Jeffrey W. Mecaskey is head of health with Save the Children UK. Since 1980, he has worked to improve health with attention to the inequity that marks the excess burden of disease born by society’s least advantaged. Trained at London, Liverpool and Harvard Universities, Mecaskey has worked on the intersection of community priority setting, national policy, and the political economy of international development. Prior to becoming head of health with Save the Children UK, he was vice president with Axios International, founding vice president of the International Trachoma Initiative, and associate with the Edna McConnell Clark Foundation.

One of the challenges in getting the health related MDGs back on track is the chronic under-investment in high-impact communications, advocacy and campaigning. Far too often, paediatricians, obstetricians, and health economists (like me) make decisions related to changing public perception and mobilizing political support. To reach the full potential of existing knowledge and technologies, we must reach out and partner with communications, advocacy and campaigning professionals. Moving beyond our own technical domains, we must draw on people who understand how to tap political processes, leverage public perception, and achieve political change. How we manage this, will be the stuff that defines how we are judged change. How we manage this, will be the stuff that defines how we are judged.
**Commission focuses on access to healthcare for all children**

Hosted at WHO, the Commission on Social Determinants of Health brings together leading scientists and practitioners to provide evidence on policies and practices that improve health by addressing the social conditions in which people live and work.

The ninth meeting of the Commission was held in Beijing, 24-26 October. The agenda included a session on PPfHC, taking Child Health as an example. The interim findings presented to the Commission included:

- Children from poor households are at consistently higher risk of being exposed to inadequate water and sanitation, crowding, and indoor pollution than children from wealthy families.
- Well-off families have better care-seeking patterns than poor families, and children of richer families receive better quality of care.
- As a result, poorer children are more likely to die, and suffer from infectious diseases, poor nutrition and severe illness.
- Substantial reductions in mortality can be achieved if the poorest children and their families receive the same care as the richest 20 percent in their country.
- It is a moral imperative that child survival programmes reduce financial, geographical, and cultural access inequities.
- More attention needs to be given to interventions with a proven pro-equity effect, including the Integrated Management of Childhood Illness (IMCI).

**Recent publications**

**Indoor air pollution and lower respiratory tract infections in children**

Indoor air pollution, caused by open fires, is a major risk factor for respiratory infections like pneumonia — the single greatest cause of death of children under five. The report summarizes the findings of a trial in Guatemala, of an improved chimney stove for cooking. The results were presented at a symposium of the International Society of Environmental Epidemiology in September 2006. A workshop followed, where gaps in knowledge and further research needs were identified. Design and potential sites for further research are outlined in the report, which is also a basis for advocacy to address the effect of air pollution on child health.

**Scaling-up Child Survival Interventions in Cambodia: the Cost of National Programme Resource Needs**

The Cambodia Child Survival Strategy aims to reduce high under-five mortality by scaling up coverage of twelve essential “scorecard interventions”. Based on national action plans, CAH supported efforts to estimate the cost of scaling up the scorecard interventions and related activities. Findings that at least US$80 million is needed to implement the planned activities up to 2010 can be used to support advocacy and resource mobilization for child survival. The report was prepared in collaboration with USAID through Basic Support for Institutionalizing Child Survival (BASICS), under the stewardship of Ministry of Health.

**Eliminating HIV in children: global partners commit**

Every day more than 1 400 babies are infected with HIV. Over 90 percent of children living with HIV became infected through mother-to-child transmission (MTCT). The good news is that it is preventable with the use of antiretrovirals and safer birth and feeding practices.

Ministers of Health and experts from around the world will join members of the Inter-Agency Task Team (IATT) on Prevention of HIV Transmission in Pregnant Women, Mothers and their Infants for a “Global Partners Forum” in Johannesburg, South Africa, 26-27 November. The aim of the meeting is to build consensus on the strategy and revitalize commitment to making universal access to comprehensive PMTCT services a reality.

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**Regional Adviser Child and Adolescent Health and Development, WHO Western Pacific Region**

**Marianna is a Medical Doctor with a post-graduate degree in Health Systems Management. She joined WHO in the Western Pacific Region in 1994, as a Medical Officer working on the control of diarrhoeal diseases and acute respiratory infections. She has been closely involved in the Integrated Management of Childhood Illness (IMCI) strategy since its inception. Marianna has been the regional focal point for child and adolescent health issues since 1999, and in 2006 she was appointed as the Regional Advisor for CAH.**

**In which three key areas has important progress been made in recent years?**

A great deal has been achieved in terms of political commitment and setting strategic directions for child health. We have a WHO/UNICEF Regional Child Survival Strategy that calls for regular monitoring of progress along ten core coverage indicators for under-five mortality, infant and newborn mortality and nutritional status. The goal is to achieve universal access to a package of evidence-based interventions, and boost investment in financial and human resources.

We have exceptionally good collaboration with partners. The joint development of the Regional Strategy between programmes — child, maternal, nutrition, immunization, malaria, health sector development, health care financing, health information systems, gender, poverty, and environmental health — has reinforced the sense of common purpose. Our relationship with UNICEF is rock solid, as demonstrated by day-to-day coordination, joint regional activities and missions that are the rule rather than the exception. We also enjoy excellent partnerships with AusAID, Japan, USAID and the Asian Development Bank.

We’ve paved the way for regular monitoring of implementation and tracking progress through a common framework. Country profiles have been published on Cambodia, China, Lao PDR, Papua New Guinea, the Philippines, and Viet Nam. Each country data on intervention coverage as well as information on health system capacity in terms of policies and programmes, financing and human resources.

**What are the main challenges for improving child and adolescent health in the Region?**

Under-five mortality is going down in the Western Pacific, but progress is uneven. The Region is extremely diverse. It includes some of the world’s most developed countries, transitional economies with rapid growth, and some of the least developed countries. Size is another factor that affects health planning, ranging from China to the tiniest Pacific Island. Disparities between and within countries are great, and inequitable access to essential health services is a pressing issue. The epidemiological profile of prevalent diseases also differs, so one size doesn’t necessarily fit all. To allow for this, the Regional Strategy classifies Member States into three different groups. In all settings, emphasis is on reaching poor and vulnerable children and adolescents.

Health system strengthening is key to achieving equitable access to quality services and further improving health. Financial barriers are a systems bottleneck — the Region has generally low public investment in health and high out-of-pocket payments. There is a need for financial mechanisms to improve poor families’ access to health services and protect them from catastrophic expenditures that take them deeper into poverty. Human resources for child health are a challenge in several settings where supply doesn’t meet demand. We also need to boost integrated health service delivery for children and adolescents.

Overall, while economic and social development are proven ways to improve health status in the long run, improvements in child and adolescent health are achievable, even in less developed settings, with systematic investments in scaling up a few cost-effective interventions that focus on the greatest needs of this age group.

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**Q&A**

**Dr Marrianna Trias**

**Regional Adviser Child and Adolescent Health and Development, WHO Western Pacific Region**

**A** Finnish national, Marianna is a Medical Doctor with a post-graduate degree in Health Systems Management. She joined WHO in the Western Pacific Region in 1994, as a Medical Officer working on the control of diarrhoeal diseases and acute respiratory infections. She has been closely involved in the Integrated Management of Childhood Illness (IMCI) strategy since its inception. Marianna has been the regional focal point for child and adolescent health issues since 1999, and in 2006 she was appointed as the Regional Advisor for CAH.**

**Action to address adolescent pregnancy**

Between 14 million and 15 million adolescent girls give birth each year. Adolescents aged 15-19 are more likely than older mothers to die in childbirth, and very young mothers aged 14-19 are at highest risk. For every young woman who dies in childbirth, 30-50 others are left with an injury, infection or disease.

There is increasing clarity on what needs to be done to address the key issues around adolescent pregnancy. They centre on three types of intervention targeted at:

- decreasing too early pregnancies;
- decreasing unsafe abortion, and where it occurs, decreasing deaths from unsafe abortion;
- decreasing deaths during childbirth.

Alongside efforts to build capacity and support implementation in countries, there is a need to strengthen the evidence base for addressing these issues. Information on effective interventions exists, but not in one place. Reproductive health programme managers in developing countries need ready access to a menu of evidence-based interventions to meet the specific needs of adolescents.

WHO’s Department of Child and Adolescent Health and Development is committed to making this happen. In 2008, a document on adolescent pregnancy will be developed, modelled on the recently published technical report “Preventing HIV/AIDS in young people: A systematic review of the evidence from developing countries”.

**Knowledge Networks inform the Commission of evidence-based opportunities to improve action in nine key areas. One such Network is focused on “Priority Public Health Conditions” (PPHC). It aims to identify barriers and facilitators of access to health care, and introduce pro-equity interventions within programmes, particularly in low- and middle-income countries.**

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