Our world. Your move.
31st International Conference of the Red Cross Red Crescent
Geneva, 28 November–1 December – For humanity

EN

31IC/11/5.3.2
Original: English
For decision

31st INTERNATIONAL CONFERENCE

OF THE RED CROSS AND RED CRESCENT

Geneva, Switzerland
28 November – 1 December 2011

Health inequities: reducing burden on women and children

Background report

Document prepared by
International Federation of the Red Cross and Red Crescent Societies in consultation with the International Red Cross Committee

Geneva, October 2011

BACKGROUND REPORT

Health inequities: reducing burden on women and children

I. Health Inequalities and the International Conference

The International Conference is the appropriate forum for governments, the Federation, and National Societies to agree on a common framework for addressing health inequalities and for the Movement to articulate its response to this global challenge. Health inequalities straddle public health, development, and regulatory dimensions, and the Conference brings together actors who are capable of change in all three areas.

Health inequalities, often refered to as health inequities, "unfair and avoidable differences in health status seen within and between countries," are rising.[1] Even where overall gains in health occur, inequities within countries are increasing. For example, in 18 out of 26 developing countries that reported a 10 per cent or more reduction in under-five mortality, UNICEF reports that inequality in under-five mortality between the poorest 20 per cent and the richest 20 per cent of households either increased or stayed the same. In 10 of these 18 countries, inequality in under-five mortality increased at least10 per cent.[2]

Second, simple, cost-effective measures reduce health inequities, leading to significantly better health when scaled-up. Most maternal deaths are preventable, yet many of the urban poor and rural women lack access to reproductive health services, antenatal care and skilled birth attendance. Data from 70 countries shows the poorest 20 per cent of households have less access than the wealthiest 20 per cent.[3]

Third, health is a resource that enables people to achieve their fullest potential, and 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. [4] Further, failing to reduce health inequities potentially leaves the most vulnerable at sustained risk and disadvantage. 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."[5]

II. Women, children and youth are among the most vulnerable, and focusing efforts on them promises gains for all population groups.

Focusing on women, children and youth, who are among the most vulnerable, can begin to dismantle obstacles to equity. Women have unique needs, related to pregnancy and childbirth, which demand more care. The absence of care, or the inability to access care during pregnancy and childbirth, render women more vulnerable to inequality. Social inequities compound biological differences, exacerbating vulnerabilities. For example, women may be less able to negotiate for safer sex and demand that their partners wear condoms.

---

[1] WHO, *Social Determinants of Health*, http://www.who.int/topics/social_determinants/en.
[2] *Progress for Children: Achieving the MDGs with Equity*. No. 9. New York: United Nations Children's Fund UNICEF, 2010; 23.
[3] *Id.* at 27
[4] Margaret Whitehead and Goran Dahlgren. *Leveling Up (part 1): a discussion paper on concepts and principles for tackling social inequities in health.* Copenhagen: WHO Regional Office for Europe, 2006; 3.
[5] *Narrowing the Gaps to Meet the Goals*. New York: United Nations Children's Fund (UNICEF), 2010.

Action has a multiplier effect. Reducing barriers to health equity that burden either women or children benefits the other, as the health of mothers and children often occurs in tandem. For example, mothers often care for sick children, requiring time off from work, leading to loss of income and possibly impoverishing 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, children and youth.

Benefits spill over to families and communities, rendering women, children and youth a gateway to improving population health, economic growth, and development. For example, ensuring access to affordable care at the community-level avoids expensive and complicated care later, allows children to go to school, and helps to enable women to lead healthy and productive lives. An educated, healthy workforce furnishes the human capacity for growth, development, and innovation.

III. A needs-based approach addresses the causes of health inequities and capitalizes on the Movement's strengths. Human rights offer guiding principles, informing and complimenting a needs-based approach.

A needs-based approach is a logical solution to reducing health inequities. This approach matches resources with need, thereby improving access among the most vulnerable to the resources that give rise to good health without compromising access to other segments of society.

Human rights guide action. Human rights include the right to health, education, and non-discrimination.[6] Human rights treaties offer comprehensive international standards on health and non-discrimination, so they offer guidance to states and non-state actors on reducing inequitable access to health.[7]

Public health, development, and legal and regulatory barriers produce health inequities. Rural women, children and youth may lack access to health services in their communities, or user fees may preclude the poor from obtaining available care. Poor daily living conditions, such as lack of access to improved water and sanitation and slum conditions, contribute to the ill-health. Spousal permission laws or the absence of confidential care may deter women from seeking care. Removing barriers such as these is in line with basic human rights and reduces health inequities.

---

[6] Many international human rights treaties recognize health and non-discrimination. The following are some examples. Article 25 of the Universal Declaration of Human Rights states, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family," and states, "Motherhood and childhood are entitled to special care and assistance." In Article 12 of the International Covenant on Economic, Cultural, and Social Rights (ICESCR), state parties recognize the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health." In Article 2 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), state parties "condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women" and Article 12 specifically refers to prohibiting discrimination in the delivery of health care. In Article 12(2) of the treaty, "States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation." In Article 24 of the Convention on the Rights of the Child, "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health."

[7] Some examples of international standards on health include available, accessible, acceptable, and quality care for all (ISESCR, General Comment No. 14). Availability refers to structures set in place. Accessible includes non-discrimination, and physical, financial, and informational accessibility. Acceptable refers to culturally appropriate care. Quality speaks to services that comport with standards.

IV. What is needed?

a) Provide prevention, treatment, care, and support when and where they are needed

Providing prevention, treatment, care, and support begins with implementing simple, cost-effective measures at the community level and continues with dismantling barriers to care within the formal health sector. Barriers arise from the design of the formal health sector itself, which are caused by public policies and the social determinants of health. For example, Sierra Leone eliminated user fees for children under five, and number of children under 5 getting care more than tripled.[8] Greater access to affordable care not only stimulates the supply and demand of health services among women, children and youth but also invites other groups to seek prevention, treatment, care, and support.

One often overlooked barrier is the action of some health care providers, who are gate-keepers of health knowledge, services, and goods and who contribute to equitable delivery of care. Corrupt practices, such as arbitrarily denying services or demanding bribes, impede access.[9] Personal beliefs of health care providers, which may reflect discriminatory norms, may block access to reproductive health services to adolescents, unmarried women, and women without children.[10] Health care providers may intentionally or inadvertently provide care that embarrasses, humiliates, or fails to respect women, thereby discouraging utilization of health care services.[11] Improving the quality and character of patient-provider interactions may reduce barriers to accessing health care services and improve access to care.

Prevention, treatment, care, and support are not sufficient to reduce health inequities. Tackling health inequities demands coherent efforts among all sectors. For example, rapid, unplanned urbanization means that the urban poor often have unmet water and sanitation needs, contributing to the inequitable spread of communicable diseases. The formal health sector, however, is an appropriate starting point for action today because it is capable of setting an example and leading coordination with other sectors.

b) Make accurate and reliable information available

Accurate, reliable information is essential for people to make informed decisions about their health and engage in health-seeking behaviours. Behavioral change is especially important because if people fail to use available, accessible, acceptable, and quality care, health inequities will persist. For example, several Red Cross Red Crescent National Societies in Western Africa report that women do not use antenatal services even though these services are affordable and close to home. Failure to use such services underscores the importance of providing the most vulnerable women, children and youth with accurate and reliable information on health and encouraging health-seeking behaviours.

c) Promote gender equality, non-discrimination, and non-violence

Eliminating inequities in society generally and eliminating discrimination and violence empowers people, including women, children and youth, to take control of their health. For example, without the power to negotiate safer sex with partners, women risk contracting sexually transmitted infections and having unwanted pregnancies.

---

[8] Adam Nossiter. "In Sierra Leone, New Hope for Children and Pregnant Women." NY Times. 17 July 2011. http://www.nytimes.com/2011/07/18/world/africa/18sierra.html?pagewanted=1&_r=1.

[9] DFID. *Addressing Corruption in the Health Sector.* November 2010.

[10] Paula Tavrow, "Promote or discourage: how providers can influence service use." *Social determinants of sexual and reproductive health: informing future research and programme implementation*. Ed. Shawn Malarcher. Geneva: WHO, 2010.

[11] *Id.*

V. A needs-based approach draws on existing Red Cross Red Crescent activities, and requires the following principles for action.

National Societies are called upon to:

- Use their status as auxiliaries to their public authorities to engage in dialogue, review existing health plans, and where necessary advocate for equity
- Engage in advocacy on health-seeking behaviours and strengthen partnerships with Governments and Civil Society Organizations to extend advocacy effectiveness
- Set the example of gender equality in their own policies and programs and serve as role models for governments, civil society organizations, and the private sector

Governments are called upon to:

- Encourage the formal health sector to embrace non-discrimination, and improve the quality and character of patient-provider interactions by increasing commitments to non-discrimination, ethical practices, and professional health care standards. Possible examples include posting patient rights in health centers, adopting ethical charters, forming independent ethics commissions, and training health care workers on ethical practices and gender sensitivity.