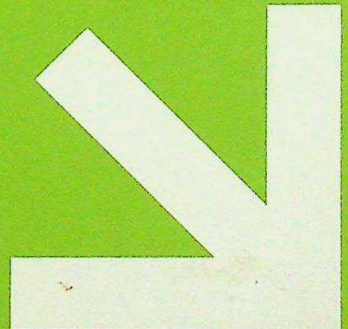


Targeting poverty and gender inequality to improve maternal health

Executive Summary

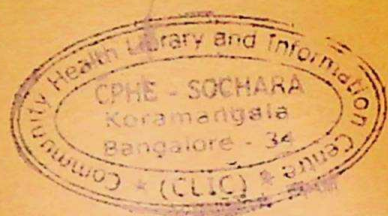
By Sílvia Paruzzolo, Rekha Mehra, Aslihan Kes, Charles Ashbaugh

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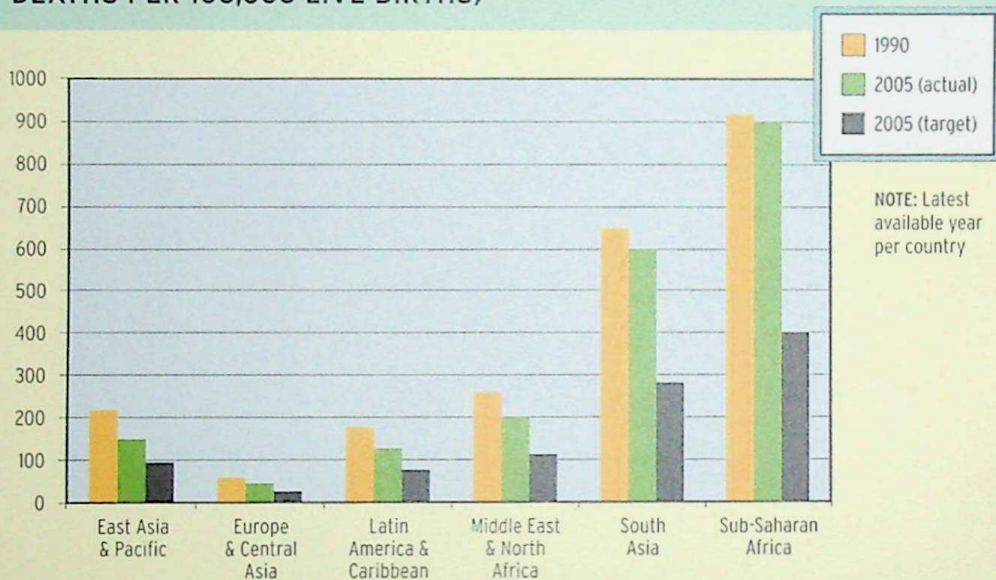




Introduction

Over half a million women die every year in childbirth or from pregnancy-related causes.¹ Virtually all (99%) of these maternal deaths occur in low-income countries.^{2,3} The lifetime risk of maternal death is 1 in 30,000 in Northern Europe as compared to a high of 1 in 6 in the poorest countries.⁴ For every woman who loses her life due to pregnancy, between 15 and 30 women suffer from life-long illness and disability.²

FIGURE 1: MATERNAL MORTALITY RATIO (MODELED ESTIMATE, DEATHS PER 100,000 LIVE BIRTHS)¹



In 2000, the UN General Council adopted “Improve Maternal Health” as Goal 5 of the Millennium Development Goals (MDG). Goal 5 has two targets: target a, to reduce the maternal mortality ratio (MMR) by three-quarters between 1990 and 2015; and target b, to achieve, by 2015, universal access to reproductive health. A decade into the MDG timeline, progress toward achieving the maternal health goal has been limited at best.¹ Despite a decline in the MMR of 2.5% globally from 1990 to 2005 and a slight drop in every region of the world,⁶ the gains are still too little (*see figure 1*).

The vast majority of maternal deaths (80%) are due to complications experienced by women during pregnancy, at delivery, or within six weeks post delivery.⁷ Significant reductions in maternal mortality could be achieved if health services were available to, and used by, all women during pregnancy, childbirth, and its immediate aftermath.

¹ Using a new methodology, Hogan et al.⁵ estimate global maternal mortality in 2008 at 342,900, a drop from the estimated 526,000 in 1980. While this shows global progress in meeting the MDG5 goal, only 23 of the 181 countries in the study are on track to achieve the target of 75% decrease by 2015. Maternal mortality continues to account for huge loss of life from preventable causes.

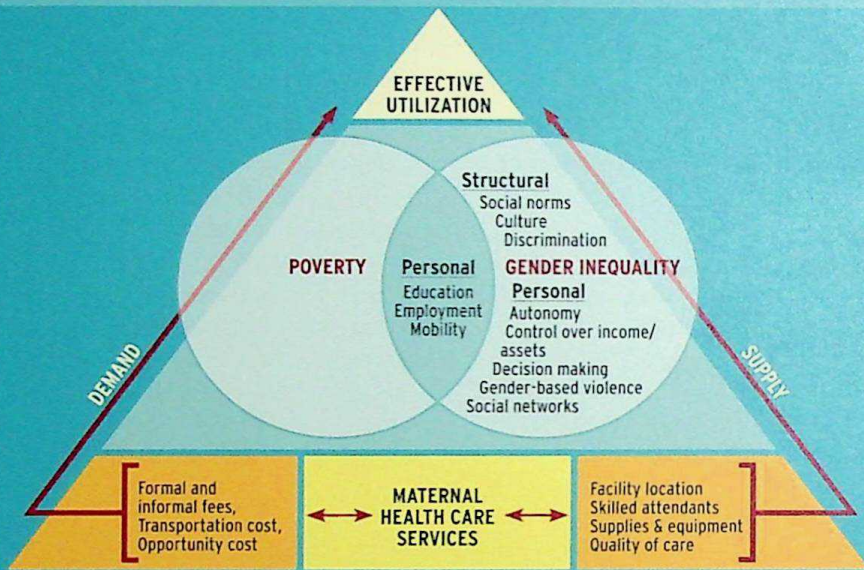
BOX 1: POLITICAL ACTION TO IMPROVE HEALTH CARE

In order to intensify efforts to meet the health-related MDGs and strengthen health systems in 49 of the poorest countries in the world, global leaders set up a Taskforce on Innovative International Financing for Health Systems in September 2008. Based on the recommendations made by the Taskforce, in September 2009, world leaders at the UN committed US \$5.3 billion in additional funding to improve health care around the world, focusing especially on women and children and building on the Global Consensus for Maternal, Newborn and Child Health. Countries such as Nepal, Malawi, Ghana, Liberia, and Sierra Leone pledged free access to health care. Overall, 10 million women and children are expected to benefit.⁹

However, to accomplish this goal, this paper argues that targeting both poverty and gender inequality, which affect the demand for, and supply of, maternal health care services, is essential. Such an approach is critical in order to maximize increased political will and greater investments to improve health care, including maternal health care (*see box 1*).

This paper examines the ways in which poverty and gender inequality pose significant barriers to maternal health care access and utilization, and thereby impact maternal mortality. It also presents key findings from an analysis of the effects of different strategies designed to increase utilization of maternal health care services. Different levels of effort are required to increase the availability and utilization of antenatal, delivery, and postnatal services. Most of the research and programming in maternal health care to date focuses on the first two levels of maternal health care while postnatal services receive somewhat lesser attention, and this is reflected in our analysis. A key part of the analysis looks at which outcomes were achieved and whether the benefits reached the poorest and most disempowered women.

FIGURE 2: WOMEN AT THE CENTER OF MATERNAL HEALTH CARE: DETERMINANTS OF AND BARRIERS TO UTILIZATION



Poverty and Gender Inequality Restrict Progress in Reducing Maternal Deaths

Figure 2 shows the demand- and supply-side factors affecting utilization of maternal health care. Poverty and gender inequality are shown in the center of the triangle that leads up to effective utilization because they act as barriers or filters and mediate an individual woman's ability to translate demand into effective utilization. The circles overlap because poverty is closely interlinked with gender inequality, although it can affect women at all socioeconomic levels. At the intersection of poverty and gender inequality lie education, employment, and mobility. Gender inequality is further determined by structural factors that include culture, social norms, and discrimination and other factors that affect women's ability to act on their own behalf, e.g., autonomy, decision making, control over income and assets, gender-based violence, and participation in social networks. Together, all these factors have an effect on women's empowerment or disempowerment and hence their ability to effectively use maternal health care.

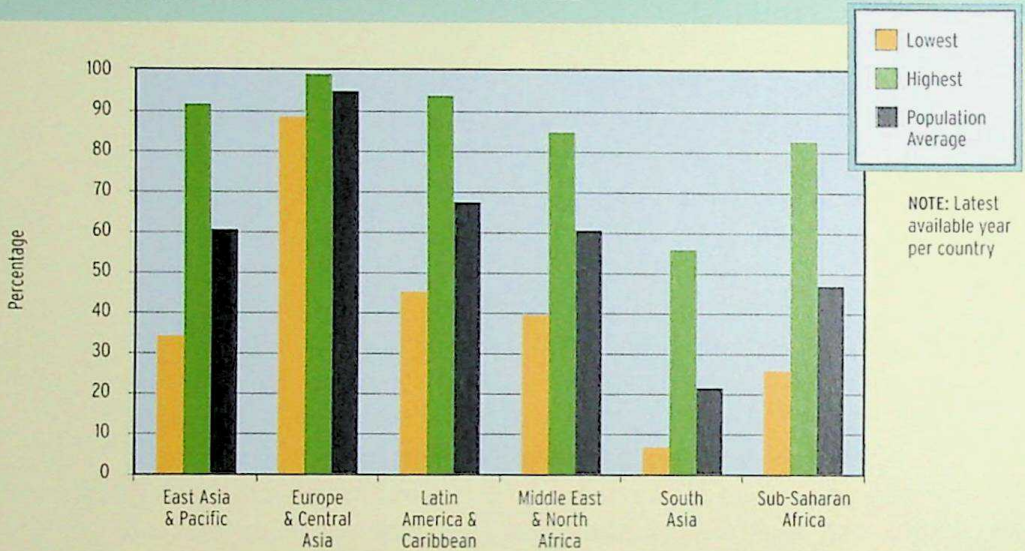
Poverty is a Key Determinant of Women's Use of Formal Maternal Health Care Services and Maternal Mortality.

A 55-country analysis of the Demographic and Health Survey (DHS) in the mid-1990s found that women in the richest quintile were 5.2 times more likely to give birth with a doctor, nurse, or midwife in attendance than the poorest quintile.⁹ As shown in figure 3a, data from the World Bank reveal similar disparities. In all regions except Europe and Central Asia, less than 50% of women in the lowest wealth quintile deliver with support from a medically trained person. Meanwhile, with the exception of South Asia, 80% or more of women in the highest wealth quintiles have their deliveries attended by trained personnel. On average, just about 22% of women in South Asia and less than half in Sub-Saharan Africa deliver with medically trained staff and, in the lowest income quintiles, just 7% do in South Asia and a quarter in Sub-Saharan Africa. Although coverage for antenatal care is generally at higher levels than attended deliveries in all regions, similar disparities exist between the richest and poorest quintiles (*see figure 3b*). Overall, the poorest women in the poorest regions of the world have the lowest maternal health care service access and use.¹⁰

There is emerging evidence of the link between poverty and maternal deaths in low- and middle-income countries. In Peru, for example, there is a six fold difference between the MMR among the richest and poorest income quintiles (800/100,000 vs. 130/100,000).⁴ In Indonesia, the risk of maternal death is around three to four times greater in the poorest than the richest group.¹¹ An analysis across 10 developing countries¹² reveals that the proportion of women dying of maternal causes increases consistently with increasing poverty.¹¹

ii The countries included in this study are Burkina Faso, Chad, Ethiopia, Indonesia, Kenya, Mali, Nepal, Peru, Philippines, and Tanzania.

FIGURE 3a: DELIVERY ATTENDED BY A MEDICALLY TRAINED PERSON BY INCOME QUINTILE¹²

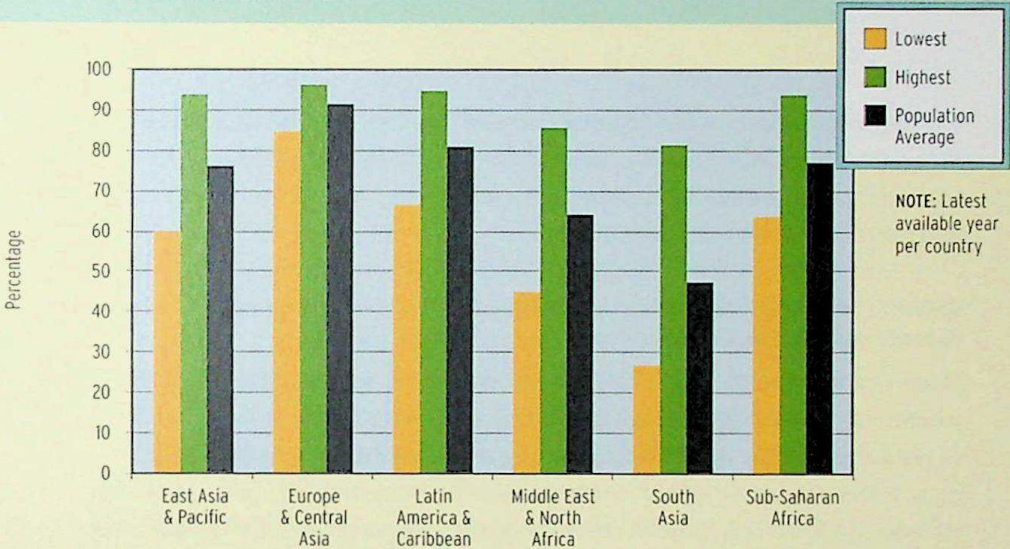


Costs are High, Unpredictable, and Possibly Catastrophic for the Poor and a Barrier to Utilization.

Costs include those for facilities and services and involve both formal and informal fees, the cost of drugs and equipment, transport to a hospital or clinic, and the opportunity cost of time lost in getting to a hospital or other health facility as well as in receiving care.¹³⁻¹⁵

Formal fees often take the form of user charges made at the time of service and are typically financed out of pocket. Such fees can be relatively high, even in public health facilities, especially for the poor. A recent study in Indonesia showed that facility-based costs alone could be as high as US \$200. For 68% of the study households in the poorest quintile, these costs amounted to over 40% of the households' disposable annual income, an amount deemed "catastrophic" by the authors.¹⁶ The costs of emergency care in the event of obstetric complications can be even higher. Thus for many poor women, costs can be prohibitively high and prevent them from receiving the maternal health care they need.¹⁵

FIGURE 3b: AT LEAST ONE ANTENATAL VISIT BY INCOME QUINTILE¹²



Informal fees are unofficial payments that may have to be made even where services are nominally free. They may be for supplies or given as incentives to staff to induce better care. Studies show that such costs can be high, often higher than formal charges. One study in Bangladesh showed actual charges for maternal care in Dhaka government hospitals—where services were ostensibly free—amounted to US \$32 for a normal delivery and US \$118 for a caesarean section.¹⁷ In one region of rural India, the poor pay almost as much for a visit to a “free” health clinic as for one to a private doctor.⁹

The cost of travel can be substantial and pose a significant barrier in many places. Studies in Tanzania and Nepal estimated transportation costs at 50% or more of the total costs of care.¹⁵ Studies from a variety of settings including the Philippines, Uganda, and Thailand show that distance had an adverse affect on women’s demand for facility-based deliveries.¹³ Transportation costs are high mainly because distances are great in the rural areas of low-income countries where the poor are concentrated, and road and transportation infrastructure are in such a poor state. Halving the distance to public health facilities in Ghana almost doubled utilization.⁹


The opportunity cost of seeking care can also be a more significant barrier for poor women, who cannot afford to take time off from their productive work and lack the means to pay someone to carry out these tasks while accessing maternal health care services.¹⁴

Gender Inequality is a Critical and Neglected Factor in Utilization of Maternal Health Care Services.

Deeply entrenched gender inequalities exist in many low-income countries where maternal deaths are high and health service utilization is low. The effects of gender inequality include relatively higher poverty among women than men, lower education, lack of autonomy and mobility, intimate partner violence, and, overall, lower social status and disempowerment.^{18,19} Gender inequalities, like race, religion, and ethnicity in some contexts, go beyond class differences.²⁰ They are often defined and perpetuated by social norms and culture, and reflect differences in power between men and women both within the household and in the wider society.^{20,21}

Such norms are particularly harmful for young women as they place them at the bottom of the family and social hierarchy. These norms may dictate early marriage for girls. Globally, around 17 million young women are married before the age of 20 and a majority of these marriages take place in low-income countries.²² Early marriage often leads to early child bearing and high total fertility, both of which are linked to higher risk of maternal mortality and morbidity.²²⁻²⁴ In fact, it is estimated that between 25% to 50% of all young women in low-income countries give birth before they turn 18.²²

Gender inequality and women's low social status and disempowerment have significant impact on women's health, maternal health, and overall demand for maternal health care services.²⁴ A study in Bangladesh showed that the probability of seeking any type of health care was 1.73 times greater among men than women.²⁵ Women's and girls' limited access to education deprives them of the knowledge and tools to make informed health decisions.^{18,20}

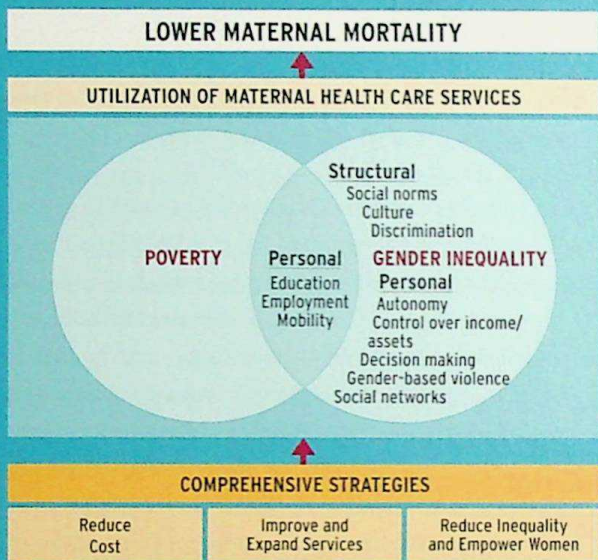


In many conservative communities, cultural and social norms restrict women's mobility and prevent them from seeking health care.^{13;26;27}

Other family members may consider childbirth as a woman's concern and not that of the household. As a result, women may find it difficult to get the money to pay for services or to obtain transport to get to medical care. In Bangladesh, where access to preventative and curative care by most women is low, women are economically dependent on their husbands who may be unwilling to pay for care.²⁸ In Indonesia, researchers found that the wife's share of household assets (an indicator of power relations between the spouses) affected use of antenatal care.²⁹ While women who had no stake in household assets were found to be at a disadvantage in terms of health care decision making, small increases in their ownership had a substantial impact on uptake of maternal health care services. Owning assets made women more likely to use antenatal care and deliver in a hospital or private doctor's office.

While it is critical for policies and programs to improve and expand services, as well as reduce the burden of cost for low-income women, these actions alone may not be sufficient to guarantee access to maternal health care. Gender inequality may still limit access and prevent women from utilizing services. Therefore, efforts to improve maternal health care utilization and outcomes must also find ways to empower women and overcome gender inequality.^{20;24} While not all such efforts may be within the purview of health care programs, it is important to discover those that are and to act on them, as well as to advocate for investments that improve women's overall status. Moreover, there is a need for more systematic research that better elucidates the factors contributing to women's disempowerment and their links to utilization of maternal health care. And finally, it is important to include gender indicators as part of assessments of health and development policies and programs focused on improving maternal health care utilization.

FIGURE 4: WOMEN AT THE CENTER OF MATERNAL HEALTH CARE: REMOVING BARRIERS TO UTILIZATION



Strategies to Increase Utilization of Maternal Health Care Services: How Well Do They Address Poverty and Gender Inequality?

As described above, a mix of economic and gender-related factors shape women's health-seeking behavior, their demand for various maternal health care services, and their ability to access and utilize services. On the supply side, delivery of services is shaped by financial, physical, and human resources to provide sustained, high quality, accessible, and affordable care.^{9,13}

Figure 4 shows the kinds of broad strategies needed to address and help women overcome the barriers posed by poverty and gender inequality in order to increase utilization. Because of the importance of poverty in deterring use, a wide variety of strategies have been designed and implemented to reduce the burden of cost. These strategies range from the removal of user fees to the provision of conditional or unconditional cash transfers. A different set of strategies on the supply side to improve and expand services have been



designed to increase utilization. They include provider incentives based on performance and contracting private organizations to provide maternal health services. Also needed, but much less common except for some community-based and participatory programs, are strategies that empower women to become active health care consumers. This paper argues for integrating all these mechanisms into comprehensive strategies for addressing poverty and gender inequality, thereby enabling poor and disempowered women to benefit from the provision of good quality maternal health care services.

This section analyzes key results from selected program evaluations. Although the focus is on rigorously evaluated programs, a few less rigorous studies are also included because they provide the only evidence available on some of the issues of interest. The analysis below presents relevant findings discussed by the authors of the published papers and reports, including—wherever possible—the extent to which the mechanisms addressed poverty and gender inequality and whether they benefited poor and disempowered women.

The review is thus not exhaustive but rather highlights a variety of recent impact evaluations conducted in low- and middle-income countries as the basis for assessing the field and for informing future directions.

Reducing the Burden of Cost

When introduced 20 years ago, user fees were expected to improve effectiveness, efficiency, and equity.³⁰ Yet, a substantial body of literature shows that they did not deliver as expected, disadvantaged the poorest women, and magnified poor-rich gaps in maternal health care use and outcomes.³⁰ Waivers and exemptions for the poor also did not help because, along with other reasons, they were difficult to administer. Recent reforms have, therefore, focused on removing user fees for all.²¹ Provision of free maternal health care is one of the five key action items in the Global Consensus for Maternal, Newborn and Child Health, and some countries have pledged free access to health care (*see box 1*).

Removing User Fees Can Increase Demand Among Low-income Women. This Increased Demand and Sustainable Financing Requires Careful Planning.

Many low- and middle-income countries have recently removed user fees to increase uptake. Results show that this can have a positive impact on utilization of maternal health care services and, in some cases, among the poorest (*see box 2*). Removal of fees in Niger in 2006 doubled antenatal visits; in Burundi, births in hospitals rose 61% and the number of cesarean sections increased 80%; in rural Zambia, utilization rates in government facilities increased by 50% and proportionally more among the poor with no reported decline in the quality of care.³¹ In Uganda, removal of health user fees in public facilities increased use of hospital services by 84% and the increase was greatest among the poorest.³²

BOX 2: REMOVING USER FEES: FINDINGS FROM GHANA

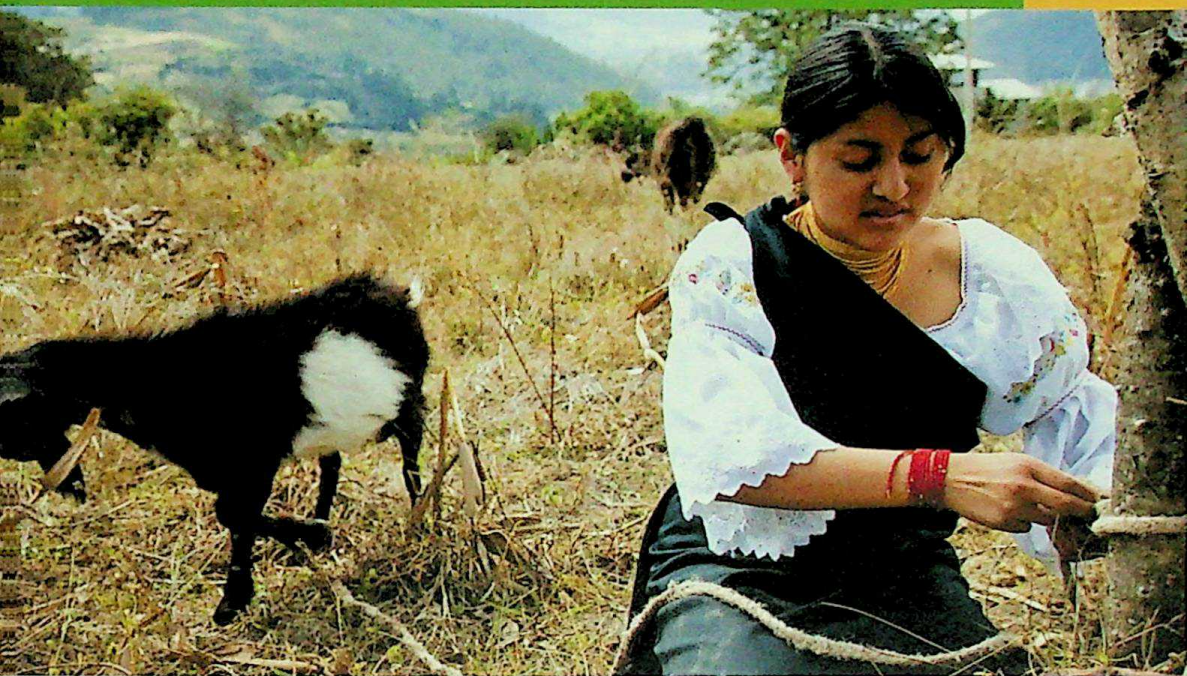
In 2004, Ghana instituted a national policy to exempt women from paying for deliveries in public and private health facilities. An evaluation of the program found that the exemptions were cost effective and that equity issues were effectively addressed—there was a significant increase in facility-based deliveries among the third and fourth poorest quintiles. Out-of-pocket spending relative to income was lowered, although more so among richer households. The proportion of households falling into poverty due to catastrophic out-of-pocket delivery payments dropped from 2.3% to 1.3%.³³

But removal of user fees can result in unintended negative consequences, including increases in demand that overburden existing health care systems and jeopardize the quality of care provided.^{34;35} Furthermore, it may result in a surge in unofficial payments to provide incentives to staff, obtain better service, and pay for basic supplies that are otherwise lacking at the provider level.¹⁵

These experiences suggest that while removal of user fees can improve access among the poorest in some cases, the process also requires careful planning to mitigate unintended negative consequences and to enhance efficiency and effectiveness of health systems. Health systems should be prepared for the higher demand for services and ensure adequate levels of staffing, availability of drugs and medical supplies, and, overall, greater financial resources for these purposes from governments and donors and exploration of alternate mechanisms for financing them sustainably and equitably.^{30;34;36}



Among alternative health financing mechanisms, tax-based financing is viewed by many as the ideal but, in many low-income countries, the lack of a large tax base and effective tax collection systems limits the usefulness of this mechanism.^{9,37,38} Social insurance generally distributes the burden of health financing between employees and enterprises and allows public funds to be channeled to subsidizing premiums for the poor.^{37,39} Among its limitations in low-income countries is its ineffectiveness in reaching the unemployed, self-employed, and those in the rural and informal sectors.^{15,37,39} The relatively new model of community-based health insurance can be effective in reaching these populations^{38,40} but to date remains limited in scale. Less than 0.2% of the population in Africa is covered by such programs⁴¹ and people still pay for services out of pocket. Where they have been successful, community-based insurance schemes are not small-scale programs but are an integral part of national health systems.³⁵



Providing Subsidies to Targeted Populations has the Potential to Increase Access and Utilization of Maternal Health Care Services by Poor Women.

A program that offered vouchers to pregnant women to offset costs for antenatal care and delivery in a health center or hospital (e.g., user fees, transportation costs) was evaluated in three districts in Cambodia.⁴² The study found that the vouchers improved access to antenatal care and safe delivery for poor pregnant women. Over a 12-month period, the number of facility deliveries increased and the number of voucher beneficiaries increased also, without a decrease in the number of self-paying deliveries. Thus the vouchers resulted in additional poor pregnant women delivering in public health facilities. However, not all eligible poor women were reached and not all of the vouchers distributed for deliveries were used. Reasons for non-use of vouchers included dissatisfaction with health center staff, perceived difficulty in finding transportation in the middle of the night, concern about whether the subsidy would fully cover transportation from remote areas, and the lack of people at

home to take care of the household. Overall, vouchers may work best when demand is predictable and when they are combined with social marketing to increase awareness and encourage use.⁹


Providing Conditional Cash Transfers Increases the Demand for Maternal Health Care Services and Has the Potential to Empower Women to Become More Active Health Care Consumers.

Results from an experiment in Mexico suggest that providing cash to women, conditioned upon specific behaviors, such as attending classes on maternal health care and/or accessing maternal health care services, increases the use of certain services. In the case of *Oportunidades*, introduced in 1997, cash transfers were paid to poor rural women conditional on obtaining health care and nutritional supplements and participating in health education sessions.⁴³ The results from the evaluation showed that beneficiaries accessed more antenatal visits than non-beneficiaries. Additionally, the quality of services (based on the percentage of procedures received during the visits) was significantly higher for beneficiaries. The authors believe that the difference in quality was due to the empowerment of the women beneficiaries as a result of the education requirement of the program. During the education sessions, women learned what they should expect from maternal health care visits and were encouraged to be more active health care consumers.⁴⁴

Improving and Expanding Services

Training and Posting Skilled Community-based Attendants Can Increase Coverage Among the Poor in Remote Areas.

In 1989, Indonesia launched a national program to increase professional delivery care to the poorest women. By 1996, *Bidan Di Desa* (the Village Midwife Program) had trained and posted more than 50,000 midwives throughout the country. Research showed that overall the use of professional attendants during delivery increased among the poorest quintiles and those



living in rural areas.^{45,46} However, access and use by the poor was not always uniform; in some areas, the midwives tended to supplement the income they received from the program through private fees, which disproportionately impacted negatively on service utilization by poorer women. Decentralizing the availability of skilled attendants and bringing services closer to low-income populations had a significant impact on access and use overall. But complementary measures like cash transfers or vouchers may be needed to ensure that the very poor have access to services even in places where health care providers might charge fees.

Providing Incentives to Improve Providers' Behaviors Can Increase Uptake of Maternal Health Care Services, Yet for the Poorest Women to Be Reached Special Efforts May Be Needed.

Rwanda implemented and evaluated a pay for performance scheme from 2006 to 2008 in which providers received bonuses conditional upon the quantity and quality of maternal health care services provided.⁴⁷ While there was a significant increase in the number of pregnant women receiving a tetanus vaccination at antenatal care and delivering in an institution, there was no impact on the likelihood of women seeking antenatal care. One reason for this difference may be the level of financial incentives provided; less significant changes occurred for the services with lower financial incentives (e.g., US \$0.09 for an antenatal visit vs. US \$4.59 for an institutional delivery). Given the high return for institutional deliveries, some providers enlisted community health workers to conduct outreach to women to deliver in a facility. Unfortunately, the study report did not indicate whether the program benefited the poorest women. The study suggests that for uptake of services that are highly dependent on women's behaviors, financial incentives for facility-based providers alone may not be enough. Instead, incentives should also be considered for the clients and for community health workers to find and encourage women to use the health facilities. The *Janani Suraksha Yojana*, a central government program in India, has incorporated these incentives in its design (see box 3).

BOX 3: THE JANANI SURAKSHA YOJANA PROGRAM (JSY) IN INDIA

The JSY program in India was launched in 2005 under the umbrella of the National Rural Health Mission and as part of the Reproductive and Child Health Program Phase II. Main features of the program are cash payments to pregnant women and community health workers for institutional deliveries, careful targeting, the use of community health workers as a link between the government and pregnant women, and partnering with the private sector to ensure full coverage of the increased demand for services.

In particular, the targeting is carefully designed so that eligibility to receive the benefits as well as the amount of the cash incentive depends primarily on geographic location, level of poverty, caste, and ethnicity. The program provides benefits to all pregnant women in states with low institutional delivery rates and targets the most vulnerableⁱⁱⁱ in states with higher institutional delivery rates. Also, the amount of cash received in the rural areas is higher than in the urban areas. Community health workers receive benefits in the most vulnerable parts of the country if they identify pregnant women, encourage institutional delivery, provide a postnatal care visit, and arrange to immunize the newborn up to the age of ten weeks. While the scheme is meant to promote and increase the demand for institutional delivery, it is also designed to increase the supply of services by ensuring an adequate number of around-the-clock delivery services and by subsidizing the cost of private sector specialists for emergency care if not available at the government health facility.

Source: http://mohfw.nic.in/janani_suraksha_yojana.htm

iii Women are classified as most vulnerable either if below the poverty line (BPL) or of scheduled caste or tribe and eligible for the program only if they are 19 years of age and older and giving birth to their first or second child.

Additionally, provider incentives may be more effective in reducing income inequalities if higher amounts are awarded for increases in utilization among the poorest women.

Contracting Private Organizations to Deliver Maternal Health Care Services Can Increase Use by Poor Women, But Attention Must be Paid to the Quality of Services Provided.

A 2001 study in Cambodia found that in districts in which non-governmental organizations (NGOs) received public monies for delivering and managing maternal health care services, there was a much greater increase after 2 ½ years in antenatal care, tetanus immunization coverage, and in facility-based deliveries compared to control districts where public services were run by the government.⁴⁸ Of particular interest was that among households with low socioeconomic status, women's use of services in the contracted-out districts increased and out-of-pocket payments for health care decreased. One reason for this difference is that the NGOs, perhaps through greater efficiencies, did not charge user fees, whereas in the control districts, clients were charged user fees and other under-the-table fees.

Improving and Expanding Service Provision While Covering the Cost for the Poor

Partnering with Private Providers Can Reduce Supply Shortages, and, When Accompanied by Targeted Cost Subsidies, Can Substantially Benefit the Poor.

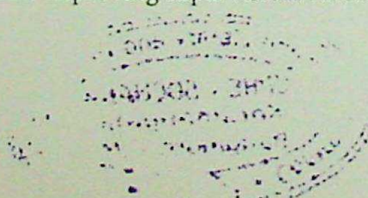
An interesting example of a program that combined demand- and supply-side strategies is the *Chiranjeevi Yojana (Long Lives to Mothers)* scheme implemented and evaluated as a pilot in a few districts in Gujarat, India, in 2005, and scaled up to the whole state in 2007.⁴⁹ The objective of the program was to improve rates of institutional delivery by simultaneously: i) increasing the supply of services accessible to poor women by paying private providers a



fixed rate for deliveries and ii) reducing the costs to families by covering some out-of-pocket costs. The scheme is not completely free as participants had to pay for medicines and some transportation costs, and not all eligible families participated. Still, the program was successful in targeting and reaching the poor in a context where acceptability of private care providers was already high. The total average cost of a delivery for program participants was only 22% of that incurred by non-participants.

Strengthening Health Care Systems and Mobilizing and Educating Communities Can Increase Institutional Deliveries, Particularly Among the Poorest.

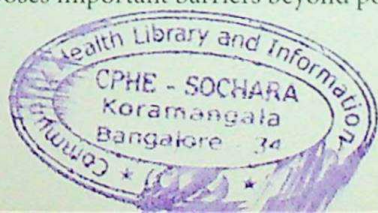
The *Skilled Care Initiative (SCI)* implemented by the Ministry of Health and Family Care International in Burkina Faso between 2003 and 2006 simultaneously addressed supply- and demand-side barriers.⁵⁰ Specifically, the program strengthened services through training providers, providing medical equipment and supplies, and improving supervision. At the community level,



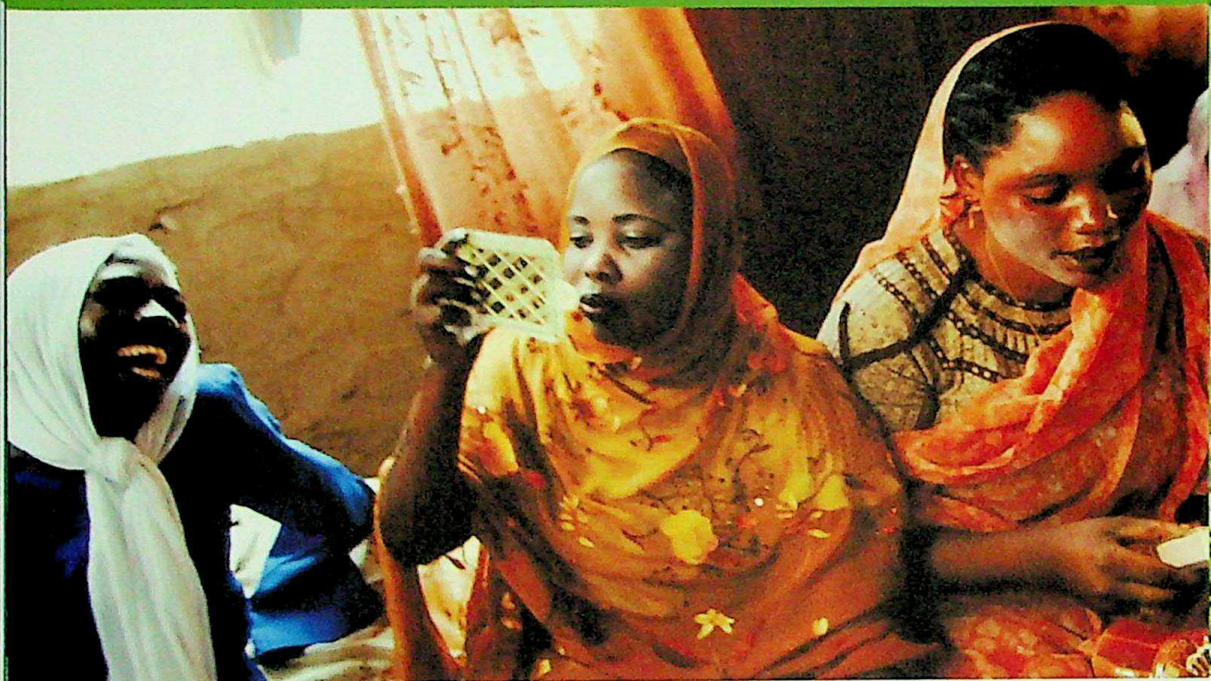


the program fostered demand through community mobilization, education, advocacy, and social marketing. A study of the program found both that the proportion of facility-based births increased much more substantially in the SCI district compared to the non-SCI district and that increases were largest among the very poor. While the study could not isolate which aspects of the program had the greatest impact, combining community outreach with institutional strengthening potentially had a synergistic effect in increasing facility-based deliveries. The authors note that this is one of the few examples of a maternal health care intervention that was able to both increase the overall use of maternal health services and reduce the disparities in use between rich and poor.

The discussion thus far has focused on specific strategies that lower the cost burden for users and those that expand and enhance services. If these strategies address gender inequality at all, they do so in a limited way. As gender inequality poses important barriers beyond poverty, it is necessary



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to obtain a better understanding of how reducing gender inequality and empowering women can affect women's utilization of services. This information will be critical to designing better comprehensive strategies that are even more effective.

Reducing Gender Inequality and Empowering Women for Better Maternal Health

Women's education is especially effective in improving utilization of maternal health services, and the literature on this issue is extensive. Evidence on the links between utilization and other empowerment factors such as employment, autonomy, and decision making is neither as clear nor as extensive, but, because they are so important in limiting utilization, they are worth investigating further and more systematically. Meanwhile, programs that foster women's active participation in addressing health care challenges are offering new insights into how to improve maternal health care.

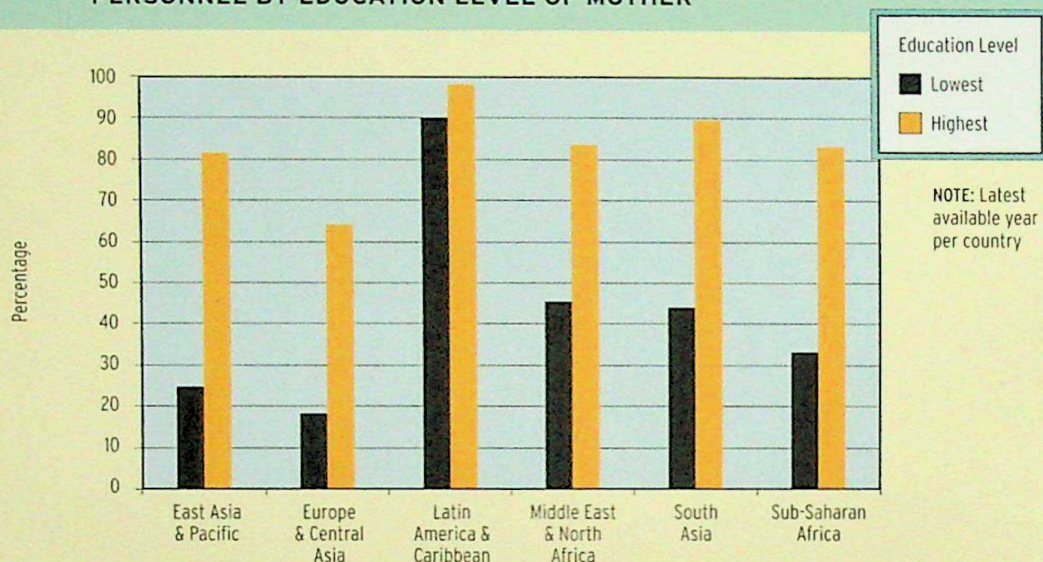


Women's Education and Employment Increase Utilization of Maternal Health Care Services.


Many studies show that women's education increases the use of maternal health services independent of a number of other factors.^{10;29;51-55} Educated women are more likely than uneducated women to use antenatal, delivery, and postnatal care.¹⁰ As shown in figure 5, in 49 out of 62 countries with data, the difference between the deliveries attended by skilled health personnel for women with the highest and the lowest education levels was 30 percentage points or higher. Improvements in secondary education for girls may be even more effective than primary education and is especially important in countries where girls face great discrimination and son preference.¹³

If women are employed, can earn, and can control the income they earn and accumulate assets, they are better able to purchase health care services themselves. They are less dependent on spouses and other members of their households and better able to make their own decisions about health. In fact,

FIGURE 5: BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL BY EDUCATION LEVEL OF MOTHER⁵⁶



the evidence suggests that women's employment has a positive effect on maternal health and is associated with reduced maternal mortality and morbidity.¹⁰ In contrast, unemployed women were four times as likely to die from causes related to pregnancy and childbirth than those who were employed.¹⁰ Simkhada et al.⁵³ found women's paid employment to be a statistically significant factor in use of antenatal care in 7 of 28 studies they reviewed. Studies in Nigeria and the Philippines showed that women working as civil servants or white collar workers used antenatal care services more than housewives and the unemployed. However, much less research has been done on the links between employment and maternal health than on the links with education, and this knowledge gap needs to be filled.



Evidence on the Links Between Maternal Health and Other Dimensions of Empowerment is Limited, and Much More Research is Needed.

Some studies cite the importance of factors such as mobility, autonomy, and control over decision making in utilization of health care services. Seven studies were found published since 2000 on this topic in Asian countries—three in India, two in Nepal and one each in Indonesia and Pakistan.^{29;54;57-61} Dimensions of autonomy examined varied greatly between studies and included asset ownership, financial autonomy, decision making power in the household, and freedom of movement. Conclusions also differed: four studies found women's autonomy to be positively and significantly associated with use of antenatal care, three did not. Of the four studies that looked at the effects of autonomy on institutional or trained attendant delivery, all found a positive association. Disaggregating further, Mistry et al.⁵⁴ found women's financial autonomy had a positive association with institutional and attended delivery, while decision making was not a significant factor. Overall, systematic research in this area of women's empowerment is even scarcer than on the links between employment and maternal health.

There is a critical need for more and better research on how assets, employment, women's autonomy, and decision making power affect both use of maternal health services and maternal health status. Greater consistency is also needed in what goes into defining autonomy, mobility, and decision making and how these variables are constructed. Also needed is evidence on whether and how intra-household gender power relations affect women's use of maternal health care services. Fortunately, data for such research are now available in the household characteristics module of the DHS surveys that ask women about their utilization of maternal care services, education, employment/occupation, and land and house ownership as well as who makes decisions at home, both financial and others. They should be used.


Engaging Women in Participatory Processes and Promoting Social Networking through Women's Groups Can Foster Greater Utilization of Maternal Health Care Services.

A low-cost, culturally acceptable participatory intervention in rural Nepal engaged women in solving their health care problems and fostered the adoption of positive health care behaviors.⁶² The program selected and trained local women to organize and facilitate participatory meetings with groups of poor women to discuss neonatal and maternal health care problems, identify strategies, and mobilize groups to take action. Examples of strategies include the collection of community funds for maternal and infant care and the production and distribution of safe delivery kits. Health care strengthening activities, such as training health workers and equipping facilities with adequate supplies, were implemented in both control and intervention areas; thus the study was able to isolate the effects of the participatory intervention. In addition to lower neonatal mortality, the intervention area demonstrated greater increases in antenatal care, institutional deliveries, and births attended by a skilled professional than the control area. Recent literature emphasizes the importance of relationships such as those created in women's groups to bring about changes that are empowering, including growth in self-confidence, capabilities, and collective action.^{63;64}

Strengthening Maternal Health Care Systems: Conclusions and Recommendations

While it is critical for policies and programs to improve and expand services, as well as reduce the burden of cost for low-income women, these actions alone may not be sufficient to guarantee access to maternal health care by the poorest and most disempowered women.

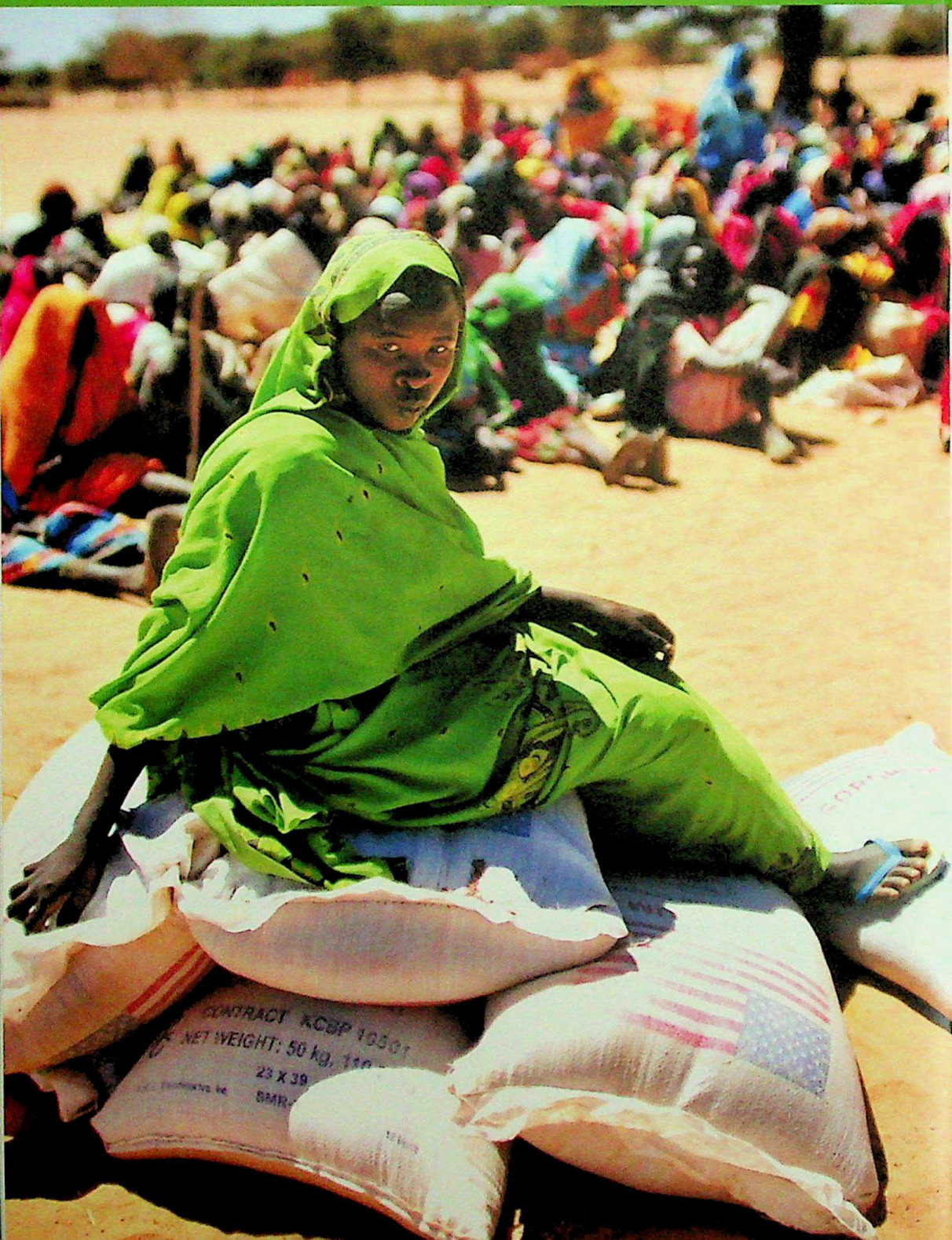
Poverty and gender inequalities pose significant barriers to maternal health care access and utilization, which has disastrous consequences for women,



and ultimately their families and communities. Yet low access and use of maternal health care, especially among the poor and remote populations, can be addressed by strategies that improve the coverage and quality of services, and that increase the active demand for services by women. This paper recommends a holistic approach that addresses both sides and positions women's needs and realities as the central drivers of policies and programs to increase maternal health care access and utilization.

As shown in this review, a number of new facility- and community-based mechanisms that go beyond the removal of user fees have shown promise in the field in increasing utilization of maternal health care services and in some cases have also successfully reached the very poor. These need to be strengthened and expanded. Yet, even when the provision of maternal health care reaches and is affordable for remote and poor populations, strategies that reduce gender inequality through education and employment and that empower women through social support, networking, and participatory learning and action are also needed.

Inequity is a multidimensional concept. Women's low social status and disempowerment represent a critical dimension of inequities in access and utilization of maternal health care that is overlooked in program design and consequently in program evaluation. More rigorous evaluations that use both qualitative and quantitative methods should be conducted to identify and measure different determinants of inequity and impact among different populations. It is important to detect differences in uptake among the poorest women, and among the ones that are most disempowered, to really understand whether and how maternal health care programs are addressing poverty and gender inequality and how to design them to more effectively achieve the desired impact.



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