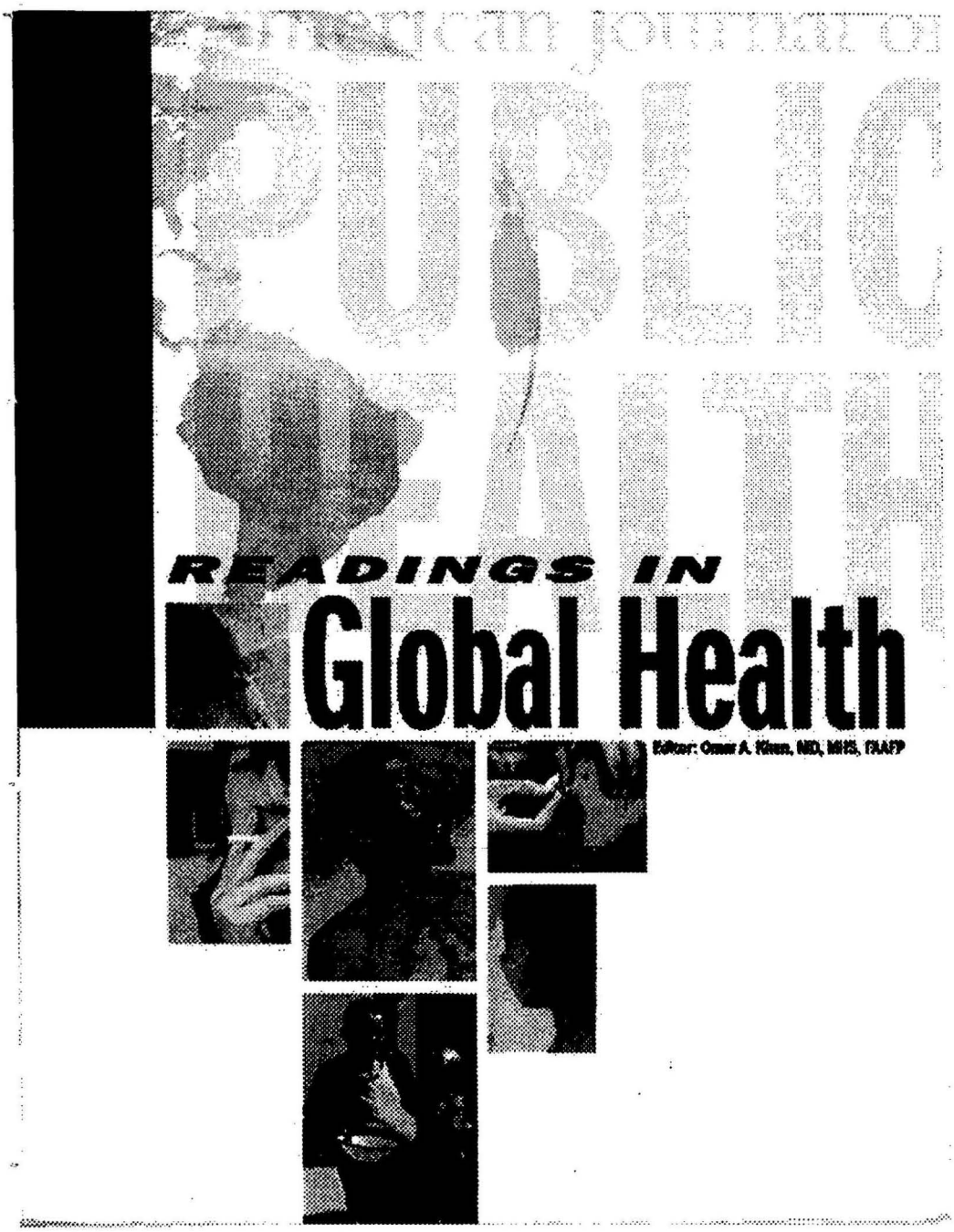

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Overview of Children, Adolescents, and Family Health Section

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This anthology includes papers published in the *American Journal of Public Health* in various years between 2001 and 2007. These can be grouped into several clusters. Three of them cover issues related to inequalities as variously defined and identified. For example, the paper by Burstrom et al. (2005) provides a historical analysis of the introduction of improved water and sanitation in the later 19th and early 20th century in the city of Stockholm, Sweden and how it had an equitable impact on some of the immediate outcome indicators. The paper by Rodwin et al. (2005) also covers four major urban settlements in the developed world—New York, London, Paris, and Tokyo—and analyzes the link between income and infant mortality rates in these cities between 1988-1992 and 1993-1997. The third study in this cluster is by Pickett et al. (2005) which reported the contribution of poor socioeconomic status, represented by income, in increased births and violence amongst the adolescents in selected rich countries.

The above three papers originate from higher-income countries. Over the past decade or so, there have been a number of initiatives that systematically considered inequities in health, particularly in low-income countries. These represented inequities in terms of access and coverage of health services and their impact on health status. One such initiative is the Global Health Equity Initiative (GHEI), spearheaded by the Rockefeller Foundation and supported by several other agencies including the World Health Organization (WHO), Canadian International Development Agency (CIDA), the World Bank, and the Swedish International Development Cooperation Agency (SIDA). It resulted in the publication of a major volume with 13 essays and a foreword by the then-serving Prime Minister of Bangladesh, Sheikh Hasina (Evans et al. 2001).

The issue of equity has been in discussion and discourse in health literature for centuries. It is central to and one of the major pillars of Primary Health Care (PHC), articulated in 1978 in Alma Ata, to which the world is reverting back after a couple of decades of uncertainties and indecision. Evans et al reported studies from different parts of the world which demonstrated convincingly the existence of huge inequities in health access and status. There were inequities not only in terms of income entitlement, but also in terms of gender, social status represented by education, ethnicity, geographical residence (rural, urban and slums) and so on. These inequities are pervasive and unfortunately drag on. Although our knowledge about the levels and causes of inequities in health are quite robust and extensive, our knowledge and experience on how to deal with these is scant at best.

As health and health inequities affect other outcomes such as income, education, environment, etc., and are also affected by these, the interventions to address health inequities may be found here, in addition to direct health measures. Evans and colleagues cite measures that have been found effective in reducing inequities in health status of children. This study, which comes from Bangladesh, reports on a women-centered poverty alleviation program run by a local non-governmental organization (BRAC) with major emphasis on micro credit and children's education. The study demonstrates this approach having reduced inequities in under-5 mortality and in bringing the rates of children of poor women at par with those of the well-to-do sections in the community (Chowdhury and Bhuiya 2001). Such micro credit and poverty alleviation programs are now being implemented all over the world, and its impact on other aspects of human well-being such as women's empowerment, nutrition, education, fertility and so on is well documented (Chowdhury and Bhuiya 2004; Bhuiya and Chowdhury, 2002). For changing health status and improving health inequities, we need to think outside the box and look for solutions in other sectors. Health measures including curative and preventive care are essential to reduce mortality and morbidity, but interventions targeted to the social determinants of health may bring the desirable results faster and in a more sustained fashion (Chowdhury, 2007; CSDH 2007).

Two papers presented in this anthology deal with post-disaster health situations. While the paper by Desai and Perry (2004) tried to track the human rights violations against women in postwar Kosovo, the paper by Becker (2006) describes a program that provided psychosocial care to child and adult survivors of the Asian Tsunami in Southern India. The Kosovo study

lamented the paucity of appropriate data to track "the scope and frequency of violent acts committed against women." Indeed this is true for most low income countries where availability of credible information on violence against women is a major limitation in undertaking any systematic monitoring and advocacy work. For many such countries the basic statistics which gives a child its basic human rights, the birth registration, is absent or faulty at best. In Bangladesh, for example, birth registration is available for less than ten percent of the population, and that too is often incomplete and faulty. In the absence of data, governmental and development agencies often depend on decennial censuses or periodic surveys. However, the censuses are too infrequent for use in development programs and the surveys are expensive.

An issue related to this is the question of research capacity. Since the publication of the report by the Commission on Health Research for Development in 1990 (COHRED 1990), there have been a number of international initiatives to promote research in low income countries. The issue of the "10/90" gap (implying that only ten percent of the resources are spent in researching health problems of 90 percent of the world's population) has caught the imagination of many agencies. With support from donor agencies, the Council on Health Research for Development (COHRED) and the Global Forum for Health Research (GFHR) are working to reduce the 10/90 gap. The Global Forum claims that there has been a sustained increase in the global spending on health research. Nobody, however, seems to know whether the gap has been reducing or not.

One issue at hand is the question of research capacity in low income countries. Research is not a part of the academic culture in most of these countries. Research is hardly taught in universities and the government decisions are hardly based on research findings. Indeed, most of the decisions and plans are made on an *ad hoc* basis without the benefit of any evidence base. Those who feel obliged to do research often get frustrated as their research is seldom translated into policies. For a sustained improvement of health in low income countries, promotion and development of research culture and capacities are essential. Birn (2005) also addresses the importance of research in the case of Uruguay, when she examines the historical reasons behind the country's institutionalizing child health as a priority.

The two papers by Rosenfield & Figdor (2001) and Bassett (2001) have brought forth the issue of MTCT (mother-to-child transmission) of HIV and the place of the *mother* in it. "Maternal" was a low priority in MCH (maternal and child health) programs in the 1980s-1990s, which led to asking the question 'Where is the M in MCH?' (Rosenfield and Maine, 1985), as a result of which the Safe Motherhood program was born. The authors, for very valid reasons, similarly draw attention to the role of mothers in MTCT.

Over the past couple of decades, the world has made significant progress in many health related fields, child health being one. Over the past few years, Bangladesh, like some other low income countries, has been able to reduce its infant and under-5 mortality rates by more than half. Unfortunately, the maternal mortality rate has not been reduced to a similar extent. "Magic bullets" for child mortality like oral rehydration therapy (ORT), immunizations, and vitamin A have been successfully scaled up to reach most of the population. Reducing maternal mortality, however, requires a more system-wide approach which involves a responsive health system that can provide emergency obstetric care (EmOC). Many of the low income countries are trailing behind in this, and unless health systems are strengthened to respond to emergencies, the health of pregnant women will remain at stake.

The paper by Foege (2001) deserves attention in this respect as well. He critiques a manual on managing newborn health, published by APHA. He says that the technology and scientific know-how to save newborns are all known. The only issue is what he calls *management*. Indeed, this remains true for most diseases that kill children and women prematurely. In its report, the Task Force on Child Health and Maternal Health of the UN Millennium Project echoed this by pointing out that the world has all the resources to prevent most maternal and child deaths—but the real challenge is how to make these available to the vast majority of the world's poor (Freedman et al, 2005). In other words, this is a question of scaling up of known and effective interventions. The Task Force report also strongly advocated for increased attention to strengthening the health system so that it is able to entertain the health needs of all: poor and rich, men and women, dominant and the minorities.

The last two papers are by Miller et al. (2006) and Roggero et al. (2007). The former, a study from Botswana where the world's highest percentage of AIDS orphaned children live, assessed the ability of households to adequately take care of the orphans. This brings to light once again the plight of a most neglected and unheard group of children whose parents fell victim to the AIDS epidemic. Botswana, even as one of the richest countries of the African continent, neither has the public sector nor the individual household-level support to provide adequate care to orphans. As the paper concludes, lessons from Botswana "provide valuable insights to policy-makers throughout sub-Saharan Africa." The latter paper presents a meta-analysis of the relationship between child labor and status of health as represented by different indicators such as mortality rate, nutritional level, and infectious morbidity.

In a way, these findings are neither surprising nor unexpected. The children who (have to) resort to labor hail from poorer households where their support is needed for the family's day-to-day survival. For many of these children, going to schools is a luxury which their households feel they can scarcely afford. The study also speculates on the longer-term health impacts of child labor. There are some policy implications associated with child labor

as well: the practice is banned in most countries, yet it continues unabated in many low income settings. The reason is simple: poorer families perceive the need for their children's support to supplement the household income. Taking a partial view of this scenario is not helpful to remove the ill effects of child labor. One has to instead recognize the facts and come up with practical, workable solutions. As a small example of the real-life clash between child health and child labor, consider that in the rural setting of countries like Bangladesh, children can provide real assistance to their parents in agriculture, e.g., by taking food to the field or herding the cattle. The school hours clash with the work hours, setting up a simple conflict. One can resolve this by setting flexible school timings; the school may be in session during times (or seasons) when there is a reduced need for children's work. This approach has been tried successfully by some Bangladeshi NGOs, and highlights the need, again, for creative solutions to intractable problems (Ahmed et al. 1993).

Lastly, the papers presented in this anthology are a substantial, thought-provoking addition to the literature and to efforts for continuing education. They provide a variety of topics with experiences from different parts of the world. They remain essential for public health practitioners and people who wish to expand their knowledge in this area.

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