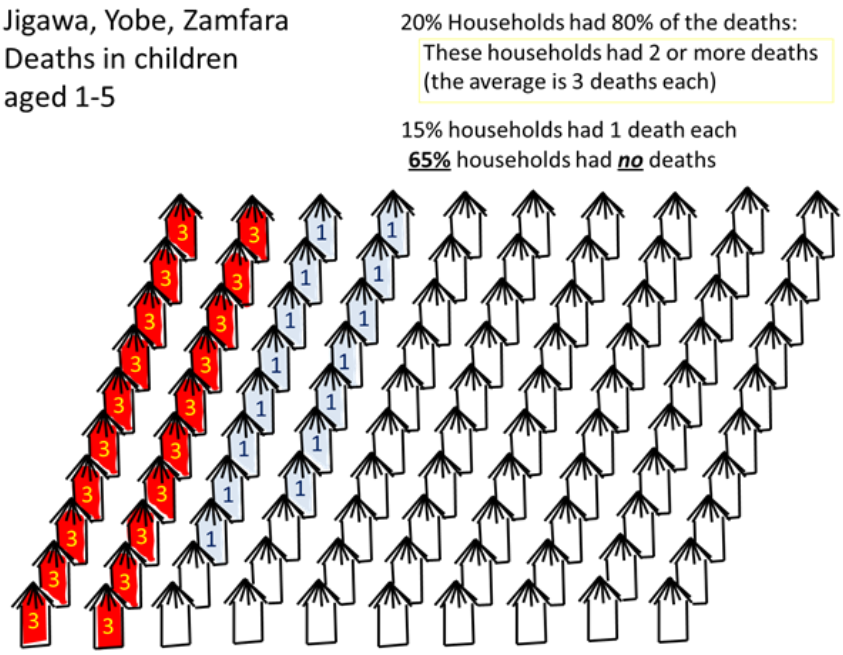
Clustering of under-five mortality – adjusting health strategies to include women and children with the least social support

A recent study[1] has shown that child deaths were clustered among a small proportion of women. Twenty percent of the households involved in the study had 80 percent of the child deaths.



The clustering occurred even within polygynous households; some women and their children in these households were affected and some were not.

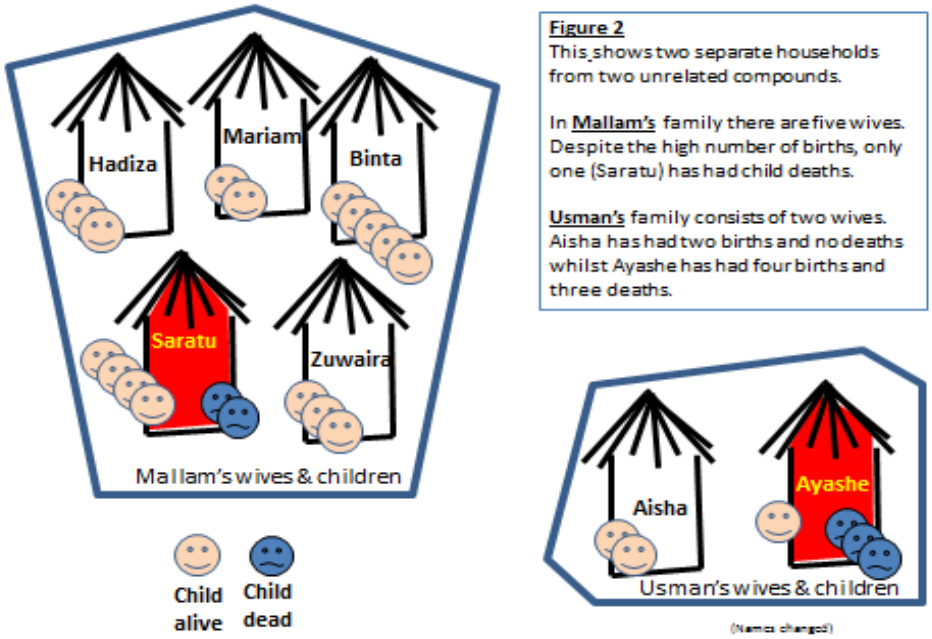


Figure 2
This shows two separate households from two unrelated compounds.

In **Mallam's** family there are five wives. Despite the high number of births, only one (Saratu) has had child deaths.

Usman's family consists of two wives. Aisha has had two births and no deaths whilst Ayashe has had four births and three deaths.

[1] See PRRINN-MNCH Policy Brief - Adjusting health strategies to include women and children with least social support by Tony Klouda (edited by Cathy Green), February 2011 based on studies in 2009/10

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The least supported have the disproportionate burden of ill health and death

It has long been recognised that social factors have an enormous influence on health. Social factors account for the disproportionate burden of ill health and death amongst the least supported, those lowest in social hierarchies and amongst the poorest. The WHO Commission on the Social Determinants of Health in 2008[2] reviewed the evidence and found that although health services will always have some impact on health, their greater impact is on those in more powerful social bands.

[2]CSDH, 2008, Final Report of the Commission on Social Determinants of Health, Geneva: WHO

The heavy skew of child mortality was not related to child spacing, distance from health facility, religion, tribe, education, culture, polygyny, marital status, seclusion, or employment. Rather, a lack of respect and social support shown to a woman at family level were found to be highly important contributing factors to the clustering.

Six Factors Strongly Correlated to Child Deaths in Northern Nigeria

- The woman rarely or never had anyone older to look after the children
- The woman had no one to turn to for support if her children had difficulties
- The woman had no one to turn to for support if she herself had difficulties
- Woman believed she had no or little respect from relatives, in-laws, husband or others
- The woman had almost no general support from own relatives and in-laws
- The general appearance of the woman, the children and of the household was very poor

The policy implications of the Northern Nigeria clustering survey are considerable. Practical and feasible courses of action exist – both within and outside the health sector – and these should lead to greater social inclusion of women, to improved self-care and care of children, and ultimately to increased use of health services and improved health.

Key recommendations are as follows:

1. Modify training of all community workers, volunteers and institutions (from health and other development sectors) to:

   (a) understand the relevance of social factors and social support systems to their work;

   (b) recognise when people lack confidence or may neglect their children or themselves as a result of lack of social support;

   (c) adapt their advice or interventions to be relevant to the capacities of the women or families in question;

   (d) advise women and their families on resources available locally that might help them in their need for support at particular times.

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2. Help community institutions and leaders develop a variety of locally available resources that will be helpful to women in general, but particularly those with poor support – in particular for child care, conflict resolution and savings schemes.
3. Stimulate the development of community mechanisms for including women with poor support in group and social activities. This will have a strong impact on the self-esteem and self-confidence of women whose belief in their capacity to improve their lives is low.

The findings of the study on clustering of child mortality has already led to plans to train Community Health Workers (CHEWs) operating in communities to recognise high risk families and respond appropriately. In addition, revisions to the training of community volunteers are planned.

Considerable advocacy with government at all levels is required in order to support these changes. The shift from a medicalised model of Primary Health Care to one that balances social and service-based policies for a more holistic and effective approach represents a very significant change in direction. The Northern Nigeria clustering of child death studies demonstrate that the evidence base for such a shift in direction exists.