World Vision

the missing link
saving children's lives through family and community care

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The missing link: Saving children's lives through family and community care

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Parveen Akter is among the women in her community in Bangladesh who participated in three months of community training on primary health care, ante- and post-natal care, nutrition, hygiene and sanitation. Parveen says gratefully: "I have learned how to take care of the children who cannot express their feelings in words..." and "now I can understand different danger signals of pregnant women on the eve of delivering a baby."

contents

executive summary

Following decades of failed global efforts to tackle poverty, the adoption of the Millennium Development Goals (MDGs) in 2000 provided a rallying point for the international community to commit to meeting eight ambitious, yet achievable, development outcomes by the deadline of 2015.

Two thirds of the way towards the target date, 2010 represents a critical milestone in the fight against global poverty. Yet despite substantial progress with respect to other goals, 2010 reveals only a one-third decline in child mortality and even less progress towards reducing maternal mortality.

World Vision believes that to meet the challenge of reducing child mortality (MDG 4) and improving maternal health (MDG 5) it is imperative to radically scale up the focus on family- and community-based health care.

Families are integral to the health and well-being of mothers *and* children, yet health services aren't reaching far enough into communities to prevent the unnecessary deaths each year of at least 350,000 mothers and of more than eight million children under the age of five.

In September 2010 the United Nations member states—including those with the largest and most powerful economies as well as countries with the worst child survival rates—are undertaking a high-level review of progress thus far.

What have we learnt?

This year's review is likely to highlight uneven progress towards the achievement of the MDGs—with those related to child and maternal health remaining among the most off-track.

This dismal showing is even more scandalous because we already know how to save the lives of mothers and children with proven, cost-effective interventions such as skilled birth attendance, immunisations, mosquito nets and oral rehydration therapy. Even resource-strapped nations such as Malawi and Bangladesh demonstrate how prioritising these types of interventions can save the lives of children and their mothers.

Since the ink dried on the Millennium Declaration, there have been numerous efforts to reach MDG targets with the launch of a multitude of commitments, frameworks and initiatives. The most recent of these is the Global Strategy for Women's and Children's Health announced by United Nations Secretary-General Ban Ki-Moon. This global strategy offers a new agenda that brings together a wider range of stakeholders, including emerging economic powers, low-income countries, the private sector and non-governmental organisations (NGOs). Traditional donors, superpowers and all concerned stakeholders will be expected to take action and to support the financing, policy and implementation mechanisms necessary to transform aspiration into reality.

The UN Secretary-General is calling for an unprecedented global effort to address MDGs 4 and 5. His dedication is matched by the determination of advocates from all over the world to place maternal, newborn and child health at the forefront of the global agenda and to address this 'silent emergency' once and for all.

Effective interventions are now available that can dramatically reduce maternal and child mortality by up to two thirds. These need to be expanded and

more precisely targeted if they are to reach the poorest and most vulnerable women and children, their families and communities.

Why family and community care is vital

Measurement of progress towards the MDG targets is flawed because it is based on national averages and macro-level analyses instead of examining discrete regions and communities. This ignores the differences between rich and poor, urban and rural. In other words, countries could declare that they have met the health-related MDGs by targeting the easy wins, and ignoring constituents living in the most poor and remote communities. To reach these impoverished millions, World Vision believes that all stakeholders must focus on providing increased access to family and community care.

Why is family and community care so important? It is because so many millions of children live and die beyond the reach of formal health services and clinics. Extending the reach of health services into communities is crucial to meeting the needs of the world's poorest families who face the greatest barriers, whether point-of-use health care fees or transport costs. Families and communities can, and will, effectively deliver prevention, treatment and care—provided they receive the support of a trained cadre of community-based health workers.

A good example of the difference that family and community care has made is in Malawi, which, despite endemic poverty, has improved child health outcomes by prioritising community-level health interventions. These include preventing and treating pneumonia, diarrhoea and malaria—three of the leading causes of child mortality.

Evidence and experience also reveal that quality health care must be available when and where it is needed – a continuum of care, both across time and across place. The period from conception to age five requires far more interaction with health care: from ensuring a mother's health and nutrition at the time of conception, good nutrition and ante-natal care during pregnancy, the critical time of childbirth, those vulnerable early hours and days after birth, through to

Key messages

- **The current failure to make sufficient progress towards the MDGs on child and maternal health is due in part to the failure to address effective prevention and treatment at the family and community levels.**

- **If global progress on child and maternal health is to be accelerated, effective interventions—including those involving the health system as well as the broader social context—need to be better targeted to the most vulnerable women and children, their families and communities.**

- **The full potential of targeted and timely care at the level of family and community requires community-based health workers, and it can be realised fully only with strengthened community structures and a supportive, functional and decentralised health system.**

five years of age. And this care should be taking place from within the household, at the wider community level, all the way to the health facility.

But many current efforts, including those of the UN Secretary-General's Global Strategy for Women's and Children's Health, take a narrower definition of health care—one that gives little attention to family and community care, and extends only to the first month of life, not from conception to five years of age. In doing so, they risk reducing their potential impact on child and maternal health.

Recommendations

Governments of high-burden countries should

- prioritise family and community care within national and district health plans and budgets, to ensure universal coverage of critical interventions
- improve monitoring and establish more robust health information systems that extend to capturing data at the community level
- ensure the availability of health education and the promotion of public health programmes, to encourage health-seeking behaviour and the full participation of citizens and communities in the design and delivery of their own health care
- develop and implement plans to ensure that sufficient numbers of community-based health workers are adequately trained, supported and supervised
- increase investment to address the social determinants of health in proportion to their contribution to the burden of disease
- maximise investments in health by ensuring an integrated approach between health and related sectors such as nutrition, sanitation and water.

Multilateral organisations should

- ensure that operational plans for the roll-out of the Global Strategy for Women's and Children's Health include a strong focus on family and community care
- undertake research to capture evidence and lessons from countries that have been successful in implementing family and community care.

Civil society actors should

- ensure that their health programming is linked to national and district health plans and includes family and community care
- share context-specific knowledge and experience with the Ministry of Health and appropriate national poverty-monitoring systems
- provide support to citizens and community structures to become active participants in improving their own health and in holding governments accountable for the delivery of health care.

Donor countries should

- recognise that support for health to scale up progress towards MDGs 4 and 5 must include greater priority and funding for family and community care
- support governments of high-burden countries in the strategic development of national and district health plans that give priority to family and community care
- 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.

introduction

World Vision believes that family and community care has a central role to play in the achievement of Millennium Development Goals 4 and 5. Despite decades of accumulated evidence, national governments, donors, multilaterals and other stakeholders are still failing to adequately prioritise and resource this pragmatic, inexpensive and evidence-based approach to health care delivery.

This short document summarises global progress towards MDGs 4 and 5, and examines the significant benefits of expanding child and maternal health care interventions to encompass the family and community.

Many of the factors that contribute to maternal and child health operate at the household level, and there is overwhelming evidence that prevention and treatment interventions can be successful at this level. While there is wide recognition of the importance of health system strengthening, often this lacks sufficient focus on the community and family—so the potential to deliver major improvements in maternal and child health outcomes is not being realised.

Promoting demand for, and ensuring the delivery of, key interventions at the family and community level remains a central tenet of World Vision's own health programming strategy. This means delivering health care to those most in need when and where they need it: during critical periods such as pregnancy and childbirth and during the first days, weeks, months and years of a child's life, and in their homes and local communities.

Family and community care is at its most effective, and can bring a significant improvement in maternal and child health outcomes, when delivered through a cadre of trained community health workers, who are in turn supported by a health system that will supervise and monitor their activities and be responsive to community-level demands and referrals.

World Vision's understanding of family and community care

'Family and community care' means health promotion, mobilisation and support targeted directly to households and communities. The household and the local community are where behaviour, beliefs, traditions and culture intersect with the health of children and their families.

The evidence is clear that simple home-based care can prevent many child and maternal deaths in developing countries—not with high-tech health equipment, but with access to solid knowledge, support from community-based health workers, and basic supplies.

Family and community care empowers families and community members to take charge of their own health and well-being. It equips them with the knowledge and skills to implement a set of simple interventions that will lead to reductions in child and maternal mortality, including

- exclusive breastfeeding
- malaria prevention
- vitamin A supplementation
- treatment for diarrhoea
- care-seeking for pneumonia
- access to clean water and safe sanitation
- de-worming
- family planning
- appropriate complementary feeding, and
- adequate maternal nutrition.

Family and community approaches to health also respond to the broader social context and environmental factors, such as sanitation and water, that formal health sector approaches often miss.

World Vision's approach is household- and community-based and child-focused. It recognises that family and community care should play an integral part of a functional health system—the responsibility for which ultimately falls to governments.

Strengthening the capacity of families and care-givers to implement proven interventions that will reduce illness and mortality of children and their mothers works best when supported by a network of trained community-based health workers, backed up by a strong referral system and universal access to quality primary care facilities.

progress towards MDGs 4 and 5: a mixed picture

Progress towards MDGs 4 and 5 is occurring—but unevenly and too slowly. The global mortality rate in children five years and younger fell by only 28 per cent between 1990 and 2008. This means that, worldwide, an estimated 8.8 million children under the age of five still die of preventable causes every single year.[1]

Ninety-nine per cent of these deaths occur in poor countries. Almost half (4.2 million) of these are in Africa and a further 2.4 million in Asia.[2] Estimates of maternal mortality vary greatly, from a high of approximately 500,000 per year to a recently calculated lower figure of just over 340,000.[3] Although there are indications that maternal mortality has declined somewhat, it is clear that progress towards MDG 5 is lagging—particularly in sub-Saharan Africa, where large numbers of women still lose their lives from preventable causes, including AIDS.

Moreover, differences in maternal and child mortality rates *within* a country are often greater than those between countries—with wide disparities between the rich and the poor. Unfortunately, research shows that in many countries these gaps are widening, with mortality rates increasing among poor children but decreasing among those born to wealthier families.

Disturbingly, these inequities are not reflected in the data, which usually draw on national averages and not on a community-by-community basis. Children living in the poorest communities are still unable to access even the most basic care. Application of an equity analysis to maternal health outcomes shows similar results.

In other words, most suffering and deaths of children and mothers is concentrated in poor *communities* within poor countries.

Such disparities are due to a combination of factors that operate both outside the health sector (generally referred to as 'social and environmental determinants'), and within it (often termed 'health system factors').

References

1. UNICEF (2009)
2. Bhutta et al (2010)
3. Hogan et al (2010)

when and why are mothers and children dying?

Approximately 40 per cent of all child deaths occur during the newborn period, in the first month of life. Most of these are owing to pre-term complications and difficulties during and shortly after delivery. Most newborn deaths occur in low birth weight (LBW) infants, and low birth weight is linked to short gaps between pregnancies, maternal infections (such as malaria and HIV) and poor nourishment before and during pregnancy. Insufficient food of reasonable quality, and sub-optimal child care practices—especially inadequate breastfeeding and poor complementary feeding—are among the most common underlying causes of undernutrition.

Between one month and five years of age, infections such as pneumonia, diarrhoea and malaria account for a high percentage of child deaths, with undernutrition a contributing factor in one third of all child deaths. HIV also contributes to child mortality in high-prevalence contexts—especially in southern Africa. Common infections such as diarrhoea and pneumonia occur more frequently in environments where water and sanitation are inadequate, and where children are exposed to indoor smoke from poorly ventilated fires.

Infections in young children evolve rapidly, especially when immunity is compromised by undernutrition and/or HIV. Indeed, death can come quickly and with little warning—sometimes in only a matter of hours following the onset of symptoms. Thus, early detection and the treatment of acute illnesses is key to child survival.

The close proximity of someone who is trained to recognise danger signs and facilitate access to, or provide, effective care often makes the difference between life and death—literally. A community-based health worker who can educate mothers and families about the danger signs, and who can also deliver or ensure prompt and correct care, is capable of saving hundreds, and perhaps thousands, of lives.

Most maternal deaths occur during and in the immediate period following birth—which is also when most newborn deaths occur. A knowledgeable community-based health worker or trained traditional birth attendant [4] can identify danger signs in pregnant women before complications occur, and make the necessary referral to a health care facility. However, many complications require emergency obstetric care that is available only at a properly managed and staffed general or first-level hospital.

Improving the health and well-being of young children and their mothers requires not only ensuring access to life-saving interventions but also improving their overall living environments by addressing the so-called 'social determinants of health'. These determinants of ill-health include poor housing, inadequate sanitation and lack of safe water, poor nutrition and education, as well as income poverty itself.

References

4. Kerber et al (2007)

how and where can child and maternal deaths be prevented?

Researchers estimate that fully 63 per cent of all child deaths could be averted if interventions known to be effective were successfully delivered when and where they are needed.[5] Evidence and experience reveal that there must be a *continuum* of quality health care, both across time and across place.

The period from conception to age five requires far more interaction with health care: from ensuring a mother's health and nutrition at the time of conception, good nutrition and ante-natal care during pregnancy, the critical time of childbirth and those vulnerable early hours and days after birth, through to five years of age. And this care needs to be available within the household, at the wider community level, and all the way to the health facility.

Breastfeeding is one of the most important interventions and can significantly reduce infant and child mortality resulting from diarrhoea, pneumonia and neo-natal sepsis. Other key interventions include improved hygiene, vitamin A supplementation, oral rehydration therapy for diarrhoea and the use of anti-retroviral drugs to reduce mother-to-child HIV transmission.[6]

Two interventions—oral rehydration therapy and breastfeeding—could each prevent more than 10 per cent of all deaths, while a further six interventions (insecticide-treated materials, improvement of complementary feeding, antibiotics for neo-natal sepsis, antibiotics for pneumonia, anti-malarial treatment and preventive zinc supplementation) could each prevent at least five per cent of child deaths.

The promotion of family planning, improved nutrition, micro-nutrients (iron/folate), and malaria prophylaxis through intermittent preventive treatment and insecticide-treated bednets (ITNs), also will result in improved maternal health outcomes. Safe delivery care by skilled personnel, access to 24-hour emergency obstetric care and ante-natal care will prevent much maternal death and disability. All of these contribute to the survival and well-being of children. In other words, saving the lives of mothers and children means providing a continuum of maternal, newborn and child health services and interventions.

Improving the health and well-being of young children and their mothers requires not only access to life-saving interventions, but also addressing the living conditions that put both at risk in the first place. Better nutrition makes mothers and children less susceptible to infection and better able to fight off common illnesses. Key to this is the early initiation and continuation of exclusive breastfeeding, and access to a secure and nutritious supply of food. An under-nourished mother means an under-nourished infant. Good sanitation and sufficient clean water, as well as reduction in smoke exposure in poorly ventilated homes, also will lead to improved maternal and child health.

The key role of community-based health workers

As the examples above indicate, key life-saving interventions can be effectively delivered at community level through community-based health workers. It is critical that enough of these workers are trained, and that they are properly equipped and supported.

Community-based health workers can play a major role in identifying potential or actual serious health problems, and in some cases can administer treatment—for diarrhoea or pneumonia, for example.

They should be properly trained to identify life-threatening conditions and to provide or arrange for effective treatment.

Community health workers also have great potential to improve maternal health by promoting family planning and nutrition, and providing supplements and preventive treatment for malaria. They can refer women at risk of a complicated pregnancy, or who develop complications, to a nearby health post or clinic with a skilled birth attendant, and can visit families during the immediate post-delivery period following uncomplicated deliveries.

Key to the effectiveness of community health workers are support and supervision by nurses, midwives and local health facility-based mid-level workers,[7] and strengthened community structures.

References

5. Jones, et al (2003)

6. Ibid.

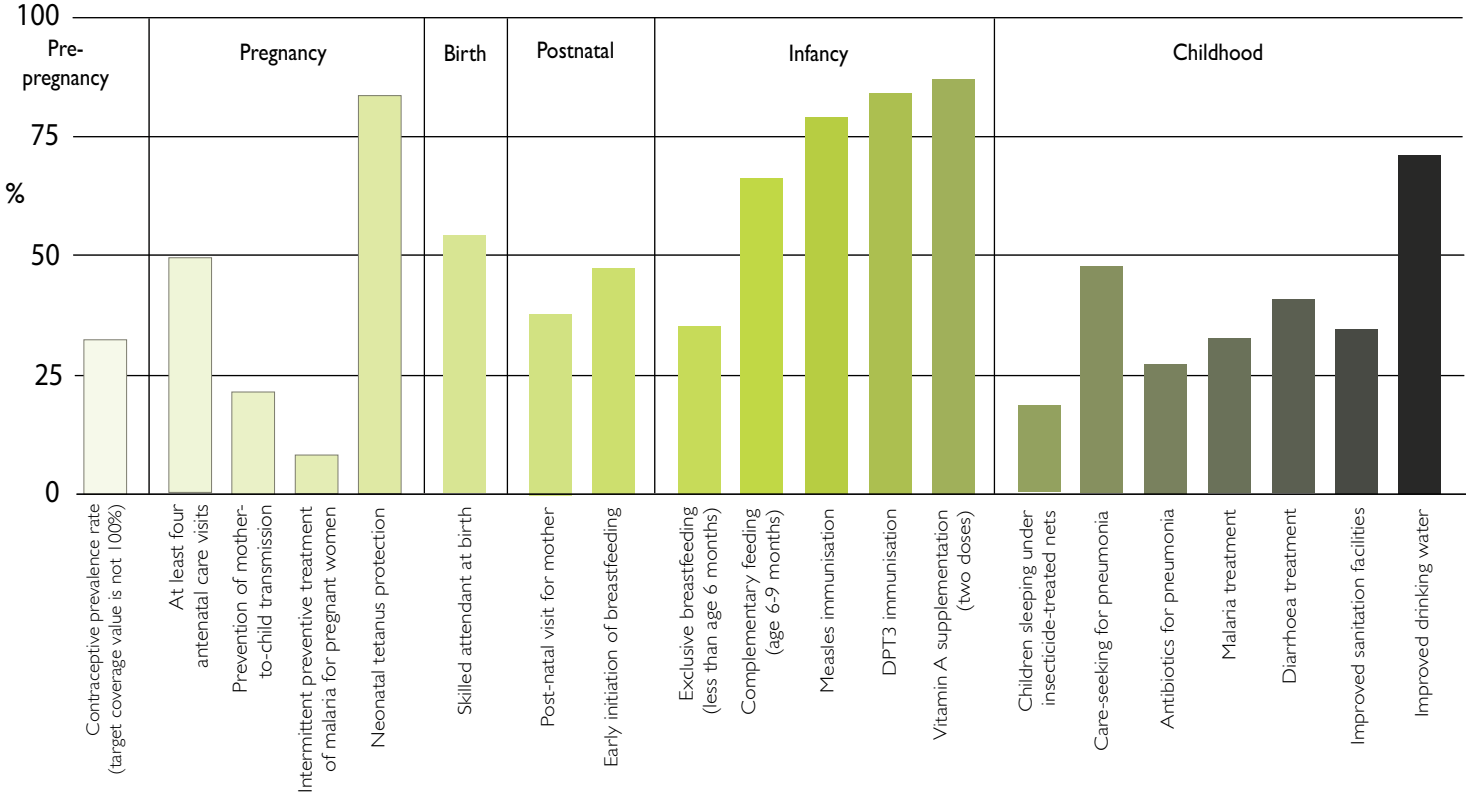
7. Lehmann & Sanders (2007)

coverage of family and community care interventions

Figure 1 shows the current coverage in 'Countdown to 2015' countries of 20 key health and environmental interventions proven to improve maternal, newborn and child health. As this figure shows, there is substantial variation in the percentages of mothers and children being reached by the different life-saving interventions along the continuum of care.

For example, there is a large gap between the percentage of children receiving vitamin A supplementation and those sleeping under insecticide-treated nets to prevent malaria. Some of these interventions can be delivered at the family and community levels but others require outreach or even facility-based care.

Figure 1
Coverage of interventions across the continuum of care



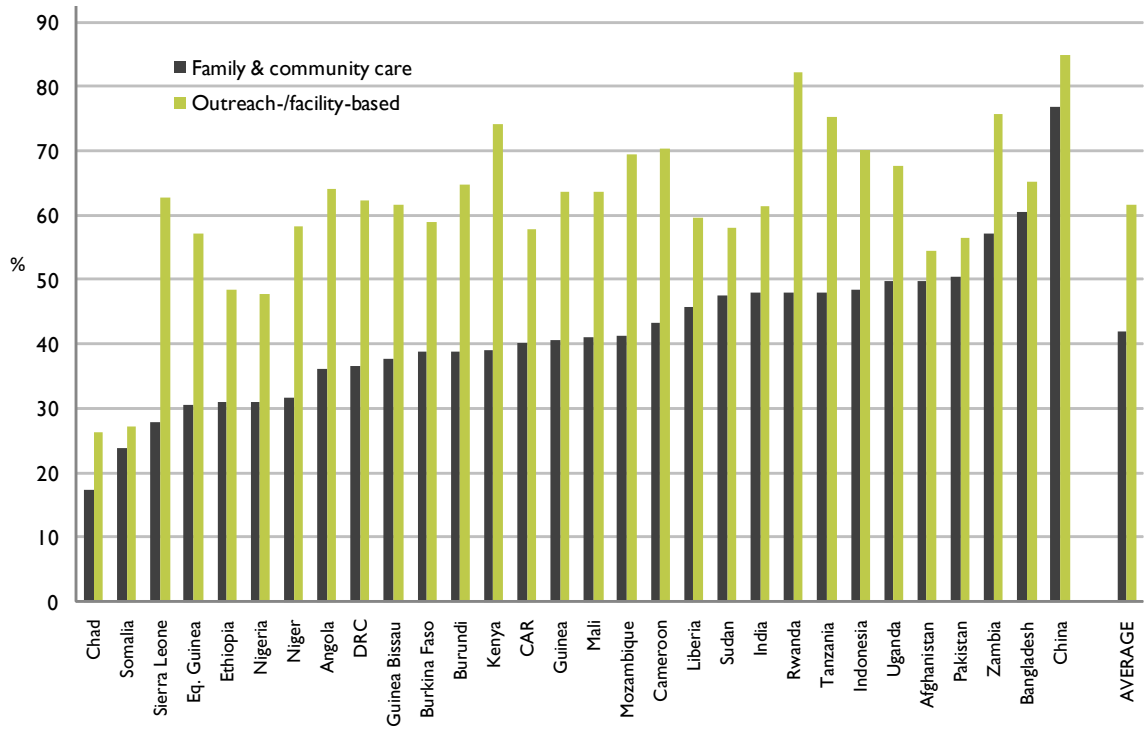
Median national coverage of interventions across the continuum of care for 20 Countdown interventions and approaches in Countdown countries, for the most recent year since 2000. Source: World Health Organization (2010)

Analysis from 30 countries with a high burden of maternal and child mortality (see ***Figure 2***) shows differences between the delivery of family and community care interventions compared to delivery of interventions that require outreach- or facility-based care.

For a package of key interventions that can be delivered at family and community level, the average coverage (or percentage of mothers and children reached) across the 30 countries is 42 per cent. By comparison, a package of outreach- or facility-based interventions for maternal, newborn and child health reached an average 62 per cent of the mothers and children across the 30 countries.

This disparity suggests that many countries' health services tend to overlook or marginalise the potential of health care delivered at the family and community level. However, in a number of these 30 high-burden countries, such Bangladesh and Zambia, the family- and community-level package provides access to almost as many interventions as those offered by outreach and facilities.

Figure 2
Average coverage of family and community care vs outreach- or facility-based health service interventions in 30 priority countries



Source: World Health Organization (2010).
Interventions classified as 'family and community care' here are exclusive breastfeeding, vitamin A supplementation, malaria prevention, diarrhoea treatment, malaria treatment, pneumonia care-seeking, contraception, water and sanitation. Interventions classified as 'outreach- and facility-based' are measles, DPT3 immunisation, prevention of mother-to-child transmission of HIV, one or more ante-natal visits, skilled birth attendance and neo-natal tetanus prevention.

As is the case for child and maternal mortality, there are great disparities between, and also within, countries in terms of health services coverage. A composite 'mean coverage index', constructed from selected indicators for reproductive, maternal, newborn and child health interventions (including both family and community care as well as outreach- or facility-based interventions) allows us to compare coverage across countries and between groups within countries.

Countries with similar levels of overall coverage upon closer examination reveal substantial inequities. Both Zambia and Guatemala, for example, have an overall coverage index of 59 per cent, but mothers and children from the poorest fifth of the population in Zambia show 55 per cent coverage, while in Guatemala this quintile experiences only 38 per cent coverage. Thus, although both countries are performing sub-optimally, the equity gap in Zambia is considerably smaller than that of Guatemala. Countries with relatively small coverage gaps between rich and poor—such as Bangladesh, Brazil, Egypt, Swaziland and Zambia—are worthy of in-depth study because they offer useful lessons as to how to bridge the health care equity gap.[8]

A study of over 40 countries reports that even those interventions generally thought to be especially 'pro-poor', such as oral rehydration therapy and immunisation, tend to benefit the wealthy more than the poor.[9] The failure of health services to reach the poor—despite their higher disease burden—is not simply because the wealthy can afford to purchase care from the private sector; poor people are also less likely to benefit from government health services. In India, for example, children born into the wealthiest families are three times more likely to receive immunisation against measles than their poorer counterparts—even when this service is universally available and free.

The poor face a number of obstacles, including lack of awareness, greater distances to services and higher out-of-pocket costs as a proportion of their income. When they are able to access health services, these are more likely to be sub-standard and often lacking quality drugs or supplies. These disparities can best be overcome by empowering families and communities to take control of their own health and well-being, encouraging health-seeking behaviour and ensuring that community-based health workers are equipped with the knowledge and means to refer patients to formal health care facilities when the need arises.

References

8. Bhutta et al (2010)

9. Gwatkin (2001)

what can be learnt from successful countries?

Several countries have made impressive strides with respect to child and—in some cases maternal—health. These can offer lessons that can be adapted to different country contexts and form the basis of a series of recommendations. Below are examples of three very different countries that nonetheless share a willingness to invest in family and community care.

Malawi

Malawi is one of the world's poorest countries, with a gross national income per capita of only US$290 in 2008 and a high prevalence (12 per cent) of HIV infection.[10] Despite an extreme shortage of paediatricians, doctors and midwives, Malawi has managed to provide its population with ready access to a number of key child survival interventions. These have been accompanied by a sharp drop in under-five mortality—from 225 per 1000 live births in 1990 to 100 per 1000 in 2008.[11]

A key factor that appears to have contributed to Malawi's decrease in child mortality is the deployment of a cadre of (predominantly male) community-based care-givers. Known as 'health surveillance assistants', their numbers have increased rapidly in order to ensure a high ratio of health workers to population. Most are attached to fixed health posts but operate at community level.

These community health workers are responsible for maternal, newborn and child health care, make post-natal visits and treat acute childhood illnesses such as malaria and pneumonia. Skilled birth attendance is high at 60 per cent and mid-level workers, who are placed at health centres and small hospitals, are trained to handle emergency obstetric care, including caesarean sections.[12]

Another key factor is that all donor assistance is pooled to ensure that funding is in alignment with health policies, and will not result in the fragmentation of health programmes. Malawi also has invested in the training of district managers and in ensuring a steady and reliable supply of essential drugs.

Bangladesh

Although Bangladesh is one of Asia's poorest countries, its progress has been impressive, making it well on track to meet the MDG target on child health. Influenced by large-scale, community-based NGOs operating since the 1970s, it continues to emphasise community care interventions, such as oral rehydration therapy, vaccinations, vitamin A distribution and family planning, along with an expansion of midwife training, and increased national commitment to the reduction of inequities.

Other factors that have contributed to improved maternal and child health outcomes include increased food availability, improved access to clean water, and increased access to education, with 85 per cent school enrolment.[13] In Bangladesh, under-five mortality has dropped from 149 per 1000 live births in 1990 to 54 per 1000 in 2008.[14]

Like most South Asian countries, gender discrimination resulted in higher female mortality rates. In the past, Bangladeshi boys were far more likely to receive life-saving interventions and be better nourished than girls. During the past few decades, however, gender disparities have all but been erased owing to interventions including micro-finance for women and a greater emphasis on the education of girls, together with greater access to health care that

contributed to improved female health. Despite this, the health care gap between the wealthy and poor continues to be a major problem.[15]

Brazil

Brazil is on target to reach the MDGs related to child health and nutrition. Under-five mortality, now at 22 per 1000, has been falling by an average of 5.2 per cent a year since 1990. The nutritional status of children under five has improved markedly, with dramatic decreases in the number of under-weight and stunted children.

Inequalities based on socio-economic status also have decreased sharply with respect to access to skilled delivery care, undernutrition and several other indicators of maternal, newborn and child health. For example, in 1996 just over 70 per cent of all mothers in the poorest socio-economic quintile received skilled care during childbirth; by 2007 coverage was universal.[16]

Brazil has developed a Unified Health System (SUS) that has decentralised health services and ensures that community representatives are involved in the planning and monitoring of services at all levels of government. Family health teams form the core of the SUS and deliver primary health care services within a defined geographical community.

Each team consists of a doctor, nurses, assistant nurses, six community health workers and sometimes a dentist. Services are provided within primary health care clinics, in individual homes or in the community—depending on requirements. Brazil employs approximately 250,000 community health workers who operate both in the cities and in the countryside. They function as an essential link to the community and are supported and guided by nurse supervisors.

While this strategy is leading to improved access and better health outcomes, it also is resulting in the more efficient use of other levels of care. This is because would-be patients no longer seek treatment at a first-level hospital for conditions that can be dealt with in the home. The strategy also encourages the community to organise, participate and collaborate in their own health care, nutritional status and education. This has substantially improved health outcomes.[17]

Brazil's conditional cash transfer programmes, which financially support vulnerable households to purchase essential provisions, cover about one third of the population, while multiple integrated health sector initiatives—including immunisation, HIV control and breastfeeding promotion activities—have been highly successful.

Perhaps the most influential policy development has been Brazil's focus on reducing regional and socio-economic disparities through the deliberate targeting of health and development policies and programmes to the most vulnerable populations.[18]

Common features of successful family and community care programmes

What Malawi, Bangladesh and Brazil have in common is the training and deployment of large numbers of community-based health workers who are equipped to implement a 'package' of core interventions and who enjoy the regular and appropriate support of formal health services at the sub-district and district levels.

How the policy decision to deploy community health care workers came about varies among the three countries. In Brazil, for example, the 2002 change in government strongly influenced policy development in general as well as in health, and one result was the establishment of the SUS.

In Bangladesh, innovations introduced by large NGOs such as the Bangladesh Rural Advancement Committee significantly influenced government policy and led to the expansion of community health worker programmes.

More recently, in Malawi, the human resource crisis and the demands of the HIV and AIDS epidemic resulted in a government response that emphasised

pragmatism over ideology and the adoption of task shifting. The latter relies heavily on trained community health workers to take on the duties of increasingly scarce doctors and nurses.

In these three country examples, different social determinants of health and social development have led to major shifts in policy. Although socio-economic inequalities continue to hamper development in Bangladesh, government policies designed to empower women (through micro-credit, the establishment of women's groups, female education, and so on) have resulted in a major reduction in gender-based health inequity.

In Brazil, government policies have gone some way towards reducing socio-economic disparities but large conditional cash transfer programmes (in the form of direct financial support to vulnerable groups) have had the most positive impact by far on reducing health and nutritional inequities.

While poverty remains widespread in Malawi, the nutritional status of mothers and children is improving because the government is now subsidising the cost of fertiliser to small farmers.

World Vision's response

World Vision focuses on the family and community model of health care delivery because it works. The evidence is unequivocal and based on decades of experience and work in the field. This is why World Vision has chosen Family and Community Care (FCC) as the framework for its global Child Health Now campaign.

At the centre of the campaign is a health and nutrition strategy, which promotes a package of key interventions—seven for pregnant women and 11 for children—designed to reach those most in need when and where they need it.

World Vision health and nutrition interventions package[19]

Targeting pregnant women: –9 months

1. **Adequate diet**
2. **Iron/folate supplements**
3. **Tetanus toxoid immunisation**
4. **Malaria prevention and intermittent preventive treatment**
5. **Healthy timing and spacing of delivery**
6. **De-worming**
7. **Facilitate access to maternal health service: ante- and post-natal care, skilled birth attendance, Prevention of Mother-to-Child Transmission, HIV/STI screening**

Targeting children: 0–24 months

1. **Appropriate breastfeeding**
2. **Essential newborn care**
3. **Handwashing**
4. **Appropriate complementary feeding (6–24 months)**
5. **Adequate iron**
6. **Vitamin A supplementation**
7. **Oral rehydration therapy/Zinc**
8. **Care-seeking for fever**
9. **Full immunisation for age**
10. **Malaria prevention**
11. **De-worming (+12 months)**

References

10. UNICEF (2009)
11. Ibid.
12. Chilopora et al (2007)
13. Mushtaque & Chowdhury (2007)
14. UNICEF (2009)
15. World Health Organization (2010)
16. Ibid.
17. World Health Organization (2004)
18. World Health Organization (2010)
19. World Vision International (2009)

Case study

Uttar Pradesh, India
Community-based behavioural change

Uttar Pradesh in north-central India is known as one of the most impoverished and lawless regions of the country. According to the National Family Health Survey, it also trails behind on mortality and fertility indicators.

Given the lack of progress, in 2003 World Vision decided the time was right to take a new look at old approaches to individual and household behavioural change. That year it launched Pragati (Hindi for 'acceleration' or 'momentum')—a child survival project that operated for four years in the three districts of Ballia, Lalitpur and Moradabad. Its objective was to ensure that pregnant women and new mothers have ready access to information on birth spacing and family planning.

One of the first issues that Pragati staff identified was that government health workers scheduled behaviour change communication (BCC) activities according to their own work or institutional schedules, and not those of the populations they were seeking to serve. This resulted in poor uptake and wasted resources—a situation that the Pragati project sought to address.

Although some of the 2,800 Pragati volunteers were nurses or midwives, the overwhelming majority were community *anganwadi* workers with the Integrated Child Development Services (ICDS), an enormous, 30-year-old community health programme that reaches deep into communities with the aim of improving child health outcomes, encouraging early education, and training and supporting local volunteers.

After undertaking BCC training, the Pragati volunteers identified and tracked pregnant women in order to deliver timed and targeted health messages that would reach them in their homes, after work or whenever and wherever was most convenient. The idea was to time information delivery so that it would come neither too early—and be forgotten—nor too late for it to be useful. For example, volunteers offered health, nutrition and family planning BCC according to where a woman was in her pregnancy, the age of her infant and/or the fertility intentions of the couple. To facilitate the acceptance of modern contraceptive methods, volunteers targeted not only individuals and couples, but also family decision-makers.

World Vision developed, tested and launched a comprehensive package of training, tracking tools, job aids and supervision protocols to ensure consistent content and quality.

The Pragati project undertook a baseline survey in 2003 and a final evaluation in 2007. Over four years, the contraceptive prevalence rate more than doubled. In Ballia the number of women reporting knowledge of at least one form of contraception leaped from 27 to 99 per cent; in Lalitpur it rose from 21 to 91 per cent, and in Moradabad from 31 to 75 per cent.

So successful was the project that the Indian government, World Vision and other NGOs are now replicating this approach, while other governments are looking to adapt it for use elsewhere.

recommendations

Most mothers and children die not in hospitals but where they live: within households and communities located in the world's poorest countries. These deaths are often preventable, but the types of interventions that would save lives are not readily available to those who need them when and where they need them.

Evidence and experience point to the crucial importance of prevention and care at the community and family level. Central to this strategy is the training and deployment of large numbers of community-based health workers who are equipped with a 'package' of core interventions and who can count on regular and appropriate support from well-functioning health services decentralised to the sub-district and district levels, and on strengthened community structures.

Underpinning this approach and vital to its success, governments and donors also must invest more effort and resources into addressing the key social and environmental determinants that are the cause of much illness and mortality and that prevent individuals and families from accessing quality health care. World Vision welcomes the fact that governments and donors increasingly recognise the importance of strengthening health systems, but investments will mean little unless families and communities are given the opportunity to participate in their own health care.

Governments of countries with the highest burdens of child and maternal mortality have the largest role to play in scaling up family and community care. But it is the responsibility of *all* stakeholders to undertake urgent coordinated action to improve maternal, newborn and child health, and they can do this by focusing more strategically on family and community care. World Vision strongly endorses the approach taken by the UN Secretary-General's Global Strategy for Women's and Children's Health to encourage specific commitments from a wide range of stakeholders to maternal, newborn and child health.

World Vision calls for a much greater focus and investment on family and community care from all stakeholders, and is committed to playing an active role in assisting efforts to expand health care services to include all people.

Governments of high-burden countries should

- prioritise family and community care within national and district health plans and budgets, to ensure universal coverage of critical interventions
- improve monitoring and establish more robust health information systems that extend to capturing data at the community level
- ensure the availability of health education and the promotion of public health programmes, to encourage health-seeking behaviour and the full participation of citizens and communities in the design and delivery of their own health care
- develop and implement plans to ensure that sufficient numbers of community-based health workers are adequately trained, supported and supervised
- increase investment to address the social determinants of health in proportion to their contribution to the burden of disease
- maximise investments in health by ensuring an integrated approach between health and related sectors such as nutrition, sanitation and water.

Multilateral organisations should

- ensure that operational plans for the roll-out of the Global Strategy for Women's and Children's Health include a strong focus on family and community care
- undertake research to capture evidence and lessons from countries that have been successful in implementing family and community care.

Civil society actors should

- ensure that their health programming is linked to national and district health plans and includes family and community care
- share context-specific knowledge and experience with the Ministry of Health and appropriate national poverty monitoring systems
- provide support to citizens and community structures to become active participants in improving their own health and in holding governments accountable for the delivery of health care.

Donor countries should

- recognise that support for health to scale up progress towards MDGs 4 and 5 must include greater priority and funding for family and community care
- support governments of high-burden countries in the strategic development of national and district health plans that give priority to family and community care
- 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.

references

Bhutta, Z. A., M. Chopra, H. Axelson, P. Berman, T. Boerma, et al. (2010). 'Countdown to 2015 decade report (2000–10): Taking stock of maternal, newborn and child survival.' *The Lancet*, 375, pp. 2032–2044.

Chilopora, G., et al. (2007). 'Post-operative outcome of caesarean sections and other major emergency obstetric surgery by clinical officers and medical officers in Malawi.' *Human Resources for Health*, 5:17.

Chowdhury, A. M. R. (1990). 'Empowerment through health education: The approach of an NGO in Bangladesh.' Cited in Streefland, P. & Chabot, J. (Eds) (1990). *Implementing Primary Health Care: Experiences since Alma-Ata*. Amsterdam: Royal Tropical Institute, p. 117.

Gwatkin, D., S. Rutstein, K. Johnson, R. Pande & A. Wagstaff (2000). *Socioeconomic differences in health, nutrition and population*. Washington (DC): World Bank.

Gwatkin, D. R. (2001). 'The need for equity-oriented health reforms.' *International Journal of Epidemiology*, 30, pp. 720–723.

Haines, A., D. Sanders, U. Lehmann, A. K. Rowe, J. Lawn, S. Jan, D. G. Walker & Z. Bhutta (2007). 'Achieving child survival goals: Potential contribution of community health workers.' *The Lancet*, 369, pp. 2121–2131.

Hogan, M. C., K. J. Foreman, M. Naghavi, S. Y. Ahn & M. Wang (2010). 'Maternal mortality for 181 countries, 1980–2008: A systematic analysis of progress towards Millennium Development Goal 5.' *The Lancet*, 375, pp. 1609–1623.

Hossain, S. M., A. Bhuiya, A. R. Khan & I. Uhaa (2004). 'Community development and its impact on health: South Asian experience.' *BMJ*, 328, pp. 830–833.

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.

Kerber, K. J., J. E. de Graft-Johnson, Z. A. Bhutta, P. Okong, A. Starrs, et al. (2007). 'Continuum of care for maternal, newborn and child health: From slogan to service delivery.' *The Lancet*, 370, pp. 1358–1369.

Lehmann, U., & D. Sanders (2007). *Community health workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers*. Geneva: WHO.

Mushtaque, A., & R. Chowdhury (2007). 'Rethinking interventions for women's health.' *The Lancet*, 370, pp. 1292–1293.

Schellenberg, J. A., C. G. Victora & A. Mushi (2003). 'Inequities among the very poor: Health care for children in rural southern Tanzania.' *The Lancet*, 361, pp. 561–566.

Tudor Hart, J. (2000). 'Commentary: Three decades of the inverse care law.' *BMJ*, 320, pp. 18–19.

UNICEF (2007). *Progress for children: A world fit for children statistical review*. http://www.unicef.org/progressforchildren/2007n6/index_41854.htm

UNICEF (2009). *State of the world's children: Special edition*. New York: United Nations Children's Fund.

Victora, C. G., J. P. Vaughan, F. C. Barros, A. C. Silva & E. Tomasi (2000). 'Explaining trends in inequities: Evidence from Brazilian child health studies.' *The Lancet*, 356, pp. 1093–1098.

Victora, C. G., A. Wagstaff, J. A. Schellenberg, M. Claesen & J. P. Habicht (2003). 'Applying an equity lens to child health and mortality: More of the same is not enough.' *The Lancet*, 362, pp. 233–241.

World Health Organization (2008). 'Flawed but fair: Brazil's health system reaches out to the poor.' *Bulletin of the World Health Organization*, 86 (4), pp. 248–249.

World Health Organization (2008). *World Health Report, 2008. Primary Health Care: Now more than ever*. Geneva: WHO.

World Health Organization (2010). *Countdown to 2015 decade report (2000-2010) with country profiles: Taking stock of maternal, newborn and child survival*. Geneva: WHO.

World Vision International (2009). *Health and nutrition start-up strategy*.

World Vision International (2009). *Child Health Now: Together we can end preventable deaths*.

Yaqub, S. (1999). 'How equitable is public spending on health and education?' Background paper for *World Development Report 2000/1*, Washington (DC): World Bank.

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Child Health Now is World Vision's first global advocacy campaign. With the aim of contributing to the reduction of preventable deaths of children under five, the campaign is already active in over 25 countries since its launch in November 2009. Through Child Health Now, World Vision will support families and communities to raise their voices about their right to quality health care, and together we will press governments and their partners to meet their responsibilities to children, mothers, families and communities.

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