Making it better: children’s place in sustainable development

There is no time like the present to make a difference to child health. Children are no longer simply ‘objects of concern’ to child health and welfare practitioners, non-government organisations and government departments. Multidisciplinary conferences on investment in children and the growing interest in children’s issues from economists1-4 and political leaders5 have carved a key place for children in sustainable economic and social development.

Investment in children in Canada, the USA, New Zealand, Australia and the UK, particularly in early years’ services, is gaining momentum. That said, these nations still lag behind the Nordic countries. Nevertheless, there are signs that the message that the time to make the greatest difference is at the very start is having an impact beyond the world of child health.6 While life-course studies show that it is never too late to make a difference, sooner is better in terms of both outcomes and cost-effectiveness.7

Public health practitioners have had a major impact on the eradication of infectious diseases; now the new agenda for children gives child public health in its widest sense the opportunity to address a much larger project. What do we know, and what are the gaps we need to fill? Twelve years of evidence-based health care through the worldwide Cochrane Collaboration, and the initiation in the last few years of the Campbell Collaboration, establishing syntheses of evidence in education, social care and criminal justice have started to make inroads into bringing together the evidence on a wide range of primary studies on what works and what doesn’t. Other initiatives, including the work of the Centre for Public Excellence in NICE on evidence and ‘What Works for Children’ (www.whatworksforchildren.org.uk) have made a contribution both to the knowledge base and to getting research into practice. Even so, it has to be acknowledged that the evidence cupboard in child public health is far from being fully stocked.

What are the interventions for reducing inequalities in child health where we have good evidence, and what are those that look promising? A good place to start to look for effective interventions is in relation to the major causes of death. In most OECD countries, accidental injury in childhood remains the biggest killer, but the most effective interventions involve a change in the balance of power between adults and children. It is easier, if less effective, to target the behaviour of children with exhortations to cross roads safely than it is to enforce speed limits and clamp down on drivers. We have also known for some time that architects and planners could do better in designing houses, public buildings and roads which are more child-friendly, less susceptible to fire, and which separate people from traffic.8,9

At a policy level, if we look at the steep social class gradient in poor health outcomes, every observational study shows that money ‘works’. At an individual level, while there is good evidence of effectiveness in relation to some outcomes from parent training, home visiting and mentoring schemes, these ‘big’ interventions remain massive black boxes. And knowing that something works for some people in New York is no guarantee that it will work in York, England or in Auckland, New Zealand. Home visiting, mentoring and parenting support provide no magic bullet for the problems of living in poverty.

What don’t we know? In spite of the growth of evidence informed policy and practice, the research agenda has a real challenge. Absence of evidence is not, of course, the same as evidence of absence. In order to fill the research evidence gaps in a way which responds to need, a cultural as well as an intellectual shift is required. At present, many practitioners, particularly in child welfare services, have a negative view of research. The ‘fit’ between their research questions and our research answers is poor, and there is much that mitigates against a learning culture. Far too often, researchers have simply transmitted their specialist knowledge rather than engaging in a dialogue with those providing or using front line services. We need to be sure we ask the right questions, and this involves ensuring that users of services (i.e. children and their families, practitioners and policymakers) participate at every stage in the research and development agenda.

It is part of our commitment to the UN Convention on the Rights of the Child, to which all countries with a democratically elected government except the USA are signatories, that we address children’s right to health. Part of this is their right to services based on the best possible evidence, rather than good intentions or an unevauluated belief in the value of a particular service.

Filling the gaps
In terms of what we still need to know, and largely as a result of the work of feminists and child advocates, violence against women and children is now firmly established as a legitimate problem and one which is much more widespread than some would like to think; but how we best address it requires more work. In other areas, even where effective interventions have been identified, we frequently know far too little about context and implementation. We know too little about the influence of ethnicity on health inequalities - we cannot assume that ethnicity and social class can each be ‘read off’ the other.

We need to know more about what matters and what counts to children and families as well as what works. This in turn requires more and better quality consultation and, in time, a demand-led research agenda.

Part of this involves risk taking - frankly
Healthcare in Kerala

CURRENT TOPICS AND OPINIONS  159

Healthcare in ‘God’s own country’, Kerala, south India

Exploring different healthcare cultures provides an opportunity to re-examine the system in which one works and gain an insight into possible alternatives. In January 2005, three nurse lecturers from Canterbury Christ Church University visited the Dr Somervell CSI Mission Hospital in Kerala State, Southern India. The aim of the study trip was to share knowledge, experience and strategies with local teams and to consider the health service delivery systems in a different context.

Kerala occupies the most south-westerly region of India, bordered by the Arabian Sea on the west and the state of Tamil Nadu to the east. Locals refer to it as ‘God’s own country’, due to its prolific greenness.

In health terms, although the infant mortality and maternal mortality rates have improved dramatically over the last few years, joblessness and frustration have led to an increase in alcoholism, suicide, domestic violence and crime.1

The Dr Somervell CSI Mission Hospital serves the community of Karakanam and was, as its name suggests, set up in 1894 by the London Mission Society. Its reputation spread after the arrival of the surgeon Dr Somervell during the inter-war period. Dr Somervell was an ex-army captain and Everest mountaineer and over time developed a reputation in the local community for being a ‘super-surgeon’, able to turn his hand to almost anything.2 The hospital owes much to his dedication and drive, which survives today in the approach taken by the current director, Dr Abraham, whose tripartite approach involves developing the local facilities, extending availability into remote communities and training healthcare workers for the future.

In the surrounding countryside amenities are few: most water comes from wells and living conditions are cramped and unhygienic by western standards. The hospital administrators believe that up to 70% of the local community are living below the poverty line and are unable to access either government or private healthcare. The hospital has developed a facility designed specifically to promote the health of this disadvantaged group. Emergency facilities are provided in the accident and emergency unit and non-urgent cases simply walk into the large outpatient building to attend ‘open clinics’.

References