



Eliminating health inequities

Every woman and every child counts



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Strategy 2020 voices the collective determination of the International Federation of Red Cross and Red Crescent Societies (IFRC) to move forward in tackling the major challenges that confront humanity in the next decade. Informed by the needs and vulnerabilities of the diverse communities with whom we work, as well as the basic rights and freedoms to which all are entitled, this strategy seeks to benefit all who look to Red Cross Red Crescent to help to build a more humane, dignified and peaceful world.

Over the next ten years, the collective focus of the IFRC will be on achieving the following strategic aims:

1. **Save lives, protect livelihoods, and strengthen recovery from disasters and crises**
2. **Enable healthy and safe living**
3. **Promote social inclusion and a culture of non-violence and peace**

Acknowledgements

The global IFRC health team responsible for this report would like to thank Dr Carole Presern and her team at the Partnership for Maternal, Newborn and Child Health for providing careful reviews of the text. We also thank all National Societies and colleagues from the Movement who provided valuable inputs and case studies. We would like to thank our colleagues from Legal and Humanitarian values and Principle departments for providing insights and contributed to the different angles expressed in this report. Our special thanks also go to our former intern Rikki Stern for collecting, compiling and analysing the data.

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Cover photo: Olav A. Saltbones/IFRC

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Foreword

Health inequities are affecting the life and future of all vulnerable groups of society across the world, creating systems of social injustice. By dismantling the barriers to health services and resources, we reduce the burden of disease that affects the future of children, impoverishes entire families and passes social injustice on through the generations. In this report, we focus on women and children not only because many of them suffer undue hardship, but also because women are instrumental in improving the health of their children, families and communities.

This report provides evidence that health inequities can and need to be addressed through a holistic approach. Health inequities, and the resulting social injustice are closely linked with other issues such as poverty, gender inequality and human rights violations which in turn, have an impact on education, transport, health, agriculture, and overall well-being. Our interventions should therefore be multi-sectoral, going beyond health to address social and economic determinants – malnutrition, alcohol abuse, poor housing, indoor air pollution and poverty, among others.

We count on our global membership of national Red Cross Red Crescent societies and you, the reader, to use this advocacy report to bring about tangible change for the years ahead. Together, we can rid the world of social injustice and contribute positively to promote a culture of respect, non-violence and peace.

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Executive summary

Health inequities

Health inequities are “unfair and avoidable differences in health status seen within and between countries”. Health inequities are systematic: they usually affect particular groups of people, and they occur across the social gradient. The most vulnerable people have the least access, not only to health services, but also to the resources that contribute to good health.

Eliminating health inequities is an ethical imperative

Health is a resource that enables people to achieve their fullest potential. It is unjust for this potential to be determined by the place where a person is born, or the racial or ethnic group to which a person belongs. Fortunately, eliminating health inequities is also economically sound. Simple and cost-effective measures, when scaled up, lead to significantly better health for all. Failing to eliminate health inequities leaves the most vulnerable at greatest risk. Without prioritizing health inequities, UNICEF warns: “We could find ourselves in 2015 facing the tough challenges of reaching the most deprived children of all – but with resources depleted, political will exhausted and a public that has moved on.”

Focusing on women and children

Women and children are the focus of our attention for three reasons.

1. Women are more likely to face health inequities because women’s biological make-up demands more care. Pregnancy and childbirth are life events that expose women to greater risks.
2. Women are the gateway to improving the health of an entire population, starting with their children and members of their households.
3. The burden of caring for sick children and the elderly mainly falls on mothers and other female carers. This leads to time off work, loss of income and further impoverishment of families. Poverty, in turn, cuts off access to the resources that give rise to good health, it precludes treatment for poor health, and perpetuates ill-health among women and children. A vicious downward spiral begins that is carried forward to the next generation.

Social inequalities compound biological differences

Wider power imbalances between men and women can prevent women from exercising control over their own health or the health of their children. Eliminating health inequities requires a holistic approach whereby the health impacts of all government policies and societal practices are recognized and addressed.

Human rights is the framework to eliminate health inequities

Human rights reflect existing obligations and provide the basis for national laws and regulations. Human rights related to health inequities are the rights to life, health, food and nutrition, water and education. Furthermore, the standards articulated in human rights can guide all stakeholders in dismantling barriers to health. Health inequities are often the result of human rights violations, and can be dealt with as such.

Public health systems: a cause and a solution to health inequities

Whilst health systems promote health, they can also lead to health inequities. For example, investment in tertiary care centres, such as high-tech hospitals and specialized care centres, disproportionately benefit the rich at the expense of the poor. Available, accessible, acceptable and quality care should be within the reach of all people. Availability refers to putting health facilities, services and goods in place. Accessibility means healthcare resources are non-discriminatory and enable all people – regardless of geography, finances or access to information – to take advantage of them.

Poverty exacerbates health inequities

Poverty – coupled with universal trends such as urbanization, migration, ageing, unhealthy lifestyles and an increase in non-communicable diseases – plays a significant role in creating health inequities, particularly where significant gaps exist in accessing resources such as adequate food and nutrition, housing, water and sanitation.

Public policies and societal traditions present opportunities to eliminate health inequities

There are laws and public policies that lead to health inequities and they need to be repealed; these include laws that impede access to maternal and perinatal health services, regulations that require spousal permission to access reproductive health services or those that limit access to life-saving treatment for pregnancy-related complications. Traditional yet harmful practices, such as female genital mutilation, can also be stopped by engaging traditional and religious leaders in their communities.

A CALL TO ACTION

The IFRC advocates on behalf of the world's most vulnerable women and children, those who have least access to the resources and conditions that will give rise to good health. The IFRC asks policy-makers, governments and donors to align resources with needs, and to work with stakeholders, multi-lateral organizations and civil society organizations towards bridging the health divide so that all people – including the most vulnerable women and children – can achieve their fullest potential.

IFRC recommendations

Governments: take the lead in prioritizing equity

- **Ensure universal access**

Governments should ensure universal access to evidence-based public health interventions for all and allocate health resources according to need.

- **Enable informed decision-making**

Governments should make accurate health information available to all so that everyone, particularly the most vulnerable, can make informed decisions about their health.

- **Take a holistic approach**

Governments should promote equality, solidarity, participation, non-discrimination and non-violence in all aspects of society, not just health, because tackling health inequities means tackling inequities in society in general.

- **Harness the power of a volunteer network**

Governments should make the most of Red Cross Red Crescent volunteers, who form part of the world's largest humanitarian network, to eliminate health inequities. Volunteers are uniquely capable of reaching the most marginalized groups. Some volunteers are themselves members of these and, therefore, are an entry point for reaching those whom the formal health sector fails to reach.

National Societies: scale up efforts

- **Reach the unreached**

Through their extensive volunteer networks, National Societies need to scale up their activities to bring prevention, treatment, care and support to those who are left out of the formal health system – the women and children who have the least access to appropriate health services. National Societies should expand their reach by encouraging health-seeking behaviours, as well as fostering social inclusion and peace.

- **Encourage prioritization and informed decision-making**

National Societies should use their status as auxiliaries to government to engage decision-makers to prioritize health equity and equity in all aspects of society and to hold authorities accountable.

- **Develop powerful partnerships**

In order to eliminate health inequities as quickly and effectively as possible, National Societies should engage in meaningful dialogue with key stakeholders and form strategic partnerships to increase the effectiveness of advocacy.

Donors: create an enabling environment

■ **Maintain and increase funding levels**

Given the current global economic crisis, any cuts in healthcare funding for mother-and-child programmes will have a devastating effect on the target groups – many will be exposed to even greater health risks and deeper levels of poverty. Peer pressure has meant that some donors have maintained their levels of funding, despite difficult economic circumstances in their own countries.

■ **Align commitments with identified gaps**

Encourage skilled and adapted human resources for health, the coverage of essential mother, child and youth health interventions, and integration with other Millennium Development Goals (MDGs). Donors must ensure a well-balanced, effective and adapted response to bridge the gaps in the health of woman, child and young people.

■ **Remember spending on health makes good economic and social sense**

Health spending is an investment that yields returns in individual and population health, education, and economic growth.

■ **Continue to innovate in health financing**

In order to increase and improve health services in the world's poorest countries, innovative funding mechanisms are necessary, which require the participation of a range of actors.

■ **Start with the person, not the project or programme**

Investment in a comprehensive, multi-sectoral, integrated health approach is the only way forward. Standalone projects do have an impact, but the impact is limited. If a child is immunized but the mother dies in childbirth because of health service failures, the child's welfare could hardly be considered to have improved.

National Societies together with civil society: help broker effective support

■ **Become a responsible stakeholder for development**

Representatives from civil society organizations, the private sector and academia should play a greater role in helping their governments broker an international commitment that puts health inequity issues high on the development agenda. They should also ensure they commit to supporting countries in implementing effective measures to reduce the health gap, particularly for mothers and children. Civil society has a key role to play in being the voice of the voiceless.

■ **Hold policy-makers to account**

Ensure that parliamentarians represent all their constituents, and take the right legislative and budgetary decisions. Ensure they hold themselves, and their executives, to account.

CASE STUDY – EGYPT

Empowering women in Al-Nahda

The city of Al-Nahda, on the northern outskirts of Cairo, is a unique community. It expanded rapidly when thousands of people lost their homes during the 1992 earthquake and were re-housed in there. Thousands of people from different communities were suddenly thrust together in a new life. In the years that followed, increasing numbers of families were re-housed in Al-Nahda – sometimes as a result of government resettlement policies – and by 2003, the population had soared from 13,000 to 37,000 families. By 2008, that figure had reached 52,000.

The future for people living in Al-Nahda has often looked bleak – many of its residents are from low socio-economic backgrounds with low levels of literacy, many people live on reduced incomes and there is high unemployment, a lack of health facilities and poor social cohesion. However, in 2004, a new centre, managed by a group of Red Crescent volunteers, was set up in Al-Nahda. Its aim was to empower community members – and women in particular – to improve the living conditions of its residents.

The Egyptian Red Crescent organized Al-Nahda city with 20 trained women selected as community coordinators. Under each coordinator, 40 women leaders have responsibility for a group of families. This coordination has proved to be incredibly effective. During the avian and human influenza pandemics, the community leaders carried out a campaign that resulted in virtually no poultry rearing in backyards.

Medical services

Polyclinics in the city offer a wide range of medical services with some 40 people accessing the maternal healthcare and reproductive health services every day. In addition to the healthcare services, there are also many ongoing health promotion activities to make the city's residents more health aware.

Female genital mutilation is still widely practised in Egypt and community information campaigns have focused on educating girls, parents and grandparents about the dangers of the practice. The Red Crescent has enlisted the help of religious leaders, doctors and sociologists to help put a stop to the practice, which is often more prevalent in low socio-economic groups.

Educational activities

Some 1,950 women have benefited from adult literacy classes. In addition, the Red Crescent offers vocational training and handicrafts with about 1,500 women taking part in income-generating activities to support their families.

The Egyptian Red Crescent experienced such significant success in Al-Nahda that it expanded the programme to reach all 53,000 families living in the city. The benefit of providing medical services, vocational training and capacity-building to the city's women has, effectively, been doubled as women assume a new role mobilizing their communities and promoting health.

Fatima, a community coordinator in Al-Nahda, said: "Early on, I just thought of the free medical services from the Egyptian Red Crescent polyclinic, but now I realize that it's much more. Being a community coordinator makes me have a responsibility towards my community to be in good health."

For more information, please visit: <http://www.egyptianrc.org/ContentPageEn.aspx?pageNo=334>



Introduction:

Health equities with a special focus on women and children deserve immediate attention and action

The last few years have seen enormous and welcome developments in global public health. However, there is growing recognition – increasingly backed by evidence – that achieving the Millennium Development Goals will demand ensuring that every woman and every child counts.

The Global Strategy for Women's and Children's Health, launched by the UN Secretary-General in 2010, noted the continuing and vast inequities that still exist. Many of the world's most vulnerable women and children die needlessly because of unequal access to information, prevention, treatment and services to meet their most basic needs. Wealth, education and place of birth significantly shape the health of women and children between countries and within them. According to UN figures, 7.6 million children still die every year around the world. Almost 95 per cent of newborn deaths occur in the developing world. A recent WHO study² has found that more than half of these deaths now occur in just five large countries – India, Nigeria, Pakistan, China and the Democratic Republic of the Congo. The Countdown to 2015 Decade Report (2000-2010) states that Millennium Development Goals 4 and 5 are still achievable, but only a dramatic acceleration of political commitment and financial investment can make it happen.*

India alone has more than 900,000 newborn deaths each year, nearly 28 per cent of the global total and 20 million pregnancies a year are exposed to risk.** The disparity between countries is stark; in Iceland the maternal mortality ratio for women is just 5 in 100,000 live births, whereas in Mozambique, the figure soars to 550 in every 100,000.³ Even within countries, poor children are at significantly greater risk of death before the age of five than their wealthier counterparts. Interestingly, in 18 out of 26 developing countries that have successfully reduced under-five mortality by 10 per cent or more, the gap in under-five mortality between the poorest 20 per cent and the richest 20 per cent of households either widened or stayed the same. So, even though there has been overall progress for children, in the first months of their lives, their situation is not improving. Additionally, there are 2.6 million stillborn babies, who are never even counted because stillborn babies are rarely included in the statistics.⁴

Furthermore, the current global economic crisis is leaving more than 100 million people in poverty every year. Having to pay out-of-pocket health expenses only exacerbates their situation – the net result is that millions have no access to any services at all.

Fact box

Based on data from 32 countries, women from the poorest quintile are less likely to hear about reproductive health messages than women from the wealthiest quintile.⁶

“When we deliver for every woman and every child, we will advance a better life for all people around the world.”

Mr. Ban Ki-moon speaking at the UN Headquarters Every Woman, Every Child side event during the 66th session of the General Assembly in 20 September 2011, in New-York.

Health is a resource that enables people to achieve their fullest potential. It is unjust for this potential to be determined by the place where a person is born or the racial or ethnic group to which a person belongs.

* Countdown to 2015 Decade Report (2000-2010), WHO and UNICEF, 2010.

** <http://goo.gl/BbSxy>

Why health inequities now?

In every region of the world, the survival of a child past the age of five is shaped, to a large extent, by the wealth of the household in which he or she resides, the region in which he or she lives, and the education of his or her parents.^{7,8} Children born in rural areas or urban slums, children born to mothers with lower levels of education, and children born to families with lower incomes fare worse than others.⁹ For example, from a selection of countries where data is available in Africa, Asia and the Americas, a child born to the wealthiest 20 per cent of households is more than twice as likely to reach the age of five compared with children born to the poorest 20 per cent of households in urban areas.¹⁰ In Europe, similar trends are observed: under-five mortality rates are at least 1.9 times higher among the poorest 20 per cent of households than among the richest 20 per cent.¹¹

A focus on primary healthcare

The differences that have been outlined earlier highlight unacceptable health inequities: progress is very uneven within a country and between countries, and there are serious rights and justice issues, as well as policy failures which demand our full and immediate attention. Focusing on primary healthcare for women and children is a 'best buy'. Women and children are among the most vulnerable, but give the greatest opportunities for gain because the health of women and children is often interdependent. Reducing the burdens that confront either women or children benefits the other. Gains often spill over to other groups, thereby strengthening community resilience. And the economic benefits are significant. It is estimated that much of the progress in East Asia over the last few decades is directly attributable to good policy choices: education for girls, access to information and services, gender equality and better representation in politics.

Public health, development and human rights are the dimensions where the causes – as well as the solutions – to health inequities reside. Yet women and children are still left behind from available strategies that can largely mitigate such a divide in accessing health services. To be effective, health programmes must be tailored to local contexts. Effective responses can:

- decrease the social marginalization and the subsequent vulnerability of women, children and young people
- increase access to healthcare and social services – these include a comprehensive package of diseases prevention, treatment, care and support interventions
- promote a health approach informed by human rights and public health principles

The Red Cross Red Crescent is acting on its commitments by increasing the resilience of women, children and young people to tackle the health risks they face in their communities. The goal is to maintain their capacity within their local communities so that they can take charge of creating an environment where people enjoy good health, and to assist in withstanding, recovering from and responding positively to any health threats they may face.

To eliminate health inequities entails increasing resilience and contributes positively to global public health. The International Federation of Red Cross and Red Crescent Societies (IFRC) calls for a holistic approach informed and complemented by human rights principles.⁵ Such an approach seeks to improve the conditions that give rise to good health among all people, including the most vulnerable women and children. Human rights furnish the underlying principles of health, non-discrimination and autonomy. The IFRC articulates three components of a holistic approach to health inequities.

1. Help ensure women and children have access to healthcare throughout their life cycle.
2. Ensure that reliable, evidence-based and accurate information on health is available, and encourage appropriate health-seeking behaviours.
3. Promote gender equality, empower women and girls, and enlist the support of men and boys.

Within the work of the Red Cross Red Crescent, while there are many examples of success, it is essential to have strong government commitment and leadership, partnership with donors and civil society organizations, and the involvement of women and children.

These differences illustrate health inequities, which are “unfair and avoidable differences in health status seen within and between countries”.¹² Health inequities are systematic in that they usually affect particular groups of people.¹³ They take place across the social gradient, and differences in health are often most pronounced among the most vulnerable people, who have the least access not only to health services, but also to the resources that contribute to good health.¹⁴ Based on data from 32 countries, women from the poorest quintile are less likely to hear about reproductive health messages than women from the wealthiest quintile.¹⁵

Health inequities deserve our full attention and require immediate action. Here are the main arguments for doing so.

Firstly, reducing health inequities is an ethical imperative.¹⁶ Health is a resource that enables people to achieve their fullest potential. It is unjust for this potential to be determined by the place where a person is born or the racial or ethnic group to which a person belongs.¹⁷

Secondly, tackling health inequities is economically sound. Simple, cost-effective measures, when scaled up, lead to significantly better health. Some of these highly cost-effective methods of reducing under-five mortality are immunization, micronutrients, treatment for diarrhoea, malaria and acute respiratory infections, as well as improved prenatal and delivery care.¹⁸ For example, data from Bangladesh, India and Pakistan suggests that home-based care reduces newborn deaths by between 30 to 61 per cent. Home-based care provides new mothers information on exclusive breastfeeding, thermal care for infants and the danger signs for newborns.

Community health workers, volunteers and midwives are examples of people who can visit with newborns and their mothers within existing health programmes.¹⁹ Simple measures not only improve maternal and child health but also create additional benefits, enabling women and children to lead healthy and productive lives, and contribute to resilient communities.²⁰ Prevention, early detection and early treatment avoids the necessity of expensive and protracted care, freeing money for food and children's education as well as for tackling women's illiteracy.²¹ Investing in skilled providers such as midwives who specialize in low-risk pregnancy, child birth and postpartum care, as well as being trained to deal with any complications, is also one of the health best buys because they can provide care in communities and primary healthcare centres. They can also link women with emergency obstetric care services if they need them. WHO estimates that countries require a minimum of six skilled birth attendants per 1,000 births if they are to achieve the aim of 95 per cent coverage.²² Health spending, therefore, is an investment that yields returns in the health of individuals and the general population, as well as in education and economic growth.

Finally, failing to eliminate health inequities potentially leaves the most vulnerable at greatest risk. Without prioritizing health inequities, UNICEF warns: “We could find ourselves in 2015 facing the tough challenges of reaching the most deprived children of all – but with resources depleted, political will exhausted and a public that has moved on.”²³

CASE STUDY – BANGLADESH

Delivering maternal and child healthcare at low or no cost

The poor in Bangladesh confront a whole host of obstacles to prevention, treatment, care and support. Health spending represents only 3 per cent of the country's GDP, of which the government only contributes 1.1 per cent.²⁴ Poor women and children in rural areas and urban slums are particularly vulnerable because continued investment in primary health centres is low²⁵ and most healthcare services are funded by direct payments.²⁶ Moreover, the critical shortage of healthcare workers is among the highest in the world.²⁷

The Bangladesh Red Crescent Society works to reduce human resources and financial obstacles by providing care at community level. Red Crescent mother and child health centres provide medical check-ups, education, counselling to pregnant women, skilled birth attendance, postnatal care and primary healthcare services. A total of 58 mother and child health centres, along with five maternity hospitals, collectively treat more than 100,000 general patients, attend over 5,000 births yearly and disseminate thousands of health messages on a regular basis.

Each centre is staffed with at least one community midwife, who provides care 24 hours a day, seven days a week. Midwives receive 18-months' training at a government-affiliated nursing institute in the country's capital, Dhaka. They then return to their communities to provide care locally. The centres are also staffed by an assistant community midwife, a skilled birth attendant, three community health promoters, an income-generating assistant, and a member of staff who provides service support. This team contributes to the effective delivery and financing of prevention, treatment, care and support.

The clinics provide inexpensive care, substantially less than private clinics. Dr Christiane Haas, a health adviser for the German Red Cross, reflects: "In a country like Bangladesh, where still more than two-thirds of health expenditure is privately financed through out-of-pocket payments, there is potential for the Red Crescent health centres to become a model for community healthcare financing mechanisms. This approach, together with a well-managed poor fund, contributes to strengthening the equitable access to healthcare and fairness in spending on health especially in rural areas."

Clinics, for example, charge only 2 to 3 cents per patient for medical advice and 3 US dollars for normal birth delivery. Each community finances a poor fund to cover the costs of people who cannot afford the fees. "The poor fund," Dr A.S. Haider, former health director of the National Society, now on mission to Haiti, explains, "is one example of how communities are working together to reduce health inequities locally. The community has really shown motivation and supported the poor fund of the MCH [mother and child health] centre over the last six years."

Mrs Shahida Begum, an 18-year-old labourer who lives in a slum in Dhaka, was able to receive care thanks to the work of the Red Crescent and the contributions of her community. Mrs Begum and her husband, a rickshaw puller, had moved to Dhaka in search of work. Soon after, Mrs Begum got pregnant. Suffering from malnutrition and anaemia, she became physically and mentally unwell. Thanks to a household visit by a community health volunteer, Mrs Begum was referred to the Jamila Khatun centre for care during her pregnancy.

Mrs Begum attended the centre, where a Red Crescent community midwife provided antenatal care and counselling. Mrs Begum was unable to pay for the services and she applied to the centre's management committee for financial assistance to cover the costs. She received care for free through finance from the community fund and went on to deliver a healthy baby on 29 January 2011 at the centre. Mrs Begum became an advocate for the work of the Red Crescent in her community, and encouraged her family, neighbours and friends to seek advice and care at the centre. This is one example of how the Red Crescent is now reaching increasing numbers of women and children each year.

Many of the health centres have been supported by the German Red Cross for over ten years. In June 2011, both National Societies celebrated the transfer of ownership and leadership to the Bangladesh Red Crescent Society. The Red Crescent mother and child health centres provide affordable primary health services to the poor and marginalized women and children of Bangladesh.





Chapter 1. Focusing on women and children is a good place to start

This report shares some of the challenges and triumphs that Red Cross Red Crescent National Societies have faced whilst working to eliminate health inequities that affect women and children in particular. The case studies may serve as useful examples of how inequities can be eliminated or reduced. Policy-makers may adapt the lessons to the needs of their own communities and tailor policies accordingly. This report shows that the path to achieving health equity is challenging but hopeful, and that focusing on women and children is a good place to start.

The unique needs of women and children

Women and children should be the focus of our attention because not only are they more likely to face health inequities, but they are also the gateway to improving the health of an entire population. Lack of access to prevention, treatment, care and support renders women more vulnerable to health inequities because women's biological make-up demands more care. Pregnancy and childbirth are life events that expose women to greater health risks, which mean they need more medical care.

Women also live longer than men, so they are at greater risk of developing chronic health problems that require medical attention.²⁸ Women's biological make-up renders women more susceptible to contracting HIV through unprotected intercourse.²⁹ Furthermore, some diseases, including HIV and AIDS, burden women disproportionately. For example, the majority of people with HIV in sub-Saharan Africa and certain countries in the Caribbean are women,³⁰ and globally HIV and AIDS is the leading cause of death among women of reproductive age.³¹

Social inequities compound biological differences

Wider power imbalances between men and women sometimes prevent women from exercising control over their health. For example, women may be less able to negotiate for safer sex and demand that their partners wear condoms.³² In addition, longer life expectancies often make women physically and financially dependent on their caregivers, and this dependency puts older women at risk of elder violence.³³

The health of mothers and children is closely linked, so reducing the burden of health inequities on either women or children improves the health of the other. For example, more than 90 per cent of the children living with HIV contract the virus through mother-to-child transmission, either during pregnancy, at birth or through breastfeeding.³⁴

Fact box

The majority of people with HIV in sub-Saharan Africa and certain countries in the Caribbean are women, and globally HIV and AIDS is the leading cause of death among women of reproductive age.

Women's biological make-up demands more care. Pregnancy and childbirth are life events that expose women to more health risks and necessitate more medical care.

Obesity and malnourishment

Today, the world's most vulnerable women and children may, on one hand, fall into hunger and malnourishment and, on the other, face obesity and overeating which exposes them, in turn to non-communicable diseases. Both phenomena are closely linked to poverty.

CASE STUDY – MALAWI

Empowering communities to fight against gender-based violence

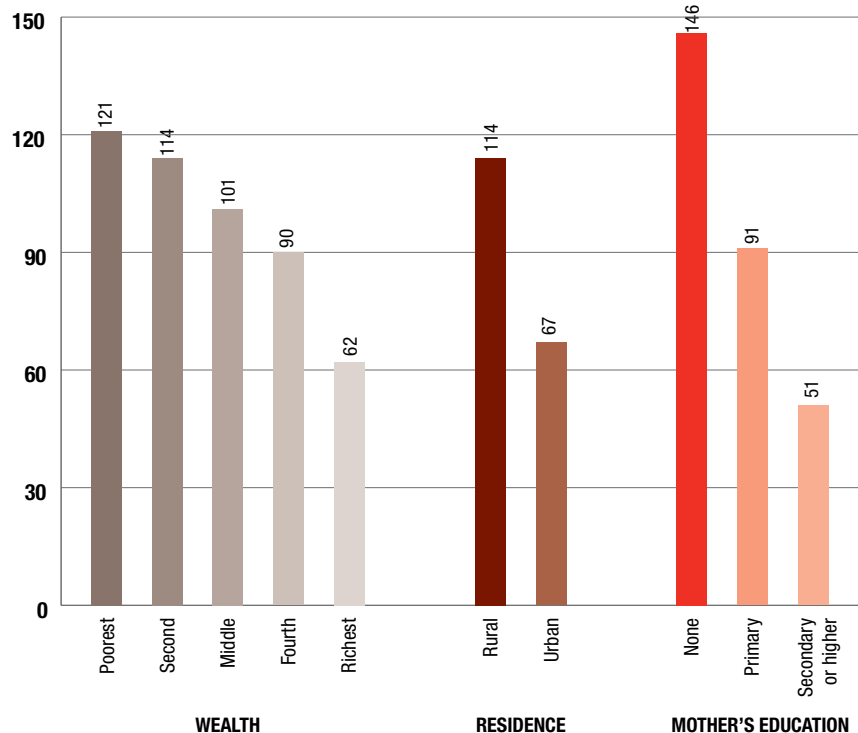
The Dzaleka refugee camp in Malawi is the temporary home of over 10,000 refugees, the majority of whom come from Burundi, the Democratic Republic of the Congo and Rwanda. Life in the camp is difficult. Some men turn to violence, and women and children in the camp are vulnerable to physical and sexual abuse. As Janette Honore, a volunteer with the anti-gender-based violence committee, explains, “A girl may need soap and lotion. Instead of just helping her, the men want sexual favours.”

Because violence against women is a critical health issue and a violation of human rights, the Malawi Red Cross empowers refugees in the camp to take control of gender-based violence in their communities. The Malawi Red Cross raises awareness among refugees on gender-based violence (often referred to as GBV) and equips them with the knowledge and skills to respond to it. “The main stakeholders in the GBV fight,” explains Joseph Moyo, Malawi Red Cross population movement manager, “are the refugees themselves.”

The Red Cross distributes leaflets and key messages, and trains volunteers to conduct GBV education in the language spoken in the camp. The Red Cross also helps resolve gender-based violence through mediation, psychosocial counselling and income-generation activities for victims. If necessary, it also helps victims seek justice through the formal legal system. Sergeant Christopher Sibale sees the success of the Malawi Red Cross through the increase in reported cases. Before, people were “victimized and disdained”, but now they come forward. Awareness activities have “really had an impact”.

Children who live in poorer households and rural areas and whose mothers have less education are at higher risk of dying before age five.

Under-five mortality rate, by wealth quintile, residence and mother's education, 2000-2010
 (deaths per 1,000 live births)



Note: Calculation is based on 39 countries with most recent Demographic and Health Surveys conducted after 2005, with further analyses by UNICEF for under-five mortality rates by wealth quintile, 45 countries for rates by residence and 40 countries for rates by mother's education. The average was calculated based on under-five mortality rates weighted by number of births. Country-specific estimates obtained from Demographic and Health Surveys refer to a ten-year period prior to the survey. Because levels or trends may have changed since then, caution should be used in interpreting these results.

Source:
http://reliefweb.int/sites/reliefweb.int/files/resources/Child_Mortality_Report_2011_Final.pdf

UNAIDS has a strategic goal to eliminate the vertical transmission of HIV and reduce AIDS-related maternal deaths by half by 2015. This involves providing anti-retroviral therapy for women with HIV for their own health, and giving anti-retroviral prophylaxis to prevent women from transmitting the virus to their children.³⁵ Such an approach illustrates how the prevention, treatment, care and support of HIV and AIDS has benefits not only in terms of maternal health, but also in child health.

The burden of caring for sick children mainly falls on mothers or other female carers. This leads to time off work, loss of income and further impoverishment of families. Poverty, in turn, cuts off access to resources that give rise to good health, precludes treatment for poor health, and perpetuates ill-health among women and children. A vicious downward spiral begins.

Children who live in poorer households and rural areas, and whose mothers have less education, are at a higher risk of dying before age of five.

Double the risk and double the neglect: HIV and women who use drugs

Many women who use drugs lack the power to negotiate safer sex. Nevertheless, most HIV-prevention strategies place the onus on women to insist on safe sex, which increases the likelihood of physical and sexual abuse.

Women who take drugs often rely on their partners to procure the drugs, and because women are often injected by their partners, they are “second on the needle”. This increases their risk of being infected with HIV and other pathogens. Refusing to share needles and syringes means female injecting drug users risk intimate partner violence – both physical and sexual – which also increases the likelihood of HIV infection.

Among women who use drugs, and particularly users of crack cocaine, the prevalence of lifetime sexual and physical violence – including from their intimate partner – is three times higher than in women who do not use drugs. Intimate partner violence is a major risk factor for HIV infection.^{37,38} However, very few evidence-based HIV-prevention strategies address these complex interactions holistically.

Reproductive health and injecting drug users

Most strategies ignore the plight of women who suffer intimate partner violence and sexual trauma, and fewer still emphasize the need for reproductive health – particularly with respect to sex workers and women who are in prison.

In many countries, pregnant drug users are unable to access HIV prevention and treatment services. Most programmes do not educate women on the effects of drug use during pregnancy, and many women face criminal action if they continue to use drugs while pregnant. The stigmatization and criminalization of drug use during pregnancy drives women to conceal their addictions from healthcare providers. This then puts their unborn infants at risk because they don’t access mother-to-child transmission prevention services.

A lack of childcare facilities or programmes makes it even more difficult for drug-dependent mothers to access the services they so desperately need. The failure to address the needs of pregnant drug-involved women means that the cycle of addiction and HIV infection is passed on to the next generation.

Women and health: the issues³⁶

- **Children and maternal death and disability**
Health is a fundamental human right, and in countries where children die early and mothers die in the act of giving life, injustice persists.
- **The spectrum of sexual and reproductive health issues**
Urgent challenges include STDs, sexual violence and access to reproductive health services.
- **All forms of disease and disability confronted by females throughout their lives**
- **Women and health, including the roles of women in the health system**
From informal providers of care to primary decision-makers about the health of their families to their increasingly important role as health professionals
- **Differences between women and men in their access to, and the quality of, the healthcare they receive**



Chapter 2. The time to act is now

Now is the time to reduce the burden of health inequities on women and children, not only because women and children are among the most vulnerable but also because action has a multiplier effect. The tandem nature of the health of women and children means that efforts to reduce the barriers to health equity that burden women, would also benefit children, and vice-versa. Furthermore, gains spill over to families and wider communities.

Progress in reaching MDGs disguises burdens

Estimates given by the UN in 2011 confirm that continued progress is being made in reaching Millennium Development Goals 4 and 5, relating to the reduction of child and maternal mortality. The UN's under-five child mortality estimates point to steady progress, with the UN estimating there were 7.6 million deaths in 2010. This represents a significant reduction when compared with the estimate of more than 12 million deaths in 1990. The rate of reduction has been gathering speed too, particularly in sub-Saharan Africa, where the pace of change has doubled since 1990, averaging a 2.4 per cent decline in child deaths each year during the period 2000–2010.

This positive news is an important marker of progress in the effort to save the lives of millions of young children each year. Clearly, we're on the right track, and yet we're not moving nearly fast enough. Only nine countries from the developing world are on schedule to meet both MDG 4 and MDG 5 by 2015. Meanwhile, the global burden is increasingly lopsided. Sub-Saharan Africa now bears 49 per cent of all under-five deaths – up from 33 per cent in 1990.

Whilst progress made in achieving MDG targets brings benefit to the majority, sadly it is often the case that the most vulnerable are left behind. The MDGs are a global rallying point and they represent achievable development goals for everywhere on earth, even the most disadvantaged and resource-poor locations. However, the MDGs are averages; they efface the differences at the extremes and, unavoidably, they hide the inequitable distribution of healthcare resources and inequitable health outcomes of the most vulnerable.

The *Millennium Development Goals Report 2011* frankly states: “Despite real progress, we are failing to reach the most vulnerable.” For example, in southern Asia, there were no reductions in hunger for children from the poorest quintile of houses.³⁹ Children in rural regions, around the world, are more than twice as likely to die before the age of five than children in urban areas.⁴⁰ And children from the poorest households are two to three times more likely to die before the age of five than their wealthier counterparts.⁴¹

“Women, rural inhabitants, ethnic minorities, people with disabilities and other excluded groups often lag well behind national averages of progress on MDG targets, even when nations as a whole are moving towards the goals. [...] The denial of human rights and the persistence of exclusion, discrimination and a lack of accountability are [...] barriers to the pursuit of human development and the MDGs.”

Helen Clark, Administrator of the United Nations Development Programme (UNDP)

The same applies to the most comprehensive newborn death estimates to date, published by the WHO in 28 August 2011.^{***} At least 2.65 million stillbirths (uncertainty range is 2.08 million to 3.79 million) were estimated worldwide in 2008 (≥ 1000 g birthweight or ≥ 28 weeks of gestation). Number of stillbirths varies significantly – ranging from 2 in every 1,000 births in Finland to more than 40 in every 1,000 births in Nigeria and Pakistan. In fact, some 98 per cent of stillbirths occur in low- and middle-income countries. Worldwide, 67 per cent of stillbirths occur in rural families, with 55 per cent occurring in rural sub-Saharan Africa and South Asia, where skilled birth attendance and caesarean sections are much lower than in urban areas. In total, there are an estimated 1.19 million intra-partum stillbirths every year (uncertainty range is 0.82 million to 1.97 million).⁴²

However, change is possible. Focusing on the people who face the greatest health inequities may bring the greatest gains in reaching the development goals.⁴³ An equitable approach to the MDGs, concerted commitment and action should inform the way forward.

CASE STUDY – ECUADOR

Improving the living conditions and strengthening the identity of the Andean population of Cotacachi

The Ecuadorian Red Cross aims to improve the living conditions and strengthen the community identity of the Andean population in Cotacachi. The idea behind it is to strengthen the intercultural practices of ancestral health and intercultural bilingual education.

According to Dr Glenda Gutierrez, National Coordinator of Health and Community Development at the Ecuadorian Red Cross, “We put an emphasis on how to process medicinal plants towards industrialization and commercialization of products, so that in the medium and long term, they can become sustainable. The project is currently managed by the union of peasant and indigenous organizations of Cotacachi, midwives, volunteers and the central committee of women.”

The project has reduced morbidity and mortality rates due to better access to health services and the incorporation of 25 new traditional health agents (ATS). Intercultural Health Campaigns have contributed to the process of bringing Andean rituals to life, such as the two solstices and the equinox. The project has also advanced to the creation of new production zones for primary materials and a processing plant to industrialize the medicinal plants with the women of the county.

<http://www.saludancestralcruzroja.org.ec/web/#>



^{***} http://www.who.int/mediacentre/news/releases/2011/newborn_deaths_20110830/en/index.html

Human rights is the framework to eliminate health inequities

Human rights offer a useful framework for eliminating health inequities because they are rights that belong to all people, they reflect existing obligations and they provide the basis for a comprehensive review of national legal frameworks for change. Some human rights related to health inequities are the rights to life, health, food and nutrition, water and education. Furthermore, non-state actors can look to the standards articulated in human rights for guidance in eliminating inequitable access to health.

For example, states parties to the International Covenant on Economic, Social and Cultural Rights – a core international human rights treaty that recognizes the right to health – are obligated to respect, protect and fulfil the right to health.⁴⁴

- To respect means that states cannot interfere with the right to health, for example, by denying or limiting access to any population – including vulnerable populations like women, children or minorities – the enjoyment of the right to health, nor can states limit access to health goods, including those related to reproductive and sexual health.⁴⁵
- To protect means that states must take measures to ensure that third parties do not interfere with the right to health, for example, by requiring spousal or parental permission to access health services.⁴⁶
- Lastly, to fulfil requires states to take appropriate measures, including but not limited to legislative, administrative, budgetary and judicial measures, to realize the right to health, including designing and implementing a detailed national health plan.⁴⁷ International human rights treaties recognize the unique needs and vulnerabilities of women and children, and grant them entitlement to special protection.⁴⁸

The right to the highest attainable standard of physical and mental health includes the right to obtain health services without fear of punishment as a result of cultural norms or family pressure. Policies that are likely to result in unnecessary morbidity and preventable mortality are breaches of a governmental obligation to respect the right to health. This right – as with any other – is inherently guaranteed under international law and without discrimination. A holistic approach to health inequities informed by human rights contributes to “levelling up”, or improving the health of the most vulnerable women and children without compromising the health of others.⁴⁹ Concrete measures should be taken to respect, protect and fulfil the right to health, for example, narrowing health disparities across the population spectrum, between the rich and the poor, and among the most vulnerable.

By the same token, a recent hard-hitting report from the UN Special Rapporteur on the right to health says all states must provide safe abortion and contraception for women. “States must take measures to ensure that legal and safe abortion services are available, accessible, and of good quality.” But the real challenge is to find out how many states will indeed change their policies accordingly.⁵⁰

...healthcare providers may intentionally or inadvertently provide care that embarrasses, humiliates or fails to respect women, thereby discouraging utilization of healthcare services.

Fact box

Sierra Leone eliminated user fees and, as a result, the number of children under five receiving care at health facilities went up by 214 per cent.



Chapter 3. The scale of the problem: the dimensions of health equities

Public health systems: a cause and a solution to health inequities

Whilst health systems can promote good health, they can also lead to health inequities, but they are also ripe with opportunities for change.⁵¹ To eliminate health inequities, all people – but particularly vulnerable groups like women and children – should be within the reach of available, accessible, acceptable and quality care. Availability refers to putting health facilities, services and goods in place. Accessibility means healthcare resources are non-discriminatory and enable all people – regardless of geography, finances or access to information – to take advantage of them. For example, investment in tertiary care centres, such as high-tech hospitals and specialized care centres, disproportionately benefit the rich at the expense of the poor.

Formal charges for services may also deter poorer populations from seeking treatment. The abolition of fees, however, can bring quick and clear gains in accessibility. Sierra Leone, for example, eliminated user fees and, as a result, the number of children under five receiving care at health facilities went up by 214 per cent.⁵² If the formal charges for services are off-putting, there are other deterrents too. The financial cost of transport to and from a health centre, the physical toll of travelling long distances and the loss of earnings or work opportunities are all contributing factors.⁵³

Acceptability strives to ensure that health facilities, goods and services comport with local beliefs. For example, local beliefs often shun away from discussing sex and sex practices, rape and intimate partner violence.⁵⁴ Taking gender issues into account, such as making female health practitioners available, is important when working to improve women's access and use of health services. Cultural accessibility also includes delivering prevention, treatment, care and support in languages spoken and understood by patients.⁵⁵ The absence of quality care, such as skilled birth attendants or emergency obstetrics services, can mean that what limited care is available is inadequate and, possibly, even harmful. The need for timely and clear planning is essential. Clear guidance on what action to take when problems occur can result in lives being saved.

The vast majority of healthcare providers deliver laudable services, often in very difficult circumstances. They are frequently the gate-keepers of health-related knowledge, services and goods, and they play a vital role in contributing to health systems that are available, accessible, appropriate and of good quality. However, corrupt practices – such as exploiting women, arbitrarily denying services or demanding bribes – do exist and impede access.⁵⁶ Healthcare practitioners may hold moralizing beliefs that lead them to deny reproductive health services to adolescents, unmarried women and women without children, effectively blocking their access to the care they need.⁵⁷

Universal coverage of health services

Today, most of healthcare costs are covered through out-of-pocket payments, leading to catastrophic medical expenditures. Many countries have endorsed universal coverage as an important goal for the development of health financing systems but, in order to achieve this long-term solution, flexible short-term responses are needed. There is no universal formula. Indeed, for many countries, it will take some years to achieve universal coverage and the path is complex. The responses each country takes will be determined partly by their own histories and the way their health financing systems have developed to date, as well as by social preferences relating to concepts of solidarity.

Source:

<http://www.who.int/bulletin/volumes/86/11/07-049387/en/e:>

Healthcare providers may intentionally or inadvertently provide care that embarrasses, humiliates or fails to respect women, thereby discouraging them from seeking medical attention or advice.⁵⁸ Improving the quality and character of patient-provider interactions through increased commitment to ethical practices and respect for human rights, including autonomy and confidentiality, will eliminate barriers to accessing healthcare services and improve access to care. Practical ways of achieving this include displaying patients' rights in health centres, adopting ethical charters and forming independent ethics commissions.

CASE STUDY – AFGHANISTAN

Culturally accessible care in the remote regions of the country

Afghanistan is one of the world's least developed countries. According to WHO, 70 per cent of the population "lives in extreme poverty and health vulnerability"⁵⁹ and maternal mortality is the highest in the world.⁶⁰ With the help of over 25,000 volunteers, the Afghan Red Crescent Society has brought first aid, health promotion and health education through community-based health programming.

To address the unique challenges of maternal, child and newborn health in remote regions of this country, the Afghan Red Crescent needed a new approach to community health that recognized local and cultural values. The Afghan Red Crescent put women at the centre of the planning process and its programme design.

The Afghan Red Crescent began by recruiting and training two female master trainers at the National Society's headquarters in Kabul. The two women, who worked on the condition that they were accompanied by their male relatives, travelled to remote regions of the country and met with community leaders. The female master trainers discussed the benefits of involving women volunteers in health promotion and solicited advice for recruiting women volunteers.

Based on these conversations, the Afghan Red Crescent recruited and trained women in remote villages through a culturally sensitive approach. Female facilitators led the trainings and no male facilitators were allowed to enter. One of the main challenges of training volunteers was illiteracy. In a country with illiteracy rates estimated at 50 per cent of men and 85 per cent of women, most of the female volunteers were illiterate. Red Crescent trainers developed innovative ways of teaching volunteers to ensure that they learned the key health messages accurately.

Communities are already benefiting from the work of female Red Crescent volunteers. They deliver key health messages to women living in villages, perform simple health interventions – such as diarrhoea treatment with oral rehydration solution – and refer women to health clinics for antenatal care, prenatal care and family planning. In a country with the compound challenges of poor infrastructure, extreme poverty, high illiteracy and gender inequalities, the Afghan Red Crescent is working to empower women at the local level to encourage health-seeking behaviours and reduce maternal mortality.

Poverty amid current universal trends exacerbates health inequities

Poverty – coupled with universal trends such as urbanization, non-communicable diseases and unhealthy lifestyles – plays a significant role in creating health inequalities, particularly where significant gaps exist in accessing resources that give rise to good health, such as adequate food and nutrition, housing, and improved water and sanitation. For example, 2.6 billion people,

or 39 per cent of the world's population, lack access to improved sanitation.⁶¹ Most of these people live in sub-Saharan Africa or Asia. Some 1.1 billion people practise open defecation, the majority of whom live in rural areas.⁶² Disparities are most pronounced in developing countries, among rural populations and the urban poor, underscoring the need for rural development and urban planning with a focus on equitable access to the basic resources that promote health and well-being.⁶³

Non-communicable diseases are also considered one of the most serious, and most prevalent, threats to health in the 21st century. The interlinkages between maternal, newborn and child health and the development of non-communicable diseases are becoming increasingly clear. The epidemic is being driven by powerful, almost universal trends: demographic ageing, rapid and unplanned urbanization, and the globalization of unhealthy lifestyles – trends that are not easily reversed.

- 80 per cent of deaths from non-communicable diseases occur in low- and middle-income countries, and a third of these deaths were in people less than 60 years old.
- Some non-communicable diseases also affect women, adolescent girls and children such as cancer. Of the 1.4 million new cases of breast cancer in women detected in 2008, about half were in poor countries.
- Nearly 43 million children under the age of five were overweight in 2010.

With the rise of rapid and unplanned urbanization, cities are hotbeds of marked health inequities, where the urban poor have considerably less access to resources that contribute to good health.⁶⁴ Unable to keep pace with population growth, rapid urbanization renders many developing countries unable to meet the water and sanitation needs of residents.⁶⁵

In urban slums, sanitation, food and nutrition, overcrowding, poor air quality, high crime rates and high unemployment are among the social determinants that contribute to the poor health of urban dwellers,⁶⁶ who “have more illness and die earlier than people in any other segment of the population”.⁶⁷ Living in urban slums also takes a particular toll on women and children.⁶⁸ Contaminated water, substandard sanitation, crowded living conditions and pollution all contribute to the spread of diseases like diarrhoea, pneumonia and malaria.

High crime rates and unemployment leave children vulnerable to violence and exploitation. Women in urban slums are particularly vulnerable because they often have less education, less control over resources, and less ability to make decisions than men.⁶⁹ Finally, urbanization may compound barriers to achieving health equity. This is highlighted by the pronounced disparities in the availability of skilled birth attendants based on wealth.

Poverty and health inequalities are interdependent and reinforce each other, and concerted government leadership is necessary to break this cycle. Committing financial resources to health services and the social determinants that give rise to good health are reasonable starting points, even for low- and middle-income countries. For example, increasing the efficiency of the tax and transfer system and using innovative financing, such as high taxes on alcohol and tobacco, generate more funds for health and enable governments to reprioritize their budgets for equity.⁷⁰

“A number of major organizations in the health field, including the Department for International Development (DFID), now have the improvement of health outcomes for the world's poor, or the elimination of poverty, as their primary aim [...] in recognition not only of the developmental importance of equity in health [...] but also of the role of ill health in the production of poverty.”

DFID, *Assessing the Health of the Poor: Towards a Pro-Poor Measurement Strategy*, 2001

“Investment in health is an investment in economic development. One key element for sustainable economic development is long-term investment in human, health and social development. The greatest asset of any society is its human capital. Human capital is crucial for the creation of wealth and employment and sustainable accumulation and transfer of knowledge and skills – a valuable prerequisite for industrial, technological and economic development. This cannot be achieved in a setting where high levels of mortality and morbidity, and low life expectancy are the norm.”

February 2011, *Note for the High Level Panel Discussion on Health Financing in Africa* on “More Health for Money and More Money for Health”

Red Cross Red Crescent statistics

- 161 projects in 54 countries
- 8,404,880 targeted beneficiaries
- 4,215,630 beneficiaries reached to date (March 2011)
- 267,104,136 Swiss francs worth of financial resources mobilized

CASE STUDY – ERITREA

Community-led total sanitation approach to reduce rural inequities

Water and sanitation are closely connected with health. Lack of access to improved water and sanitation, and lack of awareness of hygiene takes a particular toll on children, who are at a high risk of diarrhoeal disease. In Eritrea, there are significant disparities between rural and urban access to improved water and sanitation. Only 54 per cent of the rural population has access to improved water, compared with 72 per cent of urban populations. The figures for sanitation reveal even greater inequities: only 3 per cent of the rural population has access to sanitation compared with 34 per cent of the urban population.⁷¹

To improve coverage and to reduce the inequitable burden on people living in rural areas, the IFRC and the European Union sponsored a rural water and sanitation project that is being implemented by the Red Cross Society of Eritrea. The project targets 120 villages and aims to reach a total of 145,000 people.

Yosief Woldetensae, a reporting officer for the IFRC's Asmara delegation in Eritrea, reports: "Women are playing a remarkable role in realizing the community-led total sanitation programme." The community initiatives raise awareness about hygiene and encourage behavioural change using the community-led total sanitation approach. For example, one rural woman – let's call her Negisti⁷² – attended a 'community triggering' an activity that quickly raises awareness as a new form of community mobilization. She then decided to become a promoter of sanitation within her community. 'Triggers' promptly raise community awareness on sanitation and toilets, and encourage communities to stop defecating in the open.

Negisti received training from her local Red Cross branch on hygiene and sanitation awareness, latrine construction, and design, cleaning and reducing diarrhoeal-related disease. Responsible for mobilizing 15 households to perform hygiene and sanitation activities, she reports that most of the households under her care – including her own – are open-defecation free. Negisti is one of 1,969 volunteers who are mobilizing communities to be open-defecation free, which has a direct impact on the health of children, families and communities.

Negisti illustrates some of the successes of the project, but a range of challenges remain. Ensuring rural populations have consistent access to improved water, sanitation and hygiene needs the continued availability of local resources to construct latrines. And of course, there will always be people who need additional support to construct a latrine, such as the elderly. Woldetensae believes that ministries of health, local branches and community volunteers are capable of addressing these challenges and providing solutions.

In Eritrea, to date, over 11,950 latrines have been constructed and over 83 per cent of people (or 109,324) have been reached with hygiene and sanitation messages through community triggering and house-to-house visits.

Public policies committed to equity present opportunities

Laws and public policies may lead to inequities within a health system, but they also present opportunities for change. Laws that impede access to maternal and perinatal health services need to be repealed, including laws or regulations that require spousal permission for reproductive and maternal health services⁷³ or that limit access to life-saving treatment for pregnancy-related complications.⁷⁴

Whilst legislation and policies are crucial, the key is to follow them through with enforcement, and create a supportive community environment, engaging traditional and religious leaders in dealing with harmful practices. For example, in some countries, laws prohibit traditional but harmful practices such as female genital mutilation and child marriage. However, enforcement mechanisms may be either non-existent or lax, and harmful practices continue unchecked.⁷⁵

Healthcare providers and women themselves are important partners in ensuring that laws that strive to improve equity are implemented. Women healthcare providers can sometimes also contribute to injustice. For example, in some countries, laws specifically allow for reproductive health services to be available to all, but healthcare providers may deny services. Misconceptions in the law, lack of clarity, or the beliefs of healthcare providers may impede access to health equity.⁷⁶

In one study in China, 40 per cent of healthcare providers disapproved of the government providing contraceptive services to unmarried people; and 75 per cent of providers believed that contraceptives should not be available for high school students. Furthermore, the study revealed that family planning providers did not consider unmarried people as their clients. They believed that they had no responsibility to provide these services to unmarried people.⁷⁷

Political will and a commitment to change can bring about achievable changes though. Political commitment – followed through with an assessment of disparities and policy changes – are the first steps. Created by presidential decree, Brazil's National Commission on Social Determinants of Health illustrates the level of political commitment required to begin reducing health inequities. The commission, composed of 16 experts on the social determinants of health, carried out a rigorous study to assess the country's health inequities. The commission then designed informed policy solutions to address the inequities it found.⁷⁸



Chapter 4. The Red Cross Red Crescent response

A holistic approach to health equity informed by human rights

The staff and volunteers of Red Cross and Red Crescent National Societies believe that anyone – man, woman, adolescent or child – who is in need of healthcare, has a right to it, irrespective of who they are or where they live, and they should be able to access health services free of charge in a manner that respects their dignity.

On a global scale, the Red Cross Red Crescent plays a crucial role in preserving patients' human rights, lessening their feelings of alienation, fighting stigma and discrimination, and relentlessly advocating for health inequalities to be addressed.

The strength of the Red Cross Red Crescent response to health inequities lies in its 13 million Red Cross and Red Crescent volunteers. As members of their own communities, they either know or are able to find the people who are falling through the net – whether it be for financial, geographical, cultural or other reasons – and reach them. The Red Cross Red Crescent does not try to replace or replicate any formal health system, but rather it aims to supplement it.

Volunteers provide care to those who need it most and to those who cannot, for whatever reason, access the formal health system – underserved, marginalized and vulnerable populations. Volunteers can break down barriers to access, raise awareness, encourage health-seeking behaviours and empower people not reached by formal health systems. Volunteers are a truly valuable resource.

Provide prevention, treatment, care and support when and where needed

Improving equitable access to affordable healthcare, as well as the availability of prevention, treatment, care, and support at appropriate times and in appropriate places, is essential. Red Cross and Red Crescent National Societies use a community-based health and first-aid approach to improve maternal, newborn and child health. Whether delivering home-based care, immunizations, or promoting health services, volunteers make an important contribution to reducing inequitable access to care in their communities.

Principle of impartiality

It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

What can governments, legislators and policy-makers do to eliminate health inequities?

- Allocate health resources according to needs and based on sound evidence of ‘what works’.⁷⁹
- Use the continuum-of-care approach for women with a focus on key life stages – from reproductive health and family planning services to pre-pregnancy, antenatal and perinatal care (with skilled birth attendants). Postnatal care should continue into the early years of a child’s life and include the prevention and treatment of childhood diseases.⁸⁰
- Make a firm commitment to equality and non-discrimination when providing maternal, neonatal and child healthcare.

How can Red Cross and Red Crescent National Societies help?

- With a strong volunteer base, National Societies are well placed to scale up community-based efforts to reach the most vulnerable women and children. Examples include increasing women’s awareness of family planning, and the spacing and timing of births, promoting antenatal check-ups for pregnant women, and encouraging exclusive breastfeeding and the thermal protection of newborns.⁸¹
- Through their status as auxiliaries to government, National Societies can call on governments to prioritize health equity. National Societies provide a vital interface between governments and communities, and this unique position means they can inform legislators and policy-makers about the needs of the most vulnerable women and children, and highlight the obstacles they face in accessing healthcare at community level.
- National Societies can partner with civil society organizations to monitor and evaluate progress on reducing health inequities and gender inequality.

Make reliable, accurate information available and encourage health-seeking behaviours

Health education awareness is essential for enabling people to make informed, autonomous decisions about their own health and for bringing about a more equitable distribution of power, money and resources. Health education in general, like basic first aid and hygiene, can be tailored to the local context – such as swimming lessons in areas prone to floods. It strengthens community resilience by equipping people with the skills they need to lead healthy everyday lives as well as manage their own vulnerabilities during emergencies.

Awareness empowers communities, giving the most vulnerable a meaningful opportunity to take part in community needs assessments, and demand equity in the delivery of health resources and the social determinants that give rise to good health. Red Cross and Red and Crescent volunteers are a vital link in sharing knowledge with people who are often not reached by awareness campaigns. Furthermore, volunteers understand resistance to change, so they are able to help break down any local barriers that prevent people from adopting healthy behaviours. And volunteers are able to communicate in a manner that respects and promotes individual autonomy and decision-making.

CASE STUDY – DEMOCRATIC REPUBLIC OF THE CONGO

Bridging the health divide one house at a time

The Red Cross of the Democratic Republic of the Congo, in partnership with the GAVI Alliance⁸², is working to bring routine immunization to communities while also ensuring that their overall basic needs are also taken into consideration. Volunteers are an essential resource in immunization campaigns, going door to door in their communities to reach the last mile, in this case children under five and pregnant women who are missed by the formal health system.

In the Democratic Republic of the Congo, under-five mortality stands at 199 per 1,000 live births⁸³ – the fifth highest rate in the world.⁸⁴ Immunization coverage within the country is very unbalanced. For example, only 56 per cent of one-year-olds living in rural areas received the measles vaccination, compared with 73 per cent of one-year-olds living in urban areas.⁸⁵ The Red Cross of the Democratic Republic of the Congo, together with GAVI, played a key role in reaching the most remote and hard-to-reach children. GAVI committed over 5 million US dollars to the project, and Red Cross volunteers delivered the project to the most vulnerable.

The National Society made significant progress in increasing routine immunization. It trained and mobilized more than 1,300 volunteers in five provinces – Kinshasa, Katanga and South-Kivu, Kasai Oriental and Westerner – during the first phase of the partnership between 2008 and 2009.

In the second phase, during 2010–2011, volunteers concentrated their efforts in three provinces, Kinshasa, Katanga and South-Kivu. Volunteers went door to door to seek out pregnant women and children who were unvaccinated or whose vaccination calendars were incomplete. Volunteers, who speak the local language, raised awareness of the importance of vaccination, allayed fears and dispelled any myths about immunization. Working under the leadership of the health ministry, volunteers helped increase the rate of infant routine immunization coverage, reaching over 5,400 children in 2011 alone.

The Democratic Republic of the Congo faces civil unrest, inadequate funding for health services and a shortage of skilled health workers – which means the sustainability of any immunization programme remains uncertain. Undeterred, the National Society, working in a consortium with four other local organizations in receipt of GAVI funding, lobbied the government to budget for immunization. After a series of tense discussions, a reasonable budget for immunization was agreed.

How can governments eliminate health inequities?

- Take the lead in providing quality, reliable, up-to-date information on healthy behaviours and practices to all people, without discrimination and tailored to the local context.
- Ensure that education and health-seeking behaviour campaigns target the information needs of the population as a whole, but pay special attention to the needs of the most vulnerable women and children.
- Involve civil society organizations in implementing campaigns to disseminate health information.

How can National Societies help?

- Take advantage of strong volunteer networks that reach the most vulnerable women and children, together with volunteers' knowledge about local barriers to change, to scale up campaigns on health education and health-seeking behaviours.
- Use the status of auxiliary to government to encourage governments to disseminate accurate and reliable information.
- Carry out advocacy on health-seeking behaviours and strengthen partnerships with governments and civil society organizations to extend the effectiveness of existing advocacy messages.

CASE STUDY – CAMEROON

Bringing down barriers to maternal health among Central African refugees

Cameroon attracts refugees fleeing violence. It faces constant threats to its security and human rights abuses from the Central African Republic. With over 80,000 refugees from Central Africa, refugees often lack access to drinking water, sanitation and adequate health services.⁸⁶ The Cameroon Red Cross Society, in partnership with the United Nations High Commissioner for Refugees (UNHCR), plays a critical role in responding to the reproductive health needs of female refugees by raising awareness of the importance of antenatal care and skilled birth attendance.

With 35 reproductive health volunteers conducting over 700 home visits every month, the Red Cross uses volunteer home visits to reach pregnant refugees who cannot access formal health services. The work of the volunteers is crucial because only 50 per cent of refugees seek antenatal care and only 20 per cent give birth in health facilities, making pregnancy and childbirth dangerous for women. Because Central African refugees live among the community rather than in camps, home visits are an ideal way of reaching pregnant refugees. During home visits, volunteers look for visibly pregnant women and, once identified, volunteers teach them and their families about the importance of antenatal care and skilled birth attendance.

But the work of volunteers is tough. Cultural beliefs pose a formidable barrier to reproductive health and maternal care. Dr Marc Assouguena, Health Director for the Cameroon Red Cross, explains: “For many refugees living in Cameroon, antenatal care is not systematic in the habits of pregnant women.” Many do not seek antenatal care, and those who do often do seek care usually do so in the seventh month of pregnancy or thereafter. The work of Red Cross volunteers in Cameroon, however, helps to break down some of these barriers.

During a home visit, a Red Cross volunteer discovered Ms Abou Djibrilla, a 20-year-old Central African refugee. Ms Djibrilla was eight months pregnant. In preparation for delivery, she had travelled 150 kilometres over rough terrain using public transport to reach her mother’s home. Her mother lives on the edge of Mandjou, where the Red Cross is the lead UNHCR medical partner.⁸⁷ When the Red Cross volunteer found Ms Djibrilla, she was severely anaemic. The volunteer immediately referred Ms Djibrilla to the nearest health centre in Mandjou.

Ms Djibrilla attended her nearest health centre and it transpired Ms Djibrilla needed emergency antenatal care – she was referred to a regional hospital for specialized treatment. Unfortunately, she delivered her baby early. The baby suffered a neonatal infection and sadly passed away within 24 hours. Ms Djibrilla is slowly regaining her health at the regional hospital.

Ms Djibrilla’s story illustrates the vital role volunteers play in linking refugees with formal health services for acute care. Each of the 35 reproductive health Red Cross volunteers carries out home visits four days each month. In the past six months, volunteers have reached 271 pregnant women, 197 of whom sought antenatal consultations. Each volunteer performs two health talk sessions every month, raising awareness in communities on the importance of antenatal care and the dangers of giving birth at home.

Promote gender equality, empower women and girls, and enlist the support of men and boys

Eliminating health inequalities not only means providing health services and education without discrimination, but also includes tackling the broader inequities that occur in society, including gender inequality. The Red Cross Red Crescent is committed to social inclusion and peace, principles exemplified by volunteers embodying the seven fundamental principles of the Red Cross and Red Crescent, empower women and girls, and enlist the support

of men and boys to promote a culture of non-violence and peace. While volunteers are an important resource in tackling broader inequities, ultimately gender equality demands strong government leadership, political will and a commitment to change, in partnership with civil society organizations.

What can governments do?

- Make a firm commitment to gender equality, non-discrimination and non-violence in constitutions, legislation and national policies, including health policies, and ensure appropriate enforcement mechanisms.
- Empower women and girls to know and uphold their rights.
- Enlist the support of men and boys in bringing about gender equality and social inclusion.

How can National Societies help?

- Through their strong volunteer networks, scale up efforts for gender equality, non-violence and non-discrimination.
- Through their status as auxiliaries to government, engage decision-makers to commit, gender equality and non-discrimination in their constitutions, legislation and national policies.
- Partner with civil society organizations to serve as a referral source for the most vulnerable, including women and children, to claim their rights.

Obstacles and opportunities

Eliminating the health inequities that women and children face is a world-wide responsibility that requires a concerted effort at global, national and community level. A holistic approach provides a framework for delivering access, information and non-discrimination to all people, including the most vulnerable women and children.

Strong political will, effective government leadership, and financial and human resources are foundational in bringing about health equity. But governments, legislators and policy-makers are not alone. Red Cross and Red Crescent National Societies are there to help, empowering communities to bridge gaps in healthcare and strengthening resiliency to overcome vulnerabilities.

CASE STUDY – DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

Empowering women through community-based health and first-aid training

In the Democratic People's Republic of Korea (DPRK), the cost of services and drugs are free, but the non-quantifiable costs of accessing healthcare in rural areas are significant. For women and children who live in the countryside, obtaining medicines and getting care often means travelling for hours. A poorly functioning transport system compounds the problem. Red Cross community-based health and first-aid volunteers play a critical role in bringing healthcare closer to home.

The Red Cross in DPRK provides training and maintains over 2,500 first-aid posts throughout the country, using a strong volunteer network to share knowledge and carry out simple, low-cost health interventions in rural communities.⁸⁸ One trainer notes: "In the Red Cross first-aid posts far from the clinics, the main visitors are women with children. The aid helps women as they don't need to spend time travelling to the clinic."

Volunteers convey the latest and most reliable information on health and hygiene to their communities and promote healthy behaviours, such as breastfeeding. They also use simple solutions to help treat sick children, such as oral rehydration solution for dehydrated babies. Sometimes, this helps mothers avoid taking children to the doctor. One volunteer says, "I have been able to advise lactating mothers who are sick. They have been able to take care of the baby, and both survived better as a result."

Community-based health and first-aid training not only equips volunteers with skills, but also develops their confidence, strength and recognition within their communities. One volunteer at a recent Red Cross training course observed: "With community-based health and first-aid training, the women in our communities are more respected and our voice is heard. Red Cross trainers and volunteers have a very good image among the community. It has surely empowered all of us women."



The way forward

For the Red Cross Red Crescent, health inequities – with a focus on women and children – demand our immediate attention and action. Action begins by respecting human rights and dismantling the public health, development, and legal and regulatory obstacles to good health. Breaking down these barriers requires a multi-sectoral approach, policy coherence and sustained funding.

From a public health perspective, the health sector plays an important role in bringing available, accessible, acceptable and quality care within the reach of the most vulnerable populations. Providing health services, however, goes hand-in-hand with raising awareness. Knowledge and information encourage women and children to use available services, engage in behavioural change and demand equity in their communities. Services, knowledge and non-discrimination empower the most vulnerable to take control of their health, which ultimately strengthens community resilience.

From a human rights perspective, the Red Cross Red Crescent advocates for sound policies that are framed within a holistic approach to health. The IFRC calls on policy-makers to provide equitable health services to mothers and children, using a continuum-of-care approach; to promote social and economic conditions that mean mothers and children, and the communities they live in, develop greater resilience; and to use human rights as a tool for achieving health equity and equity in all spheres.

Eliminating health inequities is not the responsibility of any one actor. This global challenge demands the strong leadership of all governments in prioritizing health equity – and they must pay particular attention to eliminate the barriers that burden the most vulnerable women and children. The IFRC is calling for a clear commitment for a global action plan that ensures that those mothers and children who are most at risk are fully protected, they are screened and treated in a timely way, and have access to the health services to which they are entitled.

Working in coordination with governments, National Societies are an important resource in providing the hardest-to-reach populations with access to healthcare. Volunteers are members of their communities, and indeed some belong to marginalized groups themselves. This means that they are uniquely able to identify and reach those people the formal health systems miss.

As auxiliaries to government, National Societies are in a strong position to pressure decision-makers to eliminate health inequities generally, and for mothers and children in particular. Donors also play an important role in providing funds to bring about change, whilst strategic partnerships with civil society organizations and others mean that all actors committed to change can join forces to achieve the same goals. Together, we can all help bring about – through our extensive reach and capacity – the greatest amount of change in the lives of women and children everywhere.

CASE STUDY – AUSTRIA

Responding to violence against elderly women within the family

The Austrian Red Cross is responsible for coordinating ‘Breaking the Taboo’ and ‘Breaking the Taboo Two’, projects that, in partnership with other European organizations, raise awareness about the growing challenge of violence against older women within families. Silence about the violence perpetrated against older women limits the collection of accurate data, but estimates suggest that 6–9 per cent of the elderly are victims of violence.⁸⁹

In addition to gender-based risk factors, women also tend to be the victims because they live longer than men and are, therefore, more likely to develop chronic diseases that increase their dependency. Violence most often occurs in the home, perpetrated by a spouse or child. Cognitive problems, like dementia, are an additional risk factor, as well as an impediment to reporting abuse.⁹⁰

Red Cross staff and volunteers are an important resource in recognizing and responding to violence against older women. “As our staff members mainly work in older peoples’ homes, they are sometimes the first point of contact for victims of abuse,” explains Karin Ploder, volunteer manager for the Styrian branch of the Austrian Red Cross.

Breaking the Taboo and Breaking the Taboo Two – which builds on the first project – builds the capacity of healthcare professionals and volunteers to deal with violence against older women. One healthcare professional in Finland sums up the extent of her knowledge: “If there is a case of physical abuse, I would not notice it, I do not know how to detect or recognize it and I do not know whom to contact.”

The projects aim to fill this gap by preparing healthcare professionals to handle situations of abuse with instructions on how to recognize abuse, talk to victims, and report instances of violence. By equipping healthcare professionals with the skills to combat violence against women, the projects contribute to reducing the inequities faced by older women.

For more information: www.btt-project.eu



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The Fundamental Principles of the International Red Cross and Red Crescent Movement

Humanity The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is world-wide.



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