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Inequalities in Women's and Girls' Health Opportunities and Outcomes. A Report from Sub-Saharan Africa

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BACKGROUND

The Millennium Development Goal 5 (to improve maternal health) was not achieved by the majority of sub-Saharan Africa (SSA) countries. Women in SSA account for two thirds –201,000 deaths in 2015[1] – of total maternal deaths in the world. Despite progress for all maternal, newborn and child health interventions, substantial disparity remains in coverage levels of essential interventions between and within countries. As a result, the most disadvantaged women are not reached. The Sustainable Development Goals (SDGs) offer a new opportunity to reverse this unjust and avoidable situation. However, further progress in improving women's and adolescents' health and well-being can only be made by reducing inequalities, a pre-requisite to leave no woman or girl behind.

THE HUMAN OPPORTUNITY INDEX

When services are scarce, individuals' chances to access them are influenced by their circumstances, which in turn produce inequalities in access to opportunities between groups differentiated by characteristics such as geographic location, wealth status, education levels, and family structure, among others. In this context, the **Human Opportunity Index (HOI)** measures the coverage rate of an opportunity, discounted by inequality in its distribution across circumstance groups.

OPPORTUNITIES The minimum set of essential goods and services that enable individuals to realise their human potential.
CIRCUMSTANCES The economic and social attributes of the individual and his/her family.
D-INDEX (or dissimilarity index) The share of opportunities (the coverage) that is misallocated in favour of some groups (defined by circumstances) over others.

In other words, it is a composite indicator that measures how many opportunities (i.e. services and health outcomes) are available (coverage rate) and how equitably those opportunities are distributed across people with different circumstances (D-index).

The HOI can be disaggregated allowing ascertainment of which circumstances are generating the highest inequalities between groups of individuals.

THE REPORT AT A GLANCE

The **inequalities in women's and girls' health opportunities and outcomes** report uses the most recent data available[2] to analyse 15 health opportunities for women of reproductive age (15-49 years), including two subgroups: pregnant women and older adolescent girls (15-19 years), within and across 29 SSA countries[3].

Both individual country analysis and analysis for the region as a whole (multi-country pooled analysis) have been performed.

The introduction of new metrics, such as the HOI, into the study of maternal and reproductive health allows new understanding of the constraints and opportunities to achieving equity in maternal and reproductive health.

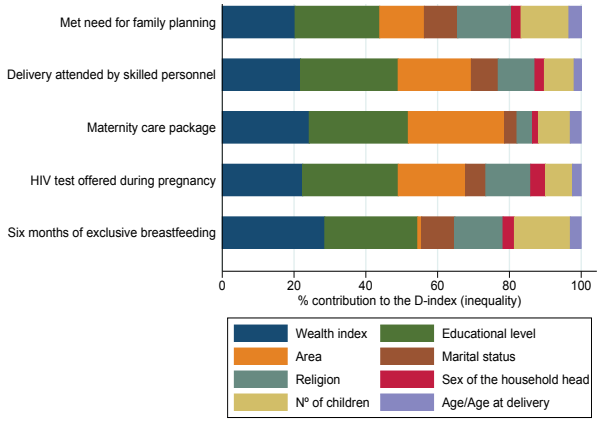
FINDINGS: WOMEN OF REPRODUCTIVE AGE (15-49 YEARS OLD) AND PREGNANT WOMEN

OPPORTUNITIES

Not having anaemia
BMI between 18.5 and 24.99
Met need for family planning
Knowledge of where to get an HIV test
Four antenatal care visits
Delivery attended by skilled personnel
Postnatal checkup
Maternity care package
Malaria prophylaxis during pregnancy
HIV test offered during pregnancy
Infant checkup after delivery
Six months of exclusive breastfeeding

- On average, there are marked inequalities both at country level and across countries for most opportunities. The most unevenly distributed were the reproductive and maternal health opportunities analysed (for example "met need for family planning", "delivery attended by skilled personnel"), while "not having anaemia" and "exclusive breastfeeding" are the more egalitarian (Figure 4).
- On average, **wealth** and related circumstances such as **education** and **area of residence** are the main sources of inequality for women of reproductive age health opportunities at country level in SSA.

Figure 1. Multi-country pooled analysis for women of reproductive age and pregnant women: circumstances' contributions to the D-index

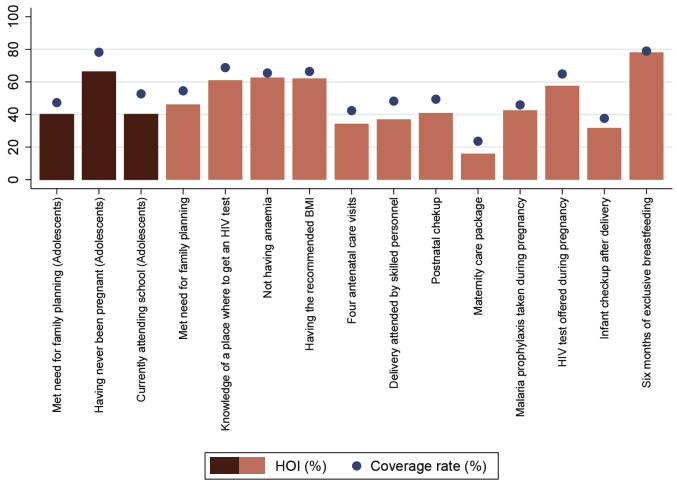


- In the multi-country pooled analysis, a more prominent role of religion and a reduced contribution of wealth are observed for some variables. Religious groups distribution within and across countries combined with other factors could lead to these results.

[1] WHO, UNICEF, UNFPA, World Bank Group & UN Population Division. Trends in Maternal Mortality : 1990 to 2015. 32, (2015).
[2] Most recent Demographic Health Surveys 2010 or later.
[3] Benin, Burkina Faso, Burundi, Cameroon, Comoros, Congo Republic, Congo Democratic Republic, Côte d'Ivoire, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Liberia, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

- Overall coverage rate for most opportunities is remarkably low, highlighting pervasive exclusion levels (Figure 2).
- Importantly the **maternity care package** ("four antenatal care visits", "delivery attended by skilled personnel" and "postnatal checkup") has very **low coverage** with **large inequalities**. Individually, each one of these indicators also shows high inequalities, with "**delivery attended by skilled personnel**" being the most unequal (Figure 4).
- "**Breastfeeding**" has a high coverage in SSA with **low inequalities** within and across countries (Figures 2 and 4).
- Countries with higher HIV prevalence obtain better HOI scores for HIV related opportunities ("knowledge of where to be tested" and "test offered during antenatal care").

Figure 2. HOIs and coverage rates: multi-country pooled analysis



FINDINGS: OLDER ADOLESCENT GIRLS (15-19 YEARS OLD)

OPPORTUNITIES
Met need for family planning
Having never been pregnant
Currently attending school

- The opportunities analysed for this age subset are among the most unevenly distributed indicators (Figure 4).
- **Marital status** (being married) is the main contributor to inequalities for older adolescent girls' reproductive health and education indicators and outcomes (Figure 3). In general, once "marital status" is controlled for, **wealth** becomes the first contributor to inequalities at country level.
- Controlling for marital status, for the opportunity "currently attending school", **employment status** of adolescents is the main source of inequality.
- The multi-country pooled analysis also reveals a significant contribution to inequalities of **religion** across countries for some variables (e.g. "met need for family planning", "currently attending school") (Figure 3).
- Overall coverage for older adolescents' opportunities is low: adolescent girls are the most neglected subgroup in terms of access to contraceptive information and services. The "met need for family planning" multi-country coverage rate is 47.29% versus 54.52% for women of reproductive age, and for school attendance, almost half of older adolescent girls are not attending school.

CONCLUSIONS

1. Overall reproductive and maternal health opportunities for women and girls in SSA are scarce –half of the women and girls are not receiving the most essential interventions– and unequally distributed. Inequality is more concentrated among the worst-off, the less educated and those living in rural settings.

2. Adolescent girls are a highly vulnerable subgroup with the worst results in terms of access to reproductive health services and educational achievements, with early marriage being the main contributor to poor maternal and reproductive health indicators.

3. Ensuring access for all women to an essential maternity care package of services, especially skilled attended childbirth should be prioritised.

4. Universal health coverage initiatives appear to be the key health system innovation to enable equitable provision of essential interventions that can curb the most important causes of mortality and disease among women and girls.

5. Actions outside the health system focused on poverty reduction and improving physical accessibility to healthcare in communities (adult women), ending child marriage and raising educational achievements (adolescent girls), can help reduce inequalities in maternal and reproductive health.

6. Putting equity at the heart of all strategies requires political mobilisation, sustained financing for health system strengthening and new tools and knowledge from SSA countries and the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) community at large.

Figure 3. Multi-country pooled analysis for older adolescent girls: circumstances' contributions to the D-index

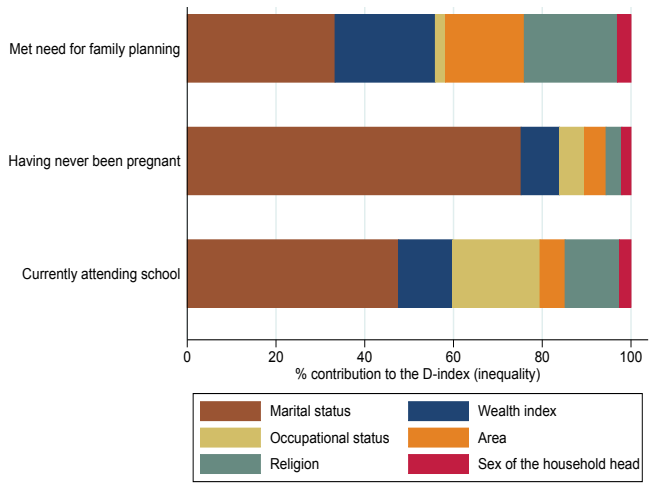


Figure 4. D-indexes: multi-country pooled analysis