World Vision®

THE KILLER GAP

A GLOBAL INDEX OF HEALTH INEQUALITY FOR CHILDREN

CHILD HEALTH NOW

Together we can end preventable deaths

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EXECUTIVE SUMMARY

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We are making remarkable progress in child health. As an international community of families, civil society, corporations, governments, the UN and organisations like World Vision, we should celebrate the success we've seen in the past 20 years, reducing the number of preventable deaths of children under the age of five: from 12 million children in 1990, to nearly seven million in 2011.

But the number is still far too high. Every child lost is a tragedy for their family, community and country. And every child lost is a reminder that we have a lot of work left to do.

As we make the final push towards the deadline for the Millennium Development Goals (MDGs), we rightly feel an urgency to do more, to do everything we can to understand – and take action on – the reasons why we are still so far off reaching the MDG targets that UN member states set themselves in 2000. Put simply, we have failed to reach the poorest and most vulnerable children.

World Vision has produced the Global Health Gap Index to try and do exactly this; to analyse where and why children are still dying, and to outline what can be done. This Index demonstrates that despite global progress in reducing the number of deaths of children under the age of five, some of the poorest children in the world are still not being reached. It is a timely and stark reminder that the gap between those who have good access to life-saving health services and those who don't remains unacceptably large.

Nisha Das, a confident and inspiring 15-year-old from India, is a powerful reminder of why inequity matters: for the children whose lives are being saved, and the millions more who we need to concentrate on reaching.

"I feel sad to see children all over the world are still not treated with dignity and equality in spite of the world moving so forward. It is a paradox. Many children are not educated and not included in societies because they are poor, disabled or invisible in society," Nisha told the UN when she spoke at an inequality debate recently. "Children need the same opportunities whether they're rich or poor, boys or girls, disabled or not."

With little more than 800 days until the MDGs deadline, at World Vision we are working with families and communities to amplify voices like Nisha's. Join us at www.childhealthnow.org to urge leaders to do what they can to close the gap in children's health:

- Ensure that greater attention at the highest political level is given to closing the health gap for women and children.
- Address the problem of missing data for vulnerable groups by establishing routine data collection systems locally, nationally and internationally to measure the health gap.
- Engage and empower families and communities in data collection and in the planning, delivery and review of health services.
- Prioritise child and maternal health in the post-2015 development agenda, through the inclusion of ambitious goals to end preventable child and maternal deaths and significantly reduce stunting.

Andrew Hassett
Child Health Now Campaign Director
World Vision International

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MIND THE GAP

With just two years left to achieve the Millennium Development Goals (MDGs), the gap in the provision and delivery of life-saving health services and the health outcomes for children between and within countries remains huge. World Vision's new Global Health Gap Index gives a snapshot of how well governments are addressing the health of all people in their countries, and demonstrates that a child's chances in life rely on much more than his or her family's wealth.

The size and impact of the gaps between the 'health rich' and 'health poor' can have disastrous repercussions, particularly for children under the age of five. A large health gap in a country means its most vulnerable children have decreased chances of accessing much-needed treatment and health facilities. It means that children remain health poor, despite global or national progress.

The aggregated numbers and averages generally used to assess global and national progress in achieving the MDGs have meant that some countries have been able to achieve their targets without addressing the needs of their most vulnerable children. As this gap widens, the poorest women and children are being left behind. Closing the global health gap means first understanding who and where they are.

At a time when major improvements in global health are rightly being celebrated, we need to look at why 19,000 children under the age of five still die every day. As life and health have improved for some, why haven't they for others? The MDGs have aimed to improve global poverty, so why do preventable birth complications and treatable diarrhoea still kill so many every year?

This Global Health Gap Index demonstrates that it's because access to good health care remains little more than a dream for millions of children. Evidence is exposing the unequal health outcomes existing within countries, and showing that certain groups of vulnerable children and families are being left behind.

19,000 children under the age of five **will die today**

WHO ARE THE 'HEALTH RICH'?

People with the most access to the best health education, awareness, prevention and treatment are health rich.

WHO ARE THE 'HEALTH POOR'?

People who face the most barriers to accessing health education, awareness prevention and treatment are health poor. These barriers can be due to geography, direct or indirect costs for service, language, refugee status or discrimination related to a number of other factors.

THE GLOBAL HEALTH GAP INDEX – WHAT IT MEANS

World Vision's Global Health Gap Index ranks each country according to the size of the gap between their health rich and health poor using four indicators:

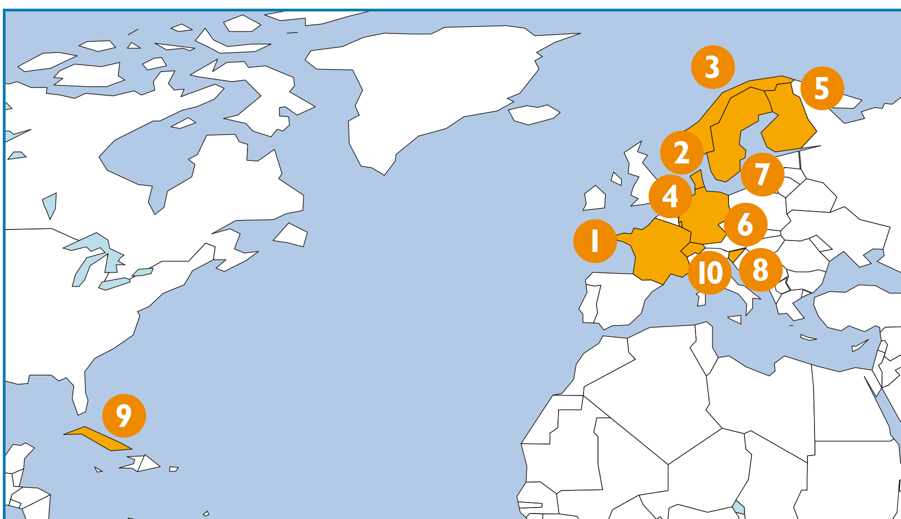
- **LIFE EXPECTANCY:** This measure shows the current inequalities in life expectancy across groups of people and different areas in a country, including deaths among newborns and children under the age of five.
- **PERSONAL COST OF USING HEALTH SERVICES:** Measured through an individual's out-of-pocket payments made for health care. Very high costs of health services for families are a key barrier to seeking care when someone is unwell. Many poorer families are forced to choose between catastrophic spending that will drive them further into poverty, or foregoing treatment.
- **THE ADOLESCENT FERTILITY RATE:** A baby's health and survival is critically linked to the health of the mother, and a mother's age is a key factor in determining the health outcome for both of them. When girls are able to delay marriage and pregnancy, they tend to have fewer pregnancies and safer deliveries and are better able to raise healthier and well-nourished children. The Adolescent Fertility Rate is a representation of the ability of a country or population group to keep its children and mothers healthy.
- **COVERAGE OF HEALTH SERVICES:** Measured by the number of physicians, nursing and midwifery staff for every 10,000 people in a country. Evidence shows that countries with fewer than 23 physicians, nurses and midwives per 10,000 people are unable to adequately reach their people with essential health services.

To draw up the Global Health Gap Index, World Vision assigned each indicator equal weight then ranked each country according to how it fared. Countries with the same number for a particular indicator were given an equal score. The total scores were added up, revealing each country's overall standing.

WHAT IS THE HEALTH GAP?

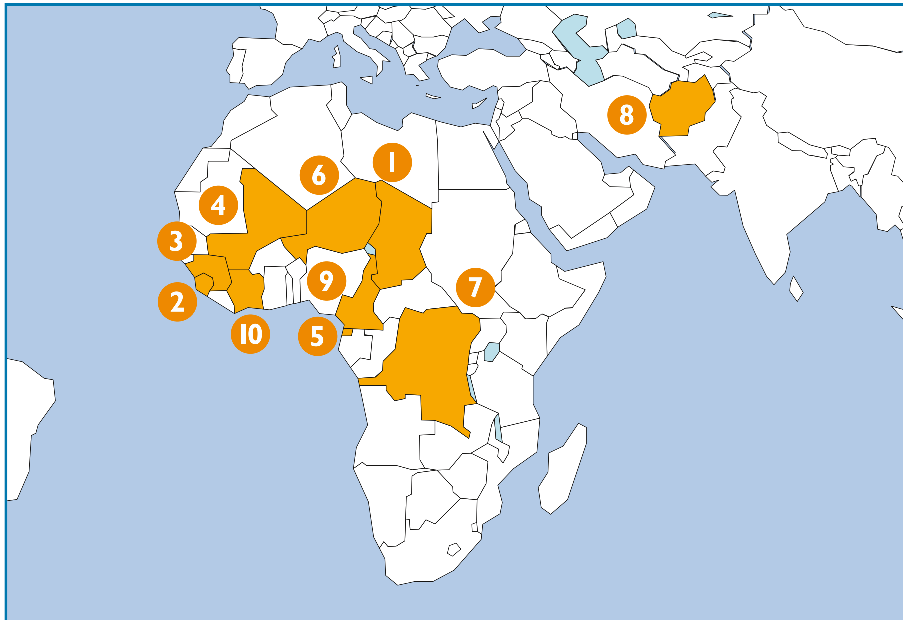
A gap between those who are 'health rich' and those who are 'health poor' exists both between countries, and within countries. Those who are health rich have the most access to health education, awareness, prevention and treatment at limited financial cost to themselves. Those who are health poor have either no access, or prohibitively expensive, geographically challenging access to health education, awareness, prevention and treatment. The relative size of the gap between countries or within a country represents the inequity the people face in accessing health.

THE GLOBAL HEALTH GAP INDEX – THE TOP 10



1. FRANCE
2. DENMARK
3. NORWAY
4. LUXEMBOURG
5. FINLAND
6. GERMANY
7. SWEDEN
8. SLOVENIA
9. CUBA
10. SWITZERLAND

THE GLOBAL HEALTH GAP INDEX – THE BOTTOM 10



1. CHAD
2. SIERRA LEONE
3. GUINEA
4. MALI
5. EQUATORIAL GUINEA
6. NIGER
7. DEMOCRATIC REPUBLIC OF CONGO
8. AFGHANISTAN
9. CAMEROON
10. COTE D'IVOIRE

EXPOSING THE GAPS

Each of the 176 countries in World Vision's new Global Health Gap Index is ranked according to the size of the gap between its health rich and its health poor. The ten countries with the lowest scores – France, Denmark, Norway, Luxembourg, Finland, Germany, Sweden, Slovenia, Cuba and Switzerland – have the smallest health gaps, while the ten countries with the highest scores – Chad, Sierra Leone, Guinea, Mali, Equatorial Guinea, Niger, the Democratic Republic of Congo, Afghanistan, Cameroon and Cote d'Ivoire – have the greatest gaps.

The Index shows that a health gap exists in all countries, developed and developing, rich and poor, which is not unexpected (though the size of some gaps is surprising). But the Index finds that the greatest gaps persist in the most poor and fragile contexts and countries, where marginalised families are often most affected, have the least capacity to cope, and where governments are less willing or able to provide for those most in need. Seven out of 10 countries with the greatest health gaps are among the poorest countries in the world.

But three of the countries with the greatest health gaps are not the poorest, proving that a country's wealth does not guarantee that all its people will benefit from access to good health care and have the chance to enjoy good health. The USA – one of the wealthiest nations in the world – comes in at number 46 out of 176, while Cuba, a far less wealthy country, sits at number nine on the Global Health Gap Index. And Equatorial Guinea, a high-income country, fares in the bottom five countries for health gaps.

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Child mortality has fallen by more than a third since 1990, but progress is still too slow to reach the target of two-thirds by 2015

© World Vision/Zeeshan Alvi

WHAT'S DRIVING THE GLOBAL HEALTH GAP?

Income levels go a long way to explaining the gaps in both low and high-income countries. From 2006 to 2011, income inequality increased within most countries around the world. Income poverty often means sub-standard living conditions, poor diets, exposure to the most illnesses and the least opportunity and education to overcome any of these. In higher-income countries the gap is most obvious in life expectancy. For example, in the Scottish neighbourhood of Calton, Glasgow, life expectancy at birth for men is 54 years, which is 28 years lower than that of men in Lenzie, a neighbourhood just a few kilometres away. In low-income countries, the effects are the same, just on a different scale.

But, as World Vision's Global Health Gap Index highlights, a country's overall material wealth alone does not guarantee good health chances for all of its people.

Only eight countries have achieved Millennium Development Goal number four – "reduce child deaths by two-thirds by 2015". Bangladesh is one of these, yet sits at number 128 on the Global Health Gap Index, highlighting how critical it is to ensure that progress is felt in all parts of society, even the most marginalised communities.

Preterm complications **kill one million** children each year

More than 40 per cent of child deaths happen in the first month of life.

CAUSES OF THE GAP ACROSS ALL TYPES OF COUNTRIES INCLUDE:

- The conditions in which people are born, grow, live, work and age.
- Lack of equal investment in the early years of life, which is the period that holds the greatest potential for life-long good health.
- Policies and practices that have prioritised urban growth, leaving rural communities to suffer from chronic underinvestment in infrastructure and amenities.
- Unequal employment and working conditions.
- Lack of social security: globally, four out of five people lack the back-up of basic social security coverage. Generous social protection systems contribute to better health, including lower mortality.
- High out-of-pocket health care spending.
- Lack of investment in national health workforces: there is little balance between rural and urban health worker density within countries.
- Gender disparities; the position of women in society is associated with child health and survival.

There are a number of factors beyond income that separate the most vulnerable children from the least. In all countries, they include discrimination, disability, race and socio-economic norms. In poorer countries, they include mothers and children remaining hidden because of a lack of adequate data and counting systems. They include facilities being too far away or inaccessible for people to reach them in time for vital treatment to be given. At times, they include a lack of the right amount and type of funding, meaning that money earmarked for health sits at a national level and doesn't reach the areas where it's needed most.

All of these factors are preventable or treatable, which is what makes the massive health gaps all the more disturbing. Cracks in the system prevent the delivery of vital health services to those in greatest need. Most significantly – as the Global Health Gap Index process discovered – no data often means no recognition of the problem. There are big holes in the type of health information collected by all countries, making it difficult to analyse in great detail who suffers as a result of health gaps. The Index reveals which countries that have the greatest health gaps, but who is most affected is not always obvious. Many countries still do not monitor the groups who most suffer from the effects of the global health gap – such as children not registered at birth, children living with disabilities, orphaned children, children of ethnic minorities, stateless children, and mothers giving birth without the help of skilled birth attendants. Collecting more in-depth information, revealing where children and families live, what they're suffering – and dying – from, is crucial in order to reach them.

Governments need to prioritise meeting the needs of all their people, including the most poor and vulnerable, by developing strong nationwide health systems that those most in need can access.

Newborns have the highest **risk of death** among all **children**

“The deprivations faced by children and adolescents with disabilities are violations of their rights.”

ANTHONY LAKE, UNICEF

GLOBAL INDEX TOTAL RANKING

TOP 10

COUNTRY	Inequality-adjusted HDI	Out-of-pocket expenditure	Adolescent fertility	Health personnel	Total score	RANK
France	9	7	14	16	46	1
Denmark	11	20	11	6	48	2
Norway	5	21	20	7	53	3
Luxembourg	4	13	23	24	64	4
Finland	6	45	21	2	74	5
Germany	7	16	17	35	75	6
Sweden	3	33	11	33	80	7
Slovenia	8	19	8	49	84	8
Cuba	18	4	61	11	94	9
Switzerland	8	62	6	20	96	10

TOP 20

COUNTRY	Inequality-adjusted HDI	Out-of-pocket expenditure	Adolescent fertility	Health personnel	Total score	RANK
Czech Republic	6	28	25	44	103	11
Iceland	2	40	36	25	103	11
Belgium	11	46	35	14	106	12
Austria	9	30	31	42	112	13
Ireland	10	29	47	27	113	14
Belarus	31	50	24	13	118	15
Canada	15	25	34	44	118	15
Tonga	58	18	24	21	121	16
Japan	4	32	8	83	127	17
Oman	29	14	6	80	129	18
Netherlands	10	5	8	108	131	19
Australia	12	41	43	40	136	20

TOP 50

COUNTRY	Inequality-adjusted HDI	Out-of-pocket expenditure	Adolescent fertility	Health personnel	Total score	RANK
Croatia	19	27	33	67	146	21
Libya	38	76	1	31	146	21
Samoa	55	9	32	51	147	22
Spain	8	49	29	61	147	22
United Kingdom	13	11	76	47	147	22
Micronesia (Federated States of)	80	10	28	30	148	23
New Zealand	17	12	80	39	148	23
Estonia	22	39	62	28	151	24
Romania	37	44	40	36	157	25
Kuwait	26	38	12	82	158	26
Qatar	29	31	42	56	158	26
Israel	6	51	34	68	159	27
Maldives	30	72	10	48	160	28
Montenegro	27	77	19	38	161	29
Uruguay	35	21	77	29	162	30
Bahrain	23	36	15	89	163	31
Italy	6	48	12	98	164	32
Korea (Republic of)	10	82	2	73	167	33
Suriname	66	13	51	43	173	34
Lithuania	29	68	54	23	174	35
Bosnia and Herze-govina	37	80	18	42	177	36
Brunei Darussalam	21	26	66	66	179	37
Cyprus	8	121	12	40	181	38
Russian Federation	44	86	36	15	181	38
Portugal	14	64	44	61	183	39
Solomon Islands	85	1	45	53	184	40
Poland	21	56	37	72	186	41
Hungary	20	66	43	58	187	42
Ukraine	43	102	38	4	187	42
Serbia	33	87	24	45	189	43
Malaysia	26	85	13	66	190	44
Jordan	54	61	30	46	191	45
United States	25	15	107	47	194	46
Algeria	63	43	4	86	196	47
Malta	16	83	46	55	200	48
Moldova (Republic of)	46	112	41	3	202	49
Fiji	53	48	59	44	204	50

INCOME GROUPINGS – ACCORDING TO WORLD HEALTH STATISTICS

- HIGH INCOME
- MIDDLE INCOME
- LOW INCOME

GLOBAL INDEX TOTAL RANKING CONTINUED

TOP 100

COUNTRY	Inequality-adjusted HDI	Out-of-pocket expenditure	Adolescent fertility	Health personnel	Total score	RANK
Latvia	28	90	49	37	204	51
Turkey	52	32	52	71	207	52
Vanuatu	69	6	68	64	207	52
Greece	13	87	27	82	209	53
Saudi Arabia	47	47	10	107	211	54
United Arab Emirates	24	34	70	84	212	55
Mongolia	79	99	23	12	213	56
Singapore	1	142	7	66	216	57
Uzbekistan	90	114	12	1	217	58
Albania	46	136	19	17	218	59
Tunisia	50	100	3	65	218	59
Sri Lanka	36	111	26	48	221	60
Kyrgyzstan	82	95	42	5	224	61
Thailand	41	24	56	104	225	62
Kazakhstan	72	101	36	19	228	63
Bulgaria	32	108	58	32	230	64
Bahamas	45	75	39	76	235	65
China	56	86	5	88	235	65
The former Yugoslav Republic of Macedonia	36	92	24	84	236	66
Saint Vincent and the Grenadines	60	39	74	64	237	67
Timor-Leste	102	2	81	52	237	67
South Africa	100	7	73	62	242	68
Botswana	90	3	65	85	243	69
Slovakia	20	63	55	105	243	69
Belize	48	59	98	41	246	70
Armenia	65	130	46	6	247	71
Lebanon	56	131	17	52	256	72
Syrian Arab Republic	40	128	55	33	256	72
Turkmenistan	95	98	21	43	257	73
Papua New Guinea	92	23	42	112	269	74
Brazil	62	78	96	34	270	75
Egypt	59	140	61	10	270	75
Philippines	68	126	68	8	270	75
Mauritius	39	123	46	63	271	76
Namibia	86	8	92	86	272	77
Viet Nam	55	138	30	54	277	78
Panama	49	60	104	69	282	79
Costa Rica	32	72	84	97	285	80
Colombia	57	35	94	100	286	81
Grenada	37	127	57	66	287	82
Tajikistan	97	148	33	9	287	82
Bolivia (Plurinational State of)	91	67	97	33	288	83
Argentina	38	55	119	78	290	84
Zimbabwe	103	69	40	80	292	85
Barbados	34	73	109	79	295	86
Bhutan	89	27	63	117	296	87
Djibouti	116	79	9	93	297	88
Georgia	67	149	60	22	298	89
Iraq	83	42	113	60	298	89
Mexico	45	116	89	49	299	90
Swaziland	113	17	102	67	299	91
Azerbaijan	84	151	43	26	304	92
Haiti	105	58	25	116	304	92
Rwanda	125	57	22	101	305	93
Trinidad and Tobago	73	94	44	94	305	93
Gambia	110	54	50	93	307	94
Morocco	74	145	14	75	308	95
El Salvador	68	84	101	59	312	96
Guyana	87	37	85	103	312	96
Lesotho	112	52	48	106	318	97
Peru	64	89	70	98	321	98
Saint Lucia	42	109	78	93	322	99
Indonesia	75	120	59	72	326	100
Pakistan	106	123	16	81	326	100

INCOME GROUPINGS - ACCORDING TO WORLD HEALTH STATISTICS

- HIGH INCOME
- MIDDLE INCOME
- LOW INCOME

GLOBAL INDEX TOTAL RANKING CONTINUED

REST OF THE WORLD

COUNTRY	Inequality-adjusted HDI	Out-of-pocket expenditure	Adolescent fertility	Health personnel	Total score	RANK
Sao Tome and Principe	101	135	42	50	328	101
Myanmar	93	157	5	78	333	102
Lao People's Democratic Republic	87	104	50	94	335	103
Guatemala	78	125	116	18	337	104
Iran (Islamic Republic of)	71	137	35	96	339	105
Comoros	108	107	34	95	344	106
Paraguay	77	141	88	39	345	107
Ghana	98	71	87	90	346	108
Chile	25	88	120	114	347	109
Mozambique	124	15	94	115	348	110
Mauritania	115	82	53	99	349	111
Nicaragua	59	97	118	78	352	112
Dominican Republic	70	96	117	76	359	113
Madagascar	94	74	86	112	366	114
Burundi	134	105	6	122	367	115
Ecuador	61	124	105	77	367	115
Senegal	104	84	68	113	369	116
Eritrea	94	129	42	106	371	117
Ethiopia	114	91	47	119	371	117
Cape Verde	51	118	100	103	372	118
Congo	117	89	74	96	376	119
Venezuela (Bolivarian Republic of)	48	132	110	87	377	120
Kenya	111	113	64	93	381	121
Liberia	119	53	90	119	381	121
Honduras	76	117	111	78	382	122
Gabon	99	119	109	57	384	123
Cambodia	101	139	54	92	386	124
Nepal	81	134	67	104	386	124
Zambia	127	65	93	102	387	125
Sudan (**former)	109	152	38	91	390	126
Togo	118	113	41	118	390	126
Tanzania (United Republic of)	107	81	83	120	391	127
Bangladesh	88	143	53	109	393	128
Burkina Faso	126	83	79	107	395	129
Yemen	91	156	52	97	396	130
Benin	123	110	72	97	402	131
Guinea-Bissau	139	93	71	105	408	132
Nigeria	131	147	74	59	411	133
Uganda	121	122	95	74	412	134
India	96	144	106	70	416	135
Angola	136	70	108	104	418	136
Central African Republic	135	109	69	118	431	137
Malawi	122	22	75	116	457	138
Côte d'Ivoire	120	150	82	109	461	139
Cameroon	130	147	81	111	469	140
Afghanistan	140	154	74	102	470	141
Congo (Democratic Republic of the)	138	115	114	106	473	142
Niger	128	106	115	124	473	142
Equatorial Guinea	133	103	120	118	474	143
Mali	137	133	112	110	492	144
Guinea	129	146	99	125	499	145
Sierra Leone	132	155	91	123	501	146
Chad	141	153	103	121	518	147

INCOME GROUPINGS - ACCORDING TO WORLD HEALTH STATISTICS

HIGH INCOME

MIDDLE INCOME

LOW INCOME

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FALLING VICTIM TO THE GLOBAL HEALTH GAP

SLIPPING THROUGH THE CRACKS

Children who fall through cracks in the health system face not one but several deprivations all at once, and doing something about this is often impossible because they are uncounted and invisible. Governments especially do not routinely collect information on the most vulnerable groups of children, making it all but impossible to understand and address the poor health that kills them.

A lack of accurate birth and death registrations and collection of other data on specific groups of children mean that it is hard to know about them, what health services they have access to – or what they are dying from. Growing up uncounted or invisible means they slip through the cracks, on local, national and global levels. We don't know who they are, so how can we help them? Understanding how to fix this first requires an understanding of where the cracks are and what they mean for children.

Children who are discriminated against and neglected fall victim to the global health gap, suffering from the poor access to good health that results. Discrimination and neglect can be a result of gender, indigenous groups, HIV status, ethnic and religious minorities, race, class, age, disability and sexual orientation. In many communities, these differences are misunderstood or not understood at all and children falling into these categories are excluded from accessing the health services that can mean the difference between a full and happy life and one of misery, even death, as they remain hidden, uncounted or invisible.

An estimated **370 million** people in some **90 countries** belong to **indigenous** groups

Only eight countries have achieved Millennium Development Goal number four – "reduce child deaths by two-thirds by 2015". Peru is one, yet sits at number 98 on the Global Health Gap Index. This reflects that Peru, while reaching its targets, still faces a large gap between its health rich and health poor.

INDIGENOUS CHILDREN AND ETHNIC MINORITIES

Children born into indigenous families represent a rich diversity of cultures, religions, traditions, languages and histories, yet continue to be among the poorest and most marginalised groups in all countries. Poor nutrition, limited access to care, lack of resources crucial to maintaining health and well-being contribute to them falling victim to the health gap. For example, in Australia, babies of indigenous mothers are twice as likely to be of low birth weight as babies born to non-indigenous mothers. And indigenous Canadians face higher risks of trouble in pregnancy than the wider Canadian population, and stillbirth rates for aboriginal children are about double the Canadian average.

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ISOLATED AND HUNGRY

BY ANNILA HARRIS IN INDIA

Four-year-old Krishna loves his toy cart. Made from a CD and a stick, it's his sole source of entertainment. It is almost as if he is pretending to be a farmer like his father, tilling away with his plough-shaped cart.

Krishna is from the Korku indigenous tribe in India's Melghat region, where the ravines, hills and forests mask deadly rates of malnutrition.

The tribe's isolation means they are cut off from health services and education, resulting in a diet lacking in nutrients, poor feeding practices, large families, and generally neglected maternal and child health.

Krishna's mother Neta Sanj married at the age of 18. Frail and underweight, she gave birth to her first child Kiran, who was also underweight and malnourished. Before long, she had given birth to three more children suffering the same problems.

"The children kept falling sick. Either it was cold, cough, fever or diarrhoea," local health worker Soni says.

Persistent bouts of cold and diarrhoea weakened Krishna's immune system to the point that he started losing his ability to fight back, landing him in hospital.

It was only when a feeding and education programme opened up nearby that the children had access for the first time to high-nutrient ingredients like groundnut and jaggery, soya beans, green gram, boiled eggs and potatoes, milk, gram and green vegetables, chick peas and mung beans. His health started to improve almost immediately, and within a few weeks, he was released from hospital.

"I didn't have these privileges as a child, but I am happy that my children get to enjoy them," says Neta Sanj.

LACK OF BIRTH REGISTRATION

Perhaps the biggest contribution to the global health gap is the number of children who remain unaccounted for, from birth. Only half of all children under five in the developing world have had their births registered. Sometimes it's a national precedent; sometimes there are lower registration levels among different socio-economic, geographic or ethnic groups, even though the nationwide prevalence is high. The great health gap is both a cause and a consequence of this, as lack of awareness and education, and prohibitive costs and access, prevent parents from registering their babies' births. Without birth registration, governments remain unaware of the existence of these children. Without knowledge of their existence, the services that could be provided remain out of reach.

Only half of all children **under five** in the developing world have had their births registered

UNREGISTERED AND INVISIBLE

BY XENIA DAVIS IN MONGOLIA

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In a ger district [tent settlement] on the outskirts of Ulaanbaatar, Mongolia's capital city, nine-year-old Asar is attending a mobile health clinic, which unlike an official health clinic treats all children.

This is important for Asar because he does not have a birth certificate. According to all official records, he does not exist. Although the government must provide medical treatment for all children, in Mongolia unregistered children often go undiagnosed or untreated, as they cannot access the health care they need at official clinics or hospitals.

World Vision mobile clinic doctors diagnose vulnerable and unregistered children, treating them or referring them to local family clinics.

In ger districts, high poverty rates coupled with poor hygiene and lack of food are the cause of numerous health problems. Children are especially vulnerable and suffer from a lack of vaccinations. As many of them are also unregistered, they have no health insurance or way of paying the sometimes very small fees associated with seeking treatment.

Working with local government and family clinics, the mobile clinic doctors diagnose vulnerable, unregistered and unsupervised children and treat or refer them to family clinics. They also inform the local government of the number of unregistered children in the area as a first step to getting them identifications that allow them to attend school.

Dr Batjargal says, as he examines Asar: “The main importance is that we take care of unregistered children.”

Asar has bone cancer and had some of his leg bones removed. “It’s been six months since the mobile clinic started checking up on him,” says Asar’s grandmother. “He’s getting better. If things aren’t clear, they take him to a hospital, do x-rays and other exams and bring him back and tell us exactly what we should do. I wouldn’t get medical service any other way.”

REFUGEES AND DISPLACED CHILDREN

Children who are refugees or displaced within their own countries are harder to account for because of the nature of their living conditions. Refugees often suffer because no one feels responsible for them. They go unidentified and unrecorded, outside the attention of health service providers.

FLEEING FOR SAFETY

BY VIKKI MEAKIN IN LEBANON

Yasmin’s new home is a park bench. The four-year-old started living there shortly after arriving in the Bekaa valley, Lebanon, with her three older brothers and parents when life in Syria got too dangerous. School had stopped because of a nearby bombing, and their neighbour’s house was attacked, so the family fled with just the clothes on their back.

But, life in Lebanon is not easy either. While some refugees have been able to find modest accommodation with friends or erect a makeshift structure on rented land, Yasmin’s family hasn’t been able to find shelter anywhere.

The only toy the four children have to play with is a plastic steering wheel. They left Syria in such a hurry that there was no time to pack.

Her mother Layla, whose disabled husband is unable to work, worries about the children. They are starting to get ill and Layla knows her family is not healthy. Yasmin often sneezes, but Layla struggles to find a tissue to wipe her nose — a startling illustration of how little they have.

Layla tells us the only food they can afford is a bit of bread for the children. As the family is not yet registered as refugees, it’s hard for them to get vouchers for food or see a doctor. The priority is to find somewhere to stay, she says. “No one is worse off than us.”

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45.1 million people were displaced in 2012, the largest number in almost 20 years. Almost half of these are estimated to be children. Many of these children spend their entire childhood away from home.

CHILDREN LIVING WITH DISABILITIES

Children with disabilities are a source of shame in some communities, who will literally hide their children from the public, deny their existence, and deprive them of access to vital health services. In some cases, families hide their disabled children for fear of being judged. This invisibility results in exclusion. Children fall through the net of government data collection and health services, and yet they are among the most in need of care. They are more likely to be poor than other children, and are less likely to attend school or access the local clinic. In developing countries, households with a member or members living with a disability spend considerably more on health care. This means that even a household that technically stands above the poverty line but includes a member or members living with a disability can actually have a standard of living equivalent to that of a household below the poverty line.

Estimates put the number of children living with a moderate or **severe** disability at **93 million** children but the real figure is thought to be **much higher.**

HIDDEN FROM VIEW – AND HELP

BY KLEVISA BRESHANI IN ALBANIA

© World Vision/Klevisa Breshani

The voices of three happy children sing out from the house where 6-year-old Mysli and his two little sisters Elidona and Elda live. Elidona sings while Mysli dances, even though he cannot hear her.

Mysli might have been born deaf or, as his mother Florina says: “When he was only one year old, he had a high temperature and this might have caused his loss of hearing.”

Florina has never taken Mysli to a doctor to find out what caused the deafness, or if there is a chance of fixing it.

“I don’t know for sure how big his problem might be, but I can’t afford the prices of health care or the prices for buying medications if necessary,” she says.

The Dibra community, where Mysli and his family live, has what they call "traditional views" on disability and illness, which force families to hide children with disabilities at home. This does little more than results in further disadvantage. Instead of seeking the right – and sometimes relatively straightforward – treatment for them, the ailments of such children get worse.

Mysli lives with his mother, two sisters and grandmother in a two-room home where food and clothes are scarce. Mysli's father is an alcoholic who cannot earn money or help out around the house. Neither Mysli nor Elda attend kindergarten, because it costs too much and they can't afford it.

As Mysli grows up and his problem becomes more obvious, it will likely prevent him from playing with the other children in the neighbourhood because they stay away from children who appear to be different. "The most precious thing we have is each other's company," said Elidona. "This is what strengthens me."

CHILD LABOURERS AND TRAFFICKED CHILDREN

Children who have been forced into labour or who have been trafficked very often fall outside of the counting process. Child labourers are defined as such if they are under the minimum working age, or are legally allowed to work but do so in a job that poses a threat to their well-being. The worst forms of child labour include any form of slavery, trafficking, forced labour, prostitution, illegal activities and work that is likely to harm the health, safety or morals of children. Children who take part in or are forced to do work that is dirty, dangerous, or demeaning are less likely to attend school, less likely to have access to any form of healthcare, and fall behind in school by an average of two grades or two school years in the long term, which means a salary that is 20 per cent lower during their adult lives.

© World Vision staff

THE CHAINS OF CHILD LABOUR

BY BARDHA QOKAJ IN ALBANIA

Klodi, 10, is a smart boy with a sweet smile and big hopes. "My dream is to be a good doctor and help people with health problems," he says. He may dream about tomorrow, but first Klodi must survive today. Together with his sister, Irena, 9, he walks streets and searches bins in Albania from 9pm until 2am every night, then again from 6am every day, looking for metal to sell.

Their life is a legacy their father has passed down to them and their three siblings. Shpetim has suffered from health problems for most of his 42 years, and with only four years of education, has struggled to find a steady job, meaning his children join him on the streets, to help bring in enough money for food. It's a story repeated by many in their Roma and Egyptian community.

Klodi's family shares a small room with six others. There is no inside toilet, their "living room" contains a few bits of very old donated furniture, and the way of life plays havoc with the children's health. The poor living conditions, inadequate food and exposure to extreme cold and heat during long working hours on the streets means good health is out of reach.

Shpetim notes the children all suffer from pneumonia. "When you see your child sick and cannot afford to go to the hospital, it is the most horrible place you can be as a parent," he says.

An estimated 306 million children around the world are involved in some kind of work; 215 million of these children are classified as child labourers, and 53 million children aged 5–14 are involved in hazardous activities.

ORPHANED CHILDREN

Orphaned children – including those orphaned by HIV, who often suffer additional stigma and rejection – fall between the cracks as they are left to take care of themselves, or have to rely on already-burdened family and community members. Children orphaned by HIV may have the virus themselves and, without treatment, face painful, premature deaths. Orphaned children are not only emotionally affected by the loss of their parents, whose physical deterioration they may often have witnessed, but they are likely to be denied access to vital health services as their needs are either misunderstood or ignored.

TREKKING FOR TREATMENT

BY MAKOPANO SEMAKALE IN LESOTHO

© World Vision/Makopano Semakale

For an entire day, 13-year-old Matseleng travels by foot with her two-year-old sister, Makhotso, strapped to her back. Their destination is the clinic that provides the toddler with the HIV treatment she needs to stay alive.

The girls' father left and their mother died two years ago, leaving Matseleng in charge of Makhotso, and their two other siblings, Moliehi, 10, and Reitumetse, six.

"To care for such a small baby has been very difficult. Sometimes she is crying in the night and I am not sure what the problem is," Matseleng says.

Every month, Matseleng must repeat the trek with her sister to ensure the child has her prescription filled and remains healthy. They need to get to the village a day early, and sleep there, to ensure that the following morning they will see the doctor and have their prescription filled.

"There are times when I worry about what we will eat, but good Samaritans always come to our rescue," Matseleng says.

More than **151 million** children around the world are **orphans;** 18 million of these have lost both their parents. More than 80 per cent live in **Asia and Africa.**

PREGNANCY AND CHILDBIRTH

Lack of knowledge about the number of maternal deaths remains high. No single source identifies all the deaths, and some evidence is anecdotal. Sources include censuses, household surveys, national demographic surveys and reproductive-age mortality studies, but these all have limitations. Censuses, for instance, are only conducted at 10-year intervals, so cannot give an accurate reflection of the picture, and identify only pregnancy-related deaths, not maternal deaths. Deaths due to childbirth are under-reported because the task of attributing female deaths to childbirth is made more complex because the pregnancy status or cause of death may not be clear.

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Despite this, we know pregnancy and childbirth are the biggest killers of mothers in developing countries today. The resulting deaths not only stem from disadvantage, they cause further disadvantage. When a mother dies, the outlook for her baby is usually poor. Undernutrition is more prevalent among motherless infants. Almost half of all deaths of children under the age of five occur within a month of birth, and without the immunity provided through breastfeeding, a baby is much more susceptible to infection and disease.

Most maternal mortality estimates have high levels of misclassification and under-reporting

INFORMATION AND ACCESS CHANGING LIVES

BY ZEESHAN ALVI IN PAKISTAN

Salma doesn't have to look far to find a story about a woman in her community who suffered the effects of giving birth without a skilled birth attendant.

One of her friends delivered her baby at home and though the child was delivered safely, she was severely weakened by the labour, from a lack of nutrition during pregnancy. Safia, a young mother from the next village over had a cousin, Shamim, who died while attempting to give birth at her home.

Despite this, when 18-year-old Salma became pregnant, she wanted to give birth at home with the support of an unskilled traditional birth attendant instead of going to a health facility. She felt safer doing so, surrounded by family, health facilities are not available near to where she lives, and the family's financial situation meant even if she could get to a health centre, they couldn't afford the cost of using it.

But the stories of women who have suffered, and lost babies, haunted Salma. With information from local health workers, she began to understand the difference between her experience and that of her friend's. She learned that it was possible to give birth with the help of a skilled birth attendant, for no extra cost, at a nearby health facility.

"It saved me in terms of my health and my baby's, after the delivery. Now, when I look at my son's face my heart is filled with overwhelming gratitude to those too who helped me in making this decision."

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CLOSING THE GAPS, WITH INFORMATION

A great deal of progress has been made since the MDGs were agreed to and accepted by world leaders in 2000, but the greatest improvements have been made among communities that are the easiest to reach and educate about health services, while millions of children and families continue to suffer and die in remote, harder-to-reach locations. The global health gap is unethical, unfair and, above all, lethal. Time is running out – not just to achieve the deadline for the MDGs in 2015. It's running out for the millions of children and mothers who will continue to suffer or die needlessly as they slip through cracks in the delivery of life-saving health services.

A 'gold standard' for data collection holds the key, and needs to be established and implemented as a priority. Every nation should focus on the same indicators for data collection, to include income, disability, education, geography and ethnicity. Measures need to be put in place to ensure that even remote, hard-to-reach places and people who lack awareness and access are counted, accounted for and involved.

The easiest option has been the one chosen most often. Every case is important but it is the more complex and challenging communities that are suffering the most. Governments and policy makers need to ensure that discrimination and difficult terrain don't stop them from saving the lives of children in their own countries.

Children whose **mothers die** are ten times more **likely to die** before their **fifth birthday.**

HOW TO CLOSE THE GAP

- Ensure that greater attention at the highest political level is given to closing the health gap for women and children.
  - With just over 800 days left until the MDG deadline, there is still a chance to close the health gap. Action is needed be at the highest level of government, and should involve good coordination across all government ministries and departments.
  - Greater efforts must be made to seek out the families and communities currently being left behind in child and maternal health and to target resources where they can have the most impact.
- Address the problem of missing data for vulnerable groups by establishing routine data collection systems locally, nationally and internationally to measure the health gap.
  - Look beneath national averages and try to understand the disadvantages that different sections of society, both rich and poor, continue to face.
  - A minimum surveillance system for health equity should be nationally representative, but also include information disaggregated by, for example, gender, education, income, ethnicity, disabilities, geography, and the health of indigenous groups.
  - Registering children at birth for free is an important element of a good health information system.
  - A monitoring system should be coordinated nationally and data should be made publicly available and accessible.
- Engage and empower families and communities in data collection and in the planning, delivery and review of health services.
  - Community-based monitoring of health outcomes and health services can ensure authentic and reliable data, as well as serve to engage and empower communities to become active participants in their own health.
  - Families and communities should feel empowered to raise their voices about their right to quality health care and to hold health service providers and governments to account for their ability to provide such services.
- Prioritise child and maternal health in the post-2015 development agenda, through the inclusion of ambitious goals to end preventable child and maternal deaths and significantly reduce stunting
  - To complete the unfinished business of the MDGs and close the health gap, a high-level goal to end preventable maternal, newborn and child deaths is vital.
  - Nutrition was largely overlooked in the current MDGs and it requires much greater focus and attention in the post-2015 development framework.

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World Vision

World Vision is a Christian relief, development and advocacy organisation dedicated to working with children, families and communities worldwide to reach their full potential by tackling the causes of poverty and injustice. 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.

Child Health Now is World Vision's five-year global campaign, active in nearly 50 countries, aiming to accelerate action to end the preventable deaths of children under five.

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