



Capturing the Equity of maternal and newborn health interventions in the SDG era

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Purpose of presentation

Examine current efforts to monitor equity of maternal and newborn health interventions and present recommendations for monitoring in the SDG era

Outline of presentation

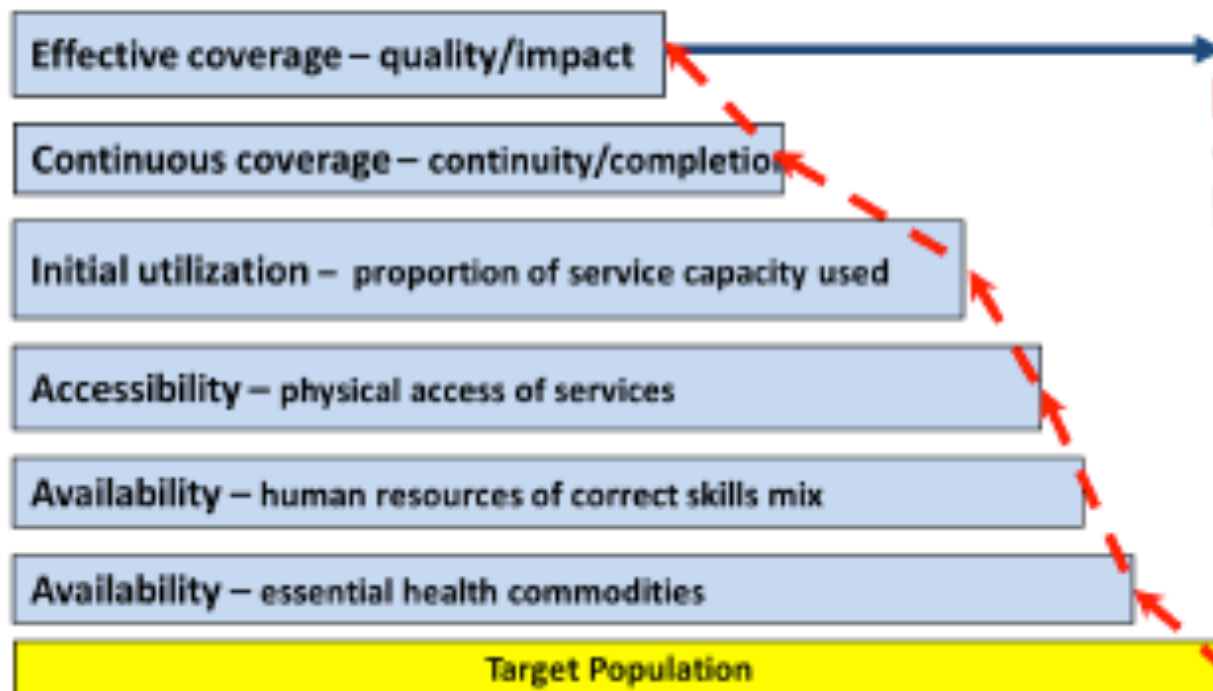
- Context of UHC in the SDG era
- Existing approaches to monitor equity
- Monitoring equity in the SDG era

Universal Health Care in SDG Era

- Achieve and maintain equity as high impact maternal and newborn health interventions are scaled up.
- Proposed SDG target for the UHC: *“Achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”*.
- Target to be monitored with a set of disaggregated tracer coverage indicators
 - WHO/World Bank framework specifies a target of a minimum 80% coverage of **quality**, essential health services, regardless of economic status, place of residence or sex.¹
- Existing tools/methods are not sufficiently monitoring UHC
 - **Need to adapt existing tools and/or develop new tools/methods**



Figure 3 A modified Tanahashi model based on analysing determinants of effective coverage
Source: adapted from Tanahashi T. Health service coverage and its evaluation. Bulletin of the World Health Organisation 1978; 56: 295-303.



Outline of presentation

- Context of UHC in the SDG era
- **Existing approaches to monitor equity**
- Monitoring equity in the SDG era

Existing ways we monitor equity

Person:

- Wealth quintiles (richest 20% vs poorest 20% or poorest 40%)
- Women's education (secondary + vs. no education)
- Sex

Place:

- Urban vs rural populations

Time:

- Change in equity between household surveys

Introducing the Countdown Report

Fulfilling the Health Agenda for Women and Children The 2014 Report

http://www.countdown2015mnch.org/documents/2014Report/The2014report/Countdown_The_2014_Report_final.pdf

*Fulfilling the Health Agenda
for Women and Children*

The 2014 Report

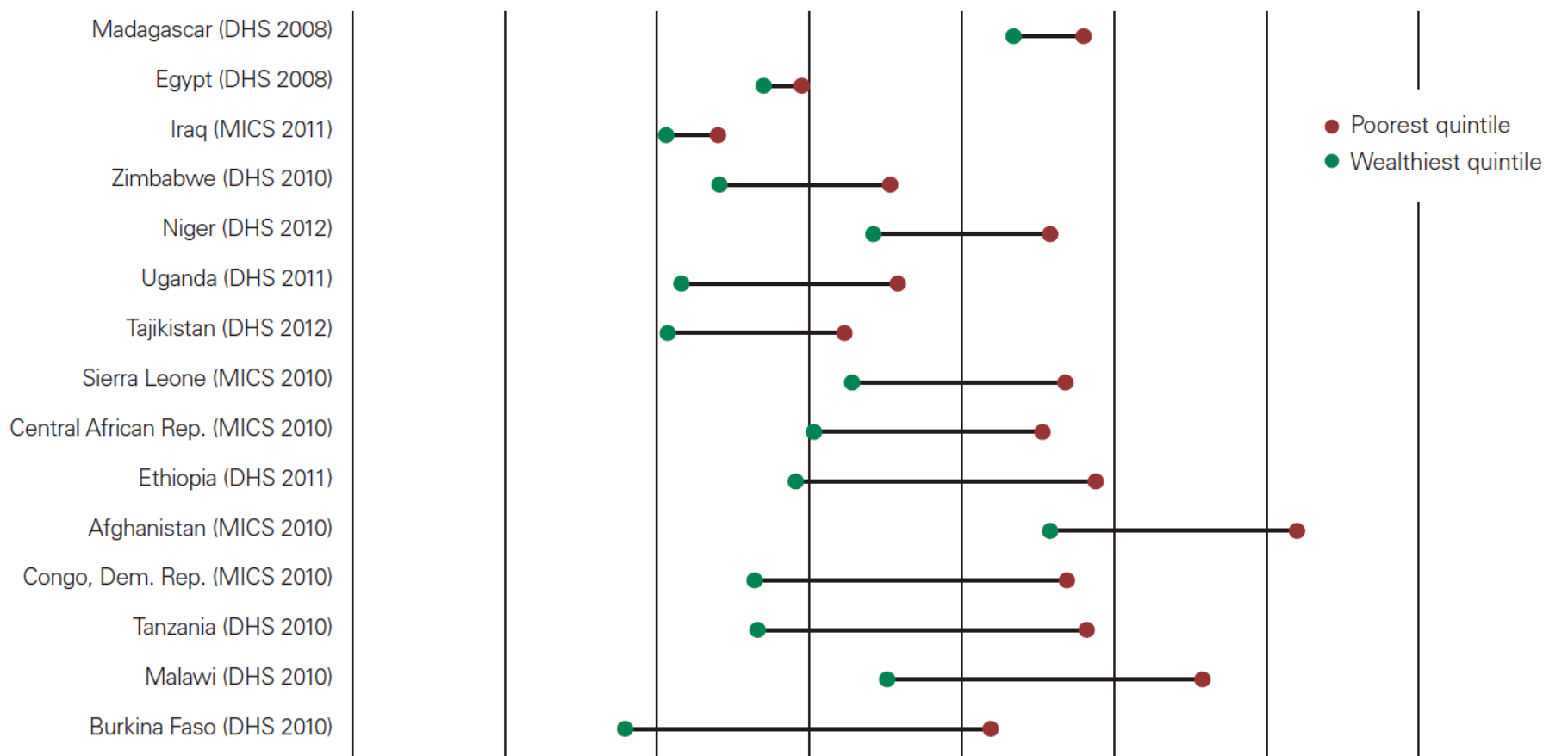



Countdown to 2015
Maternal, Newborn & Child Survival

FIGURE 2

On average across the Countdown countries, stunting prevalence is 2.5 times higher among the poorest wealth quintile than among the richest

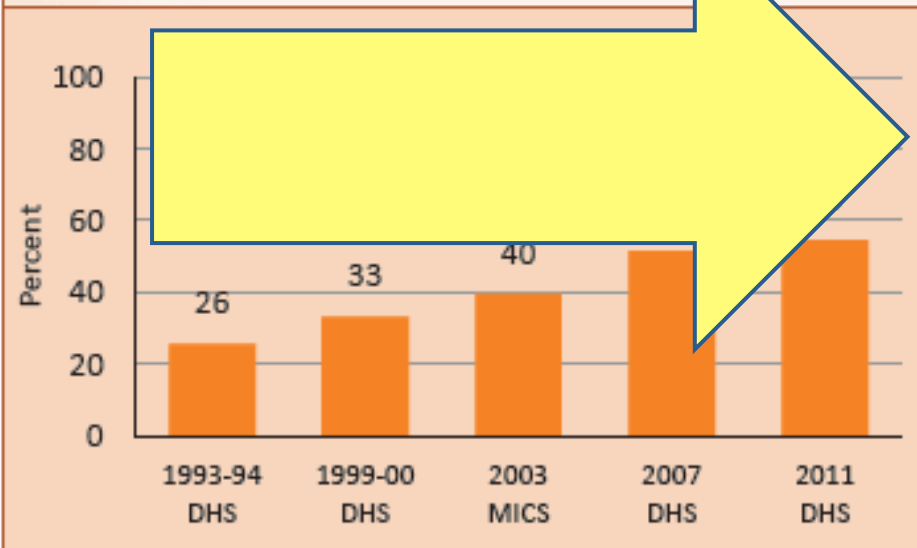
Prevalence of stunting among children under age 5, wealthiest and poorest quintiles, various years (%)



MATERNAL AND NEWBORN HEALTH

Antenatal care

Percent women aged 15-49 years attended at least once by a skilled health provider during pregnancy



Demand for family planning satisfied (%)	82	(2011)
Antenatal care (4 or more visits, %)	26	(2011)
Malaria during pregnancy - intermittent preventive treatment (%)	-	-
C-section rate (total, urban, rural; %) (Minimum target is 5% and maximum target is 15%)	17, 29, 14	(2011)
Neonatal tetanus vaccine	94	(2012)
Postnatal visit for baby (within 2 days for home births, %)	30	(2011)
Postnatal visit for mother (within 2 days for home births, %)	27	(2011)
Women with low body mass index (<18.5 kg/m ² , %)	28	(2011)

Introducing WHO Report on Inequality

State of inequality: Reproductive, maternal, newborn and child health

http://www.who.int/gho/health_equity/report_2015/en/

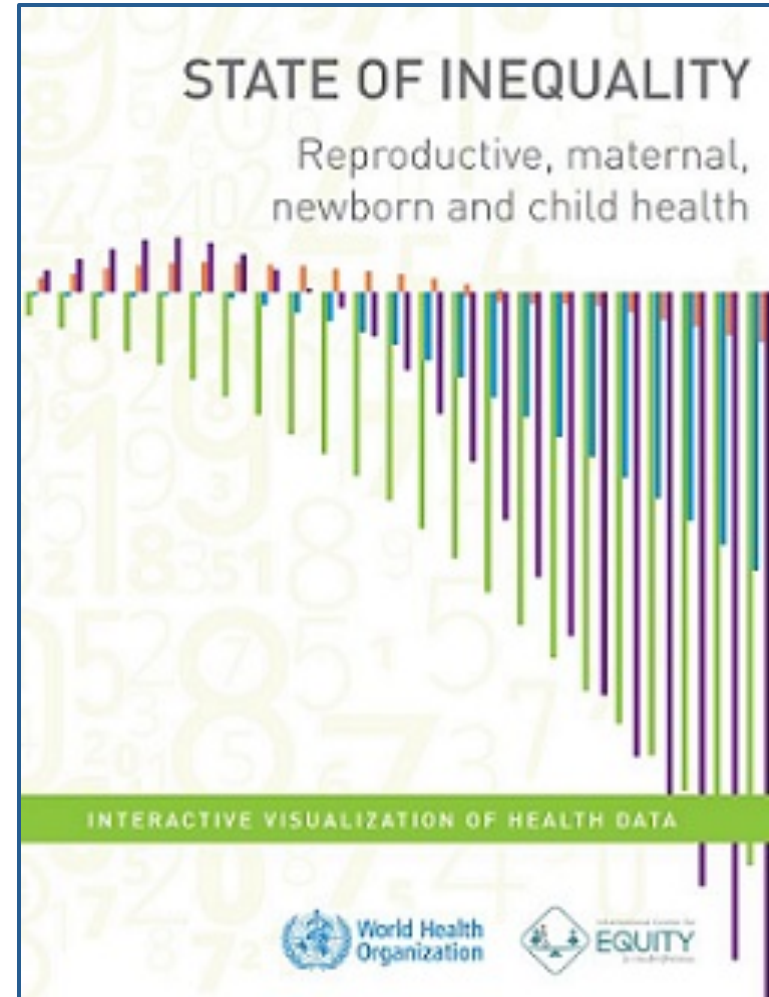
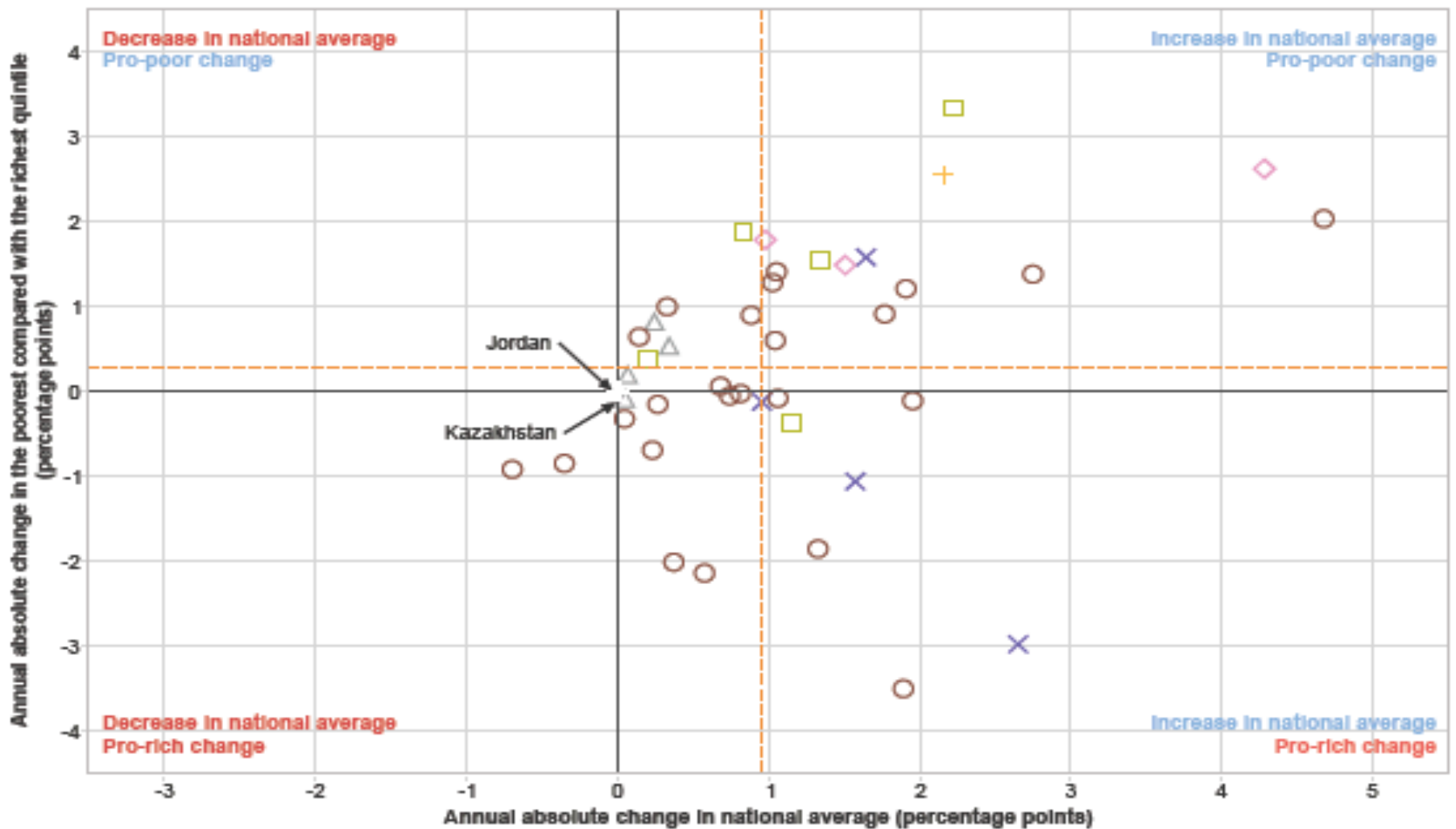


FIGURE 4.5 Births attended by skilled health personnel: change over time in national average (absolute change) and in the poorest compared with the richest quintile (absolute excess change) in 42 low- and middle-income countries (DHS and MICS 1995–2004 and 2005–2013)



○ African Region; □ Region of the Americas; × South-East Asia Region; △ European Region; + Eastern Mediterranean Region; ◇ Western Pacific Region

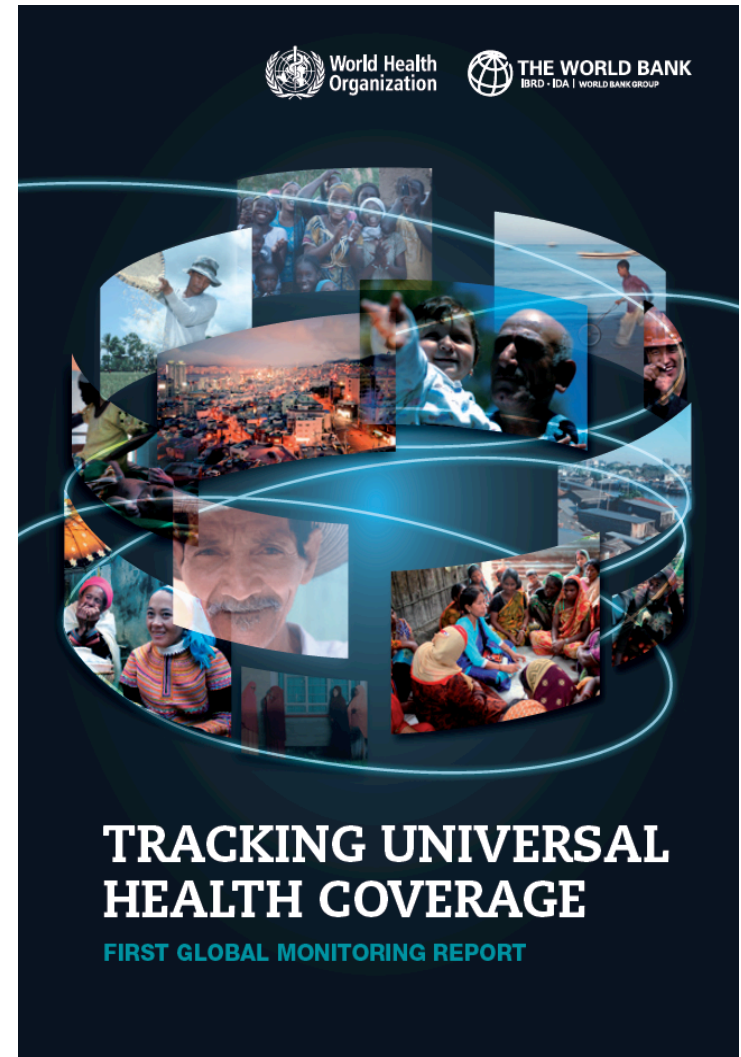
Introducing the UHC Tracking Report

Tracking universal health coverage:

First global monitoring report

Joint WHO/World Bank Group report, June 2015

http://www.who.int/healthinfo/universal_health_coverage/report/2015/en/



The main UHC monitoring challenges:

We face three main challenges in tracking UHC:¹

1. reliable data on a broad set of health service coverage and financial protection indicators;
2. disaggregating data to expose coverage inequities;
3. third, measuring effective coverage...

*...which not only includes whether people receive the services they need but also takes into account the **quality of services** provided and the ultimate impact on health.*

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→ **Report does not yet track effective coverage**

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- Context of UHC in the SDG era
- Existing approaches to monitor equity
- **Monitoring equity in the SDG era**

Monitoring UHC Progress in post-2015 SDG Era

1. Focus on gaps in achieving UHC
2. Monitor interactions between equity measures
3. Monitor effective coverage

Separate equity calculations for urban vs. rural populations

Neal, Sarah, Andrew Amos Channon, Sarah Carter, and Jane Falkingham. "Universal health care and equity: evidence of maternal health based on an analysis of demographic and household survey data." *International journal for equity in health* 14, no. 1 (2015): 56.

"Wealth has been calculated, using the standard PCA analysis, for urban and rural areas separately; by doing this an accurate view of inequalities by place of residence are revealed. Firstly it is clear that there are large differences in coverage between urban and rural areas in all countries. In urban areas 7 out of the 10 countries have coverage above 80 %; in rural areas only 1 country passes this threshold. However the poorest in urban areas are often lagging badly, with coverage far lower than their richest counterparts."

<http://www.equityhealthj.com/content/14/1/56>

doi:10.1186/s12939-015-0184-9

Neal et al. *International Journal for Equity in Health* (2015) 14:56
DOI 10.1186/s12939-015-0184-9

INTERNATIONAL JOURNAL FOR EQUITY IN HEALTH

RESEARCH Open Access

Universal health care and equity: evidence of maternal health based on an analysis of demographic and household survey data

Sarah Neal^{1*}, Andrew Amos Channon¹, Sarah Carter¹ and Jane Falkingham²

Abstract

Introduction: The drive toward universal health coverage (UHC) is central to the post 2015 agenda, and is incorporated as a target in the new Sustainable Development Goals. However, it is recognised that an equity dimension needs to be included when progress to this goal is monitored. WHO have developed a monitoring framework which proposes a target of 80 % coverage for all populations regardless of income and place of residence by 2030, and this paper examines the feasibility of this target in relation to antenatal care and skilled care at delivery.

Methodology: We analyse the coverage gap between the poorest and richest groups within the population for antenatal care and presence of a skilled attendant at birth for countries grouped by overall coverage of each maternal health service. Average annual rates of improvement needed for each grouping (disaggregated by wealth quintile and urban/rural residence) to reach the goal are also calculated, alongside rates of progress over the past decades for comparative purposes.

Findings: Marked inequities are seen in all groups except in countries where overall coverage is high. As the monitoring framework has an absolute target countries with currently very low coverage are required to make rapid and sustained progress, in particular for the poorest and those living in rural areas. The rate of past progress will need to be accelerated markedly in most countries if the target is to be achieved, although several countries have demonstrated the rate of progress required is feasible both for the population as a whole and for the poorest.

Conclusions: For countries with currently low coverage the target of 80 % essential coverage for all populations will be challenging. Lessons should be drawn from countries who have achieved rapid and equitable progress in the past.

Keywords: Maternal health, Universal health coverage, Sustainable development goals, Monitoring, Inequity

Introduction

As national and international policy makers seek to address the unfinished Millennium Development Goal (MDG) agenda as well as develop new goals and indicators to guide development there has been growing demand to place universal health coverage (UHC) as a central pillar for such efforts [1]. As a result, one of the targets linked to Goal 3 of the newly developed Sustainable Development Goals (Ensure healthy lives and promote well-being for all at all ages) is to "achieve UHC, including financial risk protection, a access to quality essential health care services, and a access to safe, effective, quality, and affordable essential medicines and vaccines for all" UHC has been defined as "all people receiving quality health services that meet their needs without being exposed to financial hardship [2]. Achieving this goal requires progress in three dimensions: expanding essential health services, increasing access to a greater proportion of the population and reducing out-of-pocket payments [3].

The MDGs have been justly criticised for failing to take into account issues of equity when monitoring progress (e.g., [4]). There is strong commitment that equity is "hard-wired" into any post-MDG Goals and strategies, which was embodied by the High Level Panel of Eminent

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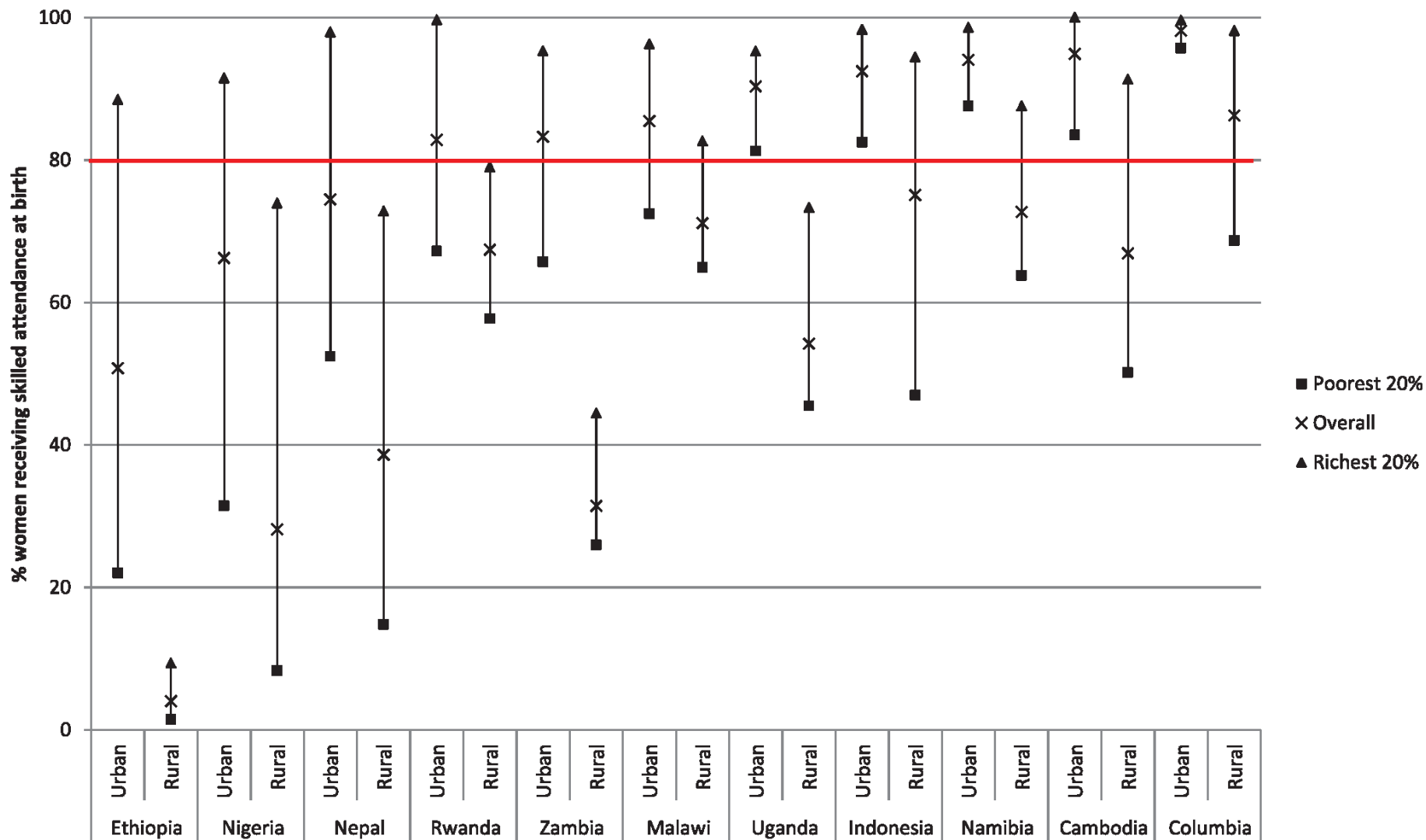
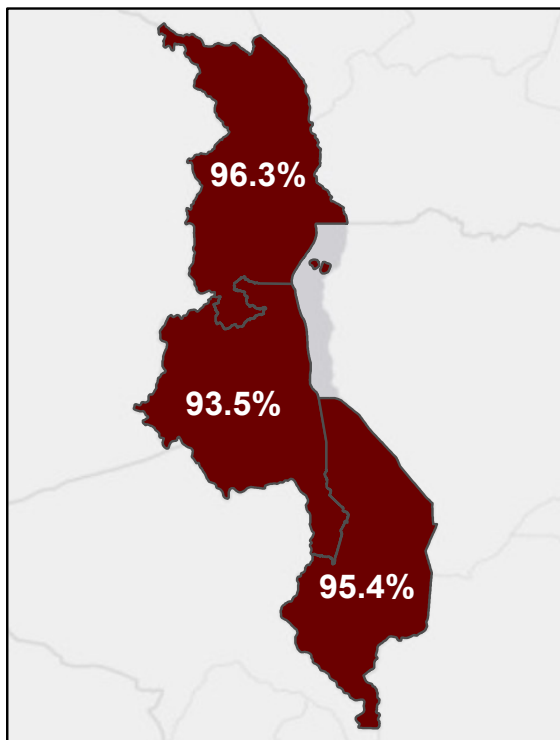


Fig. 7 SBA coverage for urban and rural residents, split by wealthiest and poorest quintiles for selected countries based on DHS data (most recent available survey 2006–2012)

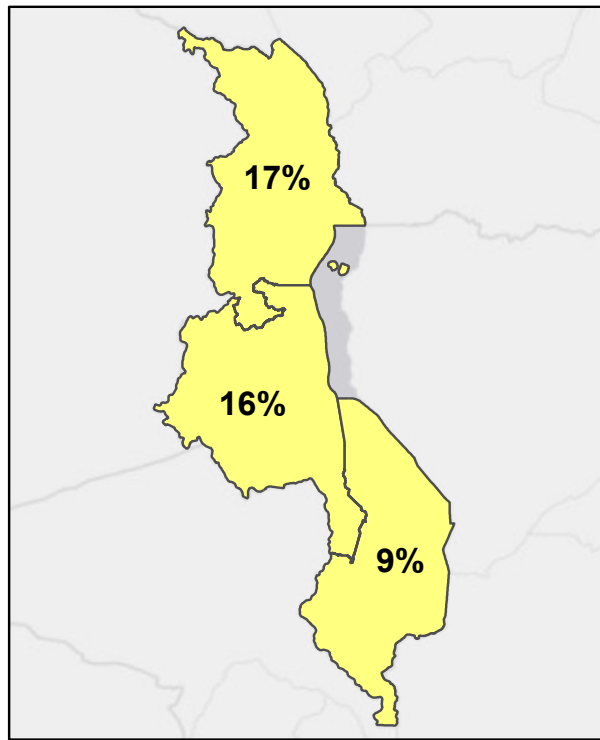
Estimating Effective Coverage of High Impact Interventions

Example of ANC for PPH
Most recent Malawi DHS & SPA

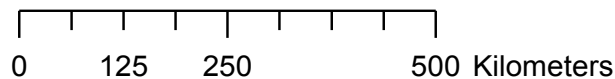
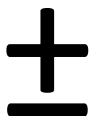
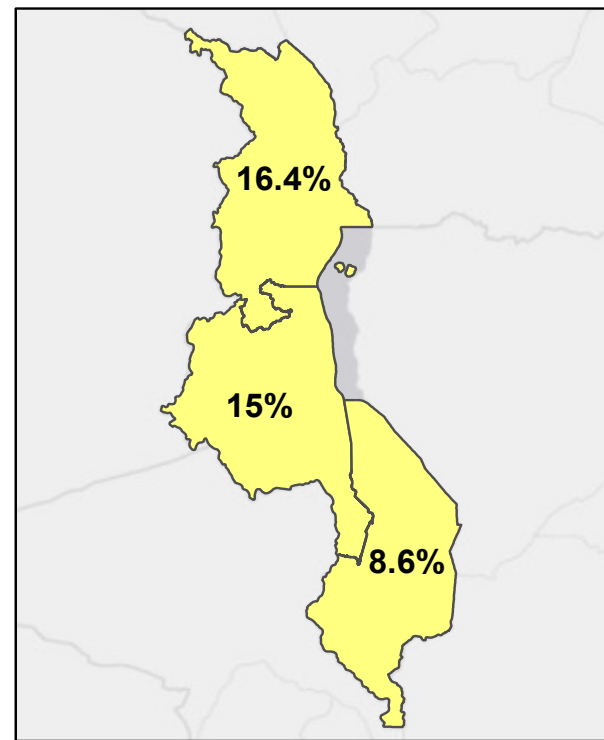
ANC w/Skilled Attendant (DHS)



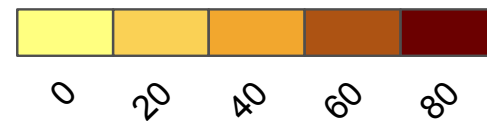
Pct Facilities w/Minimum Quality ANC/PPH-Readiness (SPA)



Estimated Effective Coverage ANC/PPH-Readiness



Legend



Components used for minimum quality standard: Facility Readiness for ANC/Hemorrhage (SPA Elements)

ANC READINESS COMPONENTS TO PREVENT MORTALITY FROM OBSTETRIC HEMORRHAGE (INCLUDING PPH)	North		Central		South	
	n (facilities)	%	n (facilities)	%	n (facilities)	%
<i>*Denominator: 119 Facilities that provide ANC services</i>						
ANC providers provide iron supplementation to pregnant women as part of routine ANC	119	82%	239	93%	285	82%
ANC providers provide folic acid supplementation to pregnant women as part of routine ANC	119	69%	239	59%	285	59%
ANC providers give blood test for anemia part of routine ANC	88	16%	198	23%	250	22%
ANC providers provide counseling on birth preparedness of preparation for delivery as part of ANC services	119	98%	239	98%	285	99%
Facility has folic acid and iron (or combo) tablets available and valid	114	96%	220	97%	277	88%
ANC providers provide IPT for malaria to pregnant women as part of routine ANC	119	100%	239	99%	285	98%
As part of routine ANC services providers provide counseling on IPTs to prevent malaria	119	99%	239	99%	285	100%
Facility offers malaria RDT (facmalrdt)	92	30%	208	33%	255	24%
Does the facility have a functional ambulance and is fuel available today OR does facility have access to an ambulance.	106	100%	208	100%	256	100%
At least one provider per facility has ever received in-service training in ANC screening	115	92%	239	98%	284	97%
At least one provider per facility has ever received in-service training in counseling for ANC (nutrition, FP, newborn care)	115	96%	239	99%	284	99%
At least one provider per facility has ever received in-service training in complications of pregnancy and their management	115	97%	239	99%	284	99%
Percent of facilities meeting minimum threshold (Facility-level Readiness only):	119	17%	239	16%	285	9%

Recommendations

- Convene stakeholders around monitoring UHC for SDGs
 - MA4Health Collaborative?
- Examine cost/benefits for:
 - Deeper disaggregation by person/place
 - Additional/timely data on quality of care
 - focus on tracer indicators and related?
- Updated recommendations for countries and donor partners investing in national survey programs
 - Sample size for key disaggregations
 - Minimum frequency and content of health facility assessments
 - Establishing minimum-minimum standards of quality
 - focus on tracer indicators and related?

Questions?

THANK YOU!