KNOWLEDGE SUMMARY: WOMEN'S & CHILDREN'S HEALTH

2010

9. ADDRESS INEQUITIES

The burden of mortality and ill-health is borne disproportionately by the women and children who are least well served. Deep-seated gender inequities in societies pose significant barriers to women's and girls' access to, and use of, healthcare services.[1,2] To scale up service coverage for reproductive, maternal, newborn and child health (RMNCH) and achieve Millennium Development Goals (MDGs) 4 and 5, countries and their partners should focus on the most vulnerable and hardest-to-reach women and children: the poorest, those living with HIV/AIDS, orphans, indigenous populations and those living farthest from health services.

The Partnership for Maternal, Newborn & Child Health

UNIVERSITY OF ABERDEEN

By definition, universal access to RMNCH care requires good quality services to be available to all. Equitable access is achieved when "avoidable and unfair" differences in healthcare are removed.[3] Inequities in RMNCH care and outcomes are a result of the socio-cultural, religious, economic, political and geographical vulnerabilities that women and children face. And, as a review on gender inequities puts it: *"The heart of the problem is that gender discrimination, bias, and inequality permeate the organizational structures of governments and international organizations, and the mechanisms through which strategies and policies are designed and implemented."*[1]

Health equity for women and children needs strong advocacy and action from all quarters and at all levels. New hope is presented by UN Women – the new agency for gender equality and women's empowerment, which can help lead the advocacy to remove gender inequities and achieve progress for RMNCH.

What do we know?

Poor women and children have poorer access

Women and children in the poorest families across the developing world bear the greatest burden of death and ill-health. They are more exposed to health risks and often have less resistance to illness owing to poor nourishment or environmental conditions.[4] Studies have shown that their access to care is also the lowest in developing countries.[5] National averages hide the inequities that exist within countries. Progress on MDG 4, for example, has been accompanied by rising inequality in under-five mortality. Even in countries with low levels of under-five mortality, most deaths are recorded amongst the poorest families.[6]

The *Countdown to 2015* analysis shows that the wealthiest households had a better coverage across all the RMNCH interventions studied (see Figure 1). The largest gaps (typically 30% to 50%) across the interventions were in South Asia and sub-Saharan Africa.[7] Such inequities were seen along the continuum of care (see Box 1 and Knowledge Summary 2).

Evidence shows that some program interventions can have unintentional effects and increase inequities. In rural Bangladesh, for example, the gap in uptake between poor and rich widened after facility-based care was introduced. Although the facility-based care was free and more women started using it, fewer women from the poorest families attended.[8]

Unfairness also manifests in other ways. Lack of respectful care in health facilities, particularly towards poor women, discourages them from using available care (see Knowledge Summary 7). In Kenya, for example, poor women also faced physical and verbal abuse from health workers in many public healthcare facilities, because they could not pay the fee.[9]

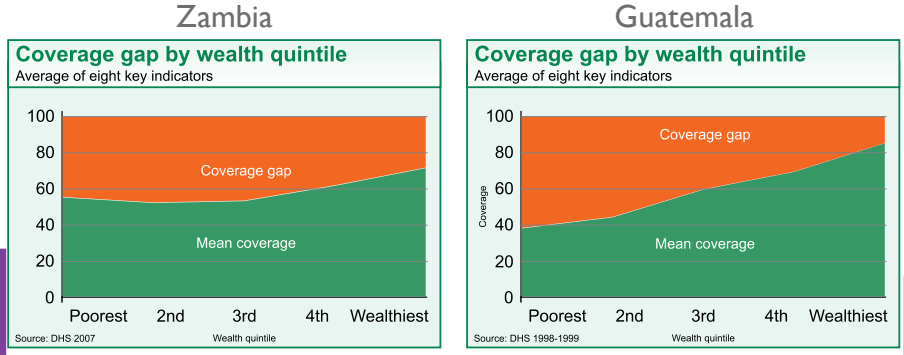
It matters where women and children live

Women and children in rural and remote areas are the most underserved. For example, women in rural Ethiopia were less likely to receive skilled birth attendance than their urban counterparts.[10] However, poor women in urban areas do not always have better access, underscoring the fact that poverty is one of the main drivers of inequity in access. In Indonesia, for example, caesarean rates were lowest among the poorest women in both rural and urban areas. A comparison of coverage across different terrains in Nepal showed that those living in the mountains were least served in terms of the eight RMNCH interventions (see Figure 2).

Women and children who are displaced by conflict, or live in conflict-affected areas, are at greater risk of ill-health and mortality. The reproductive health of women may suffer acutely with sexual violence, and the consequent risks of unsafe abortions or HIV infection.[11]

Figure 1

Zambia and Guatemala: inequities are masked by overall coverage



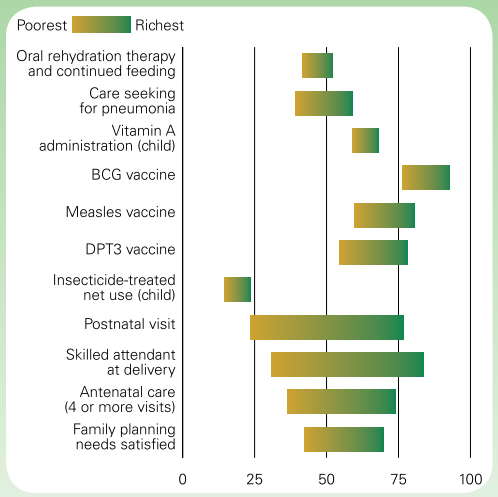
Source: Countdown to 2015 decade report (2000–10): taking stock of maternal, newborn, and child survival, (PDF) www.Countdown2015mnch.org/documents/2010report/CountdownReportAndProfiles.pdf

These two countries show similar levels of overall coverage for eight RMNCH interventions. However, uptake amongst the poorest women and children in Guatemala was only 38% compared to 55% in Zambia.

Socio-cultural origins may weaken access to quality care

Women and children in particular communities, such as ethnic groups, castes or religions, may face greater health challenges. Often such groups are also poor, lack education, experience restrictive cultural practices, face racial discrimination and live in remote areas.[12] Several Latin American ethnic groups – Mayan, Aymara, Quechua, Guarani – hold specific cultural beliefs about childbirth, which influence their use of services.[13] Similarly, in India, some ethnic groups in underdeveloped areas had poorer access to and use of family planning, and poorer maternal health and nutrition, compared to non-indigenous women.[14]

Box 1 – Health inequities exist along the continuum of care



Source: Countdown to 2015 decade report (2000–10): taking stock of maternal, newborn, and child survival, (PDF) www.Countdown2015mnch.org/documents/2010report/CountdownReportAndProfiles.pdf

The *Countdown to 2015* report analyzed coverage levels of healthcare based on eight intervention indicators (contraceptive prevalence; antenatal care; skilled attendance at delivery; vaccinations for BCG, DPT3, measles; ORT; care seeking for pneumonia). Across the 38 countries where data were available, coverage was much higher among the wealthier households. Countries that had overall similar levels of coverage showed large internal inequities. The analysis also showed that equity gaps were much wider for maternal and newborn healthcare than for children and for facility-based care (e.g. skilled attendance at birth) than for care delivered at a community level (e.g. vaccinations).

What works?

Some promising stories have recently come to light. Brazil, for example, has seen socio-economic development coupled with equity-oriented public policies. As a result, living conditions have improved markedly and child undernutrition has declined significantly. Further studies are needed to show whether these gains will be maintained under current global economic conditions.[15] Similarly, a recent analysis by UNICEF, published in two reports, demonstrates how the global community can save millions of lives by investing first in the most disadvantaged children and communities.[16,17]

Targeting is useful in some contexts

It can be helpful to target specific groups of women and children by poverty level, geographical location, type of population and other factors that characterize vulnerable populations. A pilot project that targeted internally displaced communities in Burma, by providing innovative community-based maternal health services, helped to increase use of services across the continuum of care. Skilled attendance at birth, in particular, increased tenfold.[18]

There is not enough evidence on targeting and effective interventions to improve healthcare access for orphans and vulnerable children in either low-prevalence or concentrated HIV/AIDS epidemic countries. However, doctors know that a short course of ART for mother and newborn reduces mother-to-child transmission of HIV. Educational programs and improved feeding practices can also reduce the risk of transmission, and supplementary food helps in some contexts.[19]

Economic support or free services

There is robust evidence that targeted conditional cash transfer (CCT) programs can improve the use of healthcare facilities by the poorest women and children. For example, Mexico's CCT program, *Oportunidades*, improved the quality of pregnancy care among poor women.[20] In Nepal, the Safe Delivery Incentive Program improved skilled birth attendance and facility-based delivery, but had no impact on infant mortality.[21]

However, there is insufficient evidence to show that CCTs specifically help the poorest families with orphans, and particularly those that might be affected by HIV/AIDS. In Kenya, for example, a CCT program found that, although orphans were being covered successfully, only about 40% in fact came from the poorest families.[22]

Many public health experts advocate free care for all to ensure that poor women benefit, and indeed, the removal of user fees has been seen to increase use of facility-based care. In Ghana, for example, free childbirth services led to increased use by poor women, although it did not decrease their out-of-pocket payments.[23] Such programs need to be well funded, and governments should take on strong ownership to ensure their success.

Improved quality of care encourages demand for services

Poor quality care is known to deter women and children from seeking care. This is particularly true in the most marginalized groups, who may receive care that is not only technically inadequate, but also violates their right to respectful treatment (see Knowledge Summary 7). Conversely, women and their families are encouraged to use

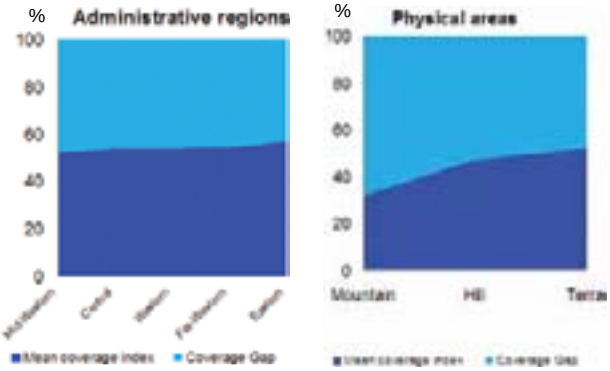
health services when quality of care is improved and assured. In Peru, for example, childbirth in healthcare facilities increased by 77 percentage points from 1999 to 2007 among indigenous women. This was a result of a program that encouraged staff at facilities to support certain culturally appropriate and safe practices and to speak the local language.[24,25]

Equity-sensitive monitoring helps to improve outreach

Data for monitoring should be disaggregated to show if the most vulnerable groups are benefiting from scaling-up activities (see Knowledge Summary 12). *Countdown to 2015* provides valuable information (as seen above) to identify groups that are left behind.[26] This facilitates prioritization and effective action, particularly when accompanied by data on costing and funding (see Knowledge Summary 3). For example, a recent analysis of donor aid flows showed that 18 conflict and post-conflict countries allocated only 2.4% of aid money to reproductive health. Countries not in conflict received 53% more aid for reproductive health than those affected by conflict.[27] Such inequities in funding flows only help to reinforce existing inequities.

Figure 2

Inequitable coverage in Nepal: administrative versus physical areas



Source: Graham W J and Hounton S (2010). The Geography of Coverage. Presentation at the 2010 Countdown to 2015 Conference, Washington DC. www.countdown2015mnch.org/index.php?option=com_content&view=article&id=266&Itemid=390

Conclusion

Universal access to healthcare is essential to improve RMNCH and achieve MDGs 4 and 5 (see Knowledge Summary 8). Access to healthcare is a basic human right, as recognized by the UNHRC. Currently, this right is being violated for many poor and marginalized women and children. Governments should uphold people's right to care. This is one of the most empowering actions they can take on behalf of vulnerable individuals.

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