. However, in-depth costing studies have been carried out for each of the main components, and these provide detailed estimates of the cost of each sub-service (see Appendix). The best estimate of total current health aid was approximately $13 billion in 2006 or around 13% of total overseas development assistance (ODA).[12] Of this, approximately $5 billion to $6 billion, or 5%, of total ODA, supported basic health programmes (community and district health services, reproductive health care and infectious disease control, excluding HIV), and around $5 billion went to HIV and AIDS programmes.[13]

This $13 billion assistance compares with a minimum estimate for 2010 of $27 billion in total external assistance required,[14] and median estimates of around $50 billion per year.[15] Therefore, aid for health needs to at least double. Indeed, it is likely that the higher estimates are more accurate, as UNAIDS and the Global Fund indicate that under realistic assumptions of developing country contributions, aid for HIV and AIDS, TB and malaria alone will need to reach at least $23 billion by 2010.[16]

Of these total health aid requirements, between $15 billion and $25 billion in aid will be required annually to ensure adequate basic health services. The higher amount largely reflects the need to recruit and train millions of new health staff and the likely need for increased salaries to attract and retain staff. In response to the weaknesses in health systems, resulting from decades of under-funding, the World Health Organization has recommended that 50% of health funding be allocated to the strengthening of health systems and that half of this amount be allocated to the recruitment, training and support of staff.[17]

Given some overlap (in staffing, equipment and facilities and some interventions) and synergies between the services (e.g. prevention programmes reducing treatment costs), it can be conservatively assumed that around 20% of estimated costs could be deducted from the above total. This indicates that at least $15 billion in aid for basic health services which prioritise maternal and child health will be required in 2010. Additional finance is required to respond effectively to HIV and AIDS.

Some of the $15 billion needed for basic health services could be covered by greater and more effective spending of domestic resources in developing countries. However, most of the low-income countries have an absolute shortage of resources and require greater financial support from donor countries to meet their essential health needs.[18] The estimates above are based on realistic assumptions of the amount that can be contributed by low-income countries in the short term.[19]

Shortfall in investment and support

In recent years donor governments have increased aid for health. Much of this funding has gone to programmes focusing on AIDS and other specific diseases, and has led to significant improvements in responses to those diseases. However, basic health services – that deal with the major causes of maternal and child death as well as the most common health issues facing poor people – have not maintained the same rates of improvement. There is a significant shortage of trained staff,[20] often very poor working conditions, a lack of infrastructure, equipment and essential medicines, and weak management. In particular, this is preventing adequate and consistent levels of basic care, slowing reductions in maternal and child mortality, and impeding expansion of services for people with HIV and AIDS. Without effective basic health

systems and structures at the community and district levels (particularly focusing on preventive interventions), the global targets of reducing child mortality by two thirds (MDG 4), reducing maternal mortality by three quarters (MDG 5), and halting and reversing the spread of HIV/AIDS, malaria and other major diseases (MDG 6), will not be met by 2015.

To maintain the gains of the last few years in tackling diseases such as HIV and AIDS, TB and malaria, additional funding needs to focus more on the strengthening of health systems at the community and district levels.[21] A commitment to provide at least 10% of ODA to community and district health services (i.e. to the OECD DAC sectors covering basic health) would double funding to this area, to around $13 billion per year by 2010, allowing a gradual increase in funds. It would also ensure the predictable and long-term funding that developing countries need to train and employ new health staff.

A large body of research and on-the-ground experience indicates that the comprehensive provision of appropriate health services at the community and district levels will make a very big difference to the lives of poor people,

- saving the lives of around six million children each year;[22]
- reducing the number of maternal deaths by around 400,000 each year;[23] and
- allowing much more effective responses to existing infectious diseases such as HIV and AIDS, malaria, and tuberculosis.

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12. OECD DAC CRS database, accessed 14 December 2007; Kates J & Lief E (2007), *Donor funding for health in low- and middle-income countries, 2001–2005*, Henry J Kaiser Family Foundation and Center for Strategic and International Studies, Washington DC, extrapolated to 2006 and assuming the share of sector-allocated ODA going to health applies to total ODA. The 2008 IMF/World Bank *Global monitoring report* estimates the total at $17 billion in 2006, however this is likely to reflect commitments rather than disbursements.
13. Kates J , Izazola J & Lief E (2007), *Financing the response to AIDS in low- and middle-income countries: International assistance from the G8, European Commission and other donor governments*, Henry J Kaiser Family Foundation, Washington DC, quotes $3.9 billion in disbursements but does not include the full value of payments to the Global Fund during 2006 by donor countries, as the authors are focusing on the distribution of funds.
14. WHO (2001), *Macroeconomics and health: Investing in health for economic development*; the $27 billion figure includes aid for health research and greater support of UN agencies.
15. World Bank (2006), *Health financing revisited*, Washington DC
16. GFATM (2007), *Resource needs for the Global Fund 2008–2010*, p 12
17. WHO (2006), *World health report 2006*
18. WHO (2001), *Macroeconomics and health: Investing in health for economic development*; World Bank (2006), Health financing revisited
19. For example, UNAIDS and the Global Fund estimate that in the short term, approximately two thirds of health support will need to come from aid, as do UNICEF, the World Bank and WHO in their recent strategic framework for reaching the Millennium Development Goal on child survival in Africa.
20. *The African report on child wellbeing* states that "While Africa bears 25 per cent of the global disease burden, it has only 3 per cent of the global health workforce. Of the estimated global shortage of health workers of four million, one million are immediately required in Africa." The African Child Policy Forum (2008), Addis Ababa, p 24
21. WHO defines health systems as: "all organisations, people and actions whose primary intent is to promote, restore or maintain health". *World health report 2000: Health systems: Improving performance*
22. Jones, Steketee, Black et al (2003), "How many child deaths can we prevent this year?", *The Lancet* (vol 362)
23. Ensuring skilled attendance at all births, backed by emergency obstetric care, could achieve a reduction in maternal deaths of at least 75%. For example, Malaysia, Thailand and Sri Lanka all have achieved decreases in maternal mortality of more than 75%. See WHO (2005), *World health report 2005*, p 66

two

the need for renewed commitment and action by high-burden countries

While increasing financial support to developing countries' health systems, donor nations could also play a key role in helping poorer countries develop and implement effective health strategies that answer their specific local challenges.

Like the donor countries, many developing countries need to increase their budget support for essential health programmes. African and other developing countries have committed to increase health funding to at least 15% of budget expenditures,[24] yet in Africa where the Abuja commitments were signed by African Heads of State in 2001, only Botswana, the Seychelles, Zambia, Burkina Faso, Liberia, Malawi and Rwanda have met this commitment. Donor countries could play a more active role in encouraging developing countries to increase their health funding in line with increases in donor support.

This would require ensuring that no budget constraints are imposed on governments that will prevent investment in health and health-related services. There are indications that some international financial institutions have imposed budget constraints on some developing countries which have prevented adequate funding of essential services.[25] Donor nations need to ensure that essential services are not jeopardised in this way.

Donor countries also need to ensure greater harmonisation and transparency in the allocation of ODA to health, in line with the commitments under the Paris Declaration.[26] Current funding allocation does not appear to be based on need. Some countries in Africa (Zambia, Uganda and Mozambique, for example) are receiving funding from multiple donors, while others (such as Malawi) seem relatively neglected. The decisions for country prioritisation are not clearly defined or transparent.

In many poor countries a large share of government health spending comes from donors. Servicing donors' requirements can take a lot of time and resources from government health staff; this is compounded by different donors having different requirements and because the funding is often short-term. Mechanisms such as the International Health Partnership (IHP) could help improve donor co-ordination and ensure that developing countries are able to access long-term predictable funding for health. This would assist them to develop and implement effective, high-quality health plans that provide comprehensive and equitable services based on cost-effective, evidence-based interventions.

It would also allow them to make necessary long-term investments in health and to cover recurrent costs such as recruitment, training and retention of essential health care staff. Currently the lack of an effective international mechanism for co-ordinating and disbursing funds and for monitoring their use means that the health sector suffers from short-term, unco-ordinated donor responses that can become an added burden on already over-stretched health staff.

The continued funding and support from donor countries also needs to be matched by firm commitment and action from countries with high burdens of child mortality. In a time of global economic contraction the value of each dollar spent needs to be carefully weighed to ensure its maximum impact on preventing child illness.

Redirecting approaches to health

This requires a change in approach to health care in many countries and a shift in focus away from curative (secondary and tertiary) health care and towards preventive (primary) health care. This approach

concentrates on supporting families and communities to protect their children from ill health. It includes a focus on issues such as improved nutrition, water and sanitation, as well as increasing people's awareness and understanding of their right to health, and strengthening the capacity of community and health care systems and structures.

Removing barriers to access

Financial and other barriers to access need to be removed to ensure that pregnant mothers and children under five are able to access health services unimpeded. World Vision recognises that out-of-pocket costs can be a barrier to health care access. If evidence at the country level shows that equity of access to health care is adversely impacted, World Vision urges governments to ensure that health services are free at the point of access.

Increasing accountability

Use of funds for all health-related services needs to be made more transparent. Parliaments and civil society have a particularly important role in monitoring and evaluating government performance on health and ensuring government accountability. Research points to a correlation between levels of corruption and child health outcomes: many of the nations that Transparency International reports are widely perceived as most corrupt also have some of the highest child mortality rates.[27]

Certainly it is not merely a lack of resources that is leading to high child mortality rates, but ineffective interventions and a lack of political will to address the issue.

24. http://www.un.org/ga/aids/pdf/abuja_declaration.pdf
25. Center for Global Development (2007), *Does the IMF constrain health spending in poor countries? Evidence and an agenda for action*, Washington DC, http://www.cgdev.org/content/publications/detail/14103
26. http://www.oecd.org/dataoecd/11/23/34570799.pdf
27. Transparency International (2008), *Corruption Perception Index, 2008*, Berlin, http://www.transparency.org/policy_research/surveys_indices/cpi/2008; *cf* "Under-five mortality rankings", UNICEF (2008), *State of the world's children, 2008*, Geneva, p 113, http://www.unicef.org/sowc08/docs/sowc08.pdf

conclusion

the cost of inaction

Currently too many health care systems in developing countries are not responding adequately to the needs of poor and marginal communities, so families in these communities are not provided with the information and support they need to care for their infants and children. This is having devastating consequences on the lives of 9.2 million children who die before the age of five each year and on the lives of around 500,000 women who die due to complications of pregnancy and childbirth.

MDGs 4, 5 and 6 can only be met if the health needs of families and communities are met. This requires mobilising the resources to bridge the gaps between national health care systems and local health care needs. These gaps exist in a number of areas, some of which are not traditionally associated with health in the narrow sense, and include child and maternal (mal)nutrition interventions (among them breastfeeding education and provision of micro-nutrients), water and sanitation for hygiene, as well as other disease prevention, immunisation, and access to community-based interventions in case of illness.

If we are to minimise the number of child and maternal deaths, we need to recognise the critical role of families and communities in identifying and responding to their own health care needs, and ensure that they have the access they need to quality basic health care services.

Children and mothers need to placed at the centre of health care responses to ensure that the gap between available resources at a national level, and the local needs of families and communities, is bridged.

Recommendations

Specific actions are needed to reduce maternal and child mortality and ensure that MDGs 4, 5, and 6 are back on track.

Donor nations need to:

1. Allocate at least 10% of their sector-allocable ODA to strengthening community- and district-level health systems,[28] in order to provide universal maternal and child health services and support the scale-up of responses to HIV and other major infectious diseases. Alternatively, donor countries should contribute their fair share[29] of the minimum $15 billion per year in aid required for basic health services by 2010;
2. Accelerate the increase in funding for HIV and AIDS, TB and malaria through the Global Fund, and other mechanisms where appropriate, in order to meet donor countries' commitments to universal HIV prevention, treatment, care and support by 2010 and their commitments to combating other infectious diseases;
3. Work with high-burden countries to assist them in developing comprehensive, adequately funded and workable health plans that focus on effective health systems, with particular focus on delivering an essential package of care through strengthened community and district health interventions;
4. Work in a co-ordinated and transparent manner with other donors, through mechanisms such as the International Health Partnership (IHP), to ensure more effective and long-term support for health in developing countries;

5. Work with the international financial institutions to ensure that they do not unduly influence or impose on developing countries fiscal conditions that hinder the provision of effective basic health services;
6. Support and adequately fund the WHO in its efforts to revitalise the Alma Ata commitments on Public Health Care.

High-burden countries need to:

1. Allocate at least 15% of government budgets to health by the end of 2010;
2. Provide detailed reports to national parliaments from this year, and each year thereafter, on progress in improving health and incorporating indicators of maternal and child health as key measures of health system performance;
3. Develop comprehensive, evidence-based, costed strategies that grant high priority to community- and district-level maternal, neo-natal and child health services;
4. Ensure that all women and children have access to essential health services by 2011 and that cost is not a barrier to accessing treatment;
5. Set up and adequately resource national health monitoring systems that include birth and death registration.

Private sector leaders are urged to:

1. Support and collaborate with the World Health Organization in its efforts to revitalise Primary Health Care as a means of addressing the child mortality crisis;
2. Use their resources and technologies, where appropriate, to support the achievement of the Millennium Development Goals on health;
3. Ensure that their employees in all countries are working in conditions conducive to good health, and support their access to effective health services; and
4. Consistently, in policy and practice, support the right to health as a universal human right.

28. That is, the sum of funding to OECD DAC sector 122 (basic health) and sector 130 (reproductive health) but excluding sub-sector 13040 (STD control including AIDS) should be at least 10% of sector-allocable ODA. Increasing use of general budget support (which cannot be sector-allocated) means that the share of sector-allocable aid, rather than total aid, is a better indicator of support for health systems and basic health care.
29. The fair share should be based on the donor country's share of the total Gross National Income of all OECD donor countries.

appendix

funding required for basic health interventions

Intervention	Main finding	Estimated minimum annual aid required in 2010 (US$)	Source of information and basis of aid estimate
Maternal and neo-natal health services	$5.3 billion per year additional funding required from all sources	**$4.7 bn**	Johns B *et al*, "Estimated global resources needed to attain universal coverage of maternal and newborn health services", *Bulletin of the World Health Organization*, April 2007, 85 (4). Our calculation assumes $1.7 bn currently provided in aid to this area and that two-thirds of the total funding requirements in low-income countries will be covered by aid in the short term (in line with UNICEF, World Bank and World Health Organization, 2007, *A strategic framework for reaching the Millennium Development Goal on child survival in Africa*).
Child health services	$5.6 billion per year additional funding required from all sources	**$5.3 bn**	Stenberg K *et al*, "A financial road map to scaling up essential child health interventions in 75 countries", *Bulletin of the World Health Organization*, April 2007, 85 (4). We assume $2.3 bn currently provided in aid to this area and that two thirds of the additional need will be covered by aid as above.
Family planning	$11–$14 billion total per year required from all sources	**$3.7 bn**	UN Millennium Project, 2006, *Final report of the Sexual and Reproductive Health Taskforce*. We have conservatively used the minimum estimate and, in line with the International Conference on Population and Development, assumed one third of total costs are required in aid.
Major infectious disease programmes, excluding HIV & AIDS	$8.3 billion total per year required for TB and malaria programmes	**$5.5 bn**	Global Fund to Fight AIDS, Tuberculosis and Malaria, *Resource needs for the Global Fund 2008–2010*, February 2007. In line with UNAIDS estimates, we assume that aid will be required for two thirds of costs in the short term.
Total		**$19.2 billion**	

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.

World Vision is currently spending $150 million a year globally on health programming and $300 million a year on in-kind contributions.

However, the scale of the problem requires the mobilisation of much larger resources and the implementation of structures at a far larger scale than NGOs can provide. To meet this urgent and pressing need requires commitment and effective implementation by each developing country government, and co-ordinated and well-targeted support by the international donor community.

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