

Disaggregating Progress towards Universal Health Care by region in Africa: Studying Inequalities in Maternal Health

Andrew Amos Channon, Sarah Neal, Sarah Carter

University of Southampton

As national and international policy makers seek to address the unfinished MDG agenda as well as develop new goals and indicators to guide development there has been growing demand to place universal health coverage (UHC) within a central position for such efforts. The World Health Organization (WHO) define UHC as all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for the services.

Ensuring universal access to maternal health care requires the provision of a continuum of care provided by a suitably trained health care provider. The majority of countries in sub-Saharan Africa have increased the percentage of women receiving antenatal care, skilled care at birth and postnatal care since 1990, but for many universal coverage is still a distant goal. Countries that have achieved high coverage of maternal health care from a relatively low baseline have progressed through a common pathway, whereby coverage has increased first among the urban rich, followed by the rural rich and the urban poor, with access among the rural poor being the last to be achieved (Channon et. al 2012). These inequities and the process by which they change over time are masked by indicators that measure overall population coverage for an intervention.

The Millennium Development Goals (MDGs) have been justly criticised for failing to take into account issues of equity when monitoring progress. There is strong commitment that equity is “hard-wired” into any Post MDG Goals and strategies. As part of this process the World Health Organisation and World Bank have proposed a framework for monitoring global progress towards UHC which includes an equity measure for MDG related interventions. Their target is that by 2030, all populations, independent of household income, expenditure or wealth, place of residence or gender, have at least 80% essential health services coverage. This study looks at current progress towards this goal for 21 countries in sub-Saharan Africa, but disaggregating progress by areas within countries, termed as regions in this study. This is to examine whether geographical progress within and between regions is equitable, an element that is often missed when headline country progress is used as the focus.

How great is the current gap between the poorest and richest?

Figure 1 shows the coverage level for births with a skilled birth attendant (SBA) at a country level for the poorest and richest groups based on selected Demographic and Household survey (DHS) data. While SBA coverage is very limited for all women in the poorest quintiles, with no countries attaining the 80% target, in the richest groups it is clear that in all countries, except Mali, Niger and Ethiopia, coverage is over the 80% threshold already.

Table 1 shows the average annual percentage rate of change in coverage for SBA that is needed for these countries to reach the 80% target, also broken down by wealth. In the full paper these will be further disaggregated by region. As it is an absolute rather than a relative target, the progress required by countries with currently poor coverage is far greater than for those who have already achieved higher coverage. To establish whether the rate of progress is greater than current trends table 2 presents the annual percentage change calculated for all country groupings based on trends from two DHS nine to 20 years apart.¹ As can be seen the poorest have made less progress than the rest of the population in all groups. The rate of change needed for the poorest groups is much greater than progress to date except in Cambodia and Indonesia, where all groups are expected to achieve the 80% target. However, further breaking this down by region indicates that in some areas

¹ The timescale for this calculation is uses the year of the most recent survey as the baseline

of these two countries the poor are lagging behind further with progress not at the rate required to reach the 80% target.

Fig. 1. SBA coverage for poorest and richest women for 21 African countries with DHS countries

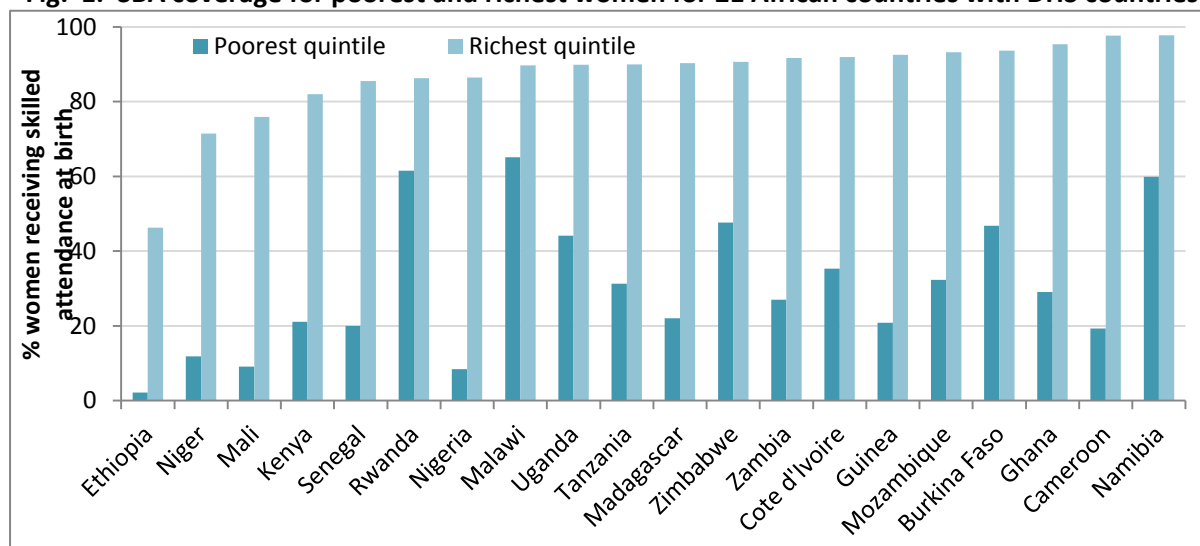


Table 1: Current percentage point increase in %SBA by country, with colours indicating whether the progress is quick enough to attain 80% coverage by 2030

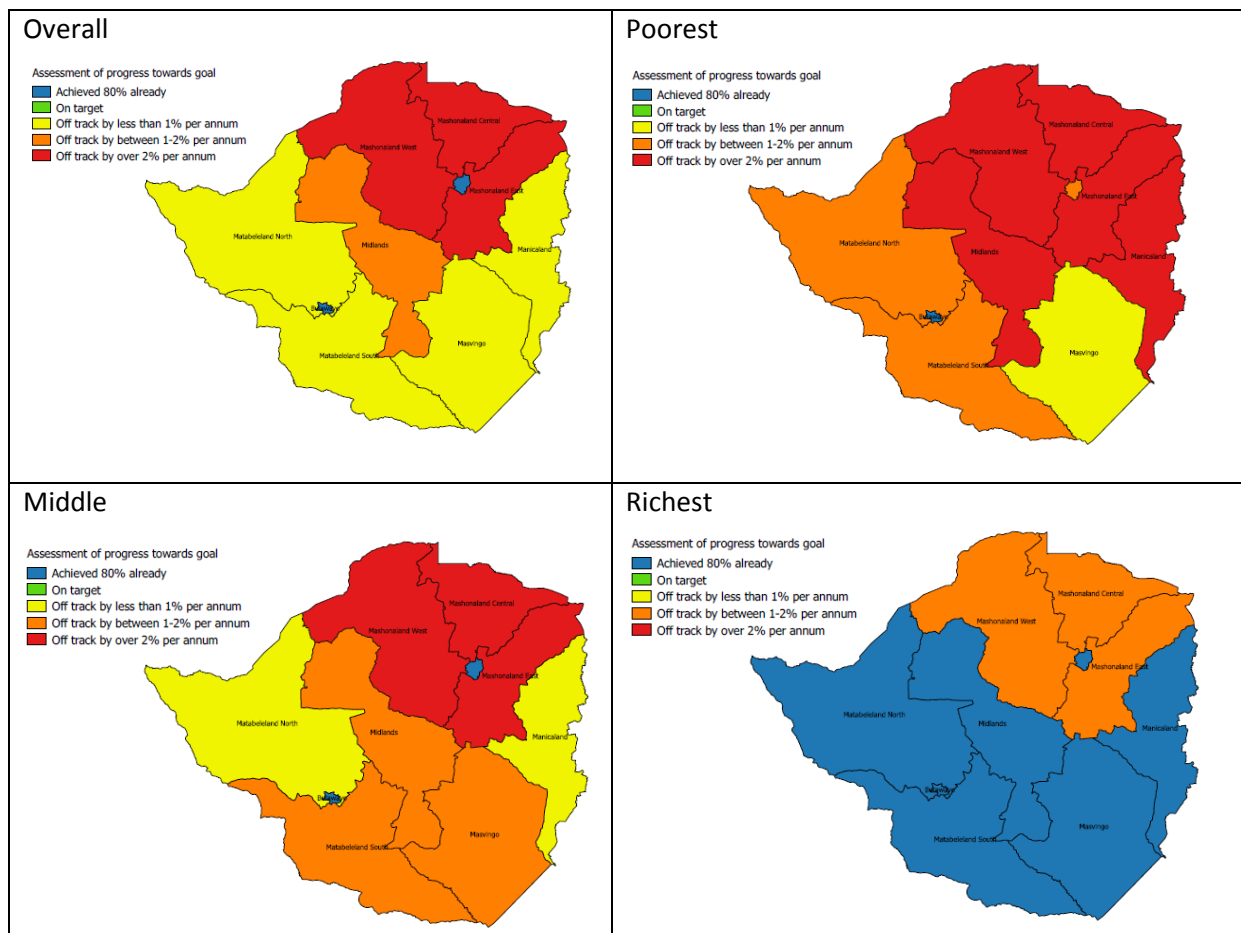
	Current % SBA	Overall	Poorest	Richest
Ethiopia	10.8	0.5	0.1	2.0
Mali	27.0	-1.1	0.0	-0.5
Niger	29.4	0.8	0.5	0.7
Nigeria	39.5	-0.4	-0.8	0.9
Madagascar	44.1	-0.3	-0.4	0.2
Kenya	44.3	0.0	-0.2	0.2
Zambia	46.6	0.0	0.6	0.0
Tanzania	49.2	0.5	0.4	0.6
Guinea	49.2	1.1	0.5	0.8
Senegal	50.5	-0.5	-0.6	-0.4
Mozambique	56.2	0.8	1.3	0.8
Uganda	59.3	1.9	2.2	1.0
Cote d'Ivoire	60.1	1.0	1.4	0.8
Ghana	61.6	1.7	0.7	1.1
Cameroon	64.2	0.4	-0.9	0.6
Zimbabwe	66.3	-0.6	-1.0	-0.3
Burkina Faso	67.4	2.8	2.2	1.4
Rwanda	69.3	4.2	4.6	2.6
Malawi	73.2	1.7	2.3	0.8
Namibia	81.6	0.9	0.6	0.4
Benin	84.4	1.3	1.9	0.1

Already attained target	On track	Up to 1% off track a year	Between 1 and 2% off track a year	Over 2% off track a year
-------------------------	----------	---------------------------	-----------------------------------	--------------------------

Progress by region – an example of Zimbabwe

The above results are for the overall country and by wealth quintiles. However it is known that there are large differences by location within countries. Due to space reasons only Zimbabwe will be discussed here, although in the full paper all countries will be discussed.

The maps below show the assessment of progress for the 10 regions of Zimbabwe. For each region specific wealth quintiles were generated, indicating relative wealth within each region, in order to highlight inequalities. The progress between 1999 and 2010 with respect to skilled birth attendance at birth is measured as percentage point increase per year (or decrease). This is combined with the required percentage point increase per year to obtain the 80% target, for each quintile. The maps below, for overall, poorest, middle and richest quintiles, indicate whether the current progress is enough or not to reach the target.



As can be seen, there is great variation across the country by region, and by quintile. Apart from the Northern regions (and Harare) the richest quintile have all achieved the 80% quintile. However, the poorest quintiles within each region have only achieved the 80% threshold in Bulawayo and Harare, with the other regions off track. This does indicate that location needs to be taken into account as well as wealth when assessing progress.

Is the 80% goal feasible for all?

The rate of progress needed for Bangladesh as a whole, and especially certain regions within the country, is challenging, but by no means unprecedented. The average annual increase required in the country is 2.8% to reach the target, while historically the improvements have been 1.3%.

However other countries and regions have shown it is possible. For instance, Cambodia has increased coverage overall at a rate of 6.9% per annum over 10 years. Those countries and regions where long term progress has been sustained could provide important guidance on how to scale up care to the poorest, although it is important that quality of care is also taken into account when assessing achievements. It is also important to note that for regions and indicators with higher coverage the 80% target may actually be unhelpful: it is not a challenging target, and therefore focus should be on reaching 100%. As the final group to be reached by services are often the rural poor in remote areas or those marginalised from mainstream health care provision in some other way strategies to reach the majority of the population may not be effective, and specific, targeted approaches may be needed for these particularly vulnerable groups.

One important characteristic of the 80% goal is that it is an absolute rather than a relative target: countries with the lowest coverage will need to make the most progress. These are countries where the infrastructure is weakest, and attempts to increase coverage of key MNH interventions will require health system strengthening and in particular a massive focus on developing a workforce that can provide an adequate level of care to women and their babies. This will require massive investment, and donors and national governments will need to ensure funding is adequately allocated and targeted.

Progress with equity: Can it be achieved?

A key question is whether progress to UHC for maternal health care services can be achieved without increasing existing inequalities. Channon et al. (2013) highlight that all countries in the past have experienced similar patterns in inequity on the road from low to high coverage of maternal health interventions – it is hypothesised that this pattern holds within regions too. However, what is clear is that some regions have transitioned more quickly through the patterns of inequitable access than others, and lessons can be learnt on how maternal health services can be developed in a way to minimise disparity. A number of writers (e.g. Gwatkin and Ergo, 2010) suggest that efforts to target interventions to the poorest can help in reducing inequities while moving towards UHC. Further analysis is needed on pro-poor approaches to developing maternal health services, and a comprehensive review of existing evidence as well as where relevant new research should be used to guide and develop policy.

References

Channon A, Neal S, Matthews Z and Falkingham J. 2012. *Maternal Health inequities over time: is there a common pathway?* Paper developed for “The World We Want” United Nations Thematic Global Consultation. <http://www.worldwewant2015.org/node/283339>

Frenz P, Delgado I, Kaufman J, and Harper S. Achieving effective universal health coverage with equity: evidence from Chile *Health Policy Plan*. First published online August 5, 2013
doi:10.1093/heapol/czt054

Gwatkin D. and A. Ergo (2010) Universal health coverage: friend or foe of health equity? *The Lancet*, Comment, Published online, November 16 2010

Kutzin, J. (2012) Anything goes on the path to universal health coverage? *Bulletin of the World Health Organisation* 2012, 90, 12 October 2012