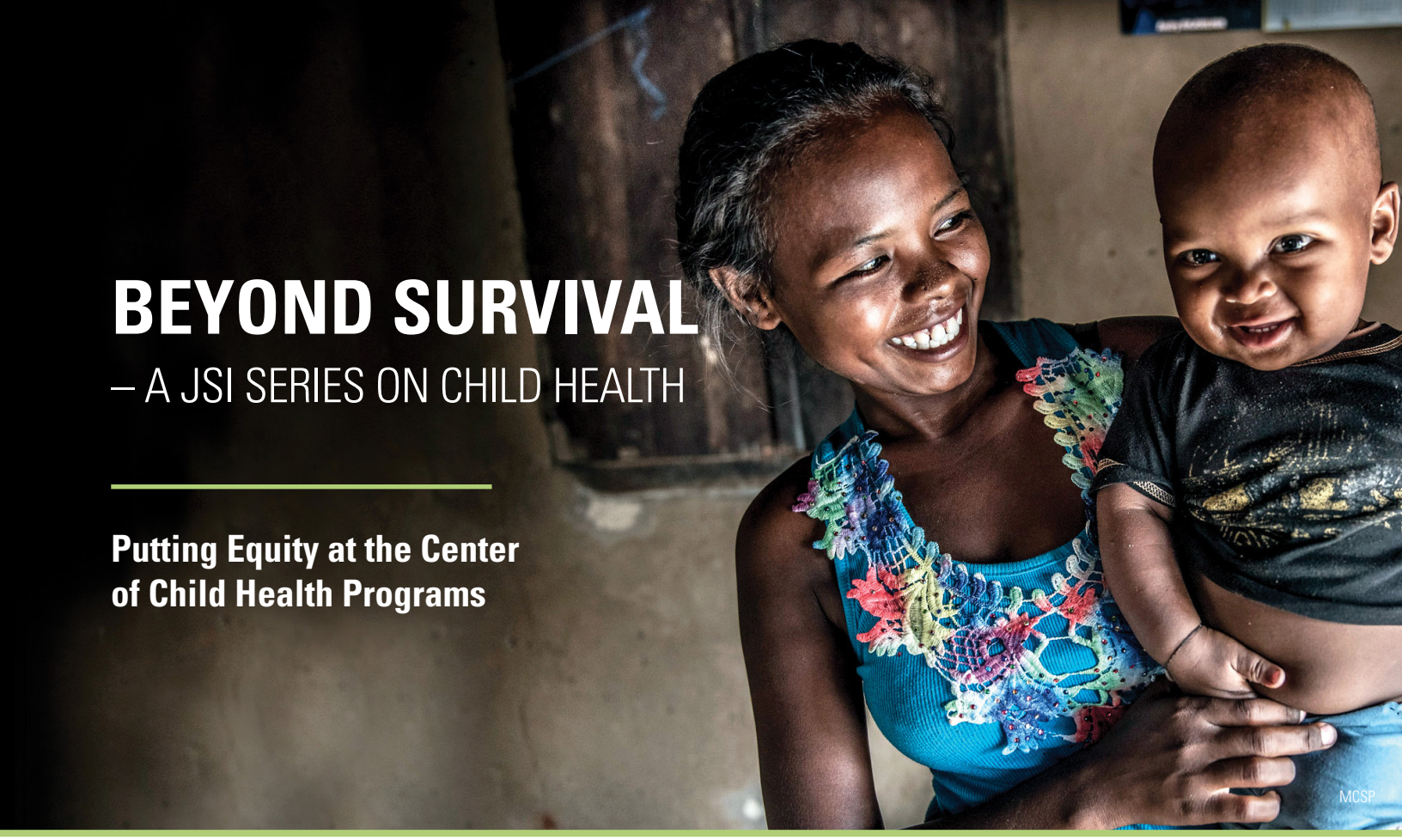


BEYOND SURVIVAL

– A JSI SERIES ON CHILD HEALTH

Putting Equity at the Center of Child Health Programs

JSI's approach to supporting the health of women and children is rooted in a life-course perspective and recognizes that biological, behavioral, environmental, and socio-economic factors determine health outcomes. Health equity is therefore integral to our work.

The life-course perspective, which provides the theoretical framework for JSI's Beyond Survival series, emphasizes how events, conditions, and circumstances throughout a child's life can greatly affect their outcomes later in life. Child health and well-being are recognized to be more than just biomedical health outcomes. As we understand it today, child health encompasses the lived experiences of children, from their families' economic opportunities, to the quality of care at health facilities, to the education that children receive. As the WHO-UNICEF-Lancet Commission on the future of children stated, "We can no longer consider child health and well-being the prerogative of health professionals."[1] Thus, efforts must be made across all sectors to achieve the child health Sustainable Development Goals (SDGs).

Across the 17 SDGs, UNICEF identified 44 child-related indicators, but child health advocates are concerned that large groups of children will not meet the minimum threshold of these indicators. Health equity is achieved when everyone can attain their full health potential. When looking at child health, an equity lens allows us to understand where, how, why, and which children are slipping through the cracks in the system. These gaps in equity may be present because of economic, social, political, and/or geographic causes, and they may be exacerbated by individual-level drivers such as race, gender, and education.

JANUARY 2022

Initial analysis of the child SDG indicators shows that children from low-income households, those who live in rural areas, and adolescent girls have a higher chance of experiencing adverse health and life outcomes. At the same time, insufficient data and monitoring makes it difficult to know if other vulnerable groups, including ethnic and racialized groups, children with disabilities, and children who are displaced, are affected in the same way.[2]

To better understand equity in the child health landscape, we reached out to JSI experts working on immunization, nutrition, primary health care, maternal and newborn health, and child health programs across Ethiopia, Ghana, Kyrgyz Republic, Zambia, Timor-Leste, and the United States. Through interviews and questionnaires, we tapped into lessons from our projects and country programs, which have informed this brief and provided important perspectives on how child health intersects with more specific program areas, such as immunization and nutrition. This input from our experts helped us contextualize the current state of inequities in child health and envision a more equitable future.

This JSI brief presents the main drivers of inequity in child health and emphasizes the paramount need for a multi-sectoral approach to health to promote equity.

KEY DRIVERS OF INEQUITY

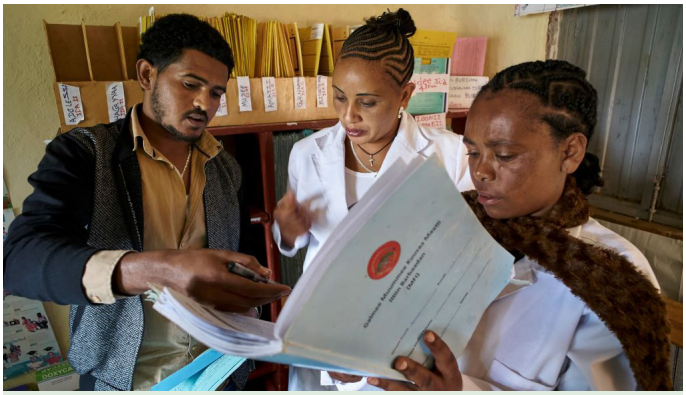
The current state of child health is beset with disparities stemming from economic, social, and political constraints. The drivers of these disparities are often inter-linked, with exposure to one driver leading to exposure to other drivers. For example, conflict often limits communities' access to economic opportunities, thereby exacerbating health disparities between children who have experienced violent conflict and those who have not. Interviews with JSI child health experts highlighted many elements contributing to the current inequities in child health, including economic, geographic, gender, conflict, and racial disparities.

Economic Disparities

Economic disparities can constrain a child's health care access and chances of survival immensely. The life-threatening consequences of economic disparities are reflected in the fact that the poorest children are 1.9 times more likely to die before the age of five than the richest children.[3] Wealth inequalities between countries create systems in which children in low-income countries often must contend with ill-equipped health systems that do not provide reliable, comprehensive, or accessible services. At the same time, within middle- and high-income countries, low-income families often face difficult decisions about how to spend their limited resources and may be unable to afford or access health care for their children. As such, inequality in wealth distribution has been found to be a main source of disparity in child health.[4]

In a study of 99 low- and middle-income countries, UNICEF predicts that 75 percent of children who make up the poorest quintile in their country will not meet the SDG target for under-five mortality rates, as compared to the 25 percent of children who live in the wealthiest quintile.[5] A WHO study from 36 countries in the Africa region found that, in every country studied, mothers and children in the poorest quintile experienced lower health intervention coverage compared to those in the wealthiest quintile.[6]

These inequities have been heightened by the COVID-19 pandemic, which has resulted in an increase in unemployment, an unravelling of financial safety nets, a loss of food security, and widespread disruptions in the daily lives of children. According to the World Food Programme, 155 million people living in 55 countries or territories in crisis faced acute hunger in 2020—20 million more than in 2019. In these countries, 75 million children under the age of five were stunted and 16 million were wasted.[7] In the United States, estimates reveal a three-fold increase from pre-pandemic times in the number of households unable to put enough food on the table, with almost 12 million children not having enough to eat.[8]



ETHIOPIA

As part of its urban health work, JSI collaborates with Ethiopia's Federal Ministry of Health to identify economically disadvantaged children in urban communities. Through the Data Use Partnership, JSI collects and analyzes household-level data to map these children and prioritize them for home-based health services. This helps to increase equity in child health outcomes across the country.

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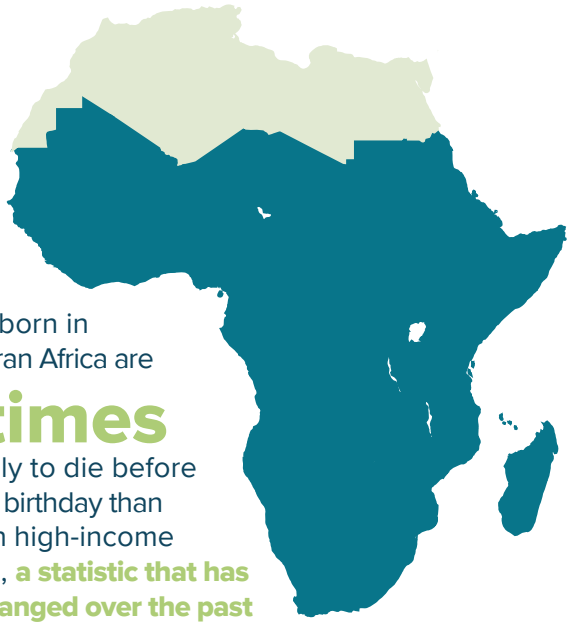


Children born in sub-Saharan Africa are

12 times

more likely to die before their fifth birthday than children in high-income countries, **a statistic that has barely changed over the past 30 years**.

Geographic Disparities

As with economic disparities, a child's geographic location has the potential to limit their access to health services and their chances of survival. Almost 80 percent of child deaths occur in sub-Saharan Africa and South Asia, and of those deaths half occur in the Democratic Republic of Congo, Ethiopia, India, Nigeria, and Pakistan.[9] Children born in sub-Saharan Africa are 12 times more likely to die before their fifth birthday than children in high-income countries, a statistic that has barely changed over the past 30 years.[10] Health disparities between rural and urban areas and between slums and non-slums in urban areas are well-documented.

Within countries, mass migration into cities is changing the landscape of child health. UNICEF notes that by 2030, "children will be more likely to live in cities, middle-income countries, and sub-Saharan Africa than they are today."[11] Health disparities in urban areas, especially in slums, have been exacerbated by many factors, including large-scale migration from rural to urban areas, unemployment, food inflation, and poor living and working conditions. The factors that threaten the health of children living in slums and informal settlements include overcrowding, a lack of water and sanitation services, as well as a lack of access to child health services.[12] For example, families that have recently moved from rural to urban areas often do not know where to access immunization services, which delays their children's access to vaccinations.[13] UNICEF predicts that by 2030, "the majority of the world's under-vaccinated children will live in disadvantaged communities in middle-income countries."[14] Additionally, the number of acutely food-insecure urban populations has risen during the global crisis related to COVID-19.[15] All of these factors have the potential to increase these children's susceptibility to pneumonia, diarrhea, tuberculosis, and measles.[16]

In the United States, some communities experience limited availability and poorer quality of products, services, and resources compared to others. In some cases, national-level policies and programs do not adequately consider the feasibility of implementation at the local

Children living in hard-to-reach rural areas face limited access to health services, including immunization services, and risk missing key vaccinations if health centers and outreach programs do not prioritize these communities. For 10 years, the JSI-led Universal Immunization through Improving Family Health Services (UI-FHS) project has improved equity in immunization in Ethiopia by working with remote, rural, and nomadic populations to reach children who have received few or no immunizations. By strengthening facility-community linkages, improving management, and building capacity to plan and monitor immunization services, UI-FHS helps children gain access to the services they need.

Child health experts from JSI's UI-FHS project provided these key lessons for achieving equity:

1. **Invest in building the capacity of health workers as they work to create trust within communities.**
2. **Use community resources and knowledge by involving non-health stakeholders, such as community leaders and local civil administrators, who can help plan outreach and mobilize resources to raise the profile and create local ownership of child health issues.**
3. **Work with communities to improve demand for services. Community members' knowledge and endorsement can enhance acceptance, improve service utilization, and track defaulter children.**
4. **Support the use of data from all available sources to strengthen program targeting and tracking.**
5. **Form quality improvement teams and use quality improvement tools that enable facilities and communities to work together to strengthen planning for service and outreach, identify service gaps, monitor progress, and address challenges.**
6. **Invest in supportive supervision to strengthen the quality of service delivery and generation of accurate data at the district and health facility levels.**
7. **Ensure that managerial staff have the skills, tools, resources, and institutional support they need to support and monitor system improvements.**

In conflict and fragile settings, children are more than twice as likely to be undernourished and twice as likely to die before the age of five compared to children in low- and middle-income countries. Almost **two-thirds of all unimmunized** children live in conflict-affected countries

level. For example, families that live in neighborhoods where fresh foods and healthy options are not available may not be able to benefit sufficiently from government-funded food programs to provide a nutritious diet to their children.

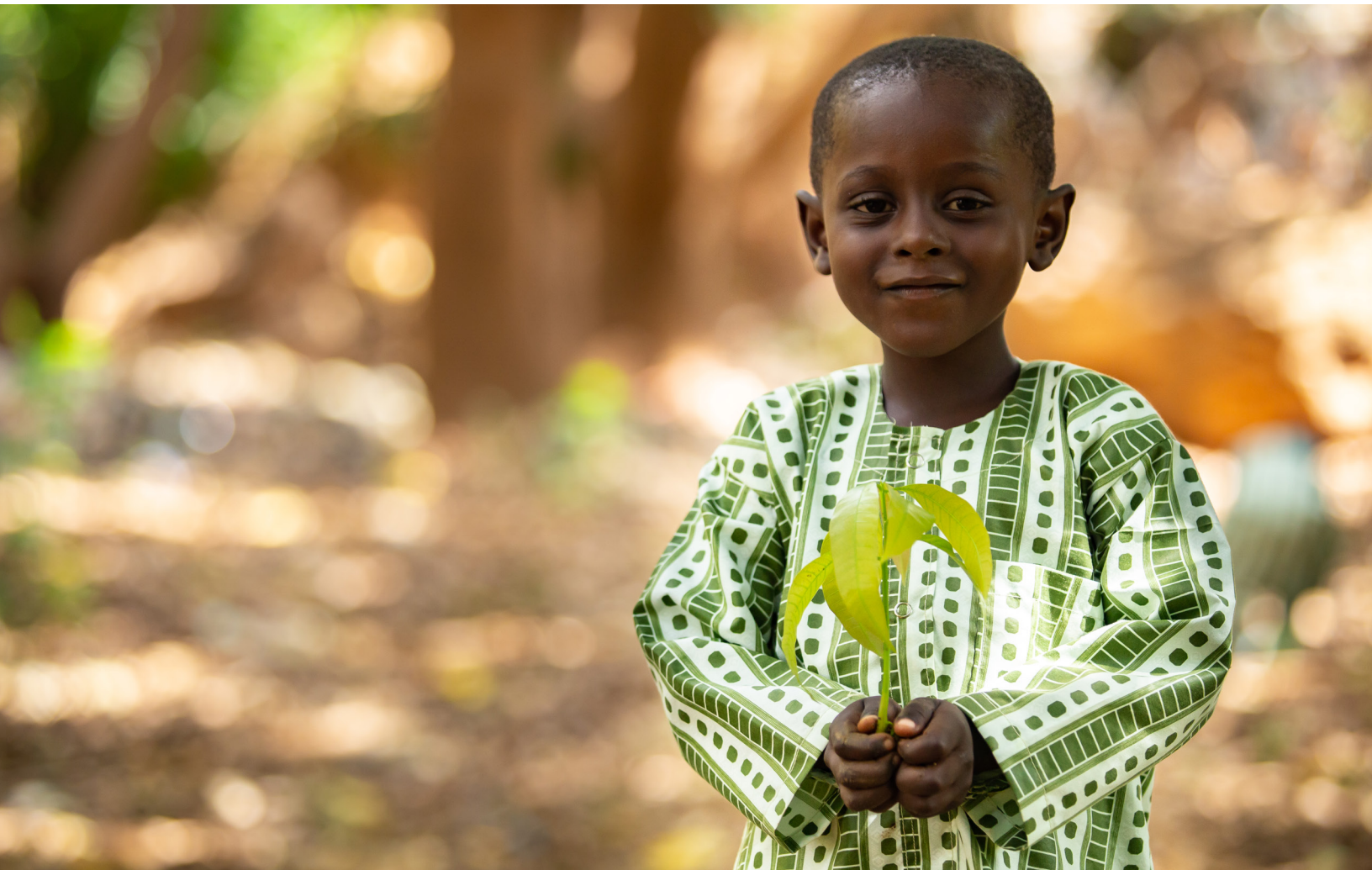
Gender Disparities

A culture's gender norms often affect children's health inequity. While women are often the primary caregivers, they face many barriers that affect their own as well as their children's access to health services. Often women may have low health literacy, as well as limited access to finances and economic opportunities. At the same time, decisions about seeking health care, especially in rural areas, are often made by men or his relatives.

Gender disparities are especially pronounced during a child's adolescent years. For example, many girls face significant barriers to health and well-being due to unwanted pregnancies. Complications during pregnancy and childbirth are the second leading cause of death for girls between ages 15 and 19.[17] While over the past two decades the global adolescent birth rate has decreased from 60 to 44 births per 1,000 among girls aged 15–19, some regions, such as sub-Saharan Africa, still have concerningly high rates.[18] Exposure to HIV continues to be a concern as girls account for three in four new infections among adolescents.[19] Adolescent girls also face high rates of malnutrition and mental health issues.[20,21] These concerns can be exacerbated in emergency settings where adolescent girls are unable to access services, information, or supplies.[22]

Conflict, Fragile Settings, and Displacement

Conflict has the potential to disrupt all aspects of life, and these disruptions can affect children's entire lives. Conflict, instability, and natural disasters often lead to displacement, which further jeopardizes a child's education and health outcomes. Displaced communities often have poor-quality or infrequent access to health care, limited economic opportunities, and continued instability. These conditions can increase the rates of infections, including vaccine-preventable diseases such as pneumonia, measles, and diarrhea.[23]



Half of the countries with the highest child mortality rates are considered fragile

In conflict and fragile settings, children are more than twice as likely to be undernourished and die before the age of five than children in low- and middle-income countries.[24] Almost two-thirds of all unimmunized children live in conflict-affected countries.[25] Half of the countries with the highest child mortality rates are considered fragile.[26] In natural disasters, women and children are more than 14 times more likely to die compared to men.[27]

In natural disasters, **women and children are more than 14 times more likely to die** compared to men

Race and Ethnicity

Racialized groups and ethnic minorities often face systemic discrimination, limiting their ability as a community and as individuals to access quality health care and attain a high standard of health. Systemic discrimination can mean that children from marginalized groups may be provided with sub-standard care and may not have their health concerns properly addressed by health care workers. Systemic discrimination, such as India's caste system, also affects children's safety, education, housing status, and economic situation, all of which impact children's health outcomes.

In the United States, these racial disparities have become even starker during the COVID-19 pandemic. Compared to their white peers, Black and Latino children were more likely to experience school disruptions, have parents who lost their jobs, and experience both poverty and inadequate food levels.[28]

ZAMBIA

The USAID DISCOVER-Health Project in Zambia strengthens outreach services for communities with limited access to health care. Through the triple care initiative—in which community health workers, health care workers, and guardians play active roles in providing and securing care—the project coordinates health care for children with special needs, such as those with HIV. Key to its success is adequate funding for transport, skilled staff, and technology that allows health workers to reach out, follow up, and track progress. The project also supports districts and facilities to strengthen their supply chain systems.

TOWARD HEALTH EQUITY

Children around the world do not have equitable access to health care, nor do they have access to the same social and economic opportunities. To reduce disparities that adversely affect marginalized groups and ensure that no child is disadvantaged in achieving their potential, we must apply an equity lens to child health goals and programming in the following areas.

Strengthening Primary Health Care

Well-funded and strong primary health care is a platform that creates a seamless system for delivering equitable health interventions for children and their families. The Astana Conference in 2018 reaffirmed the prioritization of people-centered, multi-sector, life course-designed primary health care. At its core, a primary health care approach includes three components:

- Meeting people's health needs throughout their lives through integrated service delivery.
- Addressing the broader determinants of health through multi-sectoral policy and action.
- Empowering individuals, families, and communities to take charge of their own health.

In JSI immunization programs, an increased focus is on district-level micro-planning processes, known as the Reaching Every District (RED), Reaching Every Community (REC) or, as we prefer to call it, the Reaching Every Child strategy. This strategy guides district planners to increase coverage and equity in all communities. As part of the planning processes, districts map their catchment areas to identify underserved populations and develop service delivery strategies to reach them. Community engagement and support from local leaders in both health and non-health sectors is integral to the process.

KYRGYZ REPUBLIC

In the Kyrgyz Republic, the JSI-led USAID Advancing Nutrition program improves the nutritional status of women of reproductive age and children under the age of five by strengthening health and community-level services. Through a multi-sectoral platform, the project promotes breastfeeding, nutrition, and food security policies in support of the country's nutrition agenda. The project also assists and educates local government to overcome nutrition challenges.

UNITED STATES

In the United States, more than 38 million people, including 12 million children, experience hunger. The causes are often related to systemic barriers and inequities that can only be addressed by policy- and system-level changes. Through the Supplemental Nutrition Assistance Program - Education and Obesity Prevention (SNAP-Ed) in Massachusetts, Vermont, California, and New York, JSI builds capacity to implement SNAP-Ed policy, systems, and environmental (PSE) change strategies aimed at increasing access to healthy food, and reducing food insecurity and chronic disease. JSI facilitates multi-sectoral partnerships with state agencies, healthcare organizations, schools, and community-based organizations to support community initiatives that create healthy places.

Using Data to Identify At-risk Groups

To avoid masking gaps, coverage data should be granular enough to identify at-risk groups. Programs and interventions should be designed to address populations with the greatest needs. When collecting data and implementing interventions, it is particularly important to ensure that children who face some of the worst health outcomes are identified and prioritized. The data should surface inequalities among children with disabilities, displaced children, children experiencing homelessness, and children who live in remote or rural areas and urban slums. To identify, assess, and monitor discrepancies, disparities, and inequities—including economic, geographic, gender, and racial—we must continue to collect and analyze data in a way that it can be disaggregated to a localized level, be it district, neighborhood, or community.

Budgets, Resource Allocation, and Multi-sectoral Action

Incorporating an equity analysis into budgets for child health and related sectors ensures that resources are allocated to mitigate inequities in programs and policies from the beginning. Finances, human resources, and the infrastructure that go into child health programs must be quantified and strengthened or reallocated to overcome health disparities. Improving equity will require programs and policies that are properly resourced while incorporating an equity lens from the start. A multi-sectoral approach is necessary for providing high-quality services to all underserved populations. As highlighted above, children face multiple deprivations. To achieve equity in children's health, investments across sectors including housing, transportation, education, and agriculture are required.[29]

Policies and Strategies

National-level policies and programs do not always consider how implementation plays out at the local level, which creates the potential for certain groups to be left out. We need to support governments to institutionalize the Reaching Every Child strategy, not just for immunization but for all child health activities. Governments can use this strategy as a district planning tool for outreach services, integrated community case management, and task-shifting/sharing.

To create a more equitable and healthier future for children, we must continue to center health equity in our work. Strengthened primary health care facilities will continue to connect families with health services, but data and technology will allow us to allocate resources to those with the greatest need. As we work to reduce health disparities, we must understand that health equity cannot be achieved by the health sector alone—equity is at the intersection of all sectors. Collaboration across sectors and the involvement and empowerment of communities can help support all children to achieve better health outcomes and ensure that no one is left behind.

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Dr. Dyness Kasungami is a public health physician with 20 years of experience in primary health care, program management, and creating and coordinating global health stakeholder networks to deliver better health outcomes. At JSI, she is project director for the Child Health Task Force, a network of stakeholders that strengthens comprehensive child health programs and reimagines models of technical assistance and capacity strengthening. Prior to joining JSI, Dyness managed the district health system for the government of Zambia, and as a senior health specialist for USAID and DFID, she helped implement sector-wide approaches in the country.

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Dr. Michel Pacqué is a senior child health expert at JSI with more than 35 years of international maternal, child health, and infectious diseases experience in Africa and Asia. He has worked as a clinician, researcher, program manager, and strategic advisor to nongovernmental organizations, ministries of health, and multilateral organizations. He has worked extensively for USAID-funded programs, including the Maternal and Child Survival Program, where he provided strategic technical direction for the child health portfolio in 14 countries.

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REFERENCES

1 Helen Clark, Awa Marie Coll-Seck, Anshu Banerjee, Stefan Peterson, Sarah L Dalglish, Shanthi Ameratunga, Dina Balabanova, et al. 2020. "A Future for the World's Children? A WHO–UNICEF–Lancet Commission." *The Lancet* 395 (10224): 605–58. https://doi.org/10.1016/S0140-6736(19)32540-1.
2 UNICEF Data. Progress for Every Child in the SDG Era. https://data.unicef.org/resources/progress-for-every-child-2018/
3 UNICEF. 2016. *The State of the World's Children* 2016. New York: UNICEF.
4 Satvika Chalasani. 2012. "Understanding wealth-based inequalities in child health in India: A decomposition approach," *Social Science & Medicine*, Volume 75, Issue 12, https://doi.org/10.1016/j.socscimed.2012.08.012.
5 UNICEF. 2019. *Progress for Every Child in the SDG Era: Are we on track to achieve the SDGs for children? The situation in 2019*. New York: UNICEF.
6 Fernando C Wehrmeister, Cheikh M Fayé, Inácio CM da Silva, Agbessi Amouzou, Leonardo Z Ferreira, Safia S Jiwani, Dessalegn Y Melesse, et al. on behalf of the Countdown to 2030 for Women's, Children's and Adolescents' Health regional collaboration in sub-Saharan Africa. 2020. "Wealth-related inequalities in the coverage of reproductive, maternal, newborn and child health interventions in 36 countries in the African Region." *Bulletin of the World Health Organization*. Jun 1, 98(6):394-405.
7 Food Security Information Network (FSIN) and Global Network Against Food Crises. 2021. *Global Report on Food Crises 2021*. Rome.
8 Center on Budget and Policy Priorities. 2021. *COVID Relief Bills Respond to Extraordinarily High Food Hardship*. https://www.cbpp.org/blog/covid-relief-bills-respond-to-extraordinarily-high-food-hardship
9 UNICEF. 2016. *The State of the World's Children 2016*. New York: UNICEF.
10 Ibid.
11 UNICEF. 2018. *UNICEF Immunization Roadmap: 2018-2030*. UNICEF.
12 UNICEF. 2016. *The State of the World's Children 2016*. New York: UNICEF.
13 Tim Crocker-Buque, Godwin Mindra, Richard Duncan, et al. 2017. "Immunization, urbanization and slums – a systematic review of factors and interventions." *BMC Public Health* 17, 556. https://doi.org/10.1186/s12889-017-4473-7
14 UNICEF. 2018. *UNICEF Immunization Roadmap: 2018-2030*. UNICEF.
15 FSIN and Global Network Against Food Crises. 2021. *Global Report on Food Crises 2021*. Rome.
16 UNICEF. 2016. *The State of the World's Children 2016*. New York: UNICEF.
17 Ibid.
18 Ibid.
19 UNICEF, UN Women, and Plan International. 2020. *A New Era for Girls: Taking Stock of 25 Years of Progress*. New York.
20 Ibid.
21 Elissa Kennedy, Gerda Binder, Karen Humphries-Waa, Tom Tidhar, Karly Cini, Liz Comrie-Thomson, et al. 2020. "Gender inequalities in health and wellbeing across the first two decades of life: an analysis of 40 low-income and middle-income countries in the Asia-Pacific region." *The Lancet*, Volume 8, Issue 12, https://doi.org/10.1016/S2214-109X(20)30354-5.
22 UNICEF, UN Women, and Plan International. 2020. *A New Era for Girls: Taking Stock of 25 Years of Progress*. New York.
23 UNICEF. 2016. *The State of the World's Children 2016*. New York: UNICEF.
24 Ibid.
25 UNICEF. 2018. *UNICEF Immunization Roadmap: 2018-2030*. UNICEF.
26 UNICEF. 2016. *The State of the World's Children 2016*. New York: UNICEF.
27 UNICEF. 2018. *UNICEF Immunization Roadmap: 2018-2030*. UNICEF.
28 Zachary Parolin. 2021. "What the COVID-19 Pandemic Reveals about Racial Differences in Child Welfare and Child Well-Being: An Introduction to the Special Issue." *Race and Social Problems* 13, 1–5. https://doi.org/10.1007/s12552-021-09319-2.
29 Helen Clark, Awa Marie Coll-Seck, Anshu Banerjee, Stefan Peterson, Sarah L Dalglish, Shanthi Ameratunga, Dina Balabanova, et al. 2020. "A Future for the World's Children? A WHO–UNICEF–Lancet Commission." *The Lancet* 395 (10224): 605–58. https://doi.org/10.1016/S0140-6736(19)32540-1.