Chapter 1  Towards a World Fit for Children  ..................  2
Chapter 2  Voices of Children .................................  5
Chapter 3  A Shared Agenda for Children ..................  6
  - Health Promotion, Protection and Preservation.
Chapter 4  Care for Every Child ..............................  32
  - A Multi Faith Perspective
Chapter 5  Millennium Development Goals ................  39
  - Setting a Global Platform for Human Development
Chapter 6  Children’s Status at a Glance ..................  43
“Contact” is a periodical publication of the WCC Health and Healing Programme. It is published in English, French, Spanish and Portuguese and occasionally other languages.

Contact deals with varied aspects of the community’s involvement in health and seeks to report thematic, innovative and pioneering approaches to the promotion of health and integrated development at the local, national and global levels.

The theme of this special issue of Contact is ‘CHILDREN : A Shared Agenda for Human Development.’ Shanti Ashram, Coimbatore served as the guest editors for this issue.
Dear Friends,

Welcoming the New Year has been a most sobering, at times challenging experience. The devastating weeks of the tsunami was a grim reminder of how disasters can so drastically change landscapes, making survival the first priority, and the return to living with dignity and gainful livelihood but a distant dream. However, while coming to terms with the enormity of this disaster, we have also witnessed, all of us, the overwhelming generosity of so many people reaching out.

As I listened often to the news updates, I heard again and again, tale after tale, about the sheer destruction and terrible loss of lives. But there was one moment that really gave me pause... when an old lady from a village in the Nagappattinam district of Tamilnadu, India said, “Our children have all disappeared – we are orphaned. We only have a few children left amongst us ... Where will we find hope now?” This was a telling moment for me... For through her words I understood not only the immediate plight of those children but also the larger framework in which we view and value children at large.

Two billion children are part of our global family and their young minds house enormous human potential. This is why we collectively deem them worthy of special protection and care. The reality however does not speak convincingly of how our commitments have translated into purposeful action for children. Poverty violates the lives of over a billion children. And yet, child poverty is rarely differentiated and the many dimensions of poverty - disease, morbidity, hunger, lack of access to education, shelter, illiteracy, and the resulting powerlessness – are neither fully addressed nor acted upon. Poverty deprives them of the capabilities needed to survive, develop and thrive. It makes children more vulnerable as a community.

“Children provide a sensitive viewing of how our families, communities and governments are functioning. In their care we create for ourselves an extraordinary opportunity to reverse the cumulative effects of poverty, governance—they challenge us, inform us”, said Carol Bellamy the UNICEF Executive Director at the Children’s Summit. Children are honest reflections of societal functioning. ‘Contact’, as a health journal has dealt in the past with varied aspects of the community’s involvement in health. It seeks to report thematic, innovative and participatory approaches to the promotion of health and integrated development. The vast membership of the World Council of Churches and its many partners have benefited by the thematic discussions that ‘Contact’ has initiated in the areas of health and healing.

The theme for this special issue is: ‘Children’ - A Shared Agenda for Human Development. Devoting a special issue of ‘Contact’ to children is part of this global effort to make our communities more attentive both to the challenges our children face and to the unique opportunity we have to help change the environments in which our children grow & learn.

This issue covers the following areas:

- Introduction to internationally accepted UN Conventions on the Rights of the Child and initiatives for a ‘World Fit for children’
- ‘Voices of children’
- Innovative experiences in child health from around the world. These experiential pieces cover preventive, promotive and curative aspects of Child health
- Faith-based perspectives on children
- Discussion on the human development platform MDGs provide
- Children’s Status

While working on this issue my editorial team & I were privileged to read and hear from our authors, first - hand the achievements, challenges and the continuing needs in the area of Child health. Their voices matter as they are pioneers in their particular areas of expertise. The Voices of Children have been heard and responded to by our collaboration. The ethical perspectives presented by the distinguished leaders of six world religions reaffirm the values our religious traditions provide us in working with and for children.

To my colleagues at Shanti Ashram a very special word of thanks for sharing a common commitment to children. Our faith in our collective abilities has only been strengthened by being part of this creative initiative. We hope you find this issue which has contributions from over 15 countries useful and informative.

When the first discussions for this issue was initiated in the office of Dr. Manoj Kurian, the Programme Executive of the Health & Healing section of the World Council of Churches - I was excited at this opportunity for collective thinking and sharing; I thank Manoj and his team for their advice and cooperation. To Appa and Ma, a grateful thank - you for making me see how empowering it is to be part of the solution and not of the problem. To Ashok for his constant support and meaningful presence. As I complete my work as the guest editor for this issue, I stand humbled by the willing and thought provoking contributions of all the authors, the editorial team particularly SRS Anna and Luis, the wonderful effort of the design team led by Satish and our printers Ace data.

I stand even more convinced that ....

All children have the same right to develop their potential
All children, in all situations, all of the time, everywhere!!!

Building a ‘World fit for Children’ is both a vision and a call for action to all of us engaged directly or indirectly in Child Development

Manoj Kurian
General Editor
Contact

Kezevino Aram
Editor
Special Issue No : 179 - Jan 2005
Towards a World Fit for Children

“We want a world fit for children, because a world fit for us is a world fit for everyone.”

- Children’s Forum Report, May 02

Unicef in its Priorities for Children 2003-2005 states, that, ‘Gains for children in girl’s education, integrated early childhood development, immunization plus, HIV/AIDS and protection will contribute significantly to the full realization of Children’s rights. And that progress in each will contribute to progress in others, creating a dynamic for breaking cycles of poverty, violence, discrimination and impaired human development’ I remember walking down the corridors of my medical school with 5 year old Divya...She was there to get her Mantoux test done. She suddenly stopped, turned around and asked me; “Is this the big school I will go to one day” I took a few seconds and answered why not? Her simple question has profound implications for all of us who are working for children. For her questions reflects children’s hopes for opportunities to expand and break those vicious cycles impairing their growth and development.

Building on nearly 6 decades of work Unicef has accumulated experience in child development, through its programmes, partnerships, alliances, advocacy work and internal operations. Its global network has been richly complemented by Volunteers, Religious and Faith based institutions, Community based organizations, NGO’s, Local authorities, private sectors and Governments. The voices and leadership of children themselves are increasingly heard and seen in our work for them.

In this chapter, Shri. Kul Gautam presents the framework of Unicef’s work for Children. He also highlights the Convention on the Rights of the Child, the need for the best interests of the child to be a primary consideration in all actions and decisions and the vision of ‘A World Fit For Children.’ Children’s health and welfare hold the key to sustainable human development. It is an eloquent reminder that we will be judged by our contributions in building a world where every child enjoys a caring and nurturing environment. And as Mahatma Gandhi so often said, ‘that every child will learn from example that Rights and Responsibilities go together’.
Towards a World Fit for Children

Shri. Kul Gautam
Deputy Executive Director, UNICEF

At any given time around the world, there are approximately 2 billion children walking and living among us. Two billion young bodies and young minds that house enormous human potential and whom we collectively deem worthy of special protection and care. It is therefore not surprising that the Convention on the Rights of the Child (CRC) is the most widely ratified human rights treaty in history. Ratification commits countries to a code of binding obligations towards their children.

The CRC puts child rights at the cutting edge of the global struggle for human rights, to be ensured by adult society as a matter of legal obligation, moral imperative and development priority. In the years since the CRC was adopted, the world has seen concrete results for children.

The CRC sets forth a wide range of provisions that encompass civil rights and freedom, family environment, basic health and welfare, education, leisure and cultural activities and special protection measures. The implementation of these provisions is guided by several key principles: non-discrimination; best interests of the child; right to life, survival and development; and respecting the views of the child. Non-discrimination means that all children have the same right to develop their potential, all children, in all situations, all the time, everywhere.

The best interests of the child must be a primary consideration in all actions and decisions concerning her or him. This principle must be used to assess laws, practices, budgets and policies relating to children and may also be used to prioritize among different rights when needed. The right to life, survival and development underscores the vital importance of ensuring access to quality basic services and to equal opportunities for children to achieve their full development.

The views of the child must be heard and respected in all matters concerning their rights. This means promoting children’s active, free and meaningful participation in decision-making that affects them, with the weight of their views being judged on the basis of their age and maturity and their access to relevant adopted information. Just weeks after the CRC entered into force, the largest group of world leaders convened to discuss their responsibilities to children at the World Summit for Children in September 1990. They promised to give every child a better future by giving children the “first call” on all resources. They set specific goals relating to children’s survival, health, nutrition, education and protection, which represented the clearest and most practical expression of the CRC.

When world leaders met again at the UN General Assembly Special Session on Children in May 2002, they pledged to accelerate progress on child development to meet the promises of the World Summit for Children. A new international compact - ‘A World Fit For Children’ - was born and embraced unanimously. The vision of ‘A World Fit For Children’ complemented the Millennium Development Goals (MDG’s), which were

What is unique about Childhood

A phenomenon unique to the pediatric age group is growth and development. The term growth refers to increase in the physical size of the body, and development to increase in skills and function. Growth and development are considered together because the child grows and develops as a whole. Growth and development include not only physical aspect, but also intellectual, emotional, and social aspects.

Normal growth and development take place only if there is optimal nutrition, freedom from recurrent episodes of infections and freedom from adverse genetic and environmental influences. Maternal Child Health (MCH) care is concerned with the process of growth and development, which is the foundation of human life. It is the nature of this process of physical and psychological growth and development of the child which is crucial for health or ill-health, for life or death.

Determinants of Growth and Development

The determinants of growth and development at the level of the individual child are vast. This list includes some of the more important factors influencing it. Briefly these are Genetic inheritance, Nutrition, Age, Sex, Physical surroundings, Psychological factors, Infections and parasites, Economic factors and Other factors.

The societal factors influencing the quality of life in children is discussed in subsequent chapters.
just 20 months earlier at the UN Millennium Summit. These goals have a strong focus on children and the realization of their rights.

The vision of ‘A World Fit For Children’ is a world where all children get the best possible start in life; where they all have access to free, quality basic education; a world in which we have confidence that our children would not die of measles, malaria or malnutrition; it is where children are free from the terrors of war and where all youngsters have ample opportunities to grow to their full human potential. A child friendly world is also one where the human rights of children are respected, democracy flourishes and poverty is not an insurmountable barrier to human progress.

Yet, this powerful vision of children’s rights set forth in the Convention and reinforced in ‘A World Fit For Children’ strikes a stark contrast with the actual childhood of most of the world’s children today. It will require the exercise of leadership, from the pinnacles of government to civil society at every level - from non-governmental organizations, business and private enterprises, to religious groups and academia, community, media, grassroots organizations, families and children themselves, to create a world truly fit for children. It will also require monitoring and reporting of the violations of children’s rights. Children’s health and welfare hold the key to sustainable human development.

The readers of “Contact” are trusted health professionals who are looked to for guidance by parents, governments, faith-based organizations and children themselves.

You know that an immunized child who is beaten or abused is not a healthy child.

You know that a healthy child who never goes to school will not stay healthy for long.

You know that intelligent children who are marginalized because of prejudice will never reach their potential.

You can make a difference by speaking out loud and clear, not only about the symptoms but also about the causes of these avoidable deaths and lost human and economic potential.

It is an effort in which we need you, as a community of practitioners, to raise your voices in influencing policies and resource allocation and ensuring that the rights of all children are fulfilled.

We, at UNICEF are extremely pleased that “Contact” has decided to dedicate this special issue on children. I hope that the following articles will inspire you, just as UNICEF’s work has inspired me, to be an advocate for children’s rights. Together, let us work toward the MDGs, to make the vision of ‘A World Fit for Children’ a reality for every child.
As a child I could affirm that we as children must respect each other; we must take into account other human beings. I see that nowadays between religions there is no respect for each other and they make wars, and they complain of things that happened in the past. We the children must not do things like that; we must see the present and desire to be better in the future. We hope in a future with a more developed world, that’s why we are working now.

Shalom, Peace for all the world

Ariel, Argentina

“I want to live. I want to warn other young people that they can contract HIV/AIDS through unsafe sexual practice, through receiving contaminated blood products – if they are infected and not careful they can also pass it on to their children. This must not happen. I want to warn young people about what they can do to avoid the spread of this disease.”

- Marta Naive
Uganda
Health is one of those terms which most people find it difficult to define although being confident of its meaning at a personal level. Health as we all know, in the broad sense of the word does not mean merely the absence of disease or even provision of diagnostic, curative and preventive services. It also includes as articulated by WHO a state of physical, mental and social well-being. While speaking of child health, the concept of well-being comes into play even more – one that has both objective and subjective components.

A full understanding of child health requires the understanding of the ecology of health. The right to health is one of the most important human rights for every child born. The responsibility of ensuring this right lies with parents, communities and governments – indeed it lies with everyone who can influence the strengthening of knowledge, attitude and practice for better child health. I recall the following message I read nearly a decade ago while entering the Masonic children’s hospital in Coimbatore: My bones, flesh and blood are being formed, My name is today…Do not answer me tomorrow – besides these lines was the picture of a young child. Those lines have much deeper implications for me today – for I now know how true that is in the context of Child health and development. Health development is the cumulative process, which helps progressive improvement of the health status of a population. Its product is rising level of human well being mark not only by reduced mortality, reduction in the burden of disease but also by the attainment of positive physical and mental health, productive economic functioning and livelihoods, besides social integration.

In this chapter a distinguished panel of health care providers, public health experts and development consultants share their experiences and conceptual understanding on Health Promotion, Protection and Preservation. Their voices are respected and matter because they have personally led many innovative policy, research, programmatic interventions and educational initiatives in child health. Child health has many dimensions to it. This chapter covers environmental health, mental health, nutritional challenges, infectious disease, experiences in sensitizing health care providers, primary health care approaches, partners in childcare, innovative country experiences, new indicators like gross national happiness and the voice of a practicing pediatrician. Sections have also been included on emerging challenges like urbanization, sustainable development, obesity, social accountability and the double burden of disease that has come to strongly impact the ecology of child health. Ensuring Children’s fundamental Right to Health to health is within our collective reach. Yet, for all the potential knowledge and vast resources we have available, we have failed to ensure this. The benefits of modern public health and medicine must reach all children!
Childhood experiences leading to lifestyle disorders in adulthood

Dr. M. Ramaswamy
Honorary Director, Masonic Medical Centre for Children.

The continuing burden of malnutrition

India has close to 120 million children less than 5 years of age. Out of these, about 45% of the children remain malnourished. This is in spite of the mind boggling technological and scientific advances of the 20th century. This situation is not completely unique of India...it is shared by many developing countries. Most of these malnourished children will end up as short stature adults with reduced intellectual endowment. Both diminished productivity and reduced longevity are well known consequences of malnutrition. This will not augur well both for individual growth and development as well as for national development and progress.

Childhood experience and lifestyle disorders

It is worthwhile to look at factors in childhood that might lead to lifestyle disorders in adulthood. Several such disorders afflicting the adults are currently found to have their origin in childhood. These include short stature, reduced intellect, diminished capacity to do manual work, obesity, hypertension, diabetes mellitus, premature occurrence of coronary artery disease and stroke.

Where do we start?

Identification of the following factors might be relevant in terms of either postponing or preventing these lifestyle disorders.

- Birth weight
- Breast feeding
- Linear growth and weight gain
- Energy and nutrient adequacy
- Growth monitoring
- Administration of vaccines
- Supportive environment

Birth weight:

There are strong epidemiological observations linking the low birth weight less than 2.5 kg and premature occurrence of coronary artery disease (Barker hypothesis). It is therefore essential to ensure that the newborn babies weigh at least 3 kg at birth. Birth weight around 3.0 kg not only ensures immediate well-being but also good health later on. Nearly all newborns with the optimal birth weight need only routine care. There is hardly any need for additional intervention in them.

On the contrary, both burden of illness and deaths increase progressively with decreasing birth weight and duration of pregnancy. In this context both preterm babies as well as small for dates are at risk. Preterms are those born before 37 weeks of pregnancy and small for dates are those born at term weighing less than the expected.

Among the several variables influencing the birth weight, two are believed to be the most important. They are the height (stature) and nutritional status of the pregnant women. Height of the pregnant women may not be modifiable by short-term interventions but nutritional status can be improved. Adequate supply of nutrients and periodic health monitoring will improve the situation. Sufficient supply of energy, iron, and folic acid are essential during pregnancy. Periodic prenatal check up is a must for all pregnant women. Institutional deliveries should be encouraged.

Breast feeding:

Currently WHO recommends all newborns to be exclusively breastfed for a minimum of 6 months. Besides, breast-feeding needs to be continued as long as possible with supplementation beyond 6 months of age. This single step has been well documented to provide several advantages to the infants. Initial well-being and subsequent good health are assured. The immediate benefits are reduced frequency of respiratory and gastrointestinal tract infections and long term ones are postponement of obesity, allergy and even heart disease. Though the standard text books on Child Health published from the developed countries state that proprietary milk formulas are as good as breast milk in maintaining satisfactory growth and development, the experience in many parts of the world is different and does not endorse that view. This is perhaps due to widely prevalent poor hygiene and sanitation coupled with poverty and ignorance.
Linear growth and weight gain:

It is an astonishing fact that a newborn doubles its weight in about 5 months and triples it by the first year. Cells, tissues, and organs grow and develop rapidly in children. No other period in the life of human beings, except perhaps adolescence, where there is an acceleration of growth and sexual maturation in a short span of about 5 years. This enhanced rate of the growth of infants and young children makes them easy targets to nutritional insults.

Energy and Nutrient adequacy:

Children compared to adults need more calories and nutrients due to their active growth and increased physical activity. Persistent energy and protein deficits lead to permanent long-term consequences (Dr. Gopalan). Stunting, wasting and underweight are all but different manifestations of chronic deficiency of energy and nutrients.

A simple way to calculate the energy needs of a growing child is as follows: About 1000 calories are needed per day during the first year and additional 100 calories are needed for each year till the age of 11. For instance a 3 year old will need 1200 = calories, a 5 year old 1400 calories and so on. It is desirable that proteins of good biological value meet 10% of the daily caloric needs. Field studies in southern India have shown that vast majority of children from poor households receive only 60% to 80% of their needs (Dr. Shanthi Ghosh).

Growth monitoring:

This is performed with the help of the growth charts. They are indispensable tools as they give a visual picture of child’s growth in all three dimensions: weight, length or height and head circumference. When used appropriately, it gives the health care providers as well as the parents child’s current position in relation to the known standards. It gives an accurate measure of annual rate of growth (also called velocity), which is a sensitive indicator of the health status of the child. It also helps the health care providers to calculate the body mass index (BMI). Both states of undernutrition and obesity can be easily identified before they become fully established. Given below are some illustrations of satisfactory growth, failure to thrive, and obesity.

Administration of vaccines:

Safe water supply and development of vaccines against communicable diseases are the two major interventions of the 20th century, which have brought enormous benefits to the mankind. Thanks to the availability of vaccines smallpox has been eradicated, and poliomyelitis eradication is virtually completed. The burden from several other communicable diseases like measles, diphtheria, and whooping cough has become negligible.

The 18 years of childhood gives an unparalleled opportunity to protect children from an array of communicable diseases adding to a disease-free adult life.

Supportive environment:

It has been said that children are like wet cement. Whatever falls on them makes an impression. Besides children are great imitators. We also need to remember that young infants spend most of their time with parents, toddlers with the parents and relatives, and a school going child with teachers and others in the community. Parents, relations, friends, teachers and all adult men and women who come into contact with children need to become models of behaviour and conduct.

Hence provision of supportive-culturally acceptable, socially cohesive, and intellectually stimulating environment is necessary. This has become crucial with the decline of communicable diseases like measles, whooping cough, diphtheria, and tetanus and rising frequency of lifestyle diseases such as obesity, asthma, diabetes hypertension etc.

Globalization is not an unmixed blessing. Addiction to cigarette smoking is a Pediatric disease as surveys of smokers have revealed that in most situations, habits such as these started during their adolescence. Excessive viewing of television, eating fast foods and drinking aerated drinks all add to the early onset of obesity, which is becoming an epidemic. Similarly pressure from peers and tendency to experiment may put the children at the hands of antisocial elements leading to delinquency and behaviour disturbances.

In summary, there is sufficient evidence in the current scientific literature to state unequivocally that seeds of several lifestyle disorders are sown during childhood. The poet is right when he said that the child is the father of man.
Controlling the global obesity epidemic

The challenge...

At the other end of the malnutrition scale, obesity is one of today’s most blatantly visible – yet most neglected – public health problem. Paradoxically coexisting with undernutrition, an escalating global epidemic of overweight and obesity – is taking over in many parts of the world. If immediate action is not taken, millions will suffer from an array of serious health disorders.

Obesity is a complex condition, one with serious social and psychological dimensions, that affects virtually all age and socioeconomic groups and threatens to overwhelm both developed and developing countries. In 1995, there were an estimated 200 million obese adults worldwide and another 18 million under-five children classified as overweight. As of 2000, the World Health Organization estimates, the number of obese adults has increased to over 300 million. Contrary to conventional wisdom, the obesity epidemic is not restricted to industrialized societies; in developing countries it is estimated that over 115 million people suffer from obesity-related problems.

Generally, although men may have higher rates of overweight, women have higher rates of obesity. For both, obesity poses a major risk for serious diet-related noncommunicable diseases, including diabetes mellitus, cardiovascular disease, hypertension and stroke, and certain forms of cancer. Its health consequences range from increased risk of premature death to serious chronic conditions that reduce the overall quality of life.

Societal changes and worldwide nutrition transition are driving the obesity epidemic. Economic growth, modernization, urbanization and globalization of food markets are just some of the forces thought to underlie the epidemic.

As income rise and population become more urban, diets high in complex carbohydrates give way to more varied diets with a higher proportion of fats, saturated fats and sugars. At the same time, large shifts towards less physically demanding work have been observed worldwide. Moves towards less physical activity are also found in the increasing use of automated transport, technology in the home, and more passive leisure pursuits.

What can we do about it?

- Creating supportive people-based environments
- Promoting healthy behaviours
- Mounting a clinical response to the existing burden of obesity through clinical programmes and staff training.

- Excerpts from the joint publication of the World Health Organization and United Nations Environment Programme on Urbanization.

Urbanization and its implication for Child Health

In recent decades, most Third World countries have experienced an unprecedented growth in their urban population. Yet little has been done to provide services and amenities essential for a healthy and adequate life. In virtually all countries, local and city authorities have lacked the power, resources, and trained personnel to meet their responsibilities in providing such services and facilities to affected urban populations.

Few valid generalizations can be made about urbanization in the Third World; there are very large variations in the proportions of national population living in urban centres and their distribution in centres of different sizes. Each country has its own unique and complex mix of economic, social, political, ecological, and demographic characteristics, which influence the form that urbanization takes.

This section looks at the implications of this situation for child health. In doing so one has to factor into the analysis living conditions and health problems with special reference to child health, consider ways in which people in lower income find appropriate living places and discuss strategies in tackling health problems.

The gap between needs and responses

Data on the spatial distribution of urban populations are limited (as analyses of the relationship between this distribution and socio-economic factors). It is however clear that urbanization is affecting large population. Improving the health of infants, children, young people, and adults demands action not only by health agencies but by those working in the areas of housing, planning, public works, transport, pollution control, and
education. Poverty, rapid growth of cities, population increase, overcrowded accommodation, lack of waste disposal system and limited or health care adds to the complexity of the problem.

To date, there is no indication as to where capital investment on the scale required can be obtained for alleviating the challenges of urbanization. The combination of inadequate investment in urban development, often a result of poorly defined priorities, and the low priority given by multilateral and bilateral agencies to improve the housing and living conditions of lower income groups and their access to basic services raises the crucial question of how, during a period of significant economic recession, governments in countries where incomes are low and are heavily in debt can cope with the administrative and managerial problems of urbanization. Almost 50% of today’s Third World population is estimated to live in conditions of extreme poverty! The severely detrimental social, psychological, and physical effects of this on children, especially in an urban setting, have seldom been recognized.

The fact that more children were born during 1960-1980 than in the two preceding decades and that increasing proportions of children are born and grow up in urban environments makes the problem of urbanization and its impact on child health all the more critical. Although the chances of child survival may in aggregate have improved, children’s chances of living a sound, healthy life has not. For a large number of infants and children, the future in the context of contemporary urban growth is very bleak. In many squatter settlements where there is no safe water supply for the inhabitants or facilities for the removal of household and human wastes, a child born today is 40-50 times more likely to die before the age of 5 years than one born at the same moment in a prosperous developed country.

The national and international resources devoted to the social, psychological, and physical health needs of children living in urban tenements, squatter settlements, and other inadequate environments have been even more limited than those devoted to the wider categories of housing and improvement of the physical environment. Available statistical information and studies of living conditions in low-income settlements, suggest that three major types of health problems are emerging:

(a) infectious and gastrointestinal diseases, often termed “diseases of poverty” (these have, by and large, disappeared from developed countries, but are today a major source of morbidity and mortality in children in the developing world);
(b) chronic degenerative disease associated with poor living and working conditions;
(c) pathogenic conditions associated with stress often precipitated by social isolation, insecurity, dissolution of primary (family) relations, and cultural conflict where there is rapid urban development.

With regard to infectious and gastrointestinal diseases, it is currently estimated that up to 44.4% of all deaths in children under 4 years of age can be directly accounted for by repeated episodes of diarrhoeal disease. Fourteen surveys in the African Region of WHO and 17 in its Eastern Mediterranean Region gave similarly high rates. Children affected by serious diarrhoeal diseases in these countries are likely to spend up to 20% of their first 2 years of life suffering from serious diarrhoea, with a median number of 4.9 episodes per child per year. Respiratory infections and nutritional deficiencies, are closely associated with poverty, overcrowding, and poor environmental conditions.

The success with which societies deal with deprivation in childhood and is attendant problems has major implications for their future development. The future development of societies in the Third World will be considerably influenced by the daily experiences of their children and by the opportunities provided for them today. Urbanization and its negative impact have to be addressed if we want better health for our children.
Caring for Children affected by HIV/AIDS
- An Inter-religious Approach

Mr. James Cairns
Director, Advocacy and Action for Children, World Conference of Religions for Peace

“Everybody stand up!” With these words, 7-year old Salim Yasin brought 200 adults including some of Africa’s most senior religious leaders, immediately to their feet. Through words sung and spoken, Salim shared the pain he experienced in losing both of his parents to HIV/AIDS:

“I am a child of the world.
I want my chance to live my life.
I want my life, without the pains.
I want my life, without the AIDS.
Look what gets done to me.
First it was my Papa.
Then my Mama followed.
They’ve gone for a journey, a journey never to return!”

The powerful words and presence of this one small boy made clear the true impact of this terrible disease. For that moment, he became the child of every religious leader present, and it galvanized their energy and commitment to respond to the many ways that HIV/AIDS was affecting children and families in their own religious communities all across Africa.

The event where Salim spoke was the first African Religious Leaders Assembly on Children and HIV/AIDS, held in Nairobi, Kenya in June 2002. This groundbreaking meeting brought together religious leaders of major faith traditions from all parts of Africa along with senior representatives from international agencies, NGOs and civil society. It was convened by the World Conference of Religions for Peace as part of the Hope for African Children Initiative (HACI) – a seven-organization partnership to expand care and support to children orphaned and made vulnerable by HIV/AIDS (OVC) in Africa.

I open with this story, because it captures so many elements that must be included in any response to HIV/AIDS that hopes to be successful, and in particular it points to the power inter-religious cooperation can have in achieving the goal of a generation of children free from AIDS.

First, there is the reality of the impact. More than 12 million children in Africa have lost one or both parents to HIV/AIDS. Half a million children under 5 get infected every year, and the fastest growing rates of infection are among young people 15-24, particularly girls. The OVC dimension of the AIDS pandemic combines size, duration, complexity, and immediate needs.

Second, there is the necessity of partnership. The problem is simply too big for any agency, government, or religious group to resolve alone. HACI is a great model of new styles of partnership – bringing together religious communities, major NGOs, governments, and international agencies in support of communities. This is strengthened by the clear dedication and enthusiasm of the religious communities across Africa to work with each other to fight this scourge.

Third, there is the importance of leadership. Leaders in all sectors of society must be able to speak out and engage their communities in a full-scale response to HIV/AIDS. Without it, the HIV virus can take advantage of too many places of silence, ignorance, and denial to continue its terrible spread. It is particularly important for religious leaders to take strong public action given the nature of the disease, its main modes of transmission and the stigma and shame that surround it. Their moral authority and influence in society can have a transforming impact on how AIDS is or is not addressed.

Finally, there is the truth of moral obligation. Salim was able to evoke the innate understanding present in every religion of respect and care for each person. Leaders were reminded of their responsibility to foster this spirit in their communities so that together they can mobilize a response that is inclusive, compassionate, and life affirming.

Mobilizing religious communities to work together to address issues such as the impact of HIV/AIDS on children is at the center of the mission of Religions for Peace. We use a unique method and effective inter-religious mechanisms to accomplish this. The method developed by Religions for Peace...
“Our dear children impacted by HIV/AIDS, you are persons of incalculable worth and dignity... You have suffered too much because of HIV/AIDS... Our religions teach us that you should not suffer alone and that you should not be made to feel ashamed. We are asking all religious people to be your family. You are to be known, helped, and loved as part of this family.”

James Cairns

assists religious communities to connect their capacities for action - education, advocacy, service delivery - with the specific needs of OVC. Breaking down a problem in this way reveals key, and often under-utilized assets present in religion that can be brought to bear on the problem, from religious health institutions to local women’s groups.

These capacities for action can be made more powerful and effective through inter-religious cooperation, and the mechanism for it is a network of national and regional inter-religious councils affiliated to Religions for Peace. These action-oriented councils are led by religious leaders and provide a platform for collaboration at different levels. They serve as bridges between communities, building trust and providing an efficient way to channel resources to local faith groups caring for OVC.

Working with HACI and other key partners, Religions for Peace has engaged religious communities in Africa in two critical areas of response to the pandemic: advocacy by religious leaders and service delivery through local religious organizations. Both are places where religion has a strong set of assets, ranging from the authority and legitimacy of religious leaders to the extensive presence and infrastructure of religious communities from the smallest village to the largest city. In the two and a half years since the Nairobi Assembly, Religions for Peace has worked through inter-religious councils in 10 countries across Africa that have brought together over 1500 religious leaders in national and district level workshops to raise awareness about HIV/AIDS. The result is leadership that is much more positively engaged in responding to all aspects of the pandemic providing services to children in need is the other critical area of response. HACI is currently working in nine countries: Cameroon, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Senegal, Uganda, and Zambia.

Inter-religious councils have been able to form HIV/AIDS task forces that are providing direct support to local faith-based organizations (FBO) through small grants, training programs, and advocacy efforts. Hundreds of local congregations and FBOs have been able to expand their efforts to provide educational support (uniforms, books, fees), nutrition/feeding programs, home-based care, and awareness education to children. Some examples: in Uganda, the Masanafu Child and Family Support program, linked to a local Catholic parish, has developed a vocational training program that is teaching sewing, carpentry and welding to OVC who have dropped out of school. The first group of 25 children has almost completed a 2-year training course, and the next group has already been identified. The Ananda Marga Universal Relief (AMURT) agency is connected to the Hindu Council of Kenya, and in an area just outside Nairobi, they are supporting 50 children who have lost parents to AIDS through residential care, a health clinic, and a school. Two-thirds of these children are themselves HIV+. Finally, in Malawi the Tidzuke women’s group has been counseling mothers about their HIV status and helping them provide care and support for their children.

These are just three of hundreds of examples of how religious groups across Africa are finding ways to care for children affected by HIV/AIDS. Religions for Peace is developing the inter-religious approach and mechanisms that can provide resources – material, financial and technical – to support these local groups who are acting on the deep instinct to care for those in need that is at the heart of every religion. By working together and in broader partnerships like the Hope for African Children Initiative, Africa’s religious communities can play a transforming role.

In the end, the religious communities offer more than services. This was made clear by the leaders who gathered in Nairobi. Inspired by Salim, they adopted a “Letter to our Children” that can be read in any mosque, church, temple, or other place of worship. They wrote, This pledge is at the heart of what is best and true of religion, and it can be the power that overcomes the tragedy of HIV/AIDS.
“Lead and its impact on children - the Environmental Health dimension”

Department of Environmental Health, Harvard School of Public Health

Lead poisoning has been recognized for centuries and is one of the most significant and preventable environmental threats facing children worldwide. Lead is a pervasive element found in nature that has been mined, transformed, and dispersed throughout the environment by man causing global contamination of this persistent and toxic substance (Needleman, 1999). More is known about the effects of lead than virtually any other hazardous substance. Health problems caused by lead have been well documented over a wide range of exposures on every continent. Even at low levels of exposure, adverse effects of lead have been identified.

The World Health Organization estimates that 15-18 million children in developing countries are suffering from permanent brain damage due to lead poisoning (Prüss-Ustün et al. 2003). Advancements in technology have made it possible to research and test for lead exposure at very low levels. In addition, despite overall declines in ongoing exposures, there is concern that acquired lead burdens may continue to exert substantial negative influence on human health (Hu and Hernandez-Avila, 2002).

Virtually all biochemical process and organ systems can be affected by exposure to lead. Lead can interfere with the reproductive and cardiovascular systems, with blood formation processes, vitamin D function, and neurological processes, among others (ATSDR, 1999). Of particular concern is lead’s impact on the cognitive and behavioral development of children. Numerous studies have reported that relatively low concentrations of lead in blood are associated with persistent problems in learning, school performance, behavior, and lower intelligence scores (Needleman and Gastonis, 1990). There is apparently no threshold for the lead effect suggesting that any exposure may be harmful to the central nervous system (Schwartz, 1993). In fact, deficits in cognitive function and academic skills have been associated with blood lead levels lower than 10 mg/dL (Lanphear et al. 2000; Canfield et al. 2003). The majority of those exposed to lead at low-to-moderate levels are asymptomatic and by the time physical symptoms are evident - headache, lethargy or hyperactivity, nausea, stomach aches, vomiting, and constipation - significant damage may have already occurred.

Lead is absorbed into the bloodstream, some being filtered out and excreted, but the rest gets distributed to the liver, brain, kidneys and bones. Once ongoing exposures decline, lead levels in blood and all other soft tissues decline fairly rapidly; but approximately 15 percent of all the lead that enters the body is sequestered in the skeleton, where it persists with a half-life of years to decades (Hu, et al. 1989; 1998). The long-term health effects of lead may be mediated by chronic exposure to accumulated lead stores in mineralized compartments that are released into circulation during periods of high bone turnover (e.g. pregnancy, lactation, growth, hyperthyroidism, menopause, osteoporosis).

Recognition of the toxic effects of lead has prompted interventions that have resulted in reductions in lead exposure in many countries. A worldwide initiative to phase-out lead in gasoline has already stimulated important reductions in ambient air lead levels and population blood lead levels in some countries (Romieu et al. 1992; Cortez-Lugo et al 2003).

Occupational exposure to lead remains a problem in developing countries where industries are likely unregulated and little environmental monitoring and reporting is done. Studies have documented the impact of mining activities (Benin et al. 1999); backyard
repair and recycling of batteries (Matte et al. 1989) and radiators (Dykeman et al. 2002); and the production and use of low-temperature fired lead-glazed ceramics (Hibbert et al. 1999) and tiles (Vahter et al. 1997). Recently, community concerns have forced private companies and governmental agencies to evaluate the problem and to initiate remedial actions for affected areas. However, major sources of lead still exist and vary within and between countries around the world. In some countries, like the United States, childhood lead poisoning remains a stubbornly difficult problem to curtail because of the use of lead in long-lived residential paints.

But Childhood lead poisoning is typically also more severe in developing countries due to continued reliance on leaded gasoline, inadequately controlled industrial emissions, unregulated cottage industries, and cultural practices such as use of traditional medicines and cosmetics containing lead. Elevated exposure persists in some segments of society, in large part, because of health and socioeconomic disparities. Continued lead exposure perpetuates the cycle of poverty and underdevelopment. Families depending on employment in polluting industries may suffer economic consequences when control measures are implemented. In addition, traditional practices are deeply engrained in values and long-standing beliefs. These examples illustrate the complicated nature of issues regarding environmental control of lead.

Developed countries like the United States, United Kingdom and Germany have taken aggressive actions to combat lead poisoning. In the United States, the removal of leaded gasoline in the 1970’s resulted in marked reductions in population average blood lead levels over time (Table 1). In India, as in most developing countries, the main source of lead pollution is automobile exhaust from combustion of leaded fuel. Although India issued in February 1990 its first National Emission Standards for lead and other pollutants, the recommended permissible limits of lead are still higher than those of developed countries. Lead poisoning continues to be one of the most important problems of environmental and occupational origin in developing countries due to lack of actions and implementation of regulations to control lead exposures.

The U.S. Centers for Disease Control and Prevention (CDC) recommends designing, implementing, and evaluating primary prevention strategies that prevent childhood exposure to lead (CDC, 1991). However, in areas where there is little known about the extent of the problem, targeted screening of high-risk populations and follow-up to children identified with elevated lead levels are important secondary prevention activities. Universal screening of all children in certain age groups or geographic areas may be warranted to determine the population prevalence of elevated blood lead levels and test effectiveness of population-based interventions to reduce exposures. Although chelating agents have been shown to decrease blood lead levels, the effectiveness of chelating agents in reversing or modifying the adverse developmental effects of lead is unlikely (Rogan et al., 2001; Dietrich et al. 2004). This emphasizes the importance of taking environmental measures to prevent and control exposure to lead. In addition to the different cultural patterns of manufacture of lead related products that take place in developing countries, diet is likely to play an important role (Peraza, 1998). Deficiencies of iron, calcium and zinc increase the absorption and toxic effects of lead (Goyer 1997). Iron deficiency is a prevalent condition all over the world, but it is particularly prevalent among poor children, who are more likely to be exposed to lead. Nutritional interventions may be important secondary prevention activities to mitigate the effects of past lead exposure (Mahaffey, 1995; Hu et al. 1995).

The elimination of childhood lead poisoning requires a comprehensive and coordinated cross-sectoral approach involving the identification and participation of government ministries and agencies, non-governmental organizations, and other stakeholders from the private sector (CDC, 1991). Since the effects of lead are largely irreversible, policy solutions to lead poisoning should focus on primary prevention and control of sources of exposure. Developing a plan for the elimination of childhood lead poisoning requires local data on the nature and extent of the problem for program planning and policy development and evaluation of prevention and control efforts. Public awareness campaigns and educational messages promoting lead poisoning prevention should also be aimed at policy makers to increase understanding of the need for resource allocation and control measures aimed at reducing the public’s exposure to lead. Societal benefits and economic gains from reduction in exposure, including relative effectiveness and cost of control measures, should be also considered (Schwartz 1994; Grosse et al. 2002; Landrigan et al. 2002).
Exposure to lead has far-reaching consequences. Hundreds of millions of children and pregnant women are still exposed to elevated levels of lead in many developing countries. The ongoing transition from leaded to unleaded gasoline will reduce exposure in the population at large. However, the removal of lead from gasoline and the resulting decline in ambient air lead levels accentuates the relative importance of bone lead stores as an ongoing endogenous source of lead exposure.

Women and their children will continue to be at risk for exposure long after environmental sources of lead have been abated. Therefore, even if ongoing environmental lead exposure is no longer significant, lead toxicity can remain a problem due to the long-term sequelae of the “poison within.” Clearly, this gives additional urgency to worldwide efforts to reduce and prevent lead exposure in the workplace and the community. It also provides a rationale for ongoing efforts to test strategies (e.g., nutritional supplementation) for mitigating the effects of lead that has already accumulated in millions of people around the world.

Table 1

<table>
<thead>
<tr>
<th>Year</th>
<th>Geometric Mean³ BLLs (95% CI)</th>
<th>Prevalence² of BLLs &gt;10 µg/dL (95% CI)</th>
<th>Estimated Number of Children with BLLs &gt;10µg/dL (95% CI)</th>
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</thead>
<tbody>
<tr>
<td>1976 to 1980</td>
<td>14.9 (14.1 - 15.8)</td>
<td>88.2 (83.8 - 92.6)</td>
<td>13,500,00 (12,800,00 - 14,100,00)</td>
</tr>
<tr>
<td>1988 to 1991</td>
<td>3.6 (3.3 - 4.0)</td>
<td>8.6% (4.8 - 12.4%)</td>
<td>1,700,000 (960,000 - 2,477,000)</td>
</tr>
<tr>
<td>1991 to 1994</td>
<td>2.7 (2.5 - 3.0)</td>
<td>4.4% (2.9 - 6.6 %)</td>
<td>890,000 (590,000 - 1,333,000)</td>
</tr>
<tr>
<td>1999 to 2000</td>
<td>2.2 (2.0 - 2.5)</td>
<td>2.2% (1.0 - 4.3%)</td>
<td>434,000 (189,000 - 846,000)</td>
</tr>
</tbody>
</table>

Source: Centers for Disease Control and Prevention (CDC)

“Children have the greatest stake in the preservation of the environment and its judicious management for sustainable development as their survival and development depends on it. The child survival goals proposed for the 1990s in this Plan of Action seek to improve the environment... with their relatively low use of capital resources and high reliance on social mobilization, community participation and appropriate technology...”

- Earth Summit

Community based Sustainable Human Development

As the 20th Century draws to a close and a new millennium starts, there is a desire to analyze past work and focus future action for better environment. Furthermore, people are increasingly demanding an improved quality of life – collectively we are aware that human welfare has improved more in the past fifty years than in all previous human history. However, our past actions have exploited a number of Earth’s natural resources, so simply doing more of the same is no longer viable. In this context the challenges of social development are large and complex but attainable.

A pragmatic process is urgently needed in all parts of the world for achieving sustainable human development that is effective, affordable, and transferable. Communities need to become self reliant in adapting to accelerating change. Such a positive developmental process is needed to compensate for desperation and short time horizons as people think only of immediate benefits for their families while jeopardizing the larger foundation on which development is built, the environment, the welfare of other families, the civic integrity of communities, and the debts that must be assumed by future generations.
This common vision is cast in differing patterns as the geography of natural resources, proximity to others, climate, cultures, and historical traditions define the locale specific conditions that differentiate people. Some communities are growing from population increase or migration; some are declining from migration or painful tragedies. Some are improving economically; others are getting poorer. Most communities watch in frustration as their environment deteriorate and they are finally forced into action when confronted by emergencies caused by prolonged degradation of natural resources, accumulated wastes, decreasing water or eroded soil. Such negative change affects the cohesion and capacity of a community to solve problems. Growing human pressures are usually taken out on the earth. As degradation progresses, all environments are jeopardized – as are all people. However, women and children always suffer most tragically as damage to one part of the bio-social system radiates to all parts.

To balance such negative change, communities must successfully develop locally specific strategies for protecting their environments. An approach called “Primary Environmental Care” is being promoted by different agencies including Unicef. This approach is based on the integration of three holistic perspectives: (1) sustainable management of the environment; (2) meeting livelihood and health needs and (3) empowering communities for self-directed development. Environment, livelihood, and empowerment have often been separated. However, numerous examples demonstrate that when integrated, communities can exert dramatic control over environmental change.

The world has never had greater capacity to apply knowledge or hard won expertise to local initiatives to promote positive change. An increasing sense of urgency around the world encourages efforts to find a process by which sustainable human development can be achieved on a magnitude that adequately engages the complex interacting forces of rising expectations, environmental degradation, global readjustments, economic growth in some areas and stagnation in others, and population change with its growing numbers and shifting distributions.

One way of doing this is an action audit developed by Muriel Glasgow of the UNICEF Environment Section. By asking the following questions, projects can determine their relative success and where they need to focus action.

### Exploring A Sustainable Human Development Audit ...

<table>
<thead>
<tr>
<th>Empowerment</th>
<th>Meeting Basic Needs</th>
<th>Optimizing Resources</th>
<th>Special Opportunities</th>
<th>Allocation of Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Is there a funding plan?</td>
<td>g) Is there adequate self-financing for sustainability?</td>
<td>n) How is local knowledge incorporated?</td>
<td>s) What are outside funding possibilities?</td>
<td>w) Are contracts between partners needed and/or appropriate for this project?</td>
</tr>
<tr>
<td>b) Are processes of empowerment in place? (Tools, manuals, and chosen operational frameworks)</td>
<td>h) Are technologies appropriate and gender-sensitive?</td>
<td>o) How are natural resources being protected (especially, water, soil, and fuels)?</td>
<td>t) What has been done or can be done through advocacy to prepare the situation?</td>
<td>x) Are necessary relations in place with government?</td>
</tr>
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<td>c) Are monitoring indicators in place? Most particularly, is the community role specified?</td>
<td>i) Can synergy be built among basic needs (food, fuel, water, shelter, health, etc.)?</td>
<td>p) Are there dimensions that affect biodiversity or that reduce bioresilience?</td>
<td>u) What linkages can be expanded (with ministries, with NGOs, community groups, academic groups, internationally)?</td>
<td>y) Is there a schedule specifying work and resources needed?</td>
</tr>
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<td>d) Are gender dimensions addressed?</td>
<td>j) Where are the gaps in service delivery (especially to the most at-risk)?</td>
<td>q) What opportunities exist to implement renewable or recyclable technologies (especially wind, solar, biofuels, micro-gardens, etc.)?</td>
<td>v) Can this project be made part of a local network of Agenda 21 projects?</td>
<td>z) Has the community mind or situation changed and must steps be repeated?</td>
</tr>
<tr>
<td>e) Are the needs of the youth being prepared for?</td>
<td>k) What are the linkages from the project area to urban or rural contact? How great are the urban/rural disparities?</td>
<td>r) Are there special vulnerable ecological zones (mountains, forests, rivers, deserts, urban, wetlands)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Has the needed training happened at the community level?</td>
<td>l) What are the training needs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g)</td>
<td>m) What are the unmet resource needs? Are they really severe?</td>
<td></td>
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Despite the fact that children were already covered by a number of human rights instruments, it became evident that the existing norms were insufficient to meet the special needs of children. It was also recognized that there were grave situations faced by children. Children’s issues were not considered high on the political agenda. A compulsory instrument on the rights of the child becomes essential. At this fifteenth anniversary of the Convention on the Rights of the Child (CRC), it is obvious that the CRC is unique. The CRC had been adopted unanimously by the United Nations General Assembly in 1989. It had entered into force within only ten months after its adoption. It is now ratified by almost all countries except two countries which have signed it. Its widespread implementation in countries with various contexts have led to a process of progress to advance the cause of children’s rights.

The CRC covers all kinds of rights: political, economic, social, cultural and civil rights. Four fundamental principles underlie the CRC. First, the right to life, survival and development is a platform for all other rights of the child. Second, the principle of non discrimination promotes equality of opportunities among children, for instance, girls and boys should have the same opportunity to have access to health care services. Action should be directed to the most discriminated, excluded and marginalized children. Third, in all decisions that affect children, their best interests should be considered. Fourth, in order to know what is exactly in the interests of the child it is important to listen to the child in all matters affecting his or her life. These principles contribute to a general attitude towards children. In the area of health, the States Parties are entitled to take appropriate measures to diminish infant and child mortality, to develop a primary health care system for children, to combat disease and malnutrition, the provision of nutrition, food and clean water, to ensure pre-and post-natal care for mothers, to spread awareness about child health and nutrition, including the advantages of breast feeding, hygiene and environmental sanitation and on the prevention of accidents, to develop guidance for parents and family planning.

The CRC message is that children should be put at the centre of political agenda. The implementation of the CRC is indeed to a large extent an issue of political will. In order to make a reality the principles and provisions of the CRC, State Parties are obligated to undertake political, administrative, legislative, finance and other measures; primarily the adoption of a holistic policy for children on the basis of regular deep situation analysis, a national strategy and a program for children. State Parties need to review their legislation and ensure that the process of legal harmonization involves all concerned actors including civil society and people of different competencies. Studies show that the process has to be linked to social policy design, institutional restructuring and national budget allocation. In the field of health, for example, the Constitution of the Republic of South Africa made provision for basic nutrition, shelter, basic health care services and social services. State Parties have to establish national and sub-national mechanisms to coordinate policies and to report on the implementation of the CRC. The monitoring of the CRC commands the need to consider the importance of collecting reliable data on the situation of children and putting in place relevant statistical system. Awareness and knowledge of both adults and children about child rights are key for their empowerment and participation.

The CRC makes clear the formal responsibility of the State Party and highlights the international duty to assist. Article 45 of the CRC sets out arrangements intended to foster effective implementation of the CRC and to make partnership accountable. It outlines the role for specialized agencies, UNICEF and “other competent bodies”. When appropriate, the Committee on the Rights of the Child, which makes the follow-up of the implementation of the CRC at country level would indicate a possible need for technical assistance, in its Concluding Observations on countries reports.

International cooperation is encouraged from a concern that some countries would not have the resources to fully implement all children’s rights. For instance, the provision of special care for disabled children is made subject to available resources. The CRC also deals with this crucial aspect with an innovative approach. It recognizes that some of the more resource-demanding changes cannot take place overnight. It specifies, for instance, that the right to health care could be achieved progressively. Rich or poor, it should allocate the maximum extent of its resources for the implementation of the CRC. Governments should give priority to children and should encourage discussion. The discussion leads to better understanding of the needs of children and budget allocations on all levels, which would reflect the maximum available resources.

The CRC challenges governments to demonstrate that they have done their utmost in this regard. It also challenges donor countries to ensure priority to children in their overall development aid policy and the international community to bring the rights of children into the macro-economic discussions.
“Children in Post-conflict Situations - The Cambodian Experience”

Dr. J. Bhoomikumar,
Director and Consultant Child Psychiatrist, Center for Child Mental Health (Caritas-CCMH), Cambodia.

The end of the millennium saw the cessation of cold war between two super powers but on the contrary localized low intensity conflicts are on the rise, all over the world. Whatever be the dimensions of war, whether on a large or smaller scale, local, national or international level, it is the women, children, the deprived and vulnerable sections of the population who are caught unaware and subjected to untold suffering, though they were in no way responsible for the conflict in the first place.

The impact of violence on people, particularly young growing minds at family and community level is increasingly becoming a cause for public health concern. The short and medium-term effects on perpetrators brought newer nosological entity such as ‘Post-traumatic Stress Disorder (PTSD)’, from the extensive study of the psychological problems of Vietnam veterans and Gulf war returnees. But, understanding of long-term social, psychological and spiritual implications of war on collectively traumatized victims is still to emerge. Other than the physical and psychological impact, it is the loss trust, culture and identity in post-conflict situations that are real impediments for inner healing and regeneration of traumatized societies, as is evident in Cambodia, a nation ravaged by war in the not so recent past.

War and the children of Cambodia

Cambodia was caught in the crossfire during the Indo-china war of the 70s. What followed was much worse. From 1975 to 79, the Khmer Rouge transformed the country into a virtual ‘forced labor camp’ and the Angkar (organization in Khmer) unleashed systematic destruction of family and its cohesion. Children were separated and grouped in mobile working units, away from their families. The family as an economic and residential unit and repository of cultural norms, ceased to exist, leading to loss of social structure, cultural values and self-identity. As the families were frequently moved from one place to the other in an attempt to collectivize the farms and to ban individual ownership of land, the children lost the opportunity for play and safe place to nurture themselves.

Loss of Play, Safe space and Nourishing environment

“Children feel afraid to go to rice field now because of the landmines and the fighting. Before the Pol Pot time, we were not rich but we had peace. Security is the biggest problem we face here ...We do not let the children go out freely as we used to go as children ourselves because of land mines and the fighting...if only there was peace we could feel free” (mother during the UNTAC’ time).

The very development of the child was at stake due to loss of play and lack of formal educational system. Most of the educated elite was killed in the name of agrarian revolution and the teachers were eliminated. All the schools were destroyed and the children were taught how to make bombs and defuse the landmines. The parents were too emotionally wrecked and physically exhausted to care and nurture their children, as they were living in perpetual fear of the Angkor.

The children were used as the informers, eyes and ears of the repressive regime. The people from the city were called as ‘new people’ and were put to hard labor in the fields, often supervised by child soldiers. In the words of a child from the Khmer Rouge era, “during Polpot, I lived with the team leader, and not with my family....When we did something wrong we were beaten. In the meetings they also told all the children not to miss their families, as Angkor would take care of them. But sometimes I ran home because I missed my family” (Uimone, 1994). The current situation of children in Cambodia is no better. Globalization, market economy and unfettered tourism have put the children of Cambodia at risk.

Street Children, Trafficking and Sex-tourism

Poverty, paternal alcoholism, and abusive family situation drive children to the streets of Phnom Penh and they are vulnerable for trafficking and sex trade. Girls are easily lured into prostitution. Boys join the street gangs, steal, rape and commit petty thefts, crime and robbery. 20 to 25% percent are single parent (women headed) families and the women find it difficult to manage multiple roles and are unable to give quality time to their children,
resulting in high level of conduct disorder and antisocial behavior. What makes matters worse is that the health and social welfare system is not in apposition to address these issues, as they are in total disarray.

**Destruction of health infrastructure and medical services**

During the Khmer Rouge era, all the 470 doctors were killed by the oppressive regime, but for some who fled the country. Gradually the healthcare service is limping back to normalcy, but there is a long way to go as both the number and quality of healthcare professionals is wanting. For lack of doctors, trained nurses man the primary health centers and the different specialties are just emerging. The whole of intelligentsia, even people who can read and write were eliminated in the name of extremist peasant revolution, which makes the Cambodian conflict much more complex in the context of recovery, peace building and development.

**Secondary effects of war on families and children**

Today’s children of Cambodia did not face the war directly but continue to face the after effects of war, even after two decades. The children of Khmer Rouge era who are the parents of Cambodia lived in the Pol Pot children groups and had no experience of ‘normative parenting’ and hence have difficulty in parenting. Over punitive, over-protective, or compensatory parenting are very common leading to emotional, behavior, and conduct problems among the children. “...Many Khmer children and adolescents have been highly traumatized, especially the survivors of Pol Pot’s children’s groups. These young people will attempt to mask their depression and intellectual disabilities through denial, indifference, poor school performance and antisocial behavior. Unless their problems are adequately addressed, they will become dysfunctional adults and eventually place enormous economic and social burdens on their future communities” (cited in Utting, 1994). Precisely that is what is happening in Cambodia, and the challenge is enormous given the fact 48% of the population is children below 15 years.

**Challenge and response**

The country is slowly and steadily limping back to peace and stability and the challenges of meeting the children’s physical, social, psychological and educational needs, are as enormous. The Center for Child Mental Health (Caritas-CCMH), a collaborative project between Caritas and Ministry of Health, Royal Government of Cambodia is operational from the year 1991. What started as a “center based activity” has expanded to reach the children in their own habitat and learning environment, viz. home and school. Over the period, distinct approaches and strategies have emerged in reaching the children with neuro-psychiatric, emotional and behavior problems among rural and urban poor to establish primary, secondary and tertiary prevention programs.

**Connecting children and families**

Caritas-CCMH provides a safe space for healing and recovery for the children with emotional and behavior problems, epilepsy, developmental delay and neuro-psychiatric problems and their families. The cornerstone of therapy at CCMH is to connect the children and families with respective therapists. The families with similar problems are connected between themselves to form parents association of children with developmental delay, Down’s syndrome and epilepsy, who as decision makers can lobby at the national level. Connecting children and families has been an important strategy in post-conflict Cambodia to overcome mutual distrust, collective hopelessness and apathy. The team at the center for child mental health had made efforts to build a responsive therapeutic community to address mental health needs of children and adolescents.

**Building a therapeutic community**

The fifteen-member team, comprising of the author who is a consultant child psychiatrist, the general physician, three psychologists, five nurses, a physiotherapist and a support team has developed expertise and competence in providing multi-model therapeutic services to a range of problems among children with multiple disabilities, emotional and behavior problems. The team is implementing innovative community and school based programs to promote comprehensive child development with community participation.

‘Healers heal thyself’, is an old saying and it is much more relevant in Cambodian context, for most of the staff were traumatized as children during the Pol pot era. Creative arts therapy, meditation, ‘Art of Living’ and Positive thinking are some of the programs that staffs take up on a voluntary basis to build their spiritual dimension as caregivers and prepare themselves to help the children and families.
Community Partnership

“Before the Pol Pot time, most communities were made up of families and relatives. There was a good community spirit then – each person helped the others in the fields. But now there are many people coming into the community; people don’t trust each other” (Khmer women working for an N.G.O). It is vital to build trust and confidence among families in the community. The fact that everyone has suffered loss makes it difficult to sympathize with the other because they have all been through the same kind of terrible experiences. Too many of the traumas are hidden and this ‘conspiracy of silence’, is a factor to deal with in rebuilding the communities. Somatization disorder is highly prevalent in Cambodia, where expression of emotional distress in psychological terms is traditionally inhibited and high value is placed on interpersonal harmony. People are encouraged to tell their stories, to come around health and development programs such as micronutrient deficiency control programs as part and parcel of ‘trauma recovery program’.

Involving the care givers at primary level

Analysis of ‘referral pathway’ reveals that 70 to 80% of the clients seeking help at our center consult the traditional healers (Kuru Khmer), monks and/or fortune-tellers before reaching us. That is quite culturally acceptable and understandable in most of the nations in Asia as mental illnesses and neuro-psychiatric problems are associated with supra-natural phenomena or to the realm of ‘spirit-world’. Without undermining the cultural and traditional practices, our team offers an alternative biomedical model for the parents and families to consider, also involving in it traditional healers.

Strengthening the support system

As a member of Disability Action Council (DAC), Caritas-CCMH has lobbied for the rights of children with intellectual disability and the Ministry of Education has included the special educator from CCMH in the consultative group for inclusive education. Educational and training support is offered to the Department of Psychology Royal University of Phnom Penh, Rabbit school at the Nutrition Center, National Center for Disabled Persons (NCDP) and Cambodia Trust. The CCMH team has gained expertise in ‘participatory pedagogical methods’ and training modules has been developed to build the capacity of the staff of the CCMH network agencies. Being a member of the mental health subcommittee, a technical wing of the Ministry of Health, the author played a key role in planning, formulating and drafting the national level mental health policy document. We have lobbied for the inclusion of child and adolescent mental health and consideration of children’s rights, while preparing the national level mental health policy document.

Involving the parents, teachers and peer groups, who are the primary stakeholders to bring about positive change in the wider psychosocial environment of the children to improve the quality of life of the child in the family, is the chief strategy of Caritas-CCMH. The extreme vulnerability of children due to poverty, lack of access to services, justifies an approach that reaches children in the environment where they live and interact. Parent committees, school health committees, and village health committees who are committed to spearhead the movement for promoting ‘child-friendly-villages’ and ‘child-friendly-schools’ will ultimately own the program.

Mahatma Gandhi prophetically remarked “If we were to bring peace to communities and if we are serious to prevent war, we have to begin with children”. We have begun with children of Cambodia, one of the most traumatized nations in the recent history, and we are aware there are miles to go...
Child Protection

Ms. Ruth Lee
Social Policy Officer, United Kingdom.

Can you think of a time when you last heard the words ‘child abuse’ and ‘church’ used together in a sentence, which did not refer to a high profile scandal involving a church leader who had sexually abused children? It is almost impossible to think of such an example, particularly considering the deluge of stories in the media about church related child sexual abuse over the past few years. As a result, an accusing spotlight has been shone on the inadequacies of systems within churches to protect children entrusted into their care from abuse. Church institutions have been exposed as having turned a blind eye to, or even attempting to cover up, internal cases of child abuse.

In reaction to this, many churches have been falling over themselves to introduce child protection policies into all aspects of their work with children. So much so, it almost seems that today a mother wanting to lend a helping hand at her child’s summer scout camp has to fill in long and complicated forms and go through a vigorous police check before she is declared fit to teach the intricacies of knot tying and to initiate songs around the camp fire. Of course, these steps, strides in many cases, towards better child protection are in the right direction. It is without doubt that children at Sunday school or in the church choir are much safer when a child protection policy is in operation. And it is vital that all churches shake off their self-righteousness, admit that children have been abused by a system often more interested in protecting itself, and set up and implement stringent policies on child protection.

Ensuing Policy Focus

This is all well and good. But the nagging doubt does remain whether churches would actually have started out on the journey of taking child protection seriously at all, had it not been for the extensive negative media coverage. In any case, does the ensuing focus and attention on protection policies go deep enough to really protect our children from abuse? Or is it, in a way, contributing to a neglect of the root causes of child abuse in our churches and in our communities?

The ground experience

At this point, we need to remember that all too often there is a tendency to equate ‘child abuse’ with ‘child sexual abuse’ and to forget that there is a much wider definition: ‘physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse.’ Throughout the world thousands of children are facing various forms of abuse every day. They are trafficked as a commodity of labour or sex, they are forced to work in hazardous mines and factories or fight for armies, they experience the horrors of war, they are forced to live on the streets, they are separated from their families by war or by HIV/AIDS, they are exposed to violence in their own homes and schools, the list goes on...These are cases of abuse which we rarely hear about, compared to the frequency that they occur, and which the media hardly follows. Most of these children suffer in silence and yet the impact on their lives is all too real; leading to death or suicide, to poor physical and mental health, to homelessness, to estrangement from family and friends, to difficult or abusive relationships as an adult, or to a sense of hopelessness.

Our children have something to tell us

May be you would like to hear some stories shared at recent Consultations in Asia on these issues? Perhaps you would like to hear the story of a traumatized Afghan boy, who, when he arrived at the Kabul rehabilitation centre where Nijabat Khan works, was not able to speak for several years and shook physically, due to having witnessed his parents being killed by a bomb which had fallen on their house? Or the story of a Cambodian girl, now in the care of Marie Cammal’s refuge ‘Sok Sabay’, who, after being sold to a brothel by her uncle, experienced rape at least 20 times a day and beatings if she resisted? What about the story, which Father Damien from Jaffna, Sri Lanka, tells of the continuous struggle of a girl he was counselling to deal with being raped by three gunmen who
broke into her family home one night when she was fourteen years old? Or how about the situation witnessed by Father K.U. Abraham where two children in his diocese in India were, under pressure from their community, banned from school because their parents had both died of AIDS? Or what about the stories that can be told by the house parents of a children’s home in a popular beach resort in Thailand who rescue numerous children from sexual exploitation by foreign tourists?

**Or perhaps you would prefer not to hear them?** For they alert us to the fact that, although we are outraged by such stories, efforts to prevent abuse are all too often met with resistance at all levels of society, from governments to community/religious leaders to parents. This is because child abuse occurs mostly in private and is associated with criminality and corruption. The sad reality is that it is all too often publicly denied and yet privately tolerated. Nowadays, there are many child protection mechanisms, international, national, and local, but the gap between such laws and what children experience on a daily basis remains enormous.

**The choice?**

All this puts the question ‘are churches doing enough to protect children from child abuse?’ in a very different light. As soon as a protection policy, important as it is, is in place, it does not mean that child abuse has been prevented. A comparison of the concepts of ‘prevention’ and ‘protection’ hints at the duality of these interdependent approaches to putting a stop to child abuse: the latter is more curative whereas the former demands a deeper look at the reasons why child abuse occurs in the first place. As well as putting into place important protection mechanisms, churches have a vital role to play in addressing the factors which contribute to the risk of child abuse, be they social structures based on gender, economics, caste or class, other environmental stresses, war and conflict, discrimination, the family situation (the absence of one or both parents, for example), difficulties in relationships, depression or mental health problems, or the place of children in society in general.

Perhaps this last point, which is the most important of all. Children are especially vulnerable to violence, exploitation and abuse precisely because of their vulnerability to and dependence on adults. It is when conditions are conducive to the misuse by adults of their inherent position of power in relation to children that children are abused.

**Affirming the dignity of children**

I am writing this feature on the ‘World Day of the Prevention of Child Abuse’, on November 19th, which aims to contribute to the creation of a culture of prevention of child abuse. An NGO Coalition has been formed to mark November 19th and to raise awareness, mobilize public opinion and action, and disseminate information about child abuse prevention programs. The wide range of prevention initiatives that this Coalition represents reminds us, on one hand, of the wonderful work which some churches and other civil society actors are currently involved in, and, on the other hand, of how much more churches potentially can and should do, both within churches themselves and in their wider communities.

As a member of this Coalition, finding creative ways to accompany its member churches in affirming the right of children to live lives of peace should be a crucial role for the WCC. Two examples of current efforts are:

- **The ‘On the Wings of a Dove’ Campaign which will run from 25th November until 10th December 2004 to highlight the issue of violence against women and children,**
- **The ‘Dignity of Children’ programme in Asia, which aims to create space for its member churches in Asia to reflect together with other civil society actors upon their role in affirming the dignity of children.**

Over my two years at WCC, I have been primarily involved in the latter of these initiatives. I have seen that this process of networking can lead to exciting new initiatives to heighten church involvement in children’s issue. There are so many churches throughout Asia who are practically engaging with the everyday needs of children in their communities through the running of orphanages, drop-in centres, street children shelters, Sunday Schools etc., and for such churches and church related NGOs, the chance to meet with others and share experiences is invaluable, as it makes the possibility to make their voices heard by the larger church community and its leaders, calling them to seriously address the problems facing children.
Regional, sub-regional and national network consultations have empowered churches in Asia to deepen their analysis of the situation of children in their communities from various theological and cultural perspectives and have equipped them to actively advocate for change in the structures of society which undermine children's dignity, structures which undeniably include churches themselves.

Such initiatives are small yet valid steps towards building a culture of prevention of child abuse. In many places, policies on child protection are an integral part and parcel of what is needed to do this, but we should not get bogged down in legislation only. In order to have long lasting results, initiatives need to be rooted in cultural and social reality and be seen as part of a process of holistic transformation of society and of the world. The role for the Church - and other faith communities - to play in this is vital and pressing.

And if we take up this challenge, perhaps one day the words ‘child abuse’ and ‘churches’ may conjure up a slightly more positive image than they do now...

For more information
1) http://www.overcomingviolence.org
2) www.wcc-coe.org/wcc/what/regional/index-e.html
3) www.woman.ch

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Asian Churches to Tackle Challenge of “Overcoming Violence Against Children”

Concerned about the growing plight of children in many parts of Asia, church leaders will gather in Colombo, Sri Lanka from 28-31 August and from 1-4 September in Kuala Lumpur, Malaysia, to evolve a strategy for mobilizing churches to take a more active role in overcoming violence against children in both local and national contexts in Asia.

These two consultations, jointly organized by the World Council of Churches (WCC) and the Christian Conference of Asia (CCA), will focus on creating a culture of peace for children at the community level through equipping churches to address the increasing trend of violence against children, especially in conflict-ridden countries in Asia.

Bringing together around 70 church leaders from WCC and CCA member churches in Asia, one of the main aims of the consultations will be to develop an “Ecumenical Action Plan for Overcoming Violence against Children in Asia”.

More and more often, we hear the cry of children who live unprotected from violence, exploitation and abuse. Violence against children occurs within the family, at school, in the community, at work, in institutions, on the street, or in conflict situations.

Bought and sold like commodities, children are forced to be soldiers, sex workers, bonded labourers in factories and agricultural fields, and domestic servants. In South Asia, Sri Lanka, Bangladesh and Nepal are the most affected countries; in South East Asia, it is Cambodia, Myanmar, Thailand, Vietnam, Indonesia and the Philippines.

“These two consultations are part of the global and regional ecumenical bodies’ ongoing efforts to challenge the churches in Asia not to remain silent when it comes to promoting the dignity of marginalized children, especially as a traditional charity approach to such issues often takes precedence,” said the WCC Asia secretary, Dr Mathews George Chunakara, who co-ordinates the WCC programme on the “Dignity of Children”.

The consultations tie in with the WCC Decade to Overcome Violence, which will focus on Asia in 2005, and with the 12th CCA general assembly theme, “Building communities of peace for all”.

For further information on the Web:
WCC programme on Dignity of Children
WCC Decade to Overcome Violence:
http://www.overcomingviolence.org/
Christian Conference of Asia (CCA)
http://www.cca.org.hk/

Kalyani Menon - Sen. A. K. Shivakumar
Building Gross National Happiness with Children

Dr. Atti-la Dahlgren, MD, MPH
Advisor, Bhutan Health Trust Fund

The land of the thunder dragon

The little Kingdom of Bhutan is tucked away in the mighty Himalayas between the world’s most populated nations China and India. Ninety per cent of the 650,000 inhabitants live on subsistence farming in the small scattered villages of the mountainous slopes. This is a society where traditional values, respect for nature, and the Buddhist religion play an important role in daily life. Bhutan has under the leadership of their enlightened monarchs successfully chosen a balanced way of development where respect for culture, nature, social and spiritual values harmonizes with economic and material development. When ascending to the throne in 1972 the present King Jigme Singay Wangchuck emphasized this further by launching the governing philosophy of Gross National Happiness, which now guides the country’s development. As a result of the country’s strong commitment to social development rapid improvement in health, has been achieved.

Children First

Bhutan has a young population. An estimated 60 percent of Bhutanese are younger than 24 years. Children in Bhutan have always been at the heart of development and receive high priority. Bhutan was one of the first countries to ratify the Convention on the Rights of the Child in 1990, and has progressively invested in services that benefit children. As a part of the National Plan of Action for children, the country has committed itself to achieve the Education for all and Health for all goals which targets primary school enrolment, improved access to health care services, better nutrition and child care practices. New laws are in place to protect the rights of children including prohibition of child labor. The government allocated more that 26% if its resources in 1999 to the social sector, representing the highest social sector spending in South Asia. Health care is free for all citizens and a countrywide network of Outreach Clinics and Basic Health Units provide health care in a cost effective way.

Achievements

The modern development of Bhutan started only 35 years ago, and much has been achieved in this time. In the last ten years, infant mortality has been dramatically reduced from 103 to 60.5 per thousand live births, and under-five mortality from 215 to 97 for every thousand births. Bhutan is leading in South Asia to meet this Millennium development Goal as highlighted by UNICEF in the ‘Progress for Children in 2004’ report. Maternal mortality has also dropped, from 800 to fewer than 300 cases of women dying as a result of complications due to childbirth or pregnancy for every 100,000 live births. The average life span has increased from 49 years for women and 46 years for men to 66 years for both. Eighty per cent of the population has now access to safe drinking water. An effective vaccination program is in place. No case of Polio has been seen since 1986 and neo-natal tetanus has not been reported since 1994. Public awareness and education campaigns complement health and nutrition programs for children. Iodine deficiency disorders have been significantly reduced and the iodized salt coverage is now close to 100%.

Bhutanese children still face a difficult start

In spite of these important development achievements, Bhutanese children still face a
difficult start. Infant and child mortality has come down and is one of the lowest in the region, but still six out of 100 children die in their first year. A survey in 2000 showed that acute respiratory infections accounted for 21% and diarrhea diseases for 13.3% of deaths in children under-five years of age. Waterborne diseases, worm infestation, skin and eye infections are still major health problems affecting children in Bhutan. Efforts are now being focused on the water and sanitation of schools and monastic institutions, which together harbor more than 16% of the population. Protein-energy malnutrition and iron deficiency anemia are still problems, with more than 50% of children suffering from some degree of anemia. Bhutan is also facing new challenges to protect young people from emerging problems such as HIV, drug abuse, delinquency and prostitution that has followed in the footsteps of increased urbanization and internationalization.

Outlook

There is good reason for optimism, however, as the health sector will be at the center of the overall development framework. A Health Trust Fund has been established in an effort to achieve self-reliance and a sustainable financing mechanism for the priority components of primary health care and continue to provide free health care for all. Bhutan’s unique path in development focusing on its people’s well-being and happiness is getting increased international recognition. With the assistance from bilateral, multilateral and UN agencies many governmental and non-governmental programs addresses the special needs of children and young people. The Youth Development Fund, a local NGO, is supporting programs in schools and extracurricular activities in environmental conservation, health and hygiene, reproductive health, agriculture, and sport. Special programs are in place to attend to the needs of disabled children.

In order to meet the challenges of today and improve health for children in the future, it is critical for Bhutan to keep the momentum and not fall back. The international community needs to continue its support and Bhutan should engage all levels of society to continue to improve the quality of the health services, strengthen human resource development, and reach the segments of the population who do not access health services today.

Small countries like Bhutan have an important role to play in global efforts for seeking better quality of life for its children. They can bring their unique experiences for wider discussion like the one Bhutan has initiated on Gross National Happiness. They also remind governments and people about the need of affirming an ethical framework by all for the welfare of Children. Our global efforts in making our communities more attentive to the challenges of child health must also harness the unique opportunity we have to learn from each other.

GROSS NATIONAL HAPPINESS

- Bhutan led by their King Jigme Singye Wangchuck is the one of the first countries in the world to use as a measure of its well-being - Gross National Happiness. This concept was introduced in the late 1980s. The purpose of life as expressed by the Buddhist tradition is to overcome suffering and cultivate happiness. This ethical basis was extended to the development framework by the Late King Jigme Dorji Wangchuck. This has brought into development discourse, the importance of people’s aspiration and happiness as an end outcome of all interventions. This pioneering initiative has challenged economists and sociologists alike in viewing the purpose and impact of development in a holistic manner.

- The roots of the debate on Gross National Happiness (GNH) are to be found in the background of the construction of the Human Development Index (HDI), and the use by the HDI of Amaryta Sen’s ‘capabilities approach to social development, human well-being and quality of life’.

- Clearly there is a causal relationship between the issues of public accountability and GNH. In fact, pursuance of the goals of ‘happiness’ contributed to the raising of public accountability in Bhutan. Under its goals, the people at the grassroots level were empowered to plan, to mobilize and allocate local resources and, in turn, to become clearly accountable for their actions.

- Pursuing the goals of GNH requires using culture as a mediator in implementing the country’s development activities. This requires utilization of anthropological principles as tools for discovering the possible creative relationship between culture and development.

- The debate on human capability and GNH is very much in progress and there is a need for further work to operationalize the concept of GNH.

Source: GNH- Discussion papers
The Centre for Bhutan Studies, Thimphu, Bhutan,
Preparation Health Care Providers for Primary Health Care

Dr. Thomas Chacko
Head, Department of Community Medicine, PSG Institute of Medical Sciences.

Health consequences of Societal Inequities

There are severe inequalities in the Health of people and especially so of children living in conditions where social inequities are a majority experience. This is evident from the “Excess Mortalities” observed in the developing countries which are 10 to 100 times higher than those living in developed countries. Similar inequitable distribution in health status is also observed in rural areas of developing countries compared to their more fortunate counterparts living in the urban areas within these countries.

This Excess Mortality commonly seen is mainly due to the unconquered preventable diseases, which are impacted directly by a range of health care interventions. The issue of ‘Accessible health services’ is not a new one. However, the consequence of health services not reaching people in rural areas and urban slums as well as their non-utilization has led to concern in the area of Child health.

We know that this can be corrected by strengthening health care delivery to uncovered areas and by adopting the Primary Care Approach. This in turn is crucially dependent on appropriate training of Health Care Providers, both doctors and auxiliary health workers so that they become competent for providing Primary Health Care.

Primary Health Care centered approach:

Emphasis on Primary Health Care centered approach in training of health care providers is required, since they are currently being mainly trained in Hospital Based centers with less exposure to diseases and problems that are common in the community. The world over, this is mainly achieved through Community Oriented or a Community Based Training so that the Health Care Trainees are exposed to the common conditions they would be seeing in real life situations at their workplace.

The main challenges to child health being malnutrition, diarrhoeal diseases, ARI and locally endemic diseases including the vaccine preventable diseases of childhood, Primary care needs to be provided for these conditions besides efforts to prevent them within defined population areas and vulnerable groups.

The underlying reasons for these common health problems in a given community or geographical area being poverty, maternal illiteracy, poor housing, environmental sanitation, unsafe water and poor access or utilization of Health services, these obstacles to health needs to be removed through community-based interventions through community participation.

Thus the Training of Health Care Providers must focus on the early recognition, case management and referral of those needing special care besides being able to identify the underlying social, economic and environmental factors that are leading to occurrence of these problems in the community they serve. Exposure to the benefits of Community Participation and usage of Appropriate Technology in finding solutions to common problems also needs to be undertaken.

Providing appropriate learning experiences is essential for training that is appropriate and relevant to the health needs of people (Children) where they would serve in future. Details are given in Table 1.

The learning experiences at PSG Institute of Medical Sciences & Research:

At PSG, the onus of preparing doctors for primary health care rests with the Department of Community Medicine. For this purpose it has an Urban Health Training Center with 2000 families living in slums, one Rural Health Training Center with 5000 families living in 14 villages covered by Health workers who make home visits and provide primary care. In addition we have three Rural Health sub-centers and three Government Primary Health centers where Interns have opportunities to function as Primary Care Providers.

Community Orientation: The students are exposed to the community through field visits to identify real health, development and environmental problems. This is
achieved by using the Participatory Rural Appraisal (PRA) method which makes the students to interact with different sections of the population in the community and facilitate the people themselves to identify their problems, resources and Plan for Action based on their own resources. This introduces them to the benefits of Community Participation for their health – an important principle of Primary Health Care. Another important tool towards Community Orientation of the students is Family Health Appraisal and follow-up. It is a learning experience which the students undergo when they visit families allotted to them. Here they do family case study wherein the focus is the health of the family, they identify factors influencing health like socio-economic status, beliefs and customs influencing food consumption, budgeting and expenditure on health etc. It provides opportunity to the student to see people in different stages of the Natural History of Disease. In a hospital-based training the students only see serious cases and miss out on the more common illnesses that are present in the community. The Follow-up of a case within the family also helps the student to see how the body responds to the disease over time including the consequences ranging from complete recovery to partial recovery with a disability, or in some cases chronicity and death.

Community Diagnosis and Community Health Program: This is an essential learning experience that helps to train future health care providers who besides their traditional role as care providers to sick individuals will have responsibility for health of people of a defined area or group. The students do a Community Health Survey to identify common health problems and the factors contributing to these morbidities. They are then in a position to work out solutions to the problems they have identified through community participation. Another learning experience which they undergo is the program “Problem Solving for Better Health” in which students based on their exposure to the problems seen by them during their community orientation field visits identify a Health problem, explore doable interventions to solve that problem, frame a study question including the outcome measurements and work out a protocol for the study during a 2-day faculty guided workshop. They then go out into the community to carry out the intervention and measure the effectiveness of their intervention. This experience makes them equipped to use principles of research methodology for solving health problems.

Clinico-social Case Studies of common health problems by the students is another way which enables them to identify the underlying social, environmental and other factors contributing to the illness in the case under investigation. In this exercise they study cases seen both in the hospital and in the community. This makes them realize that for long lasting effect of their case management, besides medical intervention, they need to follow a holistic approach which addresses the underlying social and environmental factors responsible for the disease.

With the growing desire to obtain better value for the increasing investment in health care, stakeholders of the health sector are being asked to demonstrate how they will contribute to improving the health care and health status of society. The introduction of quality control and total quality management are expressions of this trend towards demanding better returns from investment in the health sector.

Medical schools, too, must adapt; they cannot remain indifferent to the important health reforms society expects. They may decide to respond to what they think the changes will be, or, preferably, they may use their potential to contribute proactively to shaping the future health system. They must accept a certain degree of accountability for society’s health if they wish to continue to be forces for social progress and consequently to merit taxpayer support. To fully respond to societal needs, medical schools must accept responsibility for the outcome of their deeds.

Is there evidence that graduates perform effectively and as expected? Do research results have a positive impact on the way health care services are delivered and address health care priorities? Do delivered health care services serve as models and optimally respond to needs?

To maximize their contribution to improved health status, medical schools should develop collaborative links within and outside the health sector with those responsible for policy, planning and finance that are directly/indirectly related to health care, and with health care providers and consumers.
Health Education after making Educational Diagnosis is another learning experience that the students undergo to equip them with Health Education skills. Students identify a common health problem and then list the faulty behaviours that lead to that problem. Then they prepare an educational plan, carry out the intervention and them check / evaluate the effectiveness of the Intervention.

Internship: After Graduating, the Interns undergo training to sharpen their competencies for Case Management of Common Health Problems, Health Education and Counselling at Primary Care level in the Health centers and through home visits. Feedback is given to them so that they can improve further the next time the same skill is required for a patient care encounter.

Thus for Training Personnel for Primary Health Care, emphasis must be placed on Community-Based training so that they become familiar with the local problems, learn to find solutions locally through community participation for a sustainable Community Health & Development Program with optimum utilization of the available services.

### Table 1

<table>
<thead>
<tr>
<th>Purpose/Objectives</th>
<th>Becoming familiar with major obstacles to health: Poverty, Illiteracy, Poor Housing &amp; Environment, Unsafe water</th>
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### Examples of Learning Experiences

1. **Participatory Rural Appraisal and Planning for Community Action.** This involves going to the community, interacting with people using qualitative methods to identify their problems, their resources and helping them plan for a community development program which also includes solutions to overcoming the major obstacles to health listed. This also introduces them to Community Participation in Health & Development which is an important principle of Primary Health Care.

2. **Community Survey for Community Diagnosis and Planning for Community Health and Development.** This is a quantitative survey of the community by visiting the households in a systematic manner and collecting information like Social & Demographic distribution, the main health problems and identifying the reasons for the health problems including Health Service availability & utilization by the people.

3. **Family Health Appraisal & Follow-up.** This involves attaching the trainees to a certain number of Families to do case-studies to identify their health problems and the underlying obstacles to their health listed earlier. It also provides opportunity to observe the illness in different stages of the natural history of disease, an opportunity that is not available if the training is Hospital based.

4. **Clinico-Social Case Studies of Common Health Problems in the community** to identify the underlying factors that led to the disease in the case under study.

### Identifying the Health Needs of the Community and Planning for action

| 1. Growth Monitoring for preventing malnutrition, ensuring Immunization & early and appropriate Case Management of ARI, Diarrhoea |

1. Observing the functioning of an Under-five clinic, review it’s functioning
2. Assist in under-five clinic by doing Growth Monitoring, Immunization & Care Management of ARI, Diarrhoea
3. Giving Health Education to Mothers while they are waiting in the under-five clinic

### Nutritional Rehabilitation

| 1. Placement with health practitioners in the community and making home visits with them |

2. Using Job-aids and algorithms for care of common illnesses
3. Getting feedback from health practitioners on essential skills required for providing Primary Care while trying them out in their direct supervision using observation check-lists

### Learning Primary Health Care & Nursing skills

| 1. Interview mothers who have formed self-help groups for a better understanding of their problems and how they have overcome them collectively. |

2. Participate in the training program for mothers on home management of common ailments and when to seek help.

### Empowering mothers through self help schemes and for home management of common ailments
Recent Experiences in Infectious Diseases: Strengthening Public Health Infrastructure in Disease Surveillance

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How heavy is the burden of Infectious disease-today?

In the past century there have been remarkable achievements in the prevention and treatment of infectious diseases. Bacteria and viruses have been identified; laboratory techniques have greatly advanced; the pathogenesis and epidemiology have been defined for most diseases; and antibiotics and vaccines have been developed to treat and prevent a host of diseases. Examples are everywhere. We have eradicated smallpox and come close to doing the same for polio. Inexpensive treatments such as Oral Rehydration Therapy (ORT) for diarrhoea have greatly reduced mortality and morbidity among children. Improvements in water and sanitation helped to reduce exposure to certain pathogens.

Yet, despite these great successes in controlling and treating infectious diseases, they remain a serious medical burden in both developing and industrialized countries. It is estimated that about 15 million of the 57 million annual deaths (about 26%) are directly related to infectious diseases. This estimate does not include deaths due to the consequences of past infections (for example, rheumatic heart disease) or from complications of chronic infections (for example, hepatocellular carcinoma from hepatitis B infection).

Emerging infections

There is particular concern over what has been termed emerging infections. These can be defined as infections that have newly appeared in a population or have existed previously but are rapidly increasing in incidence and/or geographic range. These diseases can be emerging or reemerging. HIV/AIDS would be considered emerging as would the development of multi-drug resistant tuberculosis and malaria. Tuberculosis, itself, is considered a reemerging infection in many parts of the world, especially those with a high prevalence of HIV/AIDS. Over the past two decades at least 30 new diseases have emerged, many with a potential for rapid spread between countries and continents.

Globalization has clearly accelerated the scale and speed of the transmission of infectious diseases. International travel and commerce have helped to move pathogens from one region of the world to others in hours when it once took months or years. Economic development and land use has led populations to enter areas that had previously been unexplored, exposing persons to new pathogens. This process has been hastened by demographic changes such as the doubling of the world’s population in less than 35 years. Changing ecosystems (i.e. global warming) have also contributed to increasing risk of exposure in some populations. The industrialization of food production (such as large farms breeding millions of chickens) especially in developed countries, has led to increasing vulnerability of some animal populations; and the use of antibiotics in animal feed may contribute to the emergence of resistant strains of bacteria. The inappropriate use and over use of antibiotics have contributed to microbial adaptation and led to the need for more antibiotics to treat common infections as well as antimicrobial resistance as in the case of multi-drug resistance tuberculosis and gonorrhea.

Changes in human behavior

Changes in human behavior have also played a significant role in the spread of STDs and other pathogens. An overriding factor is the level of poverty and social inequality which exists in today’s world. Lack of potable water, poor quality or absence of sanitation facilities, and limited access to health care are but three examples of how poverty has put hundreds of millions at risk of exposure to infectious agents. Most recently the world has had to deal with the possibility of the intent of some people to harm others through the purposeful introduction of natural or man-made pathogens. And lastly the general breakdown or complete lack of government support for public health systems has contributed to the spread of disease and limited our ability to respond to outbreaks.
Need for a well-functioning surveillance system

It is widely agreed that a well-functioning surveillance system for infectious diseases would be a significant contribution to their control both locally and globally. A surveillance system must have trained epidemiologists, and appropriate laboratory back-up. Just as important is that there must be a strong government commitment to ensure that diseases are reported promptly and accurately. Public health professionals must feel that they have full support to tell it like it is. Without this political will, surveillance will be ineffective and the local or international community will not trust its results.

Lessons from the past

For an example of how a system failed we need only look back to 20 September 1994. On that day seven patients with pneumonia-like symptoms were admitted to Surat Civil Hospital in Gujarat State. Two died within a day and other hospitals in the area also started to admit patients with similar symptoms—all from the poor sections of Surat. Examination of patient sputum samples revealed an organism resembling plague bacillus but no bacteriological confirmation was possible as the hospitals did not have the ability to culture the organism. Government officials had to wait a week for laboratory confirmation. A few days later there were media reports of a plague breakout and about 500,000 people fled Surat and the surrounding area. This, of course, led to fears that plague might be carried to other large Indian cities and beyond. Because of the concern, a low-threshold case definition was adopted in order to include all possible cases; the consequence of this is that the number of suspected cases rose throughout western India. Drastic nation-wide measures were taken during the next week in hope of stopping the spread of suspected disease (it had still not been confirmed).

A subsequent report from the All India Institute of Hygiene and Public Health indicated that not a single case of plague was confirmed on the basis of WHO bacteriological standards. It is estimated that the “plague” outbreak cost India at least $2 billion in lost tourism and trade.

A more recent example how a well functioning surveillance system, properly implemented might have limited a national and international disaster can be found in the recent SARS epidemic that first struck China in November 2002. After months of delay in reporting a cluster of unusual cases of pneumonia, China and the WHO took a number of steps to try to control the epidemic. The WHO issued a travel advisory for the Hong Kong Special Administrative Region and the Guangdong Province of China in April 2003, the first such advisory in 55 years. This dramatic step had dire consequences for tourism and business in the region. Travel and flights were cancelled, trade was affected, populations disrupted, schools closed, and a climate of fear spread in affected regions and other areas of the world where cases appeared. The epidemic cost billions of dollars (estimates go as high as 50 billion). But it is possible that the situation did not have to become such a major crisis.

Reporting of the outbreak in its early stages in Guangdong Province was likely delayed because of the Chinese Government’s concern that news of the outbreak would affect trade and tourism. The Chinese government may well have been influenced by what happened to other developing countries reporting similar epidemics. China also lacked an effective infectious disease surveillance system. If China had the capacity to identify the outbreak early, openly transmitted the information to its own doctors and WHO, and sought assistance (if needed), there is at least the possibility that the outbreak could have been controlled much sooner.

WHO’s commitment

The WHO has been working to link national and regional disease surveillance into a global surveillance and response system to prevent the global spread of epidemics. But the system depends on two components: local capacity to detect an outbreak and open and transparent reporting to international authorities such as the WHO. Although most developed countries possess some disease-monitoring capabilities, developing countries often lack trained personnel, diagnostic laboratories and funds
that can support surveillance activities. Where countries do not have an adequate surveillance capability, inaccurate reports and rumors can rapidly lead to social disruption nationally and unwarranted panic internationally.

These observations lead to the following recommendations

- Countries must be encouraged and funded to build their surveillance capacities. At a time when many factors are pushing governments to privatize large elements of the health sector, this is an area of government that needs much greater support.
- It is necessary then to focus on training of epidemiologists, improvement of specimen collection, updating laboratory facilities, and improving the capability of the health sector to respond to outbreaks.
- There must be viable careers for physicians and others that offer exciting opportunities and pay salaries that are the equivalent of practicing physicians.
- To encourage open reporting by affected countries, measures could be taken to provide a safety net for rebuilding and recovering losses after an outbreak.
- International organizations could advocate that economic aid be given to countries affected by outbreaks. A compensation fund could be created and jointly administered by the World Trade Organization and WHO to help countries suffering economic loss.
- The role of the media must be reviewed. News organizations should understand the consequences of sensationalized reports.

Building such an infrastructure will take time and money but the amount pales in comparison to the billions lost in trade and tourism, not to mention the affect on the population’s health. Had India set aside only 5% of the $2 billion dollars it lost during the suspected plague outbreak there would have been over $100 million available to develop national epidemiology, diagnostic, and surveillance capacity!!.

Some thoughts ...

There is a “word of fear” that I shall pronounce when I utter the name of Puerperal fever: for there is almost no acute disease that is more terrible than this … There is something so touching in the death of a woman who has recently given birth to her child; something so mournful in the disappointment of cherished hopes; something so pitiful in the deserted conditions of the new—born helpless creature, forever deprived of those tender care and caresses that are necessary for it—that the hardest heart is sensible to the catastrophe. It is a sort of desecration.

- Charles Delucena Meigs,
  Professor of Midwifery and the diseases of Women and Children, Jefferson Medical College, 1851.
  Source: The Doctors’ Plague – Sherwin B. Nuland.

“The use of technology has the potential to make vast improvements in development. There is enormous scope for innovative public—private partnerships in this area—partnerships that can draw on global skills and expertise, but then apply them to local challenges. These applications can embrace a variety of important development sectors—health, education, agriculture and financial services are among those areas where technology can make a difference.

- Partnering with the Private Sectors in Development - Mark Malloch Brown
“The sacredness of life honoured in our traditions grounds our belief in the ultimate meaning and value of the child. This sacredness of life compels us to be a voice of conscience to all, throughout the world, who have held a child in love, with joy for its life, with tears for its pain”

- WCRP Declaration

While working on this section I asked my friend Prof. Anant Rambachan, “Why should we as people of faith even speak about the need to work for children”...to which he replied... “Children are God’s gifts to us. They are expressions of God’s grace and blessing. If we value the divine, we must also value the gifts of the divine. If we see and understand children as God’s gifts to us, we can never take them for granted. Their meaning for us is enhanced immeasurably, for they are also our gift to the world. By helping them to be healthy in body and mind and to achieve the fullness of their potential, we enrich the future. On the other hand, when a child fails to be all that she or he could be, through neglect and lack of basic resources, the world suffers. The world is denied the unique contribution of that child”. Indeed this is why the work for ‘All children’ has the unique potential to be grounded in our faith traditions, in our communities and in the best we have to offer to the inheritors of our common human heritage.

In this chapter ‘Care for every Child- the Multi- faith perspective’ very distinguished Leaders of World Religions lead us in revisiting the ethical basis of our work for Children. They share scriptural sources, narratives, experiences and their own deep thinking, drawing from their particular religious tradition. The contributors have addressed the many challenges that affect Children’s development and identified values and practices can that can help change such situations. There is also a universal dimension to this collective thinking and shared commitment, which makes the care of every child not only an ideal but also an ethical obligation!
Providing a Safe and Happy Environment for our Children

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Director, Bahá’í Office of External Affairs & Inter-Faith Activities

Marriage is the foundation on which the family is built, and the family is the basic unit of society. Through various media we are reminded constantly of the myriad social, economic, and political diseases arising from the prevailing confusion about the nature of human beings and the nature of society. Some of these illnesses—such as family breakdown, violence, destruction of environment, substance addiction and abuse—affect our children directly, while others—poverty, materialism, racism, casteism and sexism—appear more diffused.

How, then, can the present world, with its “entrenched pattern of conflict,” provide a safe and happy environment for our children and all the peoples who inhabit the planet. Transformation of present-day society on the basis of God’s purpose of humankind in this Age, is the essential goal of the Bahá’í Faith. Baha’u’llah wrote: “Is not the object of every Revelation to effect a transformation in the whole character of mankind, a transformation that shall manifest itself, both outwardly and inwardly, that shall affect both its inner life and external conditions?” “These fruitless strife, these ruinous wars shall pass away, and the ‘Most Great Peace’ shall come.”

The teachings and laws for individual and family life, when coupled with the overall social principles outlined by Baha’u’llah, point to the establishment of a family founded on the equality of the two marriage partners, on their constant consultation in all aspects of family, decision-making, and on respect for children and their rights. The rights and duties of family members vary, according to their roles. Children, for instance, have the duty to obey their parents. They also have the corresponding right to be cared for, educated and protected. A study of the Bahá’í Writings reveals that the spiritual education of children is essential to the process of individual growth.

Indeed, from its very inception the Bahá’í Faith has addressed the responsibility of the proper upbringing of children and it continues to be one of the serious questions that face the generality of humankind at this point of time in its history. According to the Bahá’í Writings, “The injury of one shall be considered the injury of all ... the honour of one, the honour of all...to be checked”. A child’s ability to contribute both socially and spiritually to the community must be cultivated. Parents are primarily responsible for the socialization of the child and for the transmission of moral values. In the Bahá’i view, a proper education includes moral, material, spiritual, and social training, and it is to be accorded to both girls and boys. In fact, Bahá’ís have long championed the education of women and girls. Although universal education is the goal, the Bahá’í teachings state where limited assets force a choice between education of girls or boys, preference should be given to girls, since they are primary educators of the next generation. The vast majority of children who are vulnerable to exploitation of all kinds are girls.

The worldwide Bahá’í community gives a high priority to the implementation of the United Nations Convention on the Rights of the Child and other instruments for protecting the Human Rights of all. It further urges that the right to moral education based on the principle of the oneness of humanity should receive the highest priority. Religious communities have a crucial role in educating humanity to respect all children as a sacred trust. Bahá’ís are urged to be uncompromising and vigilant in their commitment to the protection of children.
“Each child is a renewed message that God has not lost faith in humankind.” – Tagore  We cannot help but feel, deeply in our hearts, these words of Tagore’s. All children are irreplaceable gifts received from God and the Buddha. These “Children of God” and “Children of the Buddha” harbor the future.

In reality, though, today’s children have been placed in an unspeakably cruel and terrible circumstance. Since 1990, 2 million children have died in wars, another six million, severely wounded. And every year, 10 million die from illnesses linked to poverty, and 100 million cannot receive even the most basic education. A world, a society that makes children suffer so - consequently leads to a world in which all people are not valued equally.

Buddhism teaches us that all things existing in this world come into being through innumerable and infinite causes and conditions, that all things are interrelated and interdependent on one another and that therefore, they are all part of one Great Life. When we realize this Truth, ourselves and others are as one, the joy and suffering of others become our own. The Truth realized by Shakyamuni is this seeing of things in terms of their absolute Oneness, instead of looking at them relatively or in opposition to each other.

This unity of life is expressed by religious people in word such as “God’s children” or “Children of the Buddha.” To put it in universal terms, we can say that we are all “Children of Life.” This sense of commonality, which transcends the notion of “others and oneself” and transcends differences of country and race, is the very thing that dispels violence and social injustices, prompts a fair redistribution of wealth, and is the source of realizing a world of coexistence and a world of peace.

Today, our world welcomes a period in which religious values are placed at the center of international politics and economic activity. But until that has been achieved, the cruel reality confronting children will only be repeated indefinitely.

It is of utmost importance that we better the dire circumstances of children. At the same time, however, it is not possible to completely displace the self-centered values that assume that “survival of the fittest” is well and right. Doing so, though, is the mission we religious leaders take upon ourselves. I send my prayers that all children will grow up in harmony and health.
The Christian tradition reserves an extraordinary place to the child. Harshly correcting his own disciples, Jesus embraces children, blessing them, commending them as examples and announcing them as primary heirs of his Kingdom: “People were bringing little children to Jesus to have him touch them, but the disciples rebuked them. When Jesus saw this, he was indignant. He said to them, ‘Let the little children come to me, and do not hinder them, for the kingdom of God belongs to such as these. I tell you the truth, anyone who will not receive the kingdom of God like a little child will never enter it’. And he took the children in his arms, put his hands on them and blessed them.” (Mark 10, 13-16)

Jesus also praises his Father in heaven for having hidden the secrets of the Kingdom from the wise and learned, and revealed them to little children (Luke 10,21). As we can see, then, both knowledge of God and salvific participation in the reality of God is in Jesus’ message made dependent on a conversion to the child. Furthermore, just as well as our approach to God mediated through the child; God also comes to us as a child. Reflecting deeply on the implications of the mystery of the incarnation the faith in God becoming fully a human being, human flesh in the birth of Jesus Christ, thus adds to the truly radical character of the value of the child in the Christian faith tradition. Not only could we say that the incarnation shows us that humanity as such is capable of containing the divine, but also that a human child can be the bearer of the divine.

The custom of my church and many other churches to baptize small children can be seen as a liturgical and sacramental manifestation of this high esteem for the child in the Christian tradition.

These resources of faith are invaluable in the present-day work for the rights and needs of children worldwide. The churches have not always seen the full implications of these central beliefs. In spite of them, the churches many times blindly adopted the general, often adult-centered view of human beings and of reality, to the point of neglecting, marginalizing and even disrespecting the rights of children and youth. Feminist re-readings of Scripture and the Christian tradition have helped us to become aware of and overcome some of the tragic consequences of patriarchal structures in church and society. Today I am convinced a re-reading from the perspectives of children and youth from different corners of the world will help release the liberative and life-enhancing potential in the Christian tradition to secure the rights and welfare of young human beings, globally.

These resources of faith are invaluable in the present-day work for the rights and needs of children worldwide.


How Children are valued in Hindu Tradition

“...When there is a conflict between the heart and brain, let the heart be followed. The heart goes beyond the intellect and reaches what is called inspiration. Always cultivate the heart. Through the heart the Lord speaks.”

- Swami Vivekananda

Children and Dharma

His Holiness Sri Sri Sugunendra Theertha Swamiji
Jagadguru Sri Madhavaacharya Moola Mahaa Samasthanam
Sri Puttige Matha, Udupi, Karnataka, India.

Sometimes adults dissuade children from learning about dharma and religion, incorrectly, thinking that the child is too young or too immature for such knowledge. In fact, childhood years are the best time to teach children about dharma. It is also true that sometimes adults can learn better about dharma by observing children!

The importance of children and childhood is made especially clear in the doctrines and beliefs of Madhva Vedanta. After all, Madhva Vedanta is centrally focused around Lord Krishna who is often worshipped as a child. Some Madhvas seek to express their bhakti, devotion to Lord Krishna in the same way that a parent or elder shows affection for a child. For this reason, they worship Krishna as Bala-Krishna, Baby Krishna.

In the Bhagavata Purana, the story of the life of Krishna, Bala-Krishna is depicted as a naughty youngster whose mother is constantly chastising him for being so mischievous. In one well-known story, his mother Yasoda washes his mouth of the dirt that he has eaten and in so doing she sees the entire universe contained therein:

One day when Rama and the other little sons of the cowherds were playing, they reported to his mother, “Krishna has eaten dirt.” Yasoda took Krishna by the hand and scolded him, for his own good, and she said to him, seeing that his eyes were bewildered with fear, “Naughty boy, why have you secretly eaten dirt?.” Krishna said, “Mother, I have not eaten. They are all lying. If you think they speak the truth, look at my mouth yourself” “If that is the case, then open your mouth,” she said to the Lord Hari [Vishnu], the God of unchallenged sovereignty who had in sport taken the form of a human child, and He opened his mouth.

She then saw in his mouth the whole eternal universe, and heaven, and the regions of the sky, and the orbit of the earth with its mountains, islands, and oceans; she saw the wind, and lightning, and the moon and stars, and the zodiac; and water and fire and air and space itself; she saw the vacillating senses, the mind, the elements, and the three strands of matter. She saw within the body of her son, in his gaping mouth, the whole universe in all its variety, with all the forms of life and time and nature and action and hopes, and her own village, and herself. Then she became afraid and confused, thinking, “Is this a dream, or an illusion wrought by a god? Or is it a delusion of my own perception? Or is it some portent of the natural powers of this little boy, my son? I bow down to the feet of the god, whose nature cannot be imagined or grasped by mind, heart, acts, or speech; He in whom all of this universe is inherent, impossible to fathom. The God is my refuge, He through whose power of delusion there arise in me such false beliefs as I”.

For a brief moment, by seeing the universe in her son’s mouth, Yasoda is overcome with bhakti for him. The child, then, can teach or inspire an adult about bhakti! So the power of the child cannot be discounted!

From these stories it is clear that the devotion of children is to be emulated rather than scorned. Childhood is the golden period of life and is the best time to teach dharma. Children are ready to learn and whatever is registered in their minds becomes permanent. Just like Prahlada who heard the story of Lord Vishnu in his mother’s womb, children can learn dharma and become bhaktas, devotees, with far greater ease than adults. The first priority is to teach children about dharma and to praise and even emulate those children whose devotion is exemplary. These stories about Lord Krishna, about Prahlada and Dhruva, indeed confirm the saying that “the Child is the father of man.”

* Our grateful appreciation are also due to

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All religions emphasise the importance of the human soul as a manifestation of the divine will that created all intelligent life. As part of religious feeling about human rights, we know that the protection, education, love and care of children are of surpassing importance. Universal recognition of the status of the child is reflected in the ratification by 192 counties of the Convention on the Rights of the Child, and it is hoped that the USA and Somalia, the only two remaining countries who have not ratified the Convention, will do so soon.

Faith, in parallel with secular moral codes, prompts the belief that we must all work to reduce poverty, violence, drug abuse, disease, malice, ignorance and other factors which degrade the environment around children and endanger their potential of living happily, while putting the world on a better track for the future. The harmful exposure of children to the suffering of others is another dangerous factor, which should be reduced. A case in mind is the heavy psychological and social burden carried by child soldiers and witnesses of violence.

With one glance at the State of the World’s Children report, we can see the grim reality of daily life of the world’s innocent generation. At least 30,000 under fives died preventable deaths only last year, and while child mortality rates declined by one fifth over the decade, more than 10 million children perished in 2003. At least 640 million children do not have adequate shelter, while 140 million have never been to school. Safe water is something that 400 million children are denied, while 500 million live without basic sanitation. The shadow of AIDS lingers long.

Half a million children under the age of 15 died of the disease last year and 2.1 million children across the world live with HIV. In our region, of the 3,024 Palestinians killed by the Israelis, 603 were minors, and of the 429 Israeli civilians killed by Palestinians, 78 were minors. Still, governments of the world have not delivered on all the agreements they have signed regarding the protection of children, nor have they honoured the promises they have given.

From the Muslim perception, I would like to say that Prophet Mohammad (PBUH), introduced something of a social revolution into the pre-Islamic Arabia. Some of the injunctions for the protection and care of children in the Qur’an, specify, that parents may not kill their children (6:140); that children are to be carefully provided for materially (17:31 and 2:233) and that breast-feeding is recommended (2:233).

Where the Qur’an refers to children, it does so with an Arabic word ‘awladakum, which is gender neutral. In other words, female children are to be treated in the same way as male children. Learning is an obligation for both males and females. The traditions of the Prophet Mohammad report that the Prophet said, “Upon death, man’s deeds will stop except for three deeds, namely: a continuous charitable fund, endowment or goodwill; knowledge left for people to benefit from and a pious, righteous and God-fearing child who continuously prays to God, the Almighty, for the soul of his parents”. (This hadith reported by a Muslim scholar.)
‘Sacredness of Human Life’

Rabbi David Rosen
International Director of Interreligious Affairs
The American Jewish Committee

Judaim views childhood as a period of purity, joy, and beauty to be valued and cherished. The Talmud states, “Childhood is a garland of roses” and “the very breath of children is free of sin.” Babylonian Talmud, Shabbat 152, 119).

As Judaism recognizes that a child does not have the cognitive ability to fully distinguish good from evil, the parent has the ultimate responsibility of guiding the child in keeping with the words in Deut. 11 v.18 “And you shall teach them (the words of God) to your children ... in order that you may lengthen your days and your children’s days upon the earth.” Similarly Proverbs 1.v.8 enjoins, “Listen my child to the instruction of your father, and forsake not the teachings of your mother.”

Children are regarded as the hope of the future in every society, yet among the Jewish people this concept is enhanced by the view that children are a Divine trust and guarantors of the future. The Book of Psalms (127 v.3) declares, “Children are an inheritance from the Lord”, and in the ancient homiletical tradition, we read that Rabbi Meir said: “When the Children of Israel stood at Mount Sinai to receive Divine Revelation, the Holy One, blessed be He, said to them: ‘Bring me good guarantors that you will keep my Revelation and then I will give it to you.’ They replied: ‘Sovereign of the Universe, our ancestors will be our guarantors.’ Said God them: ‘Your guarantors need guarantors themselves, for they have not been without fault.’ They answered, ‘Our prophets will be our guarantors.’ God replied: ‘They have also not been without fault.’ Then the Israelites said: ‘Our children will be our guarantors.’ To which God replied: ‘In truth these are good guarantors. For their sake I will give it to you.” (Canticles Rabbah, 1:4)

Since Judaism teaches that all human beings are created in the Image of God, human life is therefore sacrosanct and the Talmud (Shabbat 15b) rules accordingly that: “One desecrates the Sabbath for the sake of a babe of one day, but not for the dead body even of David, King of Israel.” Thus, the sacredness of human life is applied to the infant as soon as she or he is born. The need to enable every child to recognize his or her own dignity and value is expressed in the teaching, “Every individual should perceive the world as having been created for his/her own sake.” (Babylonian Talmud, Sanhedrin 38). As a logical consequence of this conception, each child is entitled to be loved and cared for, in order that he or she may have the possibility of developing to his maximum capability.

Jewish law specifies the rights of children, which are the primary obligation of the natural parents, but which in the latter’s absence, incapacity or failure, become the responsibility of the community. These include not only the right to life, dignity, and freedom, but also to be provided with the skills to survive natural dangers as well as to earn a living and be self-sustaining. The abuse of children is prohibited even to parents and teachers with good intentions. This especially applies to orphans for whom the community bears responsibility for their needs (Babylonian Talmud Ketubot, 50); Maimonides (Hilchot Deot, 6:10) declares ..., “A person must be especially heedful of his behavior toward widows and orphans, for their souls are exceedingly depressed and their spirits low.”

While the most basic needs that parents and community must provide for children are those of food, clothing and protection, (Babylonian Talmud, Ketubot 49; Maimonides, Yad, Hilchot Ishut, 12) education has a special place of importance (Mishnah, Chagogah 1:2; Babylonian Talmud Sukkah, 42 & Shabbat, 121) as providing the values by which children learn to live a holy, spiritual and moral life, and subsequently pass on the Heritage to future generations.
“Development is about expanding the choices people have to lead lives that they value.”
- Global Human Development Report 2001

The Millennium Development Goals commit the international community to an expanded vision of development, one that vigorously promotes human development as the key to sustaining social and economic progress in all countries, and recognizes the importance of creating a global partnership for development. The goals have been commonly accepted as a framework for measuring development progress. All the 191 member states of the UN have committed to working towards this mission. Achieving the MDGs by 2015 will require more focus on development outcomes and less on inputs, to effectively measure national progress towards meeting the MDGs, and to engage even more closely with our partners in helping governments improve human development. Six of the eight goals directly have a bearing on the quality of life for children. Achieving the MDGs by 2015 will require more focus on development outcomes, with effective measuring of national progress, and to engage different partners in helping governments and communities improve human development. The first seven goals are mutually reinforcing and are directed at reducing poverty in all its forms. The last goal-global partnership for development- is about the means to achieve the first seven.

I recall the statement of an Indian farmer when asked about the special development package that had just been passed in the Indian parliament in the 1990’s. He said “The Honourable Prime Minister sends us an elephant, but when that elephant arrives at our village all we see of it is the its tail”. True often-global agendas and resources get diluted and reduced both in quality and number. People’s participation holds the key to sustainable development, as does public education. For development initiatives to be effective they have to be resonant of local realities, of peoples’ aspirations, of integrated problem analysis and well-monitored programme implementation. Even in better-off countries there may be regions or groups that lag behind. Countries need to set their own strategies and work, together with their global partners, to ensure that poor people are included in the benefits of development.

In this chapter Prof. M. S. Swaminathan leads us in looking at how mainstreaming nutrition can help improve development outcomes. He highlights the current socio-political context and the opportunity that the MDG’s provide in promoting Human development. Some Innovative examples which have helped break the cycle of malnutrition, disease and poverty have also been shared. How MDG’s can be one of the cornerstones in ensuring children a legacy of hope is thoughtfully articulated in this chapter!
Mainstreaming Nutrition to Improve Development Outcomes

Prof. M. S. Swaminathan
UNESCO Chair in Ecotechnology, Chairman, M. S. Swaminathan Research Foundation

UN Millennium Development Goals (MDG)

By the year 2015, all the 191 United Nations member states have pledged to meet these goals

1. Eradicate extreme poverty and hunger
   - Reduce by half the proportion of people living on less than a dollar a day.
   - Reduce by half the proportion of people who suffer from hunger.

2. Achieve universal primary education
   - Ensure that all boys and girls complete a full course of primary schooling.

3. Promote gender equality and empower women
   - Eliminate gender disparity in primary and secondary education preferably by 2005, and by all levels by 2015.

4. Reduce child mortality
   - Reduce by two thirds the mortality rate among children below five.

5. Improve maternal health
   - Reduce by three quarters the maternal mortality ratio.

6. Combat HIV/AIDS, malaria and other diseases
   - Halt and begin to reverse the spread of HIV/AIDS.
   - Halt and begin to reverse the incidence of malaria and other major diseases.

7. Ensure environmental sustainability
   - Integrate the principles of sustainable development into country policies and programmes; reverse loss of environmental resources.
   - Reduce by half the proportion of people without sustainable access to safe drinking water.
   - Achieve significant improvement in the lives of atleast 100 million slum dwellers, by 2000.

8. Develop a global partnership for development
   - Develop further an open trading and financial system that is rule-based, predictable and non-discriminatory. Includes a commitment to good governance, development and poverty reduction - nationally and internationally.
   - Address the least developed countries special needs.
   - Address the special needs of landlocked and small island developing States.
   - Deal comprehensively with developing countries debt.
   - In cooperation with the developing countries, develop decent and productive work for youth.
     - In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.
     - In cooperation with the private sector, make available the benefits of new technologies.

In our world today, the statistics on hunger continue to rise alarmingly despite general economic progress and technological advancement. The quality of peace and true democratic value and the realization of human rights remain stubborn challenges facing civilization in the twenty-first century. Both developed and developing countries have missed some crucial links that might have ensured sustainable development and a more promising ‘peace’ scenario today. In its haste, the global society has overlooked its rich heritage of cultural, moral, and ethical values as well as its basic respect for human life and promotion of human dignity, and has sadly discarded its general code of ethics and spirituality. In other words, the focus of the world has been mainly uni-dimensional on economic success and political power.

The recently concluded summits – World Food Summit in Rome and the World Summit on Sustainable Development in Johannesburg – have brought home the lack of political will and consensus to achieve even modest targets. There is need for a consensus to achieve even modest targets. There is need for a larger ethical and moral movement beyond politics and the onus is on civil society to take the lead.

Towards a hunger free world

The United Nations and its specialised agencies like FAO, UNICEF and WHO have been urging from time to time the need to accelerate progress in achieving the goal of a hunger and malnutrition free world. The UN Millennium Development Goals (MDG) include a commitment to reduce by half the proportion of people living on less than a dollar per day, as well as those suffering from hunger, by the year 2015. Other goals include reducing by two thirds the mortality rate among children under five and by three quarters the maternal mortality rate by 2015.
The UN has proposed that every country should prepare MDG national reports in order to move the Millennium goals from the global to the local level. This will help to create the necessary links between global target setting and national priority setting. FAO has recommended that countries committed to reduce hunger should prepare multi-component National Food Security programmes, based on the experience gained from FAO’s Special Programme for Food Security over the past 8 years.

Achievement of MDG targets much before 2015 is possible if the following steps are taken at the national and global levels.

- **Adopt a whole life cycle approach** to ending food insecurity at the level of each individual and during all stages in one’s life;
- **Accelerate agricultural progress** since in countries where over 50 per cent of the population depend on agriculture (crop and animal husbandry, fisheries, forestry, agro-processing and agri-business), agricultural progress is the best safety net against hunger and poverty;
- **Foster a food based approach to ending malnutrition** since this confers the double benefit of nutritional and livelihood security in rural areas, and
- **Establish a National Grid of Community Food and Water Banks** in order to make community managed food security systems characterised by greater transparency, effective delivery and low transaction cost, the main instruments for achieving freedom from hunger.

**Challenges:**

A major challenge lies in the area of linking horizontally, on a life cycle basis, the numerous vertically structured nutrition support and intervention programme. It would be useful to establish at the national and sub-national levels **Consultative Groups for Ending Malnutrition** comprising representatives of relevant government departments, academia, civil society organisations, women’s organisations, the mass media and bilateral and multilateral donors to monitor progress and fill gaps in ongoing efforts.

**Some innovative examples:**

*The Food Insecurity Atlas for India,* provides detailed data on the factors responsible for food insecurity in rural and urban areas. This was prepared by the M.S.Swaminathan Research Foundation (MSSRF) in cooperation with the World Food Programme. MSSRF has established a **Virtual University for Nutrition Security,** involving the integrated use of the internet, cable TV, community radio and vernacular press, for spreading nutrition literacy as well as information on local level strategies for eliminating chronic, hidden and transient hunger by August 15, 2007, which marks the 60th anniversary of India’s independence.

**Brazil’s Zero Hunger Project,** launched at a cost of about US$ 3 billion per year, has several interesting features. Under this programme, those who are in need of food assistance are required to undergo training programmes which will enable them to acquire marketable skills and thereby take to an exit pathway from dependency. The Zero Hunger Project includes measures to improve food safety, nutrition education and school feeding. There are thus opportunities for a lateral sharing of experiences among developing countries committed to ending hunger as soon as possible. Promoting such lateral learning among developing countries should be one of the priority goals of the UN Standing Committee on Nutrition.

**Elimination of hunger - the first requisite!**

Elimination of hunger is the first requisite for a healthy and productive life. Labour productivity is low in many developing countries due to under and malnutrition. Maternal and foetal under and malnutrition lead to the birth of babies characterised by low weight. This in turn affects
brain development and places the child at a severe handicap in this knowledge and information age. Nutrition security at the level of every child, woman and man is the foundation for socially sustainable and equitable development. Merely administering drugs among those suffering malnutrition for diseases like HIV/AIDS, tuberculosis and leprosy will not be able to control such diseases. The links between nutrition and the control of major diseases affecting the poor are yet to be widely realised. Hence, those engaged in malnutrition elimination programmes should form alliances with health care workers. Food for the cure of HIV/AIDS, tuberculosis and leprosy should be an important component of the programme of the UN World Food Programme.

More understanding and action for Nutrition Security can play a major role in conceptualising integrated solutions to malnutrition and in fostering health literacy among the public!

**Ensuring Children a legacy of Hope**

History is a constant pointer to the fact that economic development and materialistic values, without addressing the problems of inequity and hunger, are not effective recipes for peace. All key players must realize that they have a personal stake in eradicating hunger and alleviating poverty. The understanding that there is a common human agenda that includes ensuring the well being of every single person has been reiterated by all major world religions and is the need of the hour.

*There is a moral responsibility for every human being, particularly those vested with authority and influence, to ensure that suffering and deprivations are not bequests handed down to coming generations. Children do not deserve to inherit hunger as a legacy, they deserve to grow and flourish in happiness.*

"Global Health: Why it Matters?"

**Global health matters - because we cannot be healthy in an unhealthy world. Specifically, global health matters on 3 counts:**

**F**irst and foremost, global health matters on humanitarian and development grounds. The human misery and ill health should appeal to our sense of solidarity with fellow human beings in this global village. We should feel a sense of outrage knowing that although science has given us many highly cost-effective interventions, these are still available only to a small fraction of those who could benefit from them.

**S**econd, global health matters on the ground of global health security. Unlike people, diseases do not need a passport or visa to travel. No amount of border controls in today’s world can effectively seal a country from the stealthy, unannounced transmission of diseases, as we have seen most recently with the SARS outbreak. We must consider support for many health interventions in developing countries as global public goods. Campaigns to eradicate or eliminate diseases such as smallpox, polio, malaria, TB, HIV/AIDS, etc. are the classic examples of global public goods with mutual advantages for all parties concerned. The same can be said for epidemiological surveillance at the international level, analysis of global health trends, and technical cooperation among countries to combat diseases and to promote public health.

**T**hird, global health matters on economic grounds. Global health programs are not expenditure. They are an investment. The example of smallpox eradication is particularly telling in this regard: the General Accounting Office has estimated that the US recovers in savings every 26 days what it invested in the worldwide smallpox eradication effort.

So, whether it is on grounds of human solidarity, for the health security of all countries or on economic grounds, there is compelling evidence that investing in global health makes good sense. That is why today, global health is at the heart of every agenda for human development. And human development, of course, starts with investing in children, beginning with giving all children the best possible start in life, so that they survive and thrive. Few investments will pay dividends as disproportionately large. For healthy children today will ensure the well being and productivity of future generations for decades to come. That is why global health has become a pillar of commitments made by the international community in all landmark Summits and major UN conferences of recent years. Health figures prominently in the global consensus reached in the Millennium Development Goals, the agenda for building a World Fit for Children, and in key articles of the Convention on the Rights of the Child.
The fourth millennium development goal aims for a 2/3rds reduction in under 5 mortality rates between 1990 and 2015. The global gains in child survival since 1990 is significant but discrepancies within and across countries and regions are also evident. The 50% reduction in under 5 mortality between 1960 and 2000 represents great progress but much more needs to be done. The estimated 11 million totally preventable child deaths still occur every year due to acute respiratory infections, malaria, measles, HIV/AIDS etc.

Young children can be saved by basic cost effective measures like vaccines, antibiotics, micro nutrient supplement, improved breast-feeding practices etc. Globally one billion children are affected by poverty. This indicates the disadvantage that children in such great numbers have even as a start. The complex environment that children face today makes it imperative for all those working with children to continue to provide for the basic needs of children even while we grapple with new challenges like HIV/AIDS and natural disasters like Tsunami.

According to Unicef’s projection 53 developing countries will meet the millennium development goal, which aims by 2015 to have reduced the Under 5 mortality rate of 1990 by 2/3rds. But 98 developing countries lag behind. Children are half as likely to die before age 5 today as 40 years ago. But the progress is uneven.

Knowing why so many children die, suffer from disease and lack access to a basic human needs is important for informed interventions. A lost childhood is not our children deserve … they deserve our attention, they deserve our care!

### Water Facts

**Waterborne diseases (the consequence of a combination of lack of clean water supply and inadequate sanitation) cost the Indian economy 73 million working days a year. And a cholera outbreak in Peru in the early 1990s cost the economy US$1 billion in lost tourism and agricultural exports in just 10 weeks.**
DISCRIMINATE DEATH!

**Discrimination by wealth begins even before birth.** Poor, undernourished mothers are more likely to give birth to undernourished babies - and small, weak babies are more susceptible to illness and death.

Low birthweight babies are 4 - 6 times more susceptible to physical and mental handicap, and 8 - 10 times more likely to die in the first year of life. More than 23 million babies a year are born weighing less than 2,500 grammes (approx. 5.5 pounds); 90% of these are born in the developing world... where one child in four is also seriously undernourished.

Source: Rehydration Project

1. 40,000 children under the age of five die each day from malnutrition and vaccine preventable disease.

2. Universal access to just four low-cost health care measures could save the lives of half of the 15-18 million children who die each year from preventable causes. Nearly 8,000 children are dying each day because they have not been immunized; nearly 7000 are dying from dehydration caused by diarrhoea, and approximately 6000 are dying every day from pneumonia. Making available today’s low cost solutions to all of these health problems would cost approximately $2.5 billion a year.

3. Nearly 100 million children of primary school age are not taking part in any education programs.

4. Only half the children in the developing world have access to clean drinking water, and fewer have access to sanitary waste facilities.

5. Half a million mothers die annually as a result of pregnancy or childbirth.

6. Breast feeding is on the decline in many developing countries although bottle-fed infants contract far more illnesses and are as much as 25 times more likely to die in childhood than infants who are exclusively breast fed.

7. Each year at least 250,000 young children lose their sight for the lack of a small amount of vitamin A in their diet. Two 2 cent doses of vitamin A could prevent this.

8. Over 100 million children throughout the world are forced to work under hazardous and often fatal conditions; many are employed under slave-like conditions for no pay.

9. More than one billion people - the majority of them children - either have no home or live in inadequate housing.

10. There are more than 10 million child refugees around the world, comprising 60% to 70% of the refugee population.

Source: Statistics from UNICEF’s State of the World’s Children & Report of PLAN International

**EDUCATION** is the key to progress for individuals, communities and countries. Yet nearly a quarter of the world’s population is illiterate, and millions of children - more girls than boys - never go to school. About 90% of children in developing countries begin primary school but only 68% complete four years of basic education. Of the 143 million children in developing countries not attending primary school, 56% are girls. Of the world’s nearly 900 million illiterate adults, nearly two thirds are women.

### Children’s Education in Developing Countries

<table>
<thead>
<tr>
<th>Countries</th>
<th>% starting grade</th>
<th>% reaching 10th grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>74</td>
<td>47</td>
</tr>
<tr>
<td>Middle East &amp; North Africa</td>
<td>93</td>
<td>83</td>
</tr>
<tr>
<td>South Asia</td>
<td>96</td>
<td>57</td>
</tr>
<tr>
<td>East Asia &amp; Pacific</td>
<td>100</td>
<td>85</td>
</tr>
<tr>
<td>Latin America &amp; Caribbean</td>
<td>99</td>
<td>65</td>
</tr>
</tbody>
</table>

Source: The Progress of Nations 1995

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“We must preserve our planet
in order to
nurture our children;
equally,
we must nurture
our children
if we are to
preserve our planet.”

- James P. Grant
Former Executive Director of UNICEF