

Targeting Poverty and Gender Inequality to Improve Maternal Health

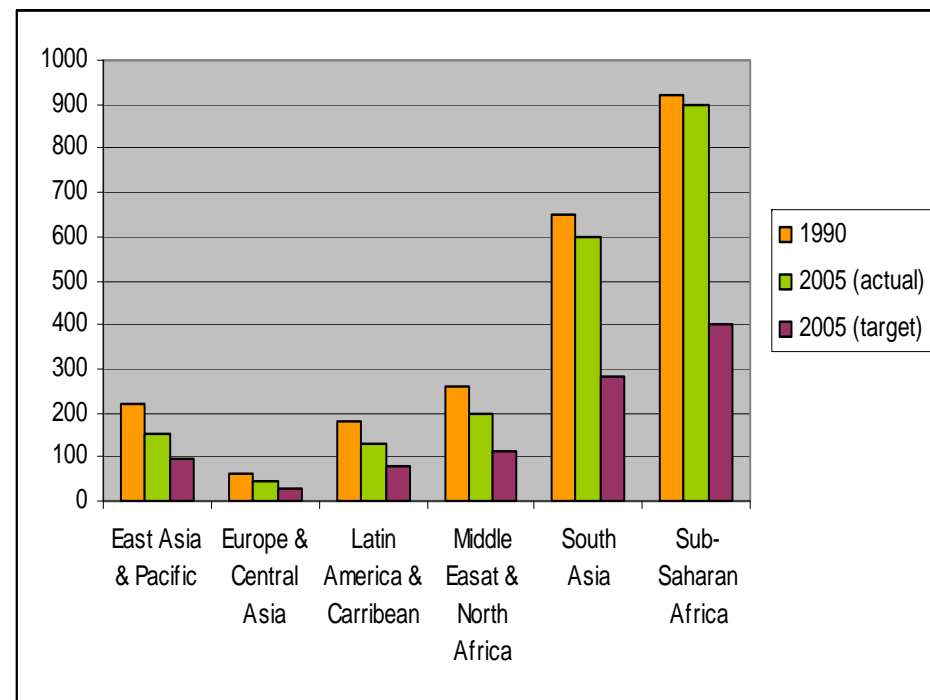
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Based on paper by:
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Maternal Mortality Ratio (MMR)*

- Between 1990 and 2005, global decline in MMR of 2.5
- Despite this progress, all regions are behind to meet the MDG5 goal by 2015—reduce MMR by 75% since 1990.



World Bank. 2009.

*modeled estimate, deaths per 100,000 live births

Achieving MDG 5 entails all women having access to and using health services.

- Poorest women in the poorest regions have lowest access and use of MHC
- Poverty and gender inequality closely linked—affect demand for and supply of MHC



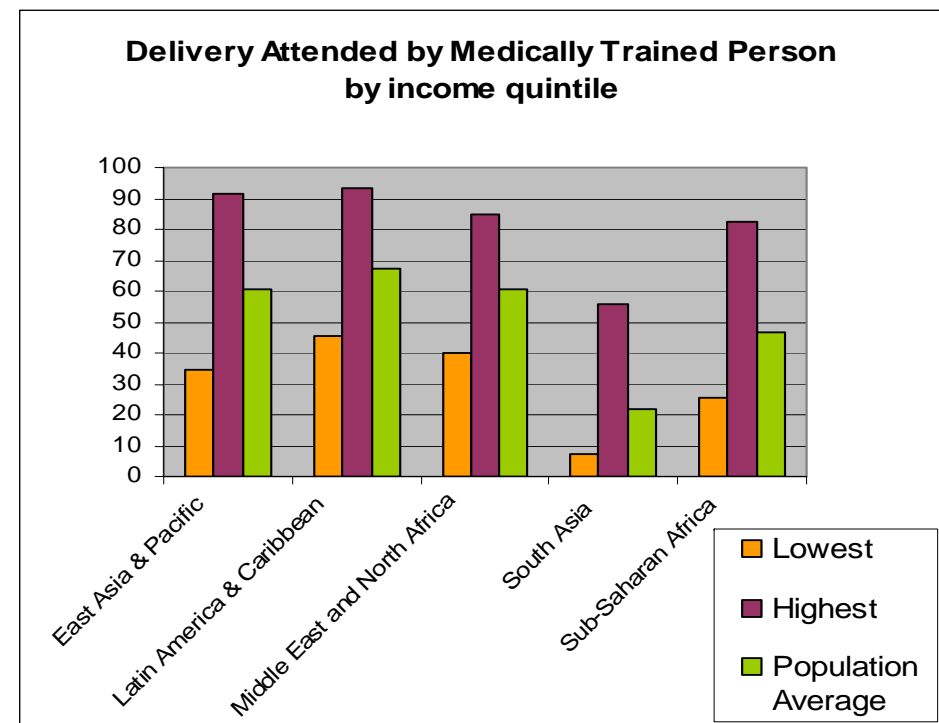
(c) D. Mhala

Key Questions

- How do poverty and gender inequality impede maternal healthcare access and utilization—specifically ANC, attended delivery and postnatal care?
- Which strategies address poverty and gender inequality and are successful in increasing utilization?

Poverty key determinant of maternal mortality and service utilization

- 10-country analysis: prop. of maternal deaths increased with greater poverty
- Indonesia: risk of maternal death 3-4X greater among poorest than richest groups
- 5 regions: less than 1/2 women in lowest wealth quintile deliver w/trained attendant.

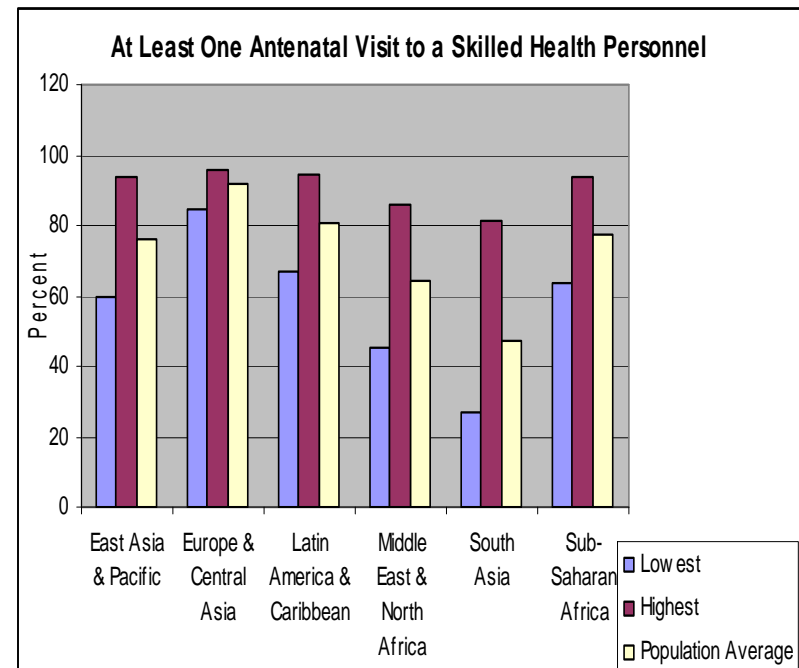


World Bank, 2004.

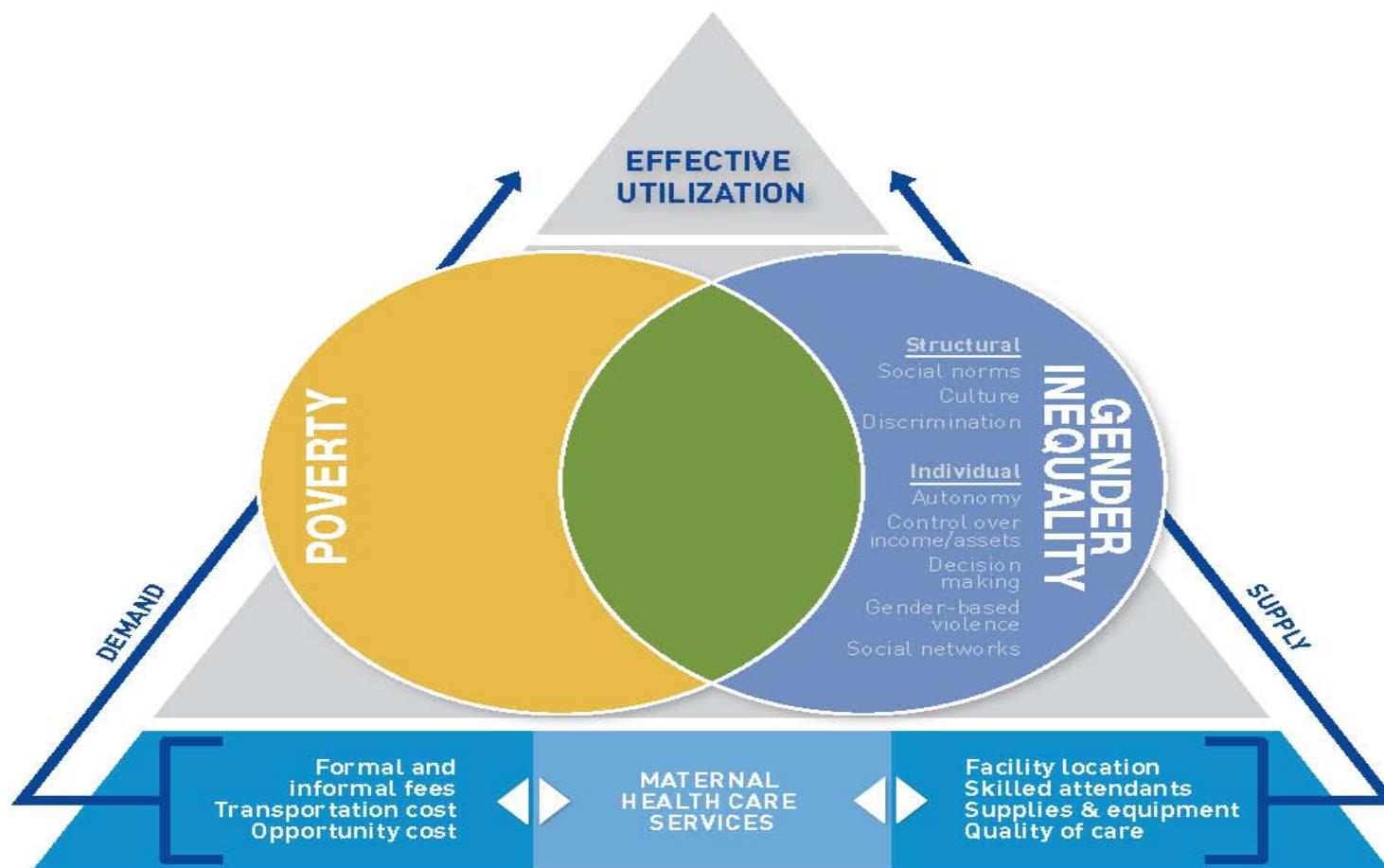
Costs are high, unpredictable and potentially catastrophic for the poor: disincentives to utilization

- Costs: formal and informal fees, drugs, equipment, transport, lost time
- Bangladesh: Hidden costs in 4 govt hospitals – US \$32 normal delivery, \$118 Caesarean (1995 data)
- Tanzania and Nepal: Transport $\geq 50\%$ of total care costs
- Indonesia: delivery costs for 68% of the poorest households was 40% of annual disposal income.

- In Middle East and North Africa and South Asia, less than 50% of women in the lowest income quintile see a skilled health professional for an antenatal visit.



**Women at the Center of Maternal Health Care:
Determinants of and Barriers to Utilization**

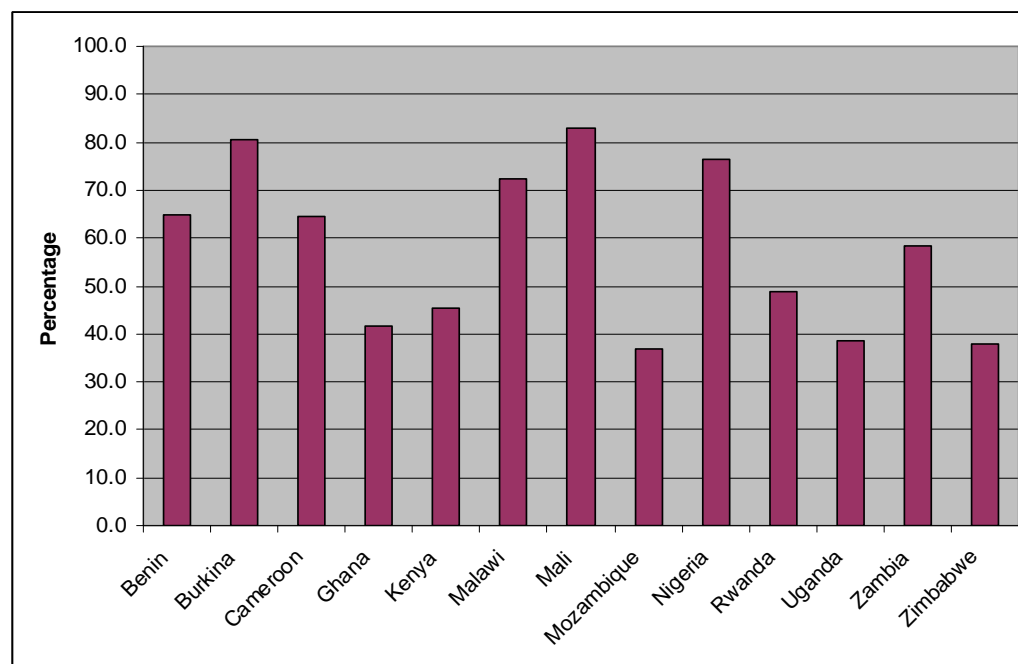


Gender inequality is a critical and neglected factor

- Women are disproportionately poor, low education, lack of autonomy and decision-making power; overall low social status. Effects of gender unequal norms:
 - early marriage → early childbearing + high fertility = higher risk of maternal mortality and morbidity
 - norms restrict mobility → impedes utilization
 - limited education → less knowledge and tools for informed health decisions

Many women cannot make decisions about their own health care

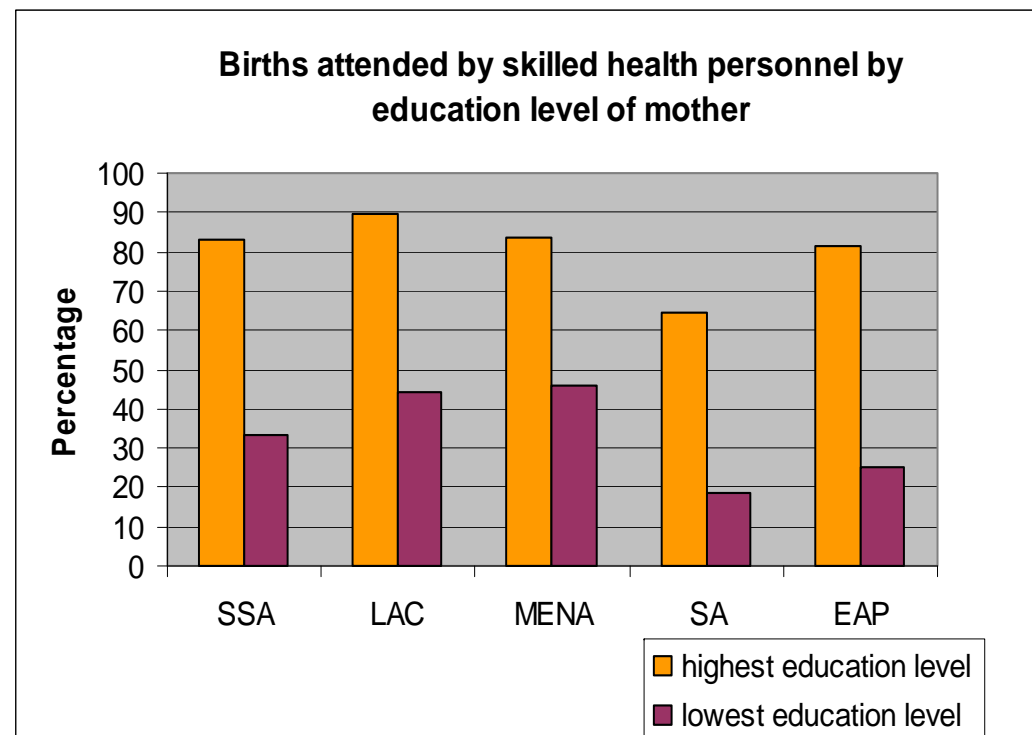
- In Burkina Faso and Mali more than 80% of currently married women cannot decide to use health care on their own;
Nigeria—76.5%
Malawi—72%
Benin—65%



Kishor S, and Subaiya L. 2008.

Women's education and employment impact on utilization and maternal mortality

- Large differences in attended deliveries between women with highest and lowest education levels (figure)
- Indonesia: MM 4X higher among unemployed women than employed women



World Health Organization. 2009.

Strategies to increase utilization

- Reduce the burden of costs
- Improve and expand services
- Reduce gender inequality and empower women



(c) Robin Hayes

Reduce the burden of cost: Removing user fees can increase demand by poor women

- Removing user fees increases demand for maternal healthcare among the poor
 - Ghana: delivery fees exempted—significant increase in facility-based care among poorest women
 - Niger: removing user fees doubled ANC visits; in Burundi hospital births were up 61%
 - Requires careful planning to handle increased demand in short-term
 - Long-term requires planning for financial sustainability

Reduce the burden of cost: Targeted subsidies can increase service utilization by women

- Subsidies, e.g., vouchers (3 districts in Cambodia):
 - # of facility deliveries increased (over 12 mths); no decline in self-paying deliveries;
 - additional poor women delivered in public health facilities
 - vouchers may work best when combined with social marketing to encourage use

Improve and expand services: Training & posting skilled attendants can increase coverage among the poor

- Indonesia Village Midwife Program: ↑ use of skilled attendants during delivery among poorest and those in rural areas.
 - Access and use by poor not uniform; some midwives charged fees—disproportionate effect on poor women
 - Cash transfers or vouchers may be needed to offset costs

While it is critical to reduce the burden of costs and improve and expand services, these actions alone may not be sufficient.

Empowering women and overcoming gender inequality requires explicit programmatic and policy approaches.

Conditional cash transfers can increase demand and empower women

- Mexico (*Oportunidades*): \$ conditioned on accessing care and health education sessions
 - Participants: More ANC visits and more procedures/visit (quality)
 - Women encouraged to be more active health consumers

Engaging women in participatory learning and networking can increase utilization

- Nepal: Local women trained to organize and facilitate group meetings on maternal and neonatal health.
 - ↑ ANC, institutional deliveries, attended births
 - Participation in women's groups: ↑ self-confidence, capabilities and collective action

Conclusions

- Poverty and gender inequality pose significant barriers to utilization
- Need comprehensive strategies that:
 - Lower costs, improve & expand services
 - Empower women through social support, networking, participatory learning & action
 - Reduce gender inequality through education and employment initiatives