

# Towards Universal Health Coverage, the need for innovative approaches to reach women and children in low-income countries.

Juliet Nabyonga-Orem gives an overview on the different drivers of inequalities in maternal and child health services in low-income countries.

## Background

Poor health indicators and sub-optimal access to health services especially for women and children is a long-standing concern especially in low-income countries. Looking at Sub-Saharan Africa, annual rate of reduction in maternal mortality ratio between 2000 - 2017 was very low at only 2.8% from 878 to 524 per 100,000 live births<sup>1</sup>. Similarly, for child survival, the period between 1990 - 2020 registered a modest reduction in Under 5 mortality rate from 181 - 74 deaths per 1,000 births - an annual reduction rate of 3.0%.<sup>2</sup> In an effort to address the poor health outcomes, the Sustainable development goals (SDG) agenda sets ambitious targets committing countries to reduce maternal mortality ratio to less than 70 per 100,000 live births (SDG target 3.1) and reduce under-5 mortality to at least as low as 25 per 1,000 live births (SDG target 3.2) by 2030.<sup>3</sup>

Attainment of Universal health coverage (UHC), defined as “all people having access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective; [and to] ensure that the use of these services does not expose the user to financial hardship”<sup>4</sup>; serves as an overarching aspiration that can guarantee equitable access to need maternal and child health services, among others, and subsequently attainment of set targets. However, coverage with essential health interventions remain low and progress towards UHC a distant milestone especially in African countries.

## Low and inequitable health service coverage in low-income countries

A recent analysis<sup>5</sup> covering the period 2000 - 2019, to assess progress in the universal health coverage service coverage index (UHC SCI), shows substantial progress with the global population weighted index improving from 45 in 2000 to 68 in 2019. The UHC SCI is computed from 14 indicators that address four programs namely reproductive, maternal, new-born and child health (RMNCH), infectious diseases, noncommunicable diseases, and service capacity and access. Global progress notwithstanding, regional inequalities are stark with the WHO African region registering the lowest average score in 2019 of 46 compared 79 in the WHO European Region. In the case of Africa attaining the set target of UHC SCI of 80 by 2030 is still a long way off. Looking at Reproductive, maternal, new-born and child health (RMNCH) sub-index, global progress was registered between 2000 - 2019 with the average score improving from 68 - 76. However, low, and lower - and middle-income countries registered lower scores.

## Persistent inequalities in accessing reproductive, maternal and child health services.

Drivers of inequalities in accessing health services disproportionately affect women and children. Wanjala B (2014) documented gendered asset inequalities in Africa and highlighted the less opportunities accorded to women regarding access to land,

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their predominant engagement (compared to men) in informal and small scale less paying entrepreneurial economic activities with low returns, lower access to formal finance systems and lower political capital.<sup>6</sup> Evidence shows that more educated women have better health seeking behaviour and coverage of interventions is higher among this group compared to less educated women or women with no education. However, access to education and retention in schools is lower for girls compared to boys<sup>7</sup>

These drivers of inequalities also explain the varied performance on the UHC SCI index with high income countries performing better than low-income countries. Favourable RMNCH sub-index coverage scores are registered among the rich (median coverage of 74% among the richest quintile compared to 61% among the poorest quintile), educated and urban dwellers.<sup>5</sup> Selebano & Ataguba, in their study of 12 countries in South African Development Cooperation (SADC); reported that wealth, education and the number of children explained the observed inequalities in antenatal care (ANC) coverage.<sup>8</sup> They further report that the majority of women who had not attended even one ANC visit were in the poorest quintile. Mwase et al reports similar findings concluding that household wealth, literacy, distance from the health facility impact coverage of maternal health services.<sup>9</sup>

Apart from the socioeconomic drivers of inequalities, women face additional challenges that relate to the health system, models of health service delivery, poor quality of health services, societal and cultural norms and household power imbalances. Hay et al argue that the restrictive gender norms (dictating what women can and cannot do, need for husband's consent regarding their health) are replicated and reinforced in health systems with resultant gender inequalities in health.<sup>10</sup> Gender disparities are also documented in the health workforce with low representation of women at senior levels of the medical profession and predominantly at the lower level (nurses, nurse midwives and community health workers) and in the informal unpaid health sector as care givers - aligned with women's traditional gender role as caregivers<sup>11,12</sup>

Silal et al<sup>13</sup> argue that inadequate attention has been paid to patient-oriented barriers in accessing maternal services, which include affordability, availability and acceptability. They further assert that these are also unequally distributed between social economic groups and geographical areas. They are not entirely wrong in their argument since rural areas are characterised by fewer and lower skilled health providers and ill-equipped health facilities. Arsenault et al also reported substantial variations in quality of health services across regions in Kenya with a 25% gap between the capital city and rural regions which impacted utilisation of maternal health services.

Cost is a documented barrier to accessing health services more so for women who already have less economic possibilities. Keya et al highlight the high transport cost as a barrier to access services for women especially in rural areas where providers are few and distanced.<sup>14</sup> A systematic review by Dahab & Sakellariou<sup>12</sup> noted that transport costs to health facilities, economic, cultural beliefs, poor quality care and lack of family support were major barriers to

utilisation of maternal health services.

### Are reforms designed to improve equitable coverage of maternal health services effective?

Countries have implemented different reforms in order to improve access to maternal health services and health outcomes but, the results are varied and the question as to what works is yet to be answered. A systematic review by Dzakpasu et al<sup>15</sup> assessed the impact of user fee abolition on utilisation of maternal health services and concluded that although generally there was a positive direction showing some evidence of increased facility delivery following fee removal, there was little evidence on tackling inequalities in accessing care. Increase in government funding for health, to increase coverage of essential health services also shows inconsistent results and Kruk et al.<sup>16</sup> It has been reported that this does not automatically result in increased skilled birth attendants among the poor.

Attempts have also been made at addressing demand side barriers in accessing maternal health services through provision of voucher schemes. Ahmed et al<sup>17</sup> report positive results in Bangladesh both in increased uptake of maternal services and a reduction in the socio-economic inequality in access. However, also note that use of maternal health services remained pro-rich implying the inadequacy of a solely demand sided intervention.

India implemented a broad approach; the National Health Mission, whose objective was to reduce maternal and child deaths through ensuring continuum of maternal health care services. The strategy was multifaced and included increase in public financing for health, bottom-up planning to ensure focus on local health needs and community participation and empowerment. Contrary to envisaged objectives, pro-rich inequity increased with women's' education and access to media partially explain this phenomenon.<sup>18</sup>

### Do the different drivers of inequalities impact the different interventions differently?

One could argue that drivers of inequalities do not impact uptake of health services in equal measure. For example, Wariri et al<sup>19</sup>, in their study of multi dimension equity gaps of immunisation systems in West Africa, found that drivers of inequalities in BCG, and DTP3 coverage and dropouts included level of wealth, geographical region (whether high or low coverage) and mother's education. Rural or urban residence and child's sex had minimal influence.

Nkoki et al<sup>20</sup> also highlight the varied impact of the different drivers of inequalities in their study on inequalities in child mortality, HIV transmission and vaccination coverage in South Africa. They found that whereas favourable outcomes in indicators of interest (Infant mortality, HIV transmission, Immunisation coverage) were recorded among wealthier populations; despite the fact that services were provided free at the point of access.

### Gender considerations in unique contexts

Diseases outbreaks and their containment measures, fragile and conflict settings, may worsen gender disparities in access to health services. Learning from the Covid-19 pandemic and associated containment measures, disruption in continuity of essential health services was reported in many countries.

The repurposing of health facilities for Covid-19 patients case management, varied levels of lockdown restricting movements and fear of contracting Covid-19 from health workers; resulted in reduction in access to essential health services. In the case of East and Southern African countries, the services impacted

most were maternal and new-born, immunisation, child health and tuberculosis services.<sup>21</sup> Decker et al<sup>22</sup> documented gender disparities in accessing contraception (favouring men); inability to meet basic economic needs affecting women more than men, women having lower decision control to move out of the house, menstrual hygiene access challenges and gender-based violence.

Conflict and fragile setting perpetuate disparities in service delivery as health service providers work under stressful conditions, often in isolated settings with minimal support, providing care of suboptimal quality. Currie et al<sup>23</sup> documented similar findings in Afghanistan further noted the need to understand factors that may explain acceptance of mistreatment in childbirth to improve quality of maternity health services in fragile and conflict affected settings.



Mother and child (Photo courtesy of Health Newborn Network)

### What needs to be done

Strengthen health research and information systems to guide development of refined approaches: Tackling inequalities needs more granular data than majority of health information systems in low-income countries can provide. This is further compounded by the complexity in the approach to categorise “disadvantaged women” to ensure no one is left behind. Ahmed et al caution against blanket approaches and draw our attention to that category of women in double jeopardy. The “disadvantaged within a disadvantaged society” for example the poorest and least educated, poor women in urban informal settlements on rural areas, the uneducated with no voice and the least educated among the inadequately educated. Health information systems must be strengthened to provide timely good quality and disaggregated data. Zhao et al<sup>24</sup> bemoan major gaps in health data in the 47 least developed countries they studied, highlighting the long survey cycles and lack of appropriate survey instruments as major hurdles to overcome.

The Covid-19 pandemic has underscored the need to embrace digital technologies in data collection and management. This will enable real time data collection to inform response efforts, monitor equitable continuity of essential health services, gather data on barriers to accessing services and enable collection of household level data through use of mobile technologies.

Multipronged approaches to concurrently tackle supply and demand side barriers: Gender inequalities in social determinants relate to inequalities in access to health services, education, economic opportunities, and participation in decision making. As such, attempts to improve women’s health must be embedded within the development goals of the country and required investments made to tackle drivers of inequalities.

Designing context specific and tailored approaches: Arguments raised by some scholars asserting that different drivers impact uptake of the different maternal and child health services differently calls for strong research and analytical capacities to guide designing of responsive service delivery models. Real time evidence needs to inform decision making and guide designing of corrective measures.

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