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

William M. Weiss, DrPH MA
Senior Monitoring & Evaluation Advisor
Ending Preventable Child & Maternal Deaths (EPCMD)
Bureau for Global Health
United States Agency for International Development
Washington, DC

ACTING ON THE CALL
ending preventable child and maternal deaths

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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
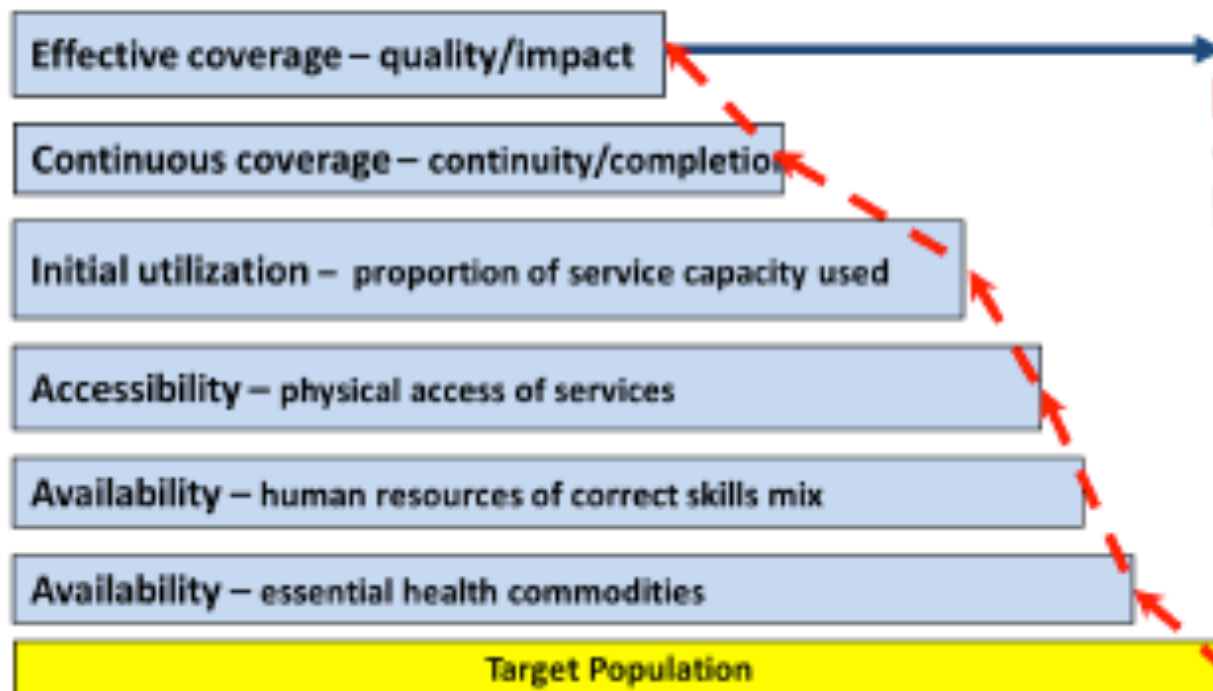
Outline of presentation

- 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

Reaching Universal Health Coverage through District Health System Strengthening: Using a modified Tanahashi model sub-nationally to attain equitable and effective coverage

December 2013
Maternal, Newborn and Child Health
Working Paper
UNICEF Health Section, Program Division

unicef
unite for children

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.

Effective coverage – quality/impact

Continuous coverage – continuity/completion

Initial utilization – proportion of service capacity used

Accessibility – physical access of services

Availability – human resources of correct skills mix

Availability – essential health commodities

Target Population

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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 (%)

Madagascar (DHS 2008)
Egypt (DHS 2008)
Iraq (MICS 2011)
Zimbabwe (DHS 2010)
Niger (DHS 2012)
Uganda (DHS 2011)
Tajikistan (DHS 2012)
Sierra Leone (MICS 2010)
Central African Rep. (MICS 2010)
Ethiopia (DHS 2011)
Afghanistan (MICS 2010)
Congo, Dem. Rep. (MICS 2010)
Tanzania (DHS 2010)
Malawi (DHS 2010)
Burkina Faso (DHS 2010)

● Poorest quintile
● Wealthiest quintile
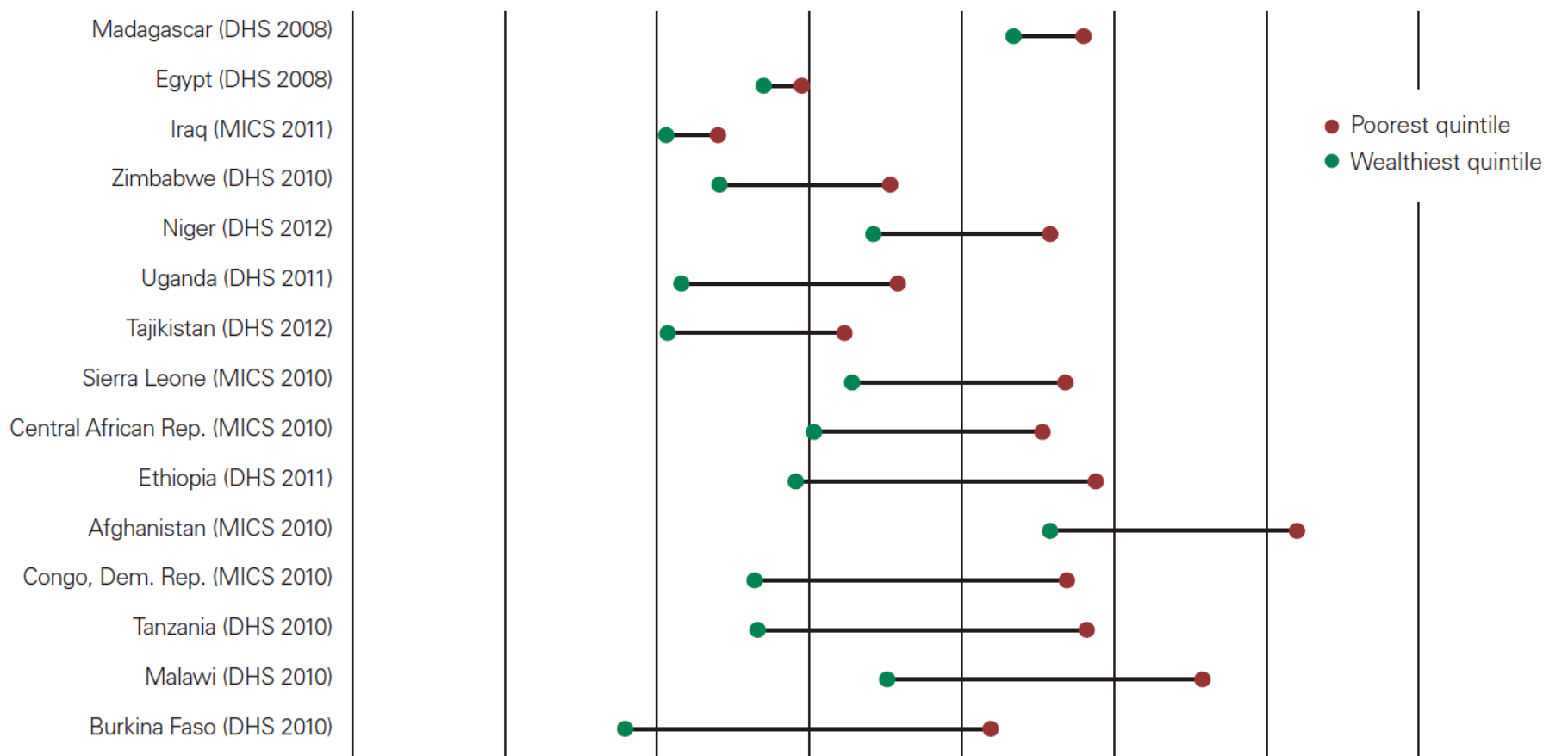
MATERNAL AND NEWBORN HEALTH

Antenatal care

Percent women aged 15-49 years attended at least once by a skilled health provider during pregnancy
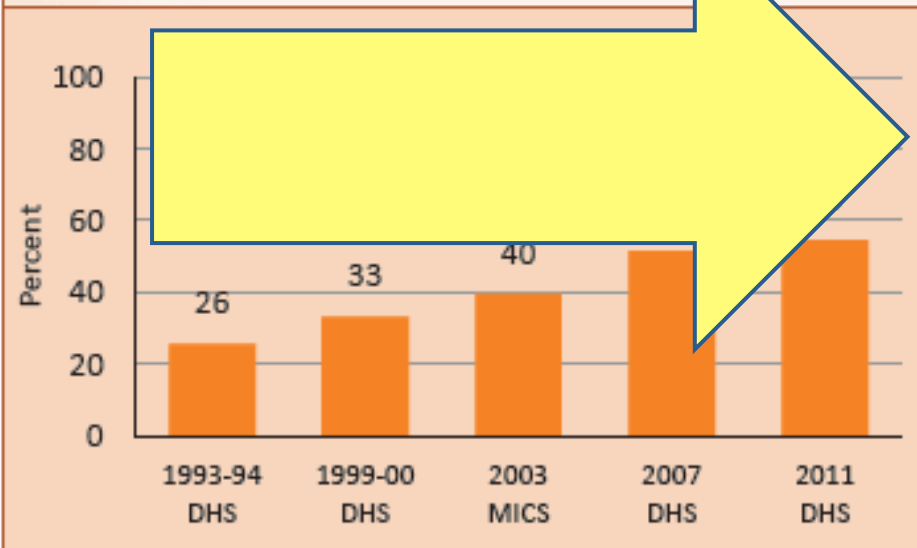
Demand for family planning satisfied (%)	82	(2011)
Antenatal care (4 or more visits, %)	26	(2011)
Malaria during pregnancy - intermittent preventive treatment (%)	-	-
C-section rate (total, urban, rural; %) (Minimum target is 5% and maximum target is 15%)	17, 29, 14	(2011)
Neonatal tetanus vaccine	94	(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/m2, %)	28	(2011)

Introducing WHO Report on Inequality

State of inequality: Reproductive, maternal, newborn and child health
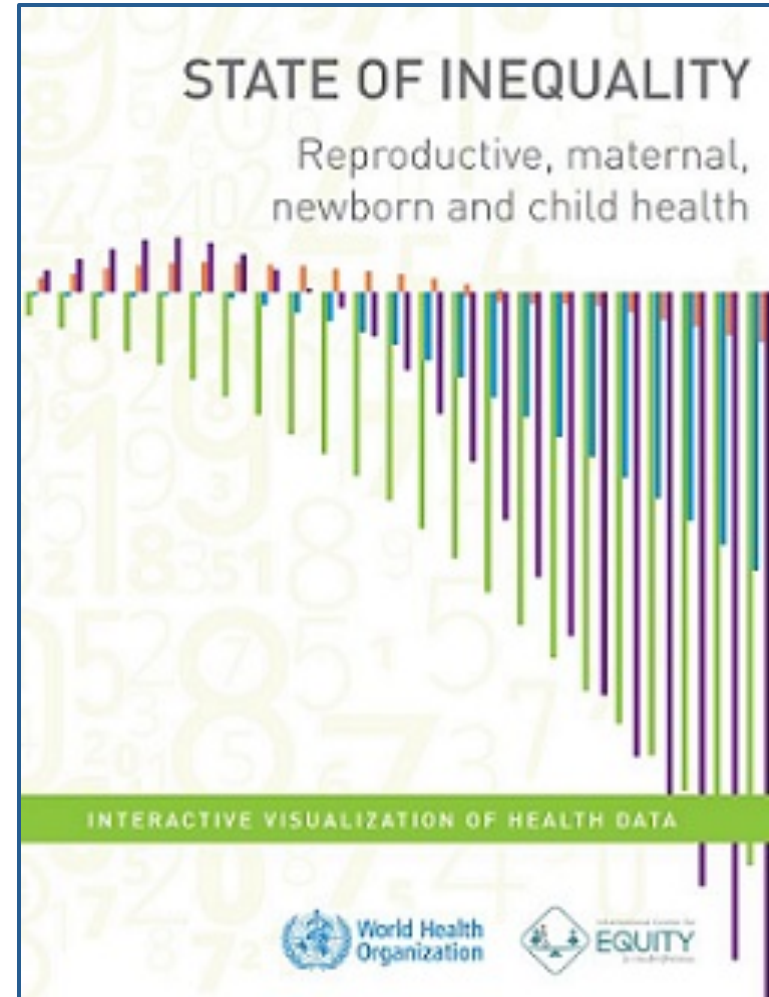
FIGURE 4.5 Births attended by skilled health personnel: change over time in national average (absolute change) and in the poorest compared with the richest quintile (absolute excess change) in 42 low- and middle-income countries (DHS and MICS 1995–2004 and 2005–2013)
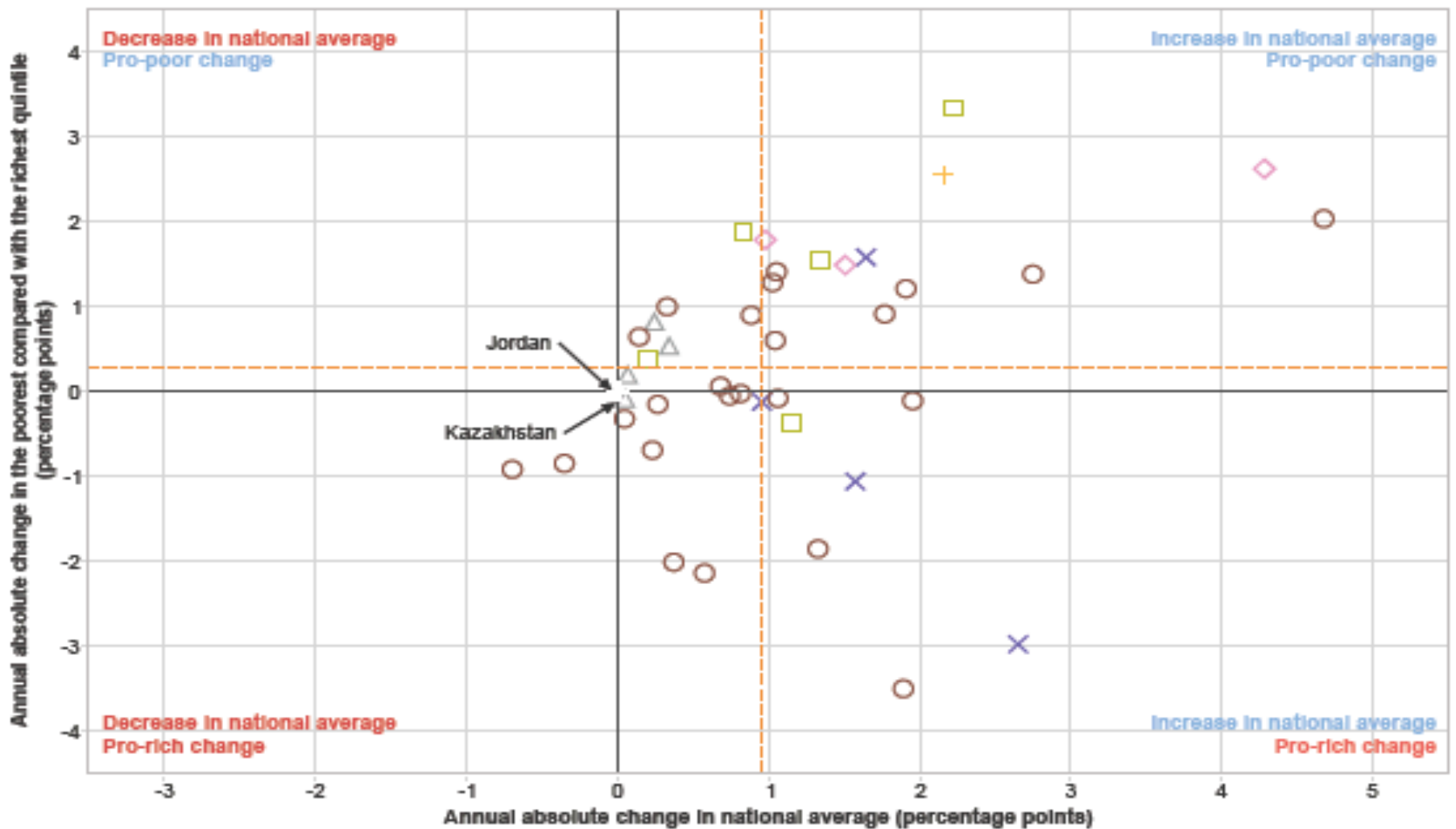
Introducing the UHC Tracking Report

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/
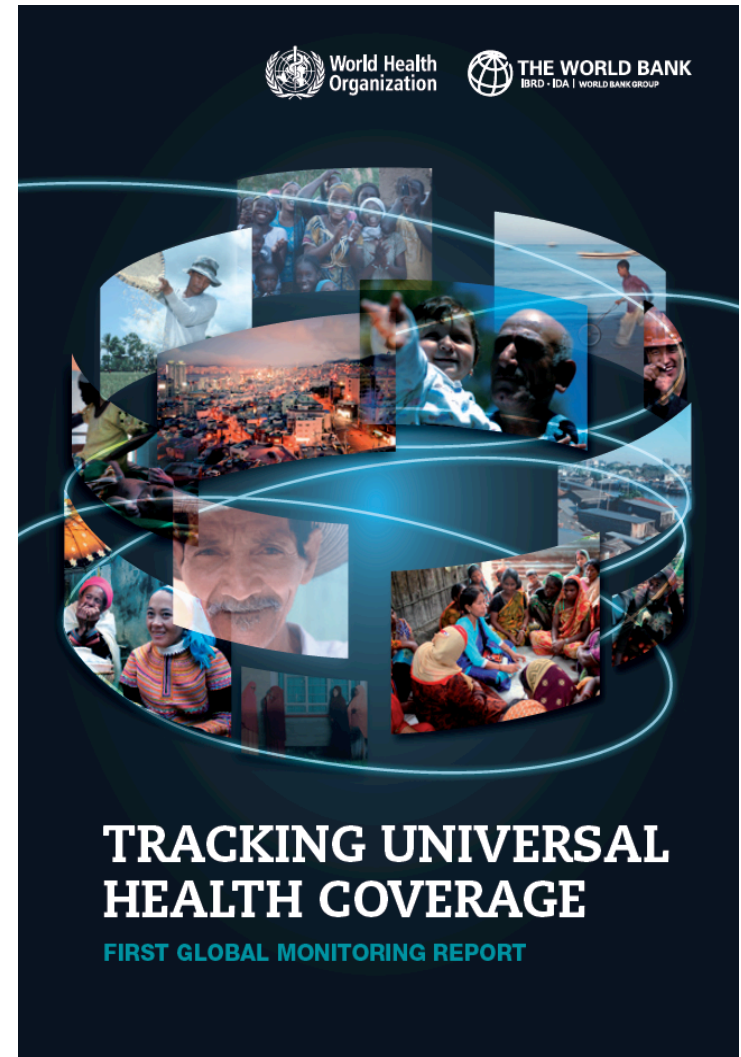
The main UHC monitoring challenges:

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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- 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
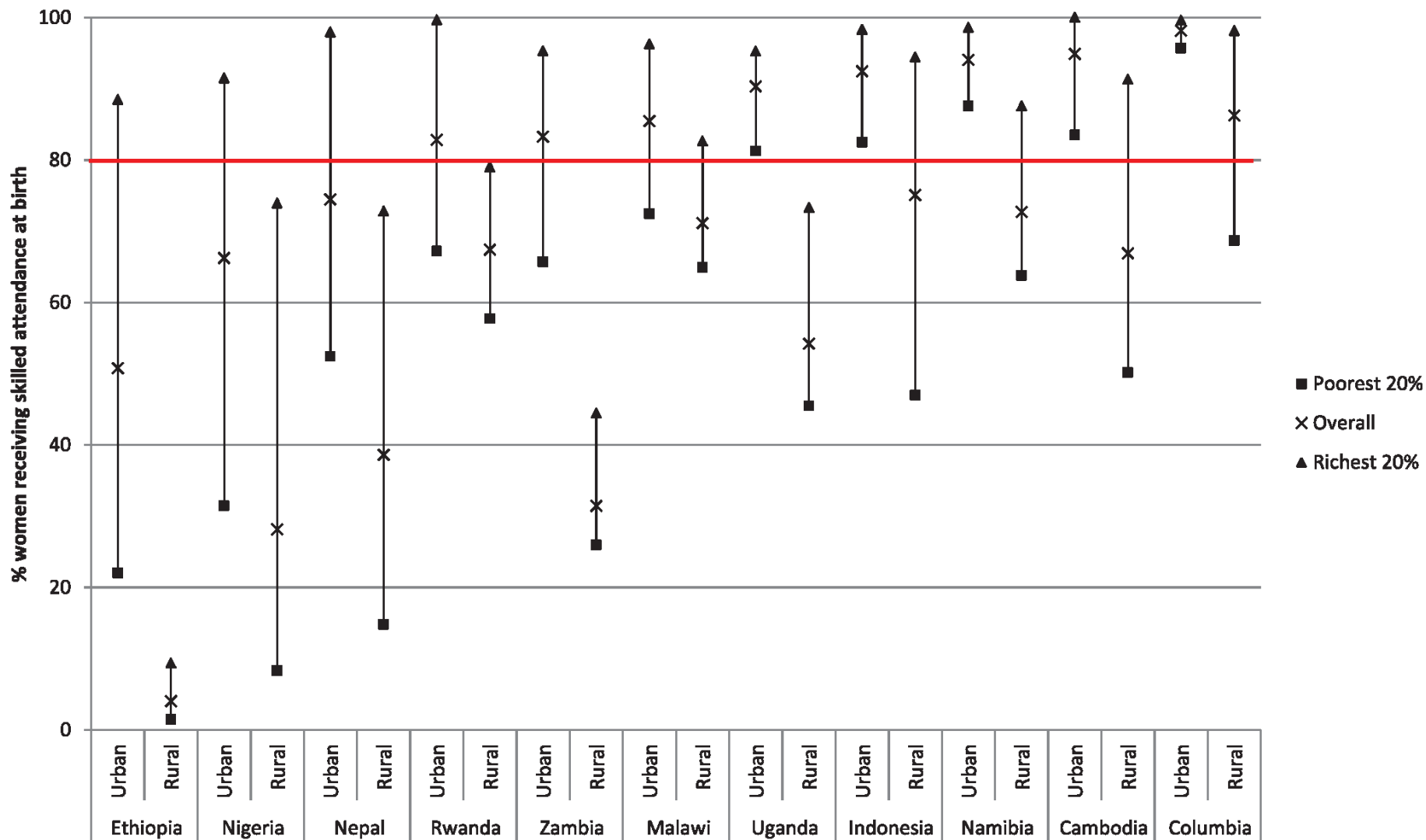
doi:10.1186/s12939-015-0184-9

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)

96.3%

93.5%

95.4%
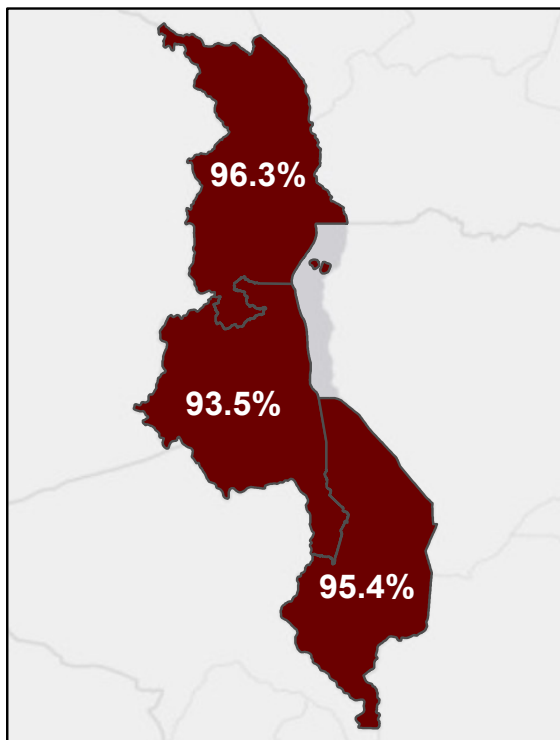
**Pct Facilities w/Minimum
Quality ANC/PPH-Readiness (SPA)**

17%

16%

9%

**Estimated Effective Coverage
ANC/PPH-Readiness**

16.4%

15%

8.6%

0   125   250   500 Kilometers

Legend

0   20   40   60   80
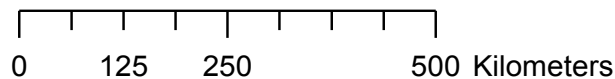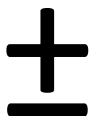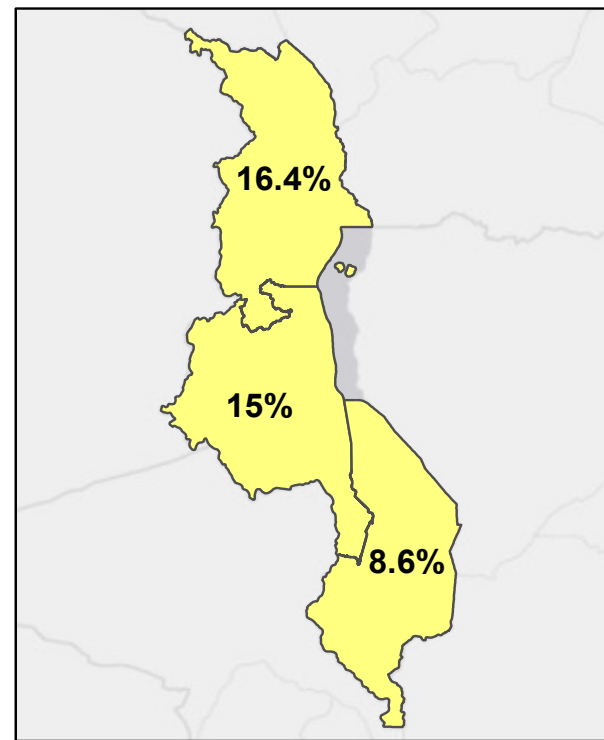
Components used for minimum quality standard: Facility Readiness for ANC/Hemorrhage (SPA Elements)
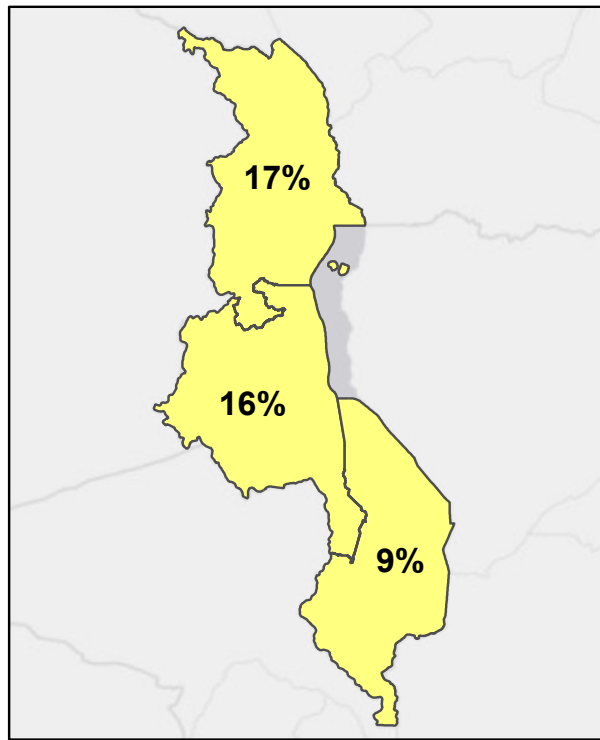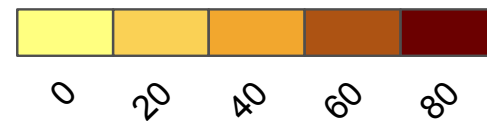
ANC READINESS COMPONENTS TO PREVENT MORTALITY FROM OBSTETRIC HEMORRHAGE (INCLUDING PPH)	North		Central		South	
	n (facilities)	%	n (facilities)	%	n (facilities)	%
Denominator: 119 Facilities that provide ANC services						
ANC providers provide iron supplementation to pregnant women as part of routine 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 amubulence and is fuel available today OR does facility have access to an ambulence.	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!