Only Connect

A WOMAN-CENTERED APPROACH ADDRESSES A WEB OF NEEDS & RESOURCES

by Chael Needle

According to UNICEF, maternal mortality—the death of women during pregnancy, childbirth, or in the forty-two days after delivery—can be caused from a multitude of health concerns, from hypertensive disorders in pregnancy to complications from unsafe abortions. A new study published in *The Lancet* shows that global maternal mortality has decreased, but it also shows that HIV is the cause of more than 60,000 maternal deaths each year. And, in general, HIV is the leading cause of death for women in their reproductive years, ages fifteen to forty-four, notes Serra Sippel, president of the Center for Health and Gender Equity (CHANGE), citing a recent WHO statistic.

U.S. foreign assistance has responded to these interconnected crises, but its established approaches to global health isolate health concerns in order to address them. HIV, maternal health, and family planning, for example, are funded, implemented, and assessed apart from each other. In this regard, CHANGE sees a missed opportunity, particularly when it comes to addressing women's health needs in developing countries.

According to its mission statement, CHANGE "seeks to ensure that U.S. international policies and programs promote sexual and reproductive health and rights through effective, evidence-based approaches to prevention and treatment of critical reproductive and sexual health concerns, and through increased funding for critical international programs and institutions." CHANGE's vision of an effective U.S. global health policy includes integration and coordination of services; a woman-centered approach; addressing health contexts (education, housing, environmental protection, and so on); a human-rights based approach; and accessibility for all no matter what age, financial status or physical capability.

The U.S.-based NGO sees in President Obama's still-forming Global Health Initiative a chance to revisit and revise policies that have not connected the dots between HIV/AIDS, maternal and infant mortality, and poor sexual and reproductive health.

CHANGE's position: While the Global Health Initiative has created a policy space in which all of the abovementioned aspects can be nurtured, true change will come only if these policies are rooted in funding commitments and tended by coordination among agencies. This other side of the equation is important because, as CHANGE has learned, the Global Health Initiative is "not like a PEPFAR. It's not its own program; it's an approach to global health, making sure there are linkages and coordination. It's more of a philosophy, or principles on how U.S. foreign assistance should be executed on the ground," says Sippel of the first government-based initiative to promote a woman-centered approach to policy and programming. In other words, funding initiatives and governmental programs need to adopt this theory as practice.

As many ASOs in the U.S. have discovered, a scatter-shot approach to healthcare—asking clients to make contact with or even commute to different sites for different health concerns—is not as effective as a "one-stop-shopping" approach. Comprehensive healthcare means that access to a single healthcare resource—be it HIV treatment, voluntary family planning and other reproductive health services, cancer screening and treatment, and safe abortion services—means access to them all.

"Up until now, policies and programs have not really started on the ground in terms of what individuals actually need, from the client perspective," says Sippel about the top-down approach, where policy ultimately starts with the policymakers. "The problem is, we should be starting with the reverse—with what's needed on the ground." In this context, women's health starts with women.

"A concrete example," offers Sippel about the importance of a woman-centered approach, "would be if you look at Botswana, which is considered a middle-income country in Africa. It gets a good amount of PEPFAR funding, [yet] it does not get any family planning funding from the United States government."

CHANGE visited Botswana to look at integration and how this might happen even if a program has only one funding stream. They met with individuals in the field running a national organization with one funding stream to provide services for people living with HIV and AIDS. "We were talking with the director of the program that does the peer mother group, which [is made up of] mothers who are HIV-positive. It was really important for that program that the women who were the peer mothers—the counselors, the leaders of that program—said they were not supposed to get pregnant. The position was that women who were living with HIV should not get pregnant; they would not be good role models for the other mothers if the peer mothers were pregnant."

The CHANGE team discussed with the director what they found problematic with the practice. "First, on a human rights level—women should be free to choose to be pregnant whether they're HIV-positive or not. But that aside, I said, 'If one of the objectives of the program is that women

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don't get pregnant, are you providing family planning services?' And [the director] said, 'No, that's not within our mandate. It's about HIV treatment, life skills for these women.' And I said, 'Well, they're in relationships, with the possibility of pregnancy and maybe they don't want to get pregnant,' and she insisted that wasn't part of the program and that the government provides family planning services and the women know where to get them so they don't need to bother with providing that information. So that decision was made from the service provider part, obviously not from the perspective of the women who are actually using the services."

Similarly, CHANGE visited voluntary counseling and testing programs in Botswana and asked if they were providing information and referrals to clients who might be sexually active and in need of family planning or maternal health services. The answer was "no."

U.S. policy, CHANGE thinks, could easily remedy this. "Not that every clinic or program has to offer all of these [services] but there are some simple and nonexpensive interventions when it comes to even a referral," says Sippel, "especially in a country like Botswana if the government is already providing family planning. Why wouldn't a program that is funded by PEPFAR—whether it's for positive women to prevent mother-to-child transmission or if it's for testing—incorporate those kinds of programs, like basic referral information for family planning or even maternal health beyond the treatment issue?"

Though Sippel asks this to point out the good sense of integration and coordination, there are reasons why such programming has not happened. One reason is ideological—the attitude that individuals with HIV should be discouraged from sexual activity. Notes Sippel: "And [the belief that] if you are a woman, you shouldn't be having sex and getting pregnant. We need to address those assumptions and tackle those head on. Then there's shame involved. If you're positive and not supposed to be having sex, then you're not going to be asking for condoms; you're not going to go to the clinic and admit that you're having sex." In Botswana, Sippel says, they saw "women who wouldn't even go to the programs that were specifically set up to prevent mother-to-child transmission. Women wouldn't go because they would be treated so poorly by the service providers, [who thought the women] weren't supposed to be pregnant.

"When U.S. foreign assistance and programming siloes these health interventions, it does increase women's risk of death related to HIV incidence because you have women going to family planning or maternal health services, where there's an opportunity to address a woman, making sure even if she's married that [she knows] marriage is a risk factor in terms of HIV....We have to link these services together because eighty percent of HIV infections are sexually transmitted; so it just makes sense that any health services related to sex or reproduction should be integrated and coordinated."

Another reason that health is not integrated and coordinated is long-entrenched programming policies that do not address whole people within the whole picture.

"It's not necessarily that the U.S. needs to also send family planning money or maternal health funding," says Sippel. What is necessary is that the philosophy of linking care and information become so pervasive that it guides decision-making on all levels, but especially with the user level in mind. "Our philosophy is that if you start with the woman you reach everyone in the community. It's not that we're neglecting men and boys; if you start with the woman, the one who is most marginalized, because of all of the social, legal barriers, then we can reach everybody."

CHANGE has seen firsthand how a woman-centered approach works to change lives. Colectiva Mujer y Salud (Women's Health Collective) in Dominican Republic and Intervention for Microfinance and Gender Equality (IMAGE) in South Africa both implement a holistic, multisectoral approach with good results.

Those involved in U.S. policy and programming, on the other hand, have only really seen the effects of the single-issue approach. "Up until now, there has not been a lot of U.S. funding that goes directly to smaller grass-roots women's organizations who have been doing this work since [the Fourth World Conference on Women in] Beijing and before. The U.S. doesn't have the know-how because they haven't been funding those groups—because it's much easier logistically and bureaucratically to give these larger grants to the larger international NGOs, and they're responsible for implementing these programs. The grass-roots women's, LGBT, and human-rights groups are often left out of that equation. With this Administration, we're really pushing them—they need to engage these grass-roots groups; they have to make sure that money goes to them....In the end it makes U.S. foreign assistance that much more effective." A woman-centered, integrated and cordinated approach makes good funding sense, notes Sippel. Issues do not need to compete with each other in a sort of advocacy derby.

A woman-centered approach may seem like a tall order, but Sippel and CHANGE are emboldened by the current political climate. "The one thing that we have in our favor is the political will of the Administration. But the woman-centered approach—that's not an expensive intervention. The biggest challenge is changing people's hearts and minds—and their approach to developing AIDS health programming."

For more information about the work of CHANGE, log on to www.genderhealth.org.

Chael Needle wrote about micronutrients' importance in immune reconstitution in the April issue.