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EDITORIAL

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Supporting those responsible for the health care for children in the developing world: CHILD2015

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Child deaths: the scale of the problem

> '28,000 children under age 5 die every day from easily preventable or treatable causes . . . basic, lifesaving remedies still are not reaching millions of mothers and children in need' (Save the Children 2007).

The numbers are familiar but need repeating, again and again. Eleven million child deaths every year, of which four million are deaths of newborn babies occurring in the neonatal period and 98% are among the poor and disadvantaged in developing countries. Two-thirds could and should have been avoided by simple, inexpensive healthcare interventions.

- Half a million deaths every year in young women related to pregnancy and childbirth.
- One in six African women die of pregnancy related complications. Three-quarters of these maternal deaths could and should have been avoided by simple, inexpensive healthcare interventions.

What is not well understood is why it continues to happen and how we can ensure that these children actually get these life-saving interventions. What is perhaps clearer is that these maternal and child deaths, as Senanayake (1995) clearly emphasises:

> 'represent merely the endpoint of the 'road to death' – a combination of factors that include high-risk pregnancy, socioeconomic disadvantage and inadequate health care.'

So why is health care so inadequate to meet the challenges?

It's not possible to lay the blame on any one factor and it is often a complex mix of different factors that result in children not receiving appropriate health care at the appropriate time. Olumole et al. (2000) note that 'up to 80% of childhood deaths in Africa occur at home, before the child reaches a health facility.' Sadly, much of the cause of failure to take a child to health care services is due to lack of trust. Faith in traditional healing practices may result in parents delaying bringing their child for medical treatment until their disease is well advanced and their chance of recovery severely limited. Lack of knowledge about treatable illnesses such as pneumonia and diarrhoea kills many children every year.

Lawn et al (2007) argue that more than two thirds of children in Africa and South Asia do not receive the correct home management for diarrhoea. Some parents, through no fault of their own are unwittingly contributing to their children's death. Four in ten mothers in Maharashtra state, India, believed they should *withhold* fluids if their baby develops diarrhoea (Wadhwani 2005).

Eighty percent of caregivers in the developing world do not recognise that fast and difficult breathing – the two key symptoms of pneumonia – indicate that their child should be treated immediately. Only half of children with pneumonia receive appropriate care and less than 20% receive antibiotics. Children are dying for lack of knowledge.

Three-quarters of doctors responsible for managing sick children in district hospitals had inadequate basic knowledge of hypoglycaemia, sepsis, severe malnutrition and pneumonia.

What are the needs of healthcare providers?

A key reason for health being inadequate, I believe, is that governments, the 'international community' and those in positions of influence are failing to listen to, understand and meet the basic needs of healthcare providers.

It is impossible for any human being, however dedicated, to provide effective healthcare without knowledge, without information, without mentor support, without a decent regular salary, without a telephone, without essential medicines, without basic equipment, without protection against occupational infection (no gloves, no appropriate disposal of sharps, no secondary prophylaxis for needlestick injuries) with HIV and other blood-borne diseases . . . The list feels endless. Solving the problems seems to be nigh on impossible. However, solutions are available and change can occur; information and knowledge are core to making these changes.

HIFA2015 and CHILD2015 – part of the solution?

Meeting the information and learning needs of healthcare providers is an area where health professionals, publishers, librarians, trainers, development professionals and others are working tirelessly. However, most healthcare providers in the developing world continue to work without basic learning and reference materials. There is of course no single 'magic bullet' that will solve this problem. However what is recognised is the need to work more effectively, independently and collectively so that a range of cost-effective solutions can be identified, developed and promoted.

To address these complex issues, a growing community of concerned people are joining hands worldwide towards a common goal: Healthcare Information For All by 2015 (HIFA2015). Over 800 professionals in 93 countries worldwide are working to meet the information and learning needs of healthcare providers in developing countries. We communicate via two email discussion groups, HIFA2015 and CHILD2015. CHILD2015, as the name suggests, focuses on improving the quality of child health care in developing countries. Our goal is 'by 2015, every child worldwide will have access to an informed healthcare provider'. This is an ambitious goal, but one that can be achieved if we can harness the experience and expertise of all those who are committed to resolve the problem.

CHILD2015 work is a campaigning, networking and learning programme. We are not aiming to be another 'health information delivery' project. Rather, we are engaging all those involved in the creation, exchange and use of healthcare information to harness expertise and experience in *how* to understand and address information needs. The discussion groups provide information exchange, prevent wheels being reinvented and can provide strategic direction. In a recent discussion focusing on the effectiveness of training workshops, ten 'key questions' were developed that CHILD2015 members recommend should be asked before developing or assessing education/training interventions (CHILD2015, 2007):

1 Is it based on a detailed and comprehensive local training needs assessment?
2 Will it address the identified training needs over a sufficient period of time (sustainability)?
3 Is it embedded in a larger staff and service development programme and will be valued by the trainees (recognition / accreditation of training)?
4 Is it sensitive to institutional barriers to change and targeted to staff who have the resources and institutional support required to change practice?
5 Does it have clearly defined, measurable outcomes?
6 Will it result in technologically sound, evidence-based interventions that are locally appropriate (e.g. culturally tolerable)?
7 Has it a feedback loop to inform future training?

8 Is it supported by a careful, informed analysis of all of the costs?

9 Is it the most appropriate use of the available funds and human resources?

10 Will it empower participants to share their new knowledge/skills with others (e.g. in their own institutions, with their patients)?

These ten questions have the potential to shape future decision making, ensure that scarce resources are spent in the most appropriately and importantly ensure that training/education is sensitive to local need.

If not already a member, I would like to invite you to join us meeting the urgent information and learning needs of health care providers. By adding your expertise and experience to our discussions, you can contribute to bridging the information gap in health care. To join, send an email to child2015-admin@dgroups.org with your name, affiliation and brief description of your professional interests.

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