

Human rights, community-based health care and child survival

by Paul Farmer and Jim Yong Kim

With 20 years of experience in rural Haiti introducing modern medical care to millions who had not previously enjoyed it, we now know many of the requirements for a successful health-care programme in areas devastated by disease and poverty. To provide primary care alongside specialized treatment for infectious disease, while promoting women's and children's health, community health-care workers must be trained and mobilized to prevent illness and to deliver quality health care. With recent expansion to Lesotho, Malawi and Rwanda, we now see that many of the lessons learned in Haiti are universal in improving the health of children and adults worldwide.

In each of the settings in which Partners In Health works, our goal is to 'do whatever it takes' to improve the health and well-being of those we serve, almost all of whom live in poverty. In each setting, we have learned that health problems do not occur in isolation from other basic needs, such as adequate nutrition, clean water, sanitation, housing and primary education. We have also learned that non-governmental organizations cannot work in isolation but must collaborate with members of the communities served and with local health authorities to strengthen public health so that future generations may come to regard these services as rights rather than privileges.

This rights-based, community-based approach to promoting health leads to a clear vision regarding the health of children

In Haiti, Lesotho, Malawi and Rwanda, Partners In Health – in collaboration with local communities and a wide range of partner organizations, including the Clinton Foundation, ministries of health, UNICEF and the François-Xavier Bagnoud Center for Health and Human Rights – has

identified five key components for a comprehensive, community-based child survival programme.

First, we work with public health authorities to roll out the interventions shown to be crucial to improved child survival. These include expanded vaccination campaigns; vitamin A distribution; the use of oral rehydration salts to treat diarrhoeal disease and safe-water programmes to prevent it; an aggressive programme for prevention of mother-to-child transmission of HIV; malaria prevention with mosquito nets, backed by improved community-based and clinical care; nutritional assistance for children suffering from or at risk of malnutrition; and the provision of high-quality in-patient and ambulatory paediatric services for those children who do fall ill. Currently, we are working with the Government of Rwanda and other partners to show how an integrated package of key child survival interventions, including prevention of mother-to-child transmission of HIV, can be rapidly deployed under the Government's strengthened rural-health-care model. With support from the international Joint Learning Initiative on Children and HIV/AIDS, a cross-sectoral, interdisciplinary exercise in collaboration between leading practitioners, policymakers and scholars, practitioners scaling up child survival interventions in rural districts are sharing innovations and results through a collaborative network that will enable them to improve service quality, even as they reach greater numbers of children and families in previously underserved areas.

Second, since the health and well-being of mothers are key determinants of child survival, our efforts promote integrated maternal and child health. Our work on behalf of children is linked to efforts on behalf of their mothers and other family members through family planning programmes, prenatal care and modern obstetrics as part of women's health programmes, efforts to promote adult literacy and poverty alleviation in general.

Third, we initiate and/or strengthen paediatric AIDS prevention and control programmes. As part of an upcoming campaign, and in the manner outlined above, we are launching a major paediatric AIDS initiative in Rwanda in concert with the Clinton Foundation and Rwandan health officials and providers. This initiative will establish a national centre of excellence for paediatric AIDS care. Quality paediatric services will be linked to community-based care for children with HIV and also to prevention efforts within primary and secondary schools in rural Rwanda.

Fourth, we need to launch operational research and training programmes designed to improve the quality of care afforded to rural children. Such research will examine the programmatic features of successful efforts to prevent HIV transmission from mother to child; the diagnosis and management of HIV among infants; paediatric tuberculosis diagnosis and care; the role of community health workers in improving care for chronic paediatric conditions, including AIDS and tuberculosis, and in preventing, diagnosing and providing home-based treatment for such common ailments as malaria and diarrhoea; and assessing the impact of social interventions, including those designed to curb food insecurity and illiteracy, on the health and well-being of children worldwide.

Fifth, we work to advance these efforts in tandem with those designed to promote the basic rights, in particular, the social and economic rights, of the child. The Partners In Health Program on Social and Economic Rights (POSER) disseminates, through tangible projects and through advocacy, a rights-based model of poverty alleviation, using access to health care as a means of meeting and working with the poorest children and families in the communities we serve. POSER backs education, agriculture, housing and water projects to guarantee basic social and economic rights for every child and every family. If we know that hunger and malnutrition are the

underlying cause of millions of child deaths each year – and we do – then we must face up to the challenge of prescribing food as an essential medicine for immunization and paediatric care. Similarly, if studies show that education reduces the risk of infection with HIV – as they do – then we must be prepared to invest in access to schooling as a potent and cost-effective element in our formulary for combating HIV and other diseases of poverty.

We now know that without a community-based, comprehensive strategy, efforts to treat children – and subsequently mothers, fathers and siblings – fail to provide the desired outcomes. Working in conjunction with ministries of health, international institutions and other non-profit organizations, we are committed to stemming the tide of childhood death and disease in the areas we serve. From experience in Haiti and now around the world, we know that community-based services to improve health and reduce poverty, linked, when necessary, to excellent clinical resources, offer the highest standard of care in the world today and the key to improving child survival.

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