

Towards greater equity in health for mothers and newborns

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The issue of equity in health outcomes, and in access to essential primary-health-care services, is receiving greater attention in the field of maternal, newborn and child health. This focus is increasingly supported by emerging evidence and research on the extent of disparities in health and other development areas. Inequities are defined as systematic differences between population groups that are unfair and avoidable, and generally include disparities related to socio-economic position, gender, ethnic group and place of residence, among other factors.

Having a skilled attendant at delivery – a key intervention for improving maternal and neonatal health and survival – is among the most inequitably distributed health interventions. Figure 2.6 shows the average share of births attended by skilled health personnel, based on results from recent national surveys of low- and middle-income countries. There are marked inequalities between the regions of the world, with Europe and Central Asia showing the highest coverage levels for all income groups, and sub-Saharan Africa and South Asia in particular trailing well behind.

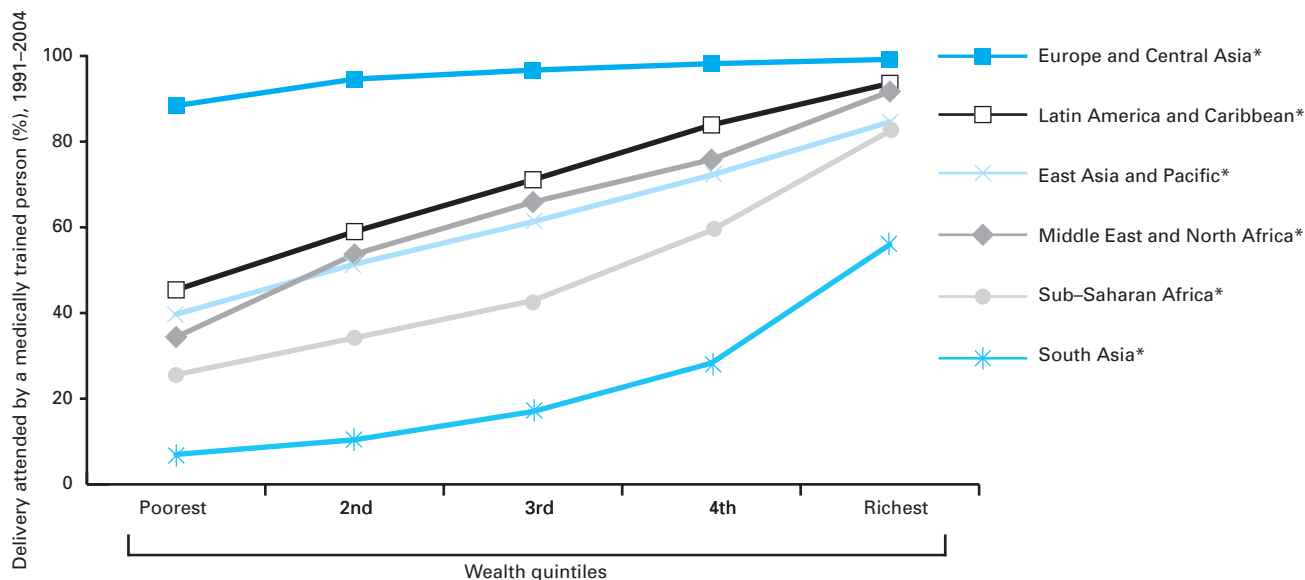
In addition to variations between regions, within each region there are important disparities by socio-economic position – as observed by comparing skilled attendance at delivery across income quintiles. Among the poorest 20 per cent of South Asian mothers, fewer than 10 per cent of births are delivered by a skilled attendant, compared to 56 per cent of births for

mothers from the richest income quintile in that region. The other developing regions exhibit similar disparities; even in Europe and Central Asia – where most countries with survey information are former socialist republics – the proportion of deliveries attended by skilled health personnel is significantly lower for the poorest women than for the most affluent.

Other measures of disparity in health-care provision are also pronounced. Urban mothers and children in developing countries tend to have greater access to health care and better health status than their rural counterparts. Socio-economic inequities are similarly marked within urban areas, where health conditions among slum dwellers are particularly adverse. Within countries, state and provincial differentials in maternal and child health are also often wide, as exemplified by the sharp variations in health indicators between Brazil's more prosperous southern states and its more impoverished north-eastern regions.

Poor mothers and children are underserved along the whole continuum of care. Data from several sub-Saharan African countries were used to document the proportion of mothers and children who received a package of four essential interventions: antenatal care, skilled attendance at delivery, post-natal care and childhood immunization. Coverage with all four interventions was two to six times higher – depending on the country – among the richest groups than it was in the poorest groups. This inequitable pattern of health-care

Figure 2.6
Mothers who received skilled attendance at delivery, by wealth quintile and region



* See References on page 108.

Source: Gwatkin, D. R., et al., *Socio-economic differences in health, nutrition, and population within developing countries: An overview*, Health, Nutrition and Population, World Bank, Washington, D.C., September 2007, pp. 123–124.

provision both reflects and entrenches the social exclusion faced by the poorest and the most marginalized groups and helps explain why maternal, neonatal and child mortality show such marked socio-economic variations.

Health systems have an important role in overcoming these disparities. Examples from across the developing world show that much can be, and is being, done to address and reduce disparities in access to essential services.

- In the *United Republic of Tanzania*, prioritizing interventions to combat diseases that affect poor mothers and children, and allocating district health budgets preferentially to these conditions, led to marked reductions in mortality.
- In *Peru*, the poorest departments (provinces) in the country are earmarked as the first to receive new vaccines; only after high coverage levels are reached in these districts are vaccines rolled out to the rest of the country.
- In *Bangladesh*, the Integrated Management of Childhood Illness (IMCI) strategy was systematically deployed in the poorest areas of the country; a similar strategy is employed by *Brazil's* Family Health Programme.

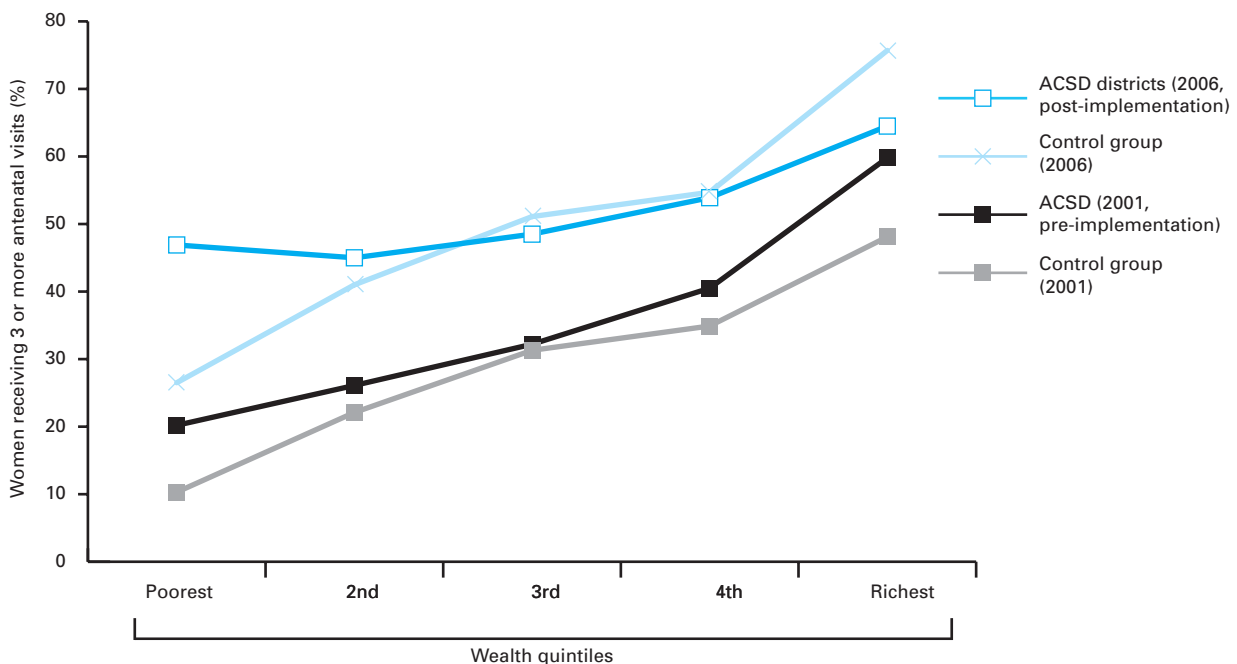
Because the poor are more likely to live in rural and remote areas, use of appropriate channels for reaching them with essential services should be a primary concern of the health

sector. Figure 2.7 shows how implementation of the Accelerated Child Survival and Development (ACSD) strategy has reduced inequities in access to antenatal care in Mali. Whereas both ACSD and control districts showed marked social disparities before the programme was deployed in 2001, five years later access to antenatal care was significantly more equitable in districts with ACSD than in the control areas. The ACSD strategy relied heavily on outreach initiatives aimed at improving access for rural mothers living in remote areas. This finding, however, was not replicated in other ACSD countries where outreach activities were not strongly implemented.

The reduction of inequalities in health is essential for the full achievement of human rights. Gaps in health-care provision contribute to the generation of these inequalities; consequently, health systems also play a role in their elimination. This is particularly true because the greatest gains in maternal, neonatal and child survival depend on effectively reaching the poorest and the most marginalized, who suffer the greatest burden of disease. There are many examples of successful initiatives that, when implemented with sufficient political support and adequate resources, have led to substantial reductions in health inequities. The main challenge for countries and societies is to disseminate these success stories, adopt best practices, and generate and sustain the political will to put equity at the top of the health agenda.

See References, page 108.

Figure 2.7 Women in Mali receiving three or more antenatal care visits, before and after the implementation of the Accelerated Child Survival and Development (ACSD) initiative



Source: Johns Hopkins University 2008.