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Title	Intersectoral debate strengthens alliances, advocacy and action for maternal survival in Zambia.
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Publication Date	2008-11-12
Publication information	Manandhar M, Maimbolwa M, Muulu E, Mwangi Mulenga M, O'Donovan D. Intersectoral debate strengthens alliances, advocacy and action for maternal survival in Zambia. Health Promotion International 2009;24:58-67.
Publisher	Oxford Journals
Link to publisher's version	http://dx.doi.org/10.1093/heapro/dan036
Item record	http://hdl.handle.net/10379/2869

Intersectoral debate on social research strengthens alliances, advocacy and action for maternal survival in Zambia

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SUMMARY

The Health Promotion Research Centre of the National University of Ireland, Galway and the University of Zambia's School of Medicine conducted operational research to understand and address the socio-cultural and gender contexts of maternal survival. Together with an analytical policy and programming review and qualitative research, the project process also involved the convening of 'Interest Group' meetings involving intersectoral stakeholders at Central (Lusaka) and Provincial (Kasama) levels. These meetings aimed to catalyse debate and stimulate advocacy on the project theme by using discussion of qualitative research as entry point. Participants came from government departments, civil society groups, the indigenous health system, academia, technical provider associations, and media, advocacy and human rights organisations.

We found that engagement in Interest Groups was successful at Provincial level with lively participation from

civil society, media and advocacy stakeholders and strong engagement by the health system. The process was welcomed as an opportunity to fill gaps in understanding about underlying social determinants of health and jointly explore intervention approaches. Overburdened government staff at central level faced with disease-focused interventions rather than underlying contextual determinants, and a weak culture of health sector engagement with civil society, academics and activists, contributed to less successful functioning in Lusaka. Final Dissemination and Discussion Events incorporated material from Interest Group Meetings to stimulate wider discussion and make recommendations.

This project highlights the potential value of intersectoral stakeholder discussions from the inception stage of research to stimulate intersectoral exchange and alliance building, inform advocacy, and catalyse the process of research into action.

Key words: social determinants of health; maternal health; intersectoral partnership; advocacy; action research

INTRODUCTION

'If you want to go fast, go alone. If you want to go far, go together.'

African proverb [quoted by Dr Margaret Chan, Executive Director of the World Health Organisation,

during a plenary session of the 'Women Deliver' conference. London, October 18–20, 2007 (www.womendeliver.org)].

Intersectoral action for health is 'a recognised relationship between part or parts of the health sector with part, or parts, of another sector

which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient of sustainable than could be achieved by the health sector working alone' (WHO, 1997). This definition is interpreted to include collaborative partnership and action between different departments and bodies within government, as well as between actors within and outside government, such as civil society organizations, for-profit private organizations and communities. It involves increasing knowledge and understanding of the key determinants of health among all partners to generate a heightened sense of responsibility. Taking a broad and positive definition of health centred on people and population groups in their social and cultural contexts, the ultimate aim is to stimulate wider supportive environments in which intersectoral working for health becomes embedded in the health system, and health is recognized as a key component in the work of other sectors (Jackson *et al.*, 2006).

Since its early championing in the Alma-Ata Declaration on Primary Health Care (WHO, 1978), making the case for intersectoral action for health has been increasing recently (People's Health Movement, 2004; WHO, 2005; Jackson *et al.*, 2006; Mannheimer *et al.*, 2007; Public Health Agency of Canada, 2007; Gilson *et al.*, 2007; Kelly *et al.*, 2007). A policy thrust for more intersectoral working for health now appears on many national health (Population Health Canada, 1999; Department of Health and Children Ireland, 2002), international development (Department for International Development UK, 2000a; Von Schirnding and Mulholland, 2002; Department of Foreign Affairs Ireland, 2006) and global health research agendas (Nuyens, 2005).

In the field of international development, there has long been an emphasis on participatory methods and intersectoral working, as well as the fostering of partnerships, networking and multi-disciplinary teams (Department for International Development UK, 2000b). However, although rigorous scientifically based methods to conceptualize and assess the effectiveness of collaborative partnerships, particularly with communities, are still lacking (Tindana *et al.*, 2007), there is operational experience from development agencies that the intersectoral approach works. Despite this experience, and stated policy rhetoric in the direction of intersectoral working for health, in many countries, including Zambia, intersectoral working for health is still thin on the ground.

Maternal mortality is getting worse in many parts of sub-Saharan Africa and South Asia (Hill *et al.*, 2007). To address this, momentum for high-level advocacy is now growing, and with it comes a consensus to look beyond the usual prescription of improving access to effective and affordable technical interventions that has been the backbone of safe motherhood programming for the past 20 years. There is clear evidence that where women have low status and are disempowered, maternal health is likely to be poor (Gill *et al.*, 2007; Marmot, 2007). Thus, policies and programmes addressing safe motherhood and women's health must be placed in a wide social context (Filippi *et al.*, 2006). They must also include research, advocacy and action on the social determinants, or 'causes of the causes' (Marmot, 2005; Secretariat of the Commission on the Social Determinants of Health CSDH, 2005) behind the unacceptable hundreds of thousands of maternal deaths every year.

As elsewhere, the Zambian Safe Motherhood Initiative has failed to yield expected results. The country continues to have one of the highest maternal mortality rates in the world, at about 750 deaths per 100 000 live births, although the real figure is probably much higher in rural areas (Central Board of Health/Ministry of Health Zambia, 2003).

METHODS

Between March 2005 and October 2007, the Health Promotion Research Centre of the National University of Ireland, Galway (NUI, Galway) and the Department of Post-Basic Nursing at the School of Medicine, University of Zambia (UNZA) conducted operational research to understand and address the socio-cultural and gender contexts of maternal survival.

A Principal Investigator at UNZA was identified to recruit and lead a local team. At an early stage, and prior to the signing of the Memorandum of Understanding, efforts were made to liaise closely with Ministry of Health officials to secure government support. This was to ensure that the project was in line with Zambian priorities and supported the strategic direction of the health sector as part of the national development process.

Ethical approval was granted by the Research Ethics Committees of both Universities. A supporting letter of approval

was also received from the Central Board of Health, Government of Zambia.

Research questions and activities

Two research questions were agreed with the Director General of the Central Board of Health and the Ministry of Health in Lusaka:

- (1) Do policies and programmes aimed at safer motherhood in Zambia take into account the socio-cultural, economic and gender contexts of health beliefs and care-seeking behaviours?
- (2) How is this contextual work for safer motherhood integrated with other priority areas (malaria, HIV/AIDS and Mother-to-Child Transmission, Sexually Transmitted Infections, family planning, tuberculosis, anaemia) that impact on maternal (and neonatal) survival?

The research partnership consisted of four components:

- (1) A comprehensive literature review on the research theme
- (2) Qualitative research in Northern Province to elicit different perspectives on the research theme:
 - (a) Semi-structured interviews among intersectoral stakeholders based in the headquarters town of Kasama who are involved in governmental and non-governmental development programme implementation in the province
 - (b) Participatory Ethnographic Evaluation and Research: PEER (Price and Hawkins, 2002) among semi-literate girls and women in a remote rural community site where government health services and related social supports were very weak and non-governmental organizations absent
- (3) Desk-based analytical review of Zambian policy, programming and research documents to determine the extent to which they currently address the socio-cultural and gender contexts of maternal and neonatal survival.
- (4) Intersectoral dialogue, dissemination and advocacy.

This paper covers the last of these components: the intersectoral process.

Intersectoral debate during the research

From the very beginning, we attempted to foster intersectoral dialogue through the convening and facilitating of periodic meetings, termed 'Interest Group Meetings', at both national and provincial levels. Using the Northern Province qualitative research as entry hook for discussion, these intersectoral meetings aimed to stimulate sharing and debate from different perspectives on the project themes and the emerging data. Their broader aim was also to catalyse increased awareness of, and attention to, the contextual social determinants of maternal health both within and beyond the health sector.

After initial brainstorming on potential names and organizations, we formally invited a small range of participants from across different government departments, civil society organizations active in health programming, the indigenous health system, technical practitioners in the health sector and their associations, the University sector, media, and advocacy and human rights organizations. The invitation was accompanied by a short description of the project and a guideline that the socio-cultural and gender contexts of maternal survival would be the focus for discussion and the sharing of experiences.

Held at the Department of Post-Basic Nursing at UNZA in Lusaka, and the Provincial Planning Office in Kasama, these intersectoral Interest Group meetings lasted between 2 to 3 h and were relatively unstructured. After the research concept and progress were reported on, any issues of interest arising were picked up by participants, with deeper discussion probed by the research team who also posed their own questions for debate. Meeting notes were taken and circulated.

A summary of participants attending the Interest Group meetings is presented in Table 1.

Intersectoral debate at dissemination events

At the end of the qualitative fieldwork period, we expanded the intersectoral process to hold day-long Dissemination and Discussion Forum events at both provincial and central levels. These two events aimed to further disseminate the research and allow a wider range of participants the opportunity to air perspectives on the

Table 1: Summary of participants (excludes research team) at Intersectoral Interest Group Meetings, and Dissemination and Discussion Events

Sector	Intersectoral Interest Group Meetings								Dissemination and Discussion Events	
	February 2006		May 2006		August 2006		November 2006		June 2007	
	Lusaka	Kasama	Lusaka	Kasama	Lusaka	Kasama	Lusaka	Kasama	Lusaka	Kasama
Zambian government										
Health		2		2		1		2	6	10
Community development, culture				2		2			1	3
Planning		1		1				1	3	2
Local government				1					1	
Gender									1	
Civil society organization	3	2		3	3	4		2	7	7
Advocacy, legal organization	1				1				4	
Indigenous health system	1	1	1	1				1	2	1
University	3								13	
Technical health provider	3		1		1				3	1
Donor, United Nations agency	2			1				1	1	1
Faith-based organization, church				1				1	1	3
Research organization									2	
Media									6	4
Gender ratio Female:Male	8:5	1:5	1:1	3:9	5:0	3:4		1:7	22:29	9:23
Total	13	6	2	12	5	7		8	51	32

research theme, react to the findings and discuss their implications for policy and programming.

In both events, the research results were presented. This was followed by a pre-selected intersectoral panel of speakers giving their responses and comments, and encouraging a wide-ranging open discussion involving all participants. A number of pre-prepared questions, drawn from the process of intersectoral debate throughout the project, were also posed and discussion facilitated. In Kasama, the panel members included active local participants from the intersectoral Interest Group meetings over the previous year. In Lusaka, care was taken to include a broad range of perspectives on the discussion panel, particularly representatives from advocacy, legal and women's rights activist, and civil society groups. A summary of participants attending the intersectoral Dissemination and Discussion Events is also presented in Table 1.

In Kasama, the event was hosted by the Provincial Health Office and attended by a high-level official from the District Administration. Most District Health Management teams from across the Province were also represented. The 14 women PEER researchers from the community site were actively involved in the proceedings, giving descriptions of research examples, performing role plays and joining in plenary discussion. Discussion and recommendations from the Kasama Event were presented to the participants at the Lusaka event which took place a few days later.

In Lusaka, the Dissemination and Discussion event was hosted by the Minister of Health, and attended by high-level officials from the Ministry of Health and the Cabinet Office. The final session of the day resulted in a series of proposed actions for follow up.

RESULTS

In this section, the intersectoral component of the Zambian research partnership project is described, first in terms of the overall process and, second, in terms of the content of discussions.

Intersectoral process

Over a 12-month period, we found that engagement in the intersectoral Interest Groups was most successful in Kasama at Provincial level

where there was consistent and wide attendance from a variety of sectors, as shown in Table 1. There was also continuity of attendance by a small number of individuals who expressed commitment to the issues raised and that this would continue beyond the lifetime of the project. Debate at these Provincial intersectoral meetings was lively, involving full participation from civil society, media and advocacy stakeholders and very strong engagement by the health system. The intersectoral discussion process was welcomed as a new opportunity to fill gaps in understanding about the underlying social determinants of health and jointly explore approaches for interventions to tackle them.

In contrast to the success at Provincial level, Table 1 shows that, at central level, Interest Group meeting attendance started off well but declined over time. Furthermore, there was a representation bias towards the University sector and the nursing profession. Even people attending from civil society were previously linked to the host institution in some way. In the early meetings, discussion focused on theory of research methods rather than the contextual theme of the research. Picking up on this, the project offered to hold a seminar on the PEER method, but this was not taken up by the University.

A similar difference emerged for the Dissemination Events. At Provincial level, the final Dissemination and Discussion Forum was a dynamic occasion, with full vocal participation from all sectors. The presence and contribution of the 14 PEER researchers was highly appreciated. The real impact of the process became clear at the end of the day when a high-status male medical doctor, turned to the women to openly thank them for their work. He admitted that, as an urban, elite-educated male, he was 'ignorant' of the lived reality for girls and women in his working area. Many of his colleagues also agreed that the intersectoral process provided them with new insights into the socio-cultural and gender contexts of their clients' health beliefs and health-care seeking behaviours that would serve them well in their future work and inform their interactions with rural communities. There was considerable local media coverage of the event.

In Lusaka, the presence of the Minister of Health, and high-level officials from several government sectors (Gender, Health) showed that engagement of government in the research theme was strong. However, in terms of

intersectoral breadth, participation was disappointing. Although invitations were drawn up for nearly 150 individuals, including government officials from health, planning and community development from Provinces across the country, only 51 people attended and almost all were from the Lusaka area. There was some national media coverage of the event, but it appeared to be driven more by political agendas rather than the research theme and data.

Content

The research questions, fieldwork and emerging research results formed the basis of intersectoral discussions. Box 1 summarizes the main themes of discussion at the intersectoral Interest Group meetings and the Dissemination and Discussion Events. The topics of gendered power inequality within contradictory legal frameworks, cultural beliefs and practices affecting health (particularly sexual health and related behaviours) with the religious rules and morality that interact with these, and communication

issues featured most prominently. Aired at the Dissemination and Discussion Events in the presence of high-level officials, these discussions served as a form of advocacy for women's health and reproductive rights.

Gender

To illustrate the persistence of gender norms that constrain women's voice and agency, we used two photographs from the community fieldwork to stimulate discussion on the responsibility that state structures, including the health system, have not to collude with gender bias. One photo showed a small group of three generations of women from one family with their newborn infants born in the bush, receiving no help from men. Another photo showed the all-male membership of the local Neighbourhood Health Committee which had recently been set up with the District Health Management Team to assess health needs in the community. Although the Committee men stated: '*We are the tribe, we have the knowledge*', they admitted that they knew nothing about pregnancy and childbirth, or any other details of women's reproductive health. Intersectoral discussion recognized that state structures, including the health system, should acknowledge and address such replication of structural injustice to women which excludes their voice, agency and potential access to information and resources.

Culture and customary law

As the research data unfolded and was discussed at the intersectoral meetings, a clear mismatch emerged between some stakeholders, including from the health sector, who talked of early marriage as a harmful traditional cultural practice, and the community respondents who claimed that early marriage is a breach of traditional cultural practice. This shows not only the value of conducting community-based research to uncover and describe the lived realities and perceptions of local people, as these are often misunderstood or dismissed by service providers, but also of the value of exposing and discussing gaps in knowledge of operating agencies, usually staffed by people external to the area. '*We should not arrive from town assuming we know what is going on*' said one of the government representatives of the central

Box 1: Discussion themes at intersectoral events

Political will is needed to address maternal mortality in rural Zambia
 The social determinants of health are relevant, but under-studied, in rural Zambia
 Early marriage as traditional cultural practice (health providers view)
 Early marriage as breach of traditional cultural practice (community view)
 Dowry payments for early (virgin) marriage and transactional sex as economic survival strategies
 The persistence of polygamy, sexual cleansing, preference for dry sex, intergenerational sex, and unsafe abortion practices
 The short and unsafe school experience for the girl child
 Contradictions between statutory and customary law affecting the health and well-being of girls and women
 The role of traditional counsellors in coming-of-age rituals, and instruction for marriage and childbirth
 The potential role of men as partners in maternal and reproductive health
 Gender inequality, power and the participation of women in community-based structures
 Songs, riddles and proverbs among Bemba people as important transmitters of social norms and values
 The role of organised religion and morality in sex, marriage and family planning
 The PEER methodology, and theoretical and practical differences with other qualitative research methods

intersectoral Dissemination and Discussion event.

The research highlighted that cultural practices such as polygamy, ‘sexual cleansing’ of widows, intergenerational sex to ‘*keep the marriage lively*’, inserting vaginal herbs to dry secretions to ensure ‘*dry sex*’ and techniques for inducing abortion persisted in the area and were widespread. During intersectoral debate, there were lengthy and often heated discussions around the contradictions between the cultural practices harmful to the health and well-being of girls and women that were condoned by customary (unwritten, male-controlled) law and formed the rules that rural people mainly lived by, and the newly introduced statutory laws (heavily influenced by colonial imported legal systems) that were often unknown and weakly enforced at Provincial and district levels. ‘*We need to stress that not all culture is being condemned, just those practices and negative parts that are inappropriate now because they are detrimental to the development process*’ said one participant.

Communication

Information–Education–Communication (IEC) is currently designed and provided by the health sector. However, during the intersectoral discussions, there was broad admission that it fails to have the desired effect of changing health-related behaviours. ‘*We are used to prescribing drugs and we think we can prescribe behaviours. First we need to listen and be more open to local terminology and ways of learning. We don’t even try to understand their knowledge*’ said one participant from the health sector. Again, we used research-generated photos to aid this discussion in the intersectoral setting. One photo showed local Stone Age rock art depicting symbols used to instruct girls and boys during their initiation ceremonies. A second photo showed a large English language sign next to the main road instructing readers to abstain from sex. The women researchers from the community responded very differently to these two photos, preferring the rock art drawings because these evoked their own initiation teaching and cultural environment, and could be interpreted through familiar songs and proverbs. In contrast, the directive road sign made little sense. Intersectoral event participants raised questions about the cultural

appropriateness of current IEC and called for more culturally compelling communication strategies and tools for health-related programming.

DISCUSSION

Generating interest for intersectoral discussion about the research met with an enthusiastic response in the Province where people from many sectors welcomed the new opportunity to meet and share different perspectives and begin a debate on solutions. The process highlighted the need to develop more cross-cutting linkages both within government sectors and with external stakeholders, particularly civil society organizations, communities and advocacy groups, and to escalate action by all sectors in the remote rural community which was the focus of the research. However, at central level, the process was not so successful.

Central challenges

There are a number of possible reasons for the poorer functioning of the intersectoral process at central level. Government personnel changes at central level meant that continuity in awareness about the research fluctuated. The research probably also suffered from competition from other priorities of an overburdened and resource-scarce health system which stresses disease-focused interventions rather than underlying contextual determinants. A donor-driven agenda, dominated by funding for vertical programmes, may also have contributed to a lack of interest. Another hindering factor could be that the culture of intersectoral collaboration is weak in Zambia, particularly between government and University sectors working with civil society, advocacy and activist groups. This makes partnering with the academic sector for transformational research problematic. The most notable absence from all intersectoral events was the education sector. The community-based qualitative research clearly shows that poor attendance of girls at school, issues of safety and risk of sexual assault are linked with loss of virginity, incidence of STIs and HIV, and unwanted pregnancy. Lack of communication and partnership between the health and education sectors is thus a major challenge in the struggle to reduce maternal deaths.

There were also administrative weaknesses and a selective agenda in engaging with potential participants outside known networks and existing partnerships. While adequate project funds were available to cover transport and subsistence allowances for participants travelling into Lusaka, and travel around the city, no 'sitting allowances' were paid to attend meetings, in line with Irish Aid policy in Zambia. This may have affected attendance.

Research-into-action

While this preliminary, small-scale experience of trying to stimulate intersectoral processes around contextual research on maternal survival in Zambia had mixed success, we feel that using a participatory research methodology, with an intersectoral discussion format introduced in the early stages of the process, is an appropriate and feasible research-into action approach.

During the course of the intersectoral Interest Group meetings, local civil society organizations came to learn more about the community in which the research was conducted, and of the real issues affecting health and well-being of girls and women there. As a direct result of debate at the meetings, four civil society organizations have since entered the area, and are working with the newly empowered PEER researcher women to conduct assessments and bring in interventions. As well as using the ethnographic research to inform the planning cycle and communication activities, the District health system has also increased its attention to the area, broadening consultation activities to include the PEER researcher women in addition to the male members of the original Neighbourhood Health Committee, and liaising with the civil society organizations now operational there. In the presence of high-ranking government officials, a number of recommendations for follow-up action were discussed and agreed in Lusaka, as summarized in Box 2.

All these are direct research-into-action outcomes that are continuing beyond the lifetime of the research project itself. However, although the stage has been set for more effective intersectoral work to take place on a wider scale, the intersectoral debate process is now unsupported and may ultimately lack sustainability.

Box 2: Recommendations for action

Senior policy makers/implementers to convene and define specific actions, timeframes and responsibilities
 Combine PEER method with Ministry's Maternal Deaths Review
 Urgently undertake a comprehensive review of current gaps and shortcomings in policies
 Shift focus away from directive health education and IEC to more strategic and culturally compelling behaviour change communication for different ethnic population groups
 Raise these discussions at all other national Forums
 Conduct a national baseline study on prevalence of early marriage across the country and links with the education of the girl child
 Undertake a comprehensive review of all customary laws across the country, with an emphasis on the impact on girl child
 Increase public spending commitment in the health sector to 15%.

Researcher as catalyst of change

The intersectoral events clearly highlighted that contextual information on cultural and gender issues in Zambia in the area of health is scarce. Moreover, the little information there is does not often appear to policy makers and programmers in a way that is easily digestible for them. Intersectoral discussion around ongoing participatory community-based research can help address this. At the project's Dissemination Event in Lusaka, the Minister of Health for the Government of the Republic of Zambia stated that '*this research has added value to national and regional efforts to reduce maternal death, and should serve as a source of learning and advocacy for future action in this area*'.

Raphael (Raphael, 2006) highlighted three key roles for health promoters in addition to their daily activities, namely education, motivation and activation, all in support of the social determinants of health. The paper argues that these will contribute to build the political momentum by which public policy in support of the social determinants of health can be implemented. Our Zambian study suggests that these three roles are also very relevant for researchers working in health promotion and public health. With the public, as well as many professionals in health and other sectors, uninformed about the importance of the social determinants of health, researchers can draw these issues out through collaborative partnerships that

include intersectoral debates around their research. In doing so, they can support advocacy efforts and act as catalytic agents of change.

CONCLUSION

Partnership for development is ultimately about the nature and quality of relationships and how they evolve over time (Taylor, 2002). Generally, to increase the chances of having an effective relationship, people need to meet, and meet regularly over a long time-frame. This project highlights the potential value of using intersectoral stakeholder discussion, starting from the earliest inception stage of the research process, to stimulate exchange of different perspectives on a health issue, inform advocacy initiatives, debate recommendations and move research-into-action. Our research partnership achieved some short-term success, particularly at Provincial level, from the empowerment of a group of rural women through participatory research to an intensification of awareness raising, intersectoral programming and policy debate on the social and gender contextual issues underlying maternal health and survival. It provides an example of the relevance of social research to the development process through acting as a catalyst for advocacy, action and change.

Intersectoral debate on priority social determinant of health issues, using contextual research as an entry point, can be a useful activity for the health system working in collaborative partnership with other sectors. Involving stakeholders outside the health sector, and networking and communicating with them can improve relationships over time in a process that can contribute to making better health an agenda for action by everyone. However, such a process is not self-sustaining. It requires investment of time and effort, and adequate resources, none of which should be underestimated by those funding research for health activities.

FUNDING

Funding for this work was provided by a Global Health Research Award (RP-04-GH) from the Advisory Board for Irish Aid, Department of Foreign Affairs, Ireland.

ACKNOWLEDGEMENTS

We acknowledge the contribution of the 14 community PEER researcher women in Northern Province, the Department of Post-Basic Nursing at UNZA Lusaka, the Kasama School of Nursing and the support of the Zambian Ministry of Health in Lusaka and the Provincial Health Office in Kasama. We thank Rachel Grellier (Options Alliance South Africa), Dr Anne Byrne, Dr Saoirse NicGabhainn and Dr Rebecca Pelan (NUI Galway), Alessandra Fantini and Aoife O'Brien (Women's Health Council of Ireland), K Mona Moore (Washington DC, USA) and Sandra MacDonagh (formerly with Options UK) for advisory inputs. We are grateful to Dr Kirstan Hawkins and Ben Rolfe of Options UK for training in the PEER methodology. We also thank Nicole McHugh, Mary Sutton and Fiona Quinn for guidance from the Advisory Board for Irish Aid, and staff of Irish Aid in Lusaka and Kasama, and at NUI Galway's Department of Health Promotion, for logistical and administrative support.

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