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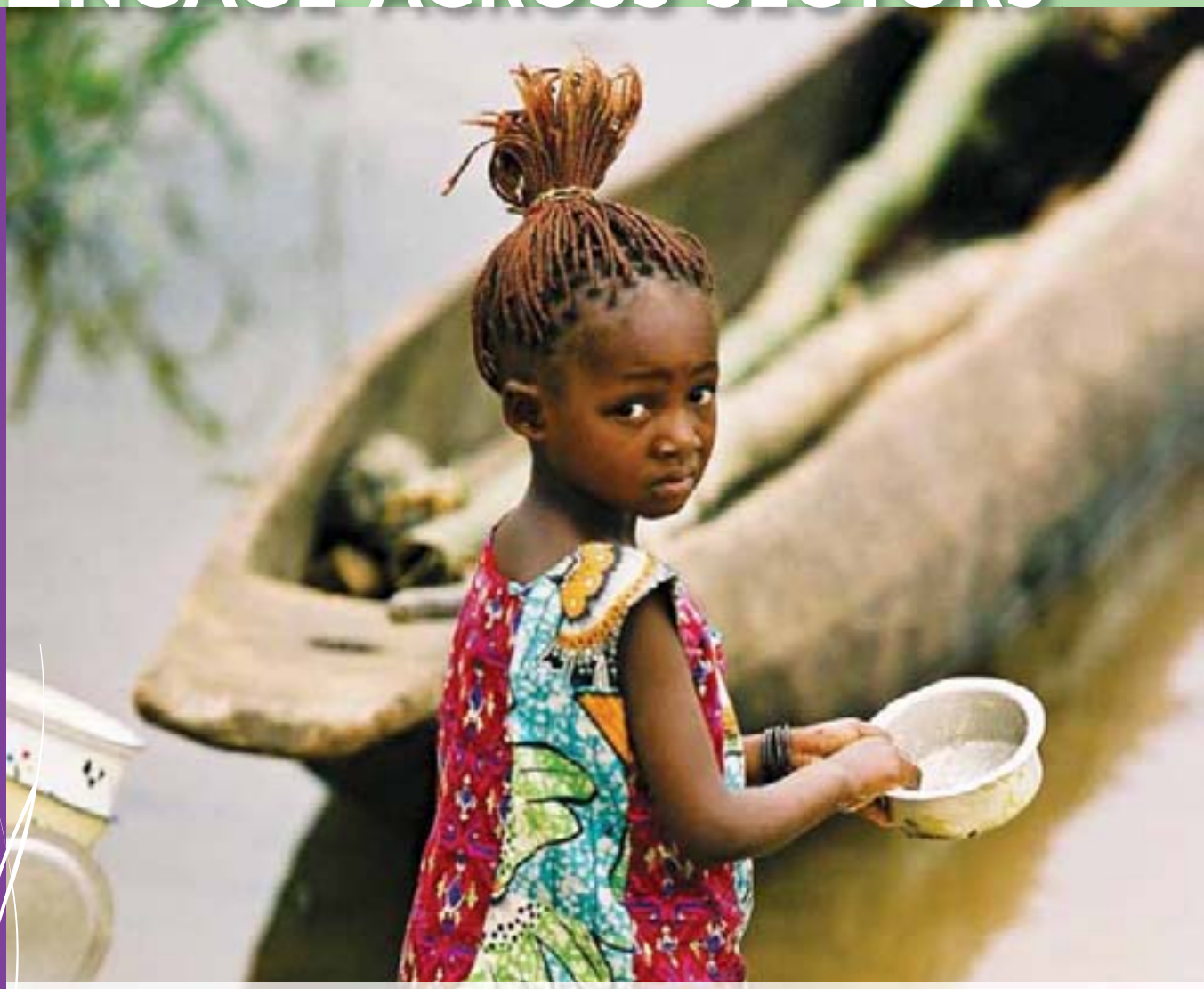
ENGAGE ACROSS SECTORS

KNOWLEDGE SUMMARY: WOMEN'S & CHILDREN'S HEALTH

2010



In 1978, the International Conference on Primary Health Care in Alma-Ata called for cooperation and coordinated effort across *"all related sectors and aspects of national and community development"*. More than 30 years later, striving to achieve broader development goals remains essential to improving reproductive, maternal, newborn and child health (RMNCH).

Providing access to good quality services is a core component of RMNCH strategies everywhere, but a range of factors act as barriers to achieving this. Poverty, gender inequities, denial of rights, lack of education and safe drinking water, inadequate roads and transport, and poor sanitary conditions are some of them. Ministries of health cannot remove these barriers alone, so inter-sectoral collaboration is essential to achieving both coherent policies and better results.

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The Partnership for Maternal, Newborn & Child Health

UNIVERSITY OF ABERDEEN

The MDGs have achieved much. Globally, communities have come together to rally around them and have successfully raised the profile of specific issues, leading to improved funding and impact of programs. More could be achieved by exploiting the synergies that exist between sectors.

What do we know?

Poverty, hunger and ill health (MDG 1)

Whilst economic growth has led to some reductions in overall poverty, this masks the inequities within countries. Moreover, sub-Saharan Africa, Western Asia and some countries in Eastern Europe will not achieve the MDG target of halving poverty. Many people have been forced into vulnerable jobs as a result of the financial crisis, and more workers now live in extreme poverty. High food prices have led to lower food intake and undernourishment.[1] Substantial evidence over the years has pointed to the inter-relationship between poverty, inequity and ill-health.[2] The poorest and least educated women and their children also have the worst access to quality services. For example, in Tajikistan, a weak economy and poor quality of services contributed to an increase in health care costs. As a result, pregnant women sought less care.[3]

Gender, education and health (MDGs 2 and 3)

Gender inequity exists both within and outside the health system and is intertwined with factors such as poverty, ethnicity, caste and race.[4] In women's daily lives, this manifests as poor access to health resources, sexual abuse and violence, including female genital mutilation. To address health inequities, it is essential to empower women and ensure that their rights and health are protected (see Knowledge Summary 9). Men play a crucial role in determining health outcomes in women. For example, negotiating condom use is difficult in many contexts due to unequal power relations. This can lead to unintended pregnancies and expose women to a higher risk of HIV infection.[5]

The links between women's education and RMNCH have been long established.[6] Gender, education and health are inter-related with poverty.[7] Confirming this, a recent review indicates that between 1970 and 2009, increased schooling levels amongst women (now aged 15 to 44) contributed to nearly 50% of the reduction in deaths among children under five in developing countries.[8] However, despite major advances in primary school enrolment, girls from the poorest households are 3.5 times more likely to be out of school than girls from the richest families. Gender parity in secondary education, particularly in rural areas, is still very low in sub-Saharan Africa, South Asia and Western Asia.[9]

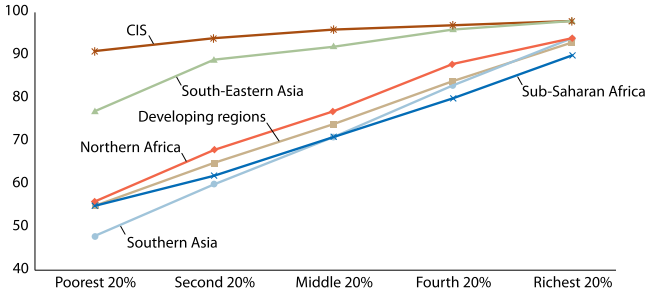
Some terms explained

Inter-sectoral coordination: "a recognized relationship between part or parts of the health sector with parts of another sector, which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone."

Source: WHO (1997). "Intersectoral action for health: a cornerstone for health-for-all in the twenty-first century." Report of the international conference (PDF). http://whqlibdoc.who.int/hq/1997/WHO_PPE_PAC_97.6.pdf

Figure 1

Inequities in care during pregnancy



Source: UN (2010). "Millennium Development Goals Report 2010." (PDF). www.un.org/en/mdg/summit2010/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%20100615%20-.pdf

Proportion of women who saw a skilled health worker at least once during pregnancy, by household wealth quintile, 2003/2008 (percentage)

Safe drinking water, sanitation and health (MDG 7)

Gender, safe water, sanitation and health have many connections.[10] For example, pregnant women are at greater risk from hookworm infestations, which can lead to low birth weight and poor growth in children.[11] Simple measures such as hand washing among new mothers and birth attendants, during and after childbirth, are suggested to have contributed to reductions in newborn deaths in Nepal.[12] Access to safe and clean water is improving in some rural areas, but is still a challenge in others. In urban Kenya and Zambia, for example, population growth was associated with a negative trend in access to safe drinking water and in vaccination coverage, and contributed to increased child deaths.[13] Sanitation continues to be a major problem. In 2008, only 52% of the population in developing countries had any improved sanitation facilities, and the problem of open defecation remains.[14] When sanitation is poor, water quality also suffers and contributes to diseases such as diarrhea, which is a leading cause of death in children under five years of age.[15]

What works?

Inter-sectoral collaboration is possible, but local contextual factors influence success

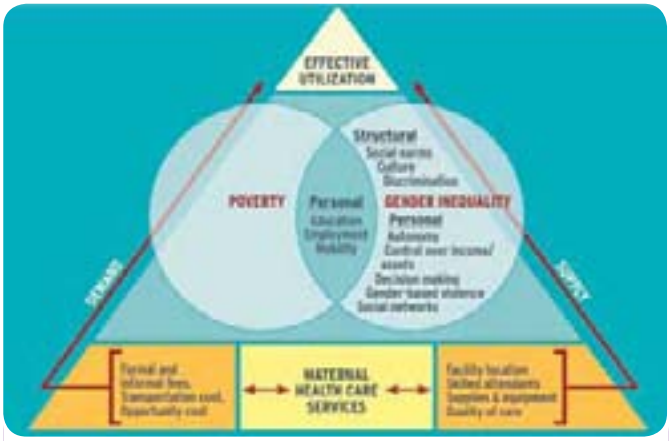
Countries like Sri Lanka, Thailand and the state of Kerala in India have successfully improved the health of women and children through a holistic approach to healthcare provision.[16] More recent examples of inter-sectoral linkages have been reported from child nutrition programs in Bolivia, HIV/AIDS programs in Nigeria,[17] and participatory public health schemes in Brazil.[18] Further examples can be found in Rwanda[19] and several other countries. However, inter-sectoral collaboration is not easy, as a review of 15 developed countries showed. [20] Comparative lessons from Sri Lanka and Uganda provide further insights (see Box 1).

Some interventions in other sectors can support progress in MDGs 4 and 5

Studies show that microfinance schemes can increase income levels, empower women and improve the health of mothers and children. Similarly, unconditional cash transfers, such as South Africa's Child Support Grant,[21] and conditional cash transfers such as *Oportunidades* in Mexico, have contributed to better outcomes in education and health.[22] Reviews have shown that midday-meal schemes at schools significantly improve children's physical and mental growth.[23] Interventions to improve hygienic practices have included household level interventions, such as water treatment,[24] hand washing and promotion of the use of improved toilet facilities. Although studies show that household level water treatment can contribute to better health,[25] the evidence to support scaling-up is weak.[26] Participatory approaches to encourage hygienic behavior and toilet use are still being tested (see Box 2).

Figure 2

Women at the centre of maternal health care



Source: Paruzzolo S et al (2010) Targeting poverty and gender inequality to improve maternal health (PDF) www.womendeliver.org/assets/Targeting_poverty.pdf

Women's empowerment and rights are central to any strategy that aims to improve women's health. Across the personal and public domains, women constantly encounter gender biases that affect their well-being.

Box 1 – Sri Lanka and Uganda: a comparative account

Sri Lanka

In 1980, the Government of Sri Lanka prioritized primary healthcare and made a commitment to attain acceptable levels of health for all by 2000. The National Health Council oversaw the inter-sectoral coordination for health. Its members include ministers from other sectors such as Agriculture, Finance, and Education. District Health Councils were set up to promote multi-sectoral and inter-sectoral activities. All this was supported by investments in education, health, food supplementation, infrastructure, essential medicines and medical and food supplies during conflict.

Sri Lanka's success in health is largely due to strong political leadership, inter-sectoral linkages and high female literacy. All stakeholders were united by a clear objective and vision.

Extracted from: Canadian Ministry of Health (2007). "Crossing sectors – experiences in inter-sectoral action, public policy and health." (PDF).
www.phac-aspc.gc.ca/publicat/2007/cro-sec/pdf/cro-sec_e.pdf

Uganda

Conflict, poverty and poor social indicators characterize Northern Uganda. In 2004, with WHO involvement, a national policy for Internally Displaced Persons (IDPs) was developed. It laid down guidelines for national and local government institutions, humanitarian agencies and NGOs, to improve the situation of IDPs. Inter-sectoral institutions were established, including District Disaster Management Committees (DDMCs). In one district, Kitgum, the DDMC had six sub-committees, including one to oversee health. This linking across sectors helped to improve a number of health problems. For example, it helped to reduce acute malnutrition and stunting among children.

However, there were several challenges. DDMC deliberations and decisions were slow, due to the diversity of its members. Political rivalries, shortage of funds, lack of adequate IDP participation and continued security issues also affected decisions and implementation.

Extracted from: Mutambi R, et al (2007). "Intersectoral action on health in a conflict situation: a case study of Kitgum district, Northern Uganda." (PDF).
www.who.int/social_determinants/resources/isa_conflict_uga.pdf

Box 2 – Community-led total sanitation

Lack of toilets invades privacy and harms health. The poorest women, infants and children (and particularly school-going and adolescent girls) in rural areas are the ones who tend to suffer most. Community-led total sanitation (CLTS) is a new way to approach the problem, and has been tried in several countries. Using participatory techniques, this approach enables local communities to be self-aware, change behavior and act on the problem. Studies have recorded successes with this approach and some communities have eliminated open defecation. Although impact analyses of CLTS have been few, one study in India shows improvements in child health in the area where it was implemented. However, it remains difficult to sustain behavior change and toilet use. Moreover, "no subsidies for toilets", as advocated by CLTS, could exclude the poorest people, who may be unable to invest in their own facilities.

Source: Community-Led Total Sanitation. www.communityledtotalsanitation.org (Accessed on 19 October 2010)

Conclusion

It is evident that the same women and children – those who are poor, living in rural areas and less educated – are also the ones who face the greatest risks of ill-health and death. Poor health is not only a consequence of poverty and disadvantage, but also a cause. This vicious cycle can be broken by recognizing these interdependencies, and through joined-up actions and effective inter-sectoral collaboration.

Useful resources

- Women Deliver www.womendeliver.org/
- A manual for integrating gender into reproductive health and HIV programs www.prb.org/igwg_media/manualintegrgendr09_eng.pdf
- WHO/UNPEP (2008): "Health Environment – managing the linkages for sustainable development – a toolkit for decision-makers." (PDF) http://whqlibdoc.who.int/publications/2008/9789241563727_eng.pdf
- BRIDGE Cutting Edge Pack on Gender and Indicators www.bridge.ids.ac.uk/go/bridge-publications/cutting-edge-packs/gender-and-indicators/

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