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Venice Forum

WHY INVESTING IN MATERNAL,
NEWBORN AND CHILD HEALTH (MNCH) IS CRITICAL
FOR SUSTAINABLE RECOVERY AFTER COVID-19



The Venice Forum

Executive Summary

Social and economic recovery after COVID-19 will depend upon healthy populations. Research shows clearly the centrality of healthy women and children to population well-being across generations. Yet national fiscal stimulus packages are insufficiently focused on the health and wellbeing of women and young children. Without this focus, future population resilience and hence economic prosperity remain at risk.

Leading biomedical and social science experts, economists, and public health leaders convened in five virtual panels over 22-24 March 2021 to consider the case for a radical rethink of current investment priorities for a sustainable future. This 'Venice Forum' is the starting point of an ambitious 2021-2022 roadmap to refocus national stimulus strategies and investments on a health and wellbeing-centred agenda for resilience and recovery. The Venice Forum is particularly focused on mothers and young children, recognizing that adolescent and adult health and wellbeing are being addressed in other fora.

The consensus emerging from the Venice Forum charts a course for investment in the health of women and young children. The Forum's recommendations for policy-makers support national governments in implementing a reprioritization and alignment of investments with a view to building productive, resilient populations for a sustainable future through MNCH.

The Venice Forum contributes to the work of The Partnership for Maternal, Newborn and Child Health. Together they will form a collaborating platform for the development and political advocacy of the investment case, working closely with leading global financing platforms such as the Global Financing Facility for Women's, Children's and Adolescents' Health, the World Bank, The Global Vaccine Alliance, The World Health Organisation, and with professional bodies and civil society organisations.

Why MNCH matters so much

Healthy populations are critical to long-term resilience and will impact on the chances of economic prosperity and sustained global recovery after COVID-19. There is clear scientific evidence for the centrality of the health of women and children to life-long and inter-generational physical and mental health. However, COVID-19 has widened the disparities experienced by women and children.

Economic realities and social justice considerations provide strong justification for addressing the long-standing gender and age-based inequalities that COVID-19 has magnified. Acknowledgement of the importance of childbearing, child-rearing, and other unpaid work to society, conducted largely by women, underscores the need to include these contributions in productivity metrics. The drive to identify investment priorities for post-COVID recovery provides the opportunity to implement bold, new policies to improve MNCH for sustained, intergenerational benefit.

Biomedical science emphasizes how COVID-19 exacerbates the passage of poor physical and mental health from mothers to young children

Research over recent decades shows clearly that parental health and the early life environment, particularly during the period from conception to two years of age, play important parts in establishing the biology of the developing fetus and child, and affecting responses to health challenges across the life-course. These processes operate in every fetus and infant, not just in those exposed to extreme conditions. Maternal and, as increasingly recognised, paternal nutritional, behavioural and social and environmental exposures affect the risk of chronic physical and mental ill-health throughout the life-course and into the next generation. Being born in either end of the spectrum of birthweight - low birthweight (LBW) / small for gestational age (SGA) or large for gestational age (LGA)/ macrosomia, can place the baby at a higher risk of NCDs. Birthweight, in turn, also depends on maternal nutrition, and both overnutrition and undernutrition in the mother can manifest as over or underweight respectively, or as micronutrient deficiencies. In particular, the relationship between birthweight and the risk of obesity, heart and renal disease and diabetes in later life is now well established. Obesity and overweight before and during pregnancy can lead to an increased risk of complications during pregnancy (Gestational Diabetes, pre-eclampsia, gestational hypertension) and long term effects for the next generation such as congenital anomalies, preterm births and altered birthweight due to intrauterine growth retardation. Recent evidence also shows that preconception obesity in the mother is a strong predictor of childhood obesity, and that intervening during pregnancy could be too late.

Children born too soon, too small, or to a mother who is underweight, overweight, or has diabetes are 1.5-6 times more likely to develop NCD than those born full-term with a healthy birthweight or to a healthy mother. Globally, preterm birth rates range from 5-15% and are rising, around 10% of full-term babies are growth restricted, and in many countries, 50% of pregnant women are overweight or obese. Thus overall, about half of all births represent children placed at risk of NCD from early life. Early life circumstances also matter. For example, a child born full term in the most deprived areas has a similar likelihood of having a speech and language problem as an extremely premature baby in the most affluent areas.

Mental health, more precisely defined as neurocognitive and emotional development, affects educational attainment and economic and wider contributions to society. The early development of executive function is particularly important as it underpins the child's ability to learn at school, pay attention and complete tasks, become socialized and develop psychological resilience. In some countries, it has been calculated that 80% of the cost of an individual's life to the state in terms of justice, welfare, housing and employment support can be predicted at the age of two years.

25%-35% of young women between the age of 15-25 have depressive and/or anxiety symptoms and there is compelling evidence that stress in pregnancy is one of the biggest factors affecting emotional development and executive function in young children. Whilst there has been an increase in the incidence of mental health

problems along with stress and domestic violence during the pandemic, evidence shows that globally the care of maternal mental problems is ineffective or non-existent, even in high income countries.

Recent research gives insights into the underlying mechanisms by which poor mental and physical health are passed across generations. Epigenetic processes, by which gene expression and thus phenotype are affected independently from inherited fixed genetic endowment, operate during critical periods of development. This explains in part why interventions in later life have proven ineffective in rectifying the consequences of early setting of an unhealthy life-course trajectory.

The longer-term consequences of poor MNCH include increased risk of non-communicable diseases, which before the COVID-19 pandemic accounted for over 70% of deaths globally. They also contribute to pre-existing conditions such as obesity and high blood pressure which give a greater risk of hospitalization and death from COVID-19, so reducing their prevalence may protect against future pandemics. The Venice Forum emphasizes the current scientific evidence provides a clear rationale for investment in MNCH.

COVID-19 has exacerbated pre-existing inequities in MNCH

Gender equity forms part of wider social justice issues raised by the pandemic. The pandemic has also affected the world's children disproportionately, amplifying pre-pandemic concerns about threats to their future. Shutdowns of maternal and child clinics and a reduction in the provision of vaccines could lead to 10-50% more deaths for women and children. In many settings, educational settings and schools empowered women to work and provide nutritional interventions. However, during the pandemic, the burden for home-schooling has fallen largely on women. School closures have led to children missing out on school meals and adolescents experiencing mental health issues due to isolation. For every 3 months of lockdown, 15 million more cases of gender-based violence are anticipated. Stringent lockdowns have also led to interruptions in supplies affecting MNCH services. Recent estimates from UNFPA indicate that an estimated 12 million women may have been unable to access family planning services as a result of the COVID-19 pandemic, resulting in an estimated 1.4 million unintended pregnancies.

In 2020 UNICEF published a six-point plan for education, nutrition and well-being, setting out government actions to avert a 'lost COVID generation'. The embodiment of disadvantage makes it clear that the separation of biological versus social, or innate versus acquired risks to health is artificial and unhelpful. The shift away from 'nanny state' policies, towards 'nudge' initiatives, and the delegation of responsibility to individuals, raises justice issues when those most in need of support lack the capability or opportunity to make 'healthy choices'. The pandemic has intensified this focus on individual risk, whether in terms of gender, age, ethnicity, or 'pre-existing conditions', many of which have their origins in early life and social disadvantage. Early interventions to promote executive function have enormous potential to change economic arguments and human capital potential. Investments in health and the education of low-income children provide the highest marginal value on public funds. For example, discounted lifetime costs per victim of nonfatal child maltreatment are estimated at £89,390 in the UK.

The key reproductive rights of populations were also affected during the pandemic. For example, due to lack of adequate information at the onset of the pandemic, early guidance on clinical care for pregnant women was often conflicted over whether women with an infection should be isolated, should be able to have a companion during delivery, should be delivered vaginally, and should have skin contact with their baby and practice kangaroo mother care. Lessons could have been learnt from the Zika epidemic when interim guidance for clinical management of pregnancy and neonates was developed within weeks of the outbreak being declared. A lack of political will can hamper the outcomes of strong work happening at the grass-root level to reduce maternal mortality and morbidity.

When articulated appropriately, reproductive rights can be used to justify both increased investments in primary healthcare (through which most MNCH services are delivered) and for RMNCH services which would reduce gender inequality. Tackle obstacles to securing women's reproductive rights during the pandemic such

as: lack of information of the disease outbreak on people's reproductive health (among public and healthcare practitioners (HCPs)), lack of a definition of what constitutes an "essential health service – which in turn determines the distribution of health system resources – funding, staff, equipment – can lead to a fall in priority for RMNCH services, and finally, the indirect effects of the pandemic on access to and use of services, including information and education, even if they have been determined as essential.

The COVID-19 pandemic caused an uptick in cases of early marriage and female genital mutilation due to a lack of access by human rights defenders. Strategies in the post-COVID era will need to ensure that these types of violence against women and girls are addressed in line with the SDGs and leaving no one behind.

The Venice Forum stresses that a new emphasis is urgently needed on social justice which recognizes the complexity of intersectional social and biological embodiments of disadvantage. This would illuminate the nature of intergenerational amplification, the adverse impact of poor MNCH on all of society, and provide clear justification for policies to end this inequity.

COVID-19 highlights the need for new economic models recognizing the contributions of MNCH to prosperity

Globally, 42-66 million people are now in extreme poverty with women, children and adolescents more affected due to the lack of social and financial protection. The direct costs of poor MNCH are considerable. In the African region, maternal death costs \$4.5 billion to productivity. Promoting healthy emotional development and reducing exposure to severe stress can save \$800 million per year in terms of global consumption of anti-depressants. 25%-35% of young women between the age of 15-25 have depressive and/or anxiety symptoms. The global economic cost of not breastfeeding is estimated to be \$341.3 billion per year (0.7% of global gross national income). The unpaid caring and child-rearing work, largely conducted by women, also incurs high opportunity and wellbeing costs which are usually not measured.

Evidence from previous societal shocks in the 20th century and the global financial crisis of 2008 shows that detrimental effects on MNCH have long-term consequences for population health. During the COVID-19 pandemic, home working became the norm for much of the white-collar salaried workforce. They joined the billions, predominantly women, who have always worked in the home and thus support economies, but are unremunerated. With schools closed during the pandemic, they also became unpaid educators, often without the resources to do so. Paid work contributes to GDP but not, for example, the value of the woman breastfeeding her baby or, less commonly, the father caring for his young child, even though they are powerful determinants of health and prosperity.

Economic models which emphasize market traded inputs and outputs do not assign such non-traded inputs such as caring work, or outcomes such as health-related quality of life, a monetary value. Although it is estimated that home-produced output contributes to 20-50% of GDP, the Organisation for Economic Co-operation and Development suggests that the inclusion of unpaid household work would increase GDP from between 15% to 70% depending on the country and method of calculation. Caring work carried out by women does not fit into the model of work and production based on manufacturing. The provision of care is based on the personal relationship between provider and receiver and the continuity of care, which is difficult to measure in terms of productivity. Investment benefits need broader definitions to include social and individual wellbeing to capture human capital, care, health and education. Definitions should not be restricted to monetary gain covering transport, buildings and technology as these create gender employment bias. Investing 1% of GDP in the care sector instead of the construction sector would create 2.7 times as many jobs in the economy, 6.3 times more jobs for women, and 1.1 times more jobs for men. Investment in the care system is environmentally sustainable as investment in care is 3 times less polluting per job created per equivalent investment than in the construction industry.

Households should not be the individual economic unit used when analysing the economy. Resources are not shared equally within a household and individuals have different standards of living and interests. Women

are more likely to sacrifice their long-term interests, experience financial abuse and outlive their household and family structures are changing in many contexts. There are additional considerations to be made in measuring unpaid work by women accurately. They include multitasking, supervision of several children and undirect activities such as washing and food preparation.

Even before the pandemic, data assembled in the latest Global Burden of Disease study emphasize the use of the Socio-Demographic Index (SDI) rather than GDP to measure economic progress. The SDI relates to healthy life expectancy and takes account of the positive effect of the number of years of schooling. Adopting an economic model that incorporates contributions that improve MNCH could kick-start sustainable COVID-19 recovery. The justification for such a new model already exists, for example in SDG 5 target 4, which calls on governments to *“recognise and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies....”*

The Venice Forum emphasizes the need to contest the definition of economic activity. Unpaid work, largely carried out by women, should be at the centre of economic models, not just seen as giving added value. Quantifying and measuring unpaid work is not valuing it. The Forum stresses the need for strategies to also value unpaid work e.g. through budgeting.

Seizing the opportunity provided by COVID-19 to invest in MNCH

The experience with COVID-19 pandemic demonstrates that when human communities and societies internationally put their minds together, they can do extraordinary things very quickly. As societies, governments and institutions move from emergency measures to combat COVID-19 towards recovery, the Venice Forum advocates building on scientific knowledge and social justice considerations to springboard a new conceptual framework for a sustainable future based on investing in MNCH. It suggests that there has been inadequate consideration of the drivers of population health and resilience across generations, upon which sustained economic recovery ultimately depends. The Forum points out that the economic models and societal attitudes of the past have persistently marginalized the health and wellbeing of women, infants and children to the detriment of all of society. However, the pandemic has forced new behaviours and ways of working, a questioning of societal norms, and driven the emergence of new industries. Most commodities for daily living are now available to be delivered to a person's house (particularly in urban and high-middle income settings) – however, this shift has not occurred for essential medicines or pharmaceuticals. Though the long-term effects of homeschooling are unknown, online learning provides an opportunity to reach hard-to-reach settings. The COVID-19 pandemic thus offers a unique opportunity for radical change through multi-faceted actions to improve MNCH as a cardinal component of investment for post-pandemic recovery.

Recommendations for action by the Venice forum

The Venice Forum explored practical steps for investment in MNCH, built on the three pillars of science, justice and economics outlined above. It advocates for public health preparedness through the following actions for multiple stakeholders including policymakers and governments.

TEN ESSENTIAL ENDEAVOURS FOR INVESTING IN MNCH -

1. Present clearly the overwhelming **EVIDENCE** for investing in MNCH.
2. Develop new **ECONOMIC** models to attribute value to the unremunerated work largely carried out by women, and embed this in economic policies aimed at promoting health, wellbeing, resilience and prosperity. Calculate and publicise the short- and longer-term costs of under-investment in MNCH.
3. Advance gender **EQUITY** through strong commitment to the prevention of violence against women and children, and call for a Global Treaty against such violence. Develop new initiatives to address the long-standing social justice (gender, age, ethnic and other social) inequity issues underlying

undervalued MNCH. Embed these within preventive efforts to address societal issues such as early marriage and misogyny.

4. **EDUCATE** and support prospective parents in preparing for pregnancy in the preconception period of their life-course through novel initiatives in schools and communities to promote physical and mental wellbeing. Engage media and social media groups to promote understanding in male partners and families of the long-term impact of MNCH and to co-create initiatives.
5. **EMPOWER** parents to provide support for nurturing child care in the pre-school years, through paid parental leave (for either parent and incentivising men), home-visiting and community-based programmes.
6. **EVALUATE** and report access to services for sexual and reproductive health and assisted reproductive technologies, safe abortion, and postpartum care as part of a needs-based continuum of care pathway, especially for the poor and vulnerable. Engage and train HCPs in fully delivering this agenda.
7. Connect MNCH to **ENVIRONMENT** issues including climate change, indoor and outdoor air pollution, environmental toxicants, sanitation and clean water and food security
8. **EXPAND** Research, development and innovation in MNCH in public, private and third sectors and require the representation of women and children in R&D.
9. **ENGAGE** with advocacy groups and organisations working in each of the above areas to grow a coalition of committed partners.
10. **ENSURE** accountability is attributed at all levels of government, professional and other support organisations for the delivery of a life-course and needs-based approach to promoting MNCH. Break down silos and prevent parallel, competing agendas.

Organising Board:

Prof Mark Hanson (Chair), Director Institute of Developmental Sciences, University of Southampton, United Kingdom

Prof Neena Modi, Imperial College London; President UK Women's Medical Federation

Dr Flavia Bustreo, Vice-Chair of Fondation Botnar, Chair of the Governance and Nomination Committee at the Partnership for Maternal, Newborn and Child Health (PMNCH)

Prof Gian Carlo Di Renzo, Director, Centre for Perinatal and Reproductive Medicine University of Perugia; Past Secretary General, FIGO

Prof Linda Giudice, President International Federation of Fertilities Societies; Chair, FIGO Committee on Reproductive & Developmental Environmental Health; University of California, San Francisco

Prof Ariadne Malamitsi-Puchner, National and Kapodistrian University of Athens

Scientific Secretariat:

Dr A/Prof Despina Briana, National and Kapodistrian University of Athens

Dr Chandni Maria Jacob, University of Southampton

Rapporteurs:

Dr A/Prof Despina Briana, National and Kapodistrian University of Athens

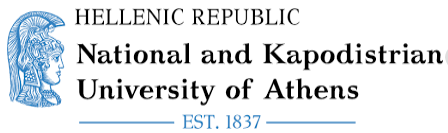
Dr Michael Penkler, Technical University of Munich

Ms Daniella Watson, University of Southampton

Dr Sunil Bhopal, Newcastle University

Dr Chandni Maria Jacob, University of Southampton

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