Chapter 1.
Introduction

1.1 Context setting

Sub-Saharan Africa (SSA) is home to more than 500 million women who account for about half of the continent's population and 14 percent of the female population worldwide[1]. About 47 percent of them are of reproductive age, defined as between 15 and 49 years. Despite the significant advancements that have been made on many of the Millennium Development Goals (MDGs) targets during the 1990-2015 period, a high proportion of SSA women face a wide range of problems and constraints in their daily lives, originating from their lower status than men in all spheres of life – i.e. family, community, labour market, religion or politics. This pervasive gender inequality in the region results in women being more likely to live in poverty and suffer ill health throughout their life cycles. As a consequence, African women carry an excessive share of the global burden of disease and death, particularly as it relates to maternal and reproductive health[2].

Despite progress during the MDGs period, in 2015, the maternal mortality ratio (MMR) in SSA was estimated at 546 maternal deaths per 100,000 live births, accounting for two-thirds (201,000) of the total maternal deaths worldwide (303,000)[3]. The fifth MDG set by the global development community in 2000 for improvement of maternal health, with the specific target of reducing MMR by 75 percent in each country between 1990 and 2015, has not been achieved by the majority of low and middle income countries (LMICs). In SSA, only four countries, Eritrea, Equatorial Guinea, Cabo Verde and Rwanda, reached the 75 percent MMR reduction, while others reduced the ratio by over 60 percent (e.g. Mozambique, Angola and Ethiopia)[4]. Despite an overall improvement in maternal survival and a 45 percent decline in MMR worldwide since 1990, SSA women continue to bear an unacceptable health burden[4]. Among the reasons for the reduction of maternal mortality in SSA are the investments made by some countries in quality maternity services accessible to the population[2]. However, as in other regions, in SSA, universal access of essential services and interventions is not a reality, and maternal health related services are not an exception[3]. As a result, millions of women are not accessing services, and undergo their pregnancies and childbirths outside the health system.

Moreover, the second target of MDG5 – universal access to contraceptive methods – remains an important challenge for women of reproductive age in SSA. Despite the fact that the proportion of women of reproductive age using contraceptives more than doubled during the MDGs period, contraceptive use is still low and insufficient[4]. In SSA, one in four married or in-union women of reproductive age who wanted to delay or avoid pregnancy were not using any contraceptive method in 2015[2]. Given current trends, the prevalence of unwanted pregnancies in SSA is predicted to further increase over the next few decades as a result of a combination of early sexual activity and low use of contraceptive methods[2].

The recently agreed development agenda, the Sustainable Development Goals (SDGs), includes new and ambitious targets for maternal and reproductive health including ending preventable maternal mortality by reducing the global MMR to less than 70 per 100,000 live births by 2030 (target 3.1 of SDG3)[4]. Achieving universal coverage of essential maternal and reproductive health interventions should be the ultimate goal for all countries in the SDG era (SDG target 3.8). However, this is challenging in the short term given the low coverage rates in most SSA countries and the inequality gaps. Notably, one of the criticisms of the MDGs has been that the targets set in terms of average outcomes might have encouraged efforts in some countries to improve indicators by focusing on easier to reach segments of the population rather than those most in need[6]. As a result, large and avoidable disparities remain in coverage of health interventions for mothers, children and adolescents both across and within countries[7,8]. Inequity, unjust and avoidable inequalities, persists in maternal and reproductive health indicators and outcomes, posing a serious threat to the achievement of the agreed SDG targets.

Box 1. Progress from MDGs to SDGs

MDGs	Baseline after MDGs	SDGs goals	Targets	By 2030
MDG4: Reduce child mortality **MDG5:** Improve maternal health	Global MMR was 216 deaths per 100,000 live births in 2015. Global under-five mortality rate was 43 deaths per 1,000 live births. The neonatal mortality rate was 19 deaths per 1,000 live births in 2015. Approximately three in four women of reproductive age who were married or in union satisfied their need for family planning by using modern contraceptive methods in 2015.	**SDG3:** Good health and well-being	**3.1**	Reduce the global MMR to less than 70 per 100,000 live births.
			3.2	End preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births.
			3.7	Ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes.
			3.8	Achieve universal health coverage (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.

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Box 1. Progress from MDGs to SDGs (continued)

MDG2: Achieve Universal Primary Education	Globally, two thirds of the adults (aged 15 and over) who were illiterate were women in 2013. One in ten girls was out of school, compared to one in 12 boys. Children from the poorest 20 percent of households are nearly four times more likely to be out of school than their richest peers. Out-of-school rates are also higher in rural areas. Completion rates for primary education in both developed and developing regions exceeded 90 percent in 2013. At the lower secondary level, the gap was at nearly 20 percentage points in 2013 (91 percent for developed regions and 72 percent for developing regions).	**SDG4:** Quality education	**4.5**	Eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations.
			4.6	Ensure that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy.
			4.7	Ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development.
MDG3: Promote gender equality and empower women	In 63 countries, the legal age of marriage is lower for women than for men. Globally, the proportion of women aged between 20 and 24 who reported that they were married before their eighteenth birthday was 26 percent in 2015. Twenty-one percent of girls and women aged between 15 and 49 experienced physical and/or sexual violence at the hands of an intimate partner in the previous 12 months.	**SDG5:** Gender equality	**5.1**	End all forms of discrimination against all women and girls everywhere.
			5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.
			5.6	Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.
MDG1: Eradicate extreme poverty and hunger	Between 2007 and 2012, 56 of 94 countries with data available increased the income of the poorest 40 percent of the population more rapidly than its national average	**SDG10:** Reduced inequalities	**10.2**	Empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion, economic or other status.
			10.3	Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard.

Source: United Nations. SDGs. Sustainable Development Knowledge Platform [Internet]. 2016. Available from: https://sustainabledevelopment.un.org/sdgs

Given this context, this report focuses on the analysis of maternal and reproductive health inequalities among women of reproductive age in SSA. It pays special attention to older adolescent girls – those between 15 and 19 years old –, a neglected population subgroup in terms of visibility and resources channelled to address their specific needs, calling for an in-depth examination of their health and reproductive issues (see Chapters 3 and 4).

1.2 Inequality of opportunity

Access to maternal and reproductive health services is unequally distributed among women in SSA countries, as is typically the case when coverage of a service falls far short of universal access. Scarcity by its very nature produces inequality between those who have access (and better outcomes as a result) and those who do not, which is often manifested as systematic and persistent gaps between individuals belonging to different socio-economic groups. Large gaps exist in coverage and access to quality maternal health services between the poorest and richest households, and between rural and urban areas. In SSA only 56 percent of births are attended by skilled health personnel in rural areas, compared with 87 percent in urban areas[4]. When services are scarce, typically, an individual's chances of accessing them are influenced by their circumstances, namely the economic and social attributes of the individual and the family. This in turn produces inequalities in access to services (and to outcomes linked to those services) between groups differentiated by characteristics such as geographic location, wealth status, education levels, family structure, depending on the country and the type of health service or outcome. These characteristics can be seen as the social determinants of health status, which act by influencing the physical environment (including the availability of services) and behavioural factors that matter for use of services or adoption of practices.

In most societies there is broad consensus around the notion that granting access to a basic set of goods and services to every individual, regardless of the circumstances s/he was born into, is fundamental to building a just society and fostering economic and social development. However, in most LMICs, including those in SSA, the goal of universal and equal access to basic goods and services remains distant—a person's circumstances still matter a great deal in determining his/her opportunities. Finally, a distinction between children and adults' opportunities can be made since the opportunities of an adult could be "affected" by his/her own decisions (Box 2).

Box 2. Opportunities

The World Bank Group (WBG) has published several human opportunity reports since 2009 to document unequal access to basic goods and services such as education, health services, safe water, sanitation and nutrition in different countries and regions around the world[9]. Opportunities in this context are understood as the minimum set of essential goods and services that enable individuals to realise their human potential. The concept of equality of opportunity, first formalised by the economist John Roemer in 1993 and 1998[10,11], requires that individuals' opportunities are independent of their life circumstances. These circumstances are the characteristics that an individual is born into and has no influence over such as race, religion, gender, place of birth, or the wealth and education of one's parents. Most of the previous WBG reports were focused on children's opportunities to access basic goods and services in education, health and infrastructure[12] – where individual effort and choice do not matter as these are considered irrelevant for children. Whilst most societies can agree on a set of basic goods and services that constitute a minimum level of opportunities for children, consensus around what could be considered opportunities for adults is less clear, because choices made by adults play some role in accessing basic services. Access to basic services, such as higher education or having a delivery attended by skilled personnel, is no doubt influenced by an individual's own decisions, which is an argument against considering these as "opportunities" in the strict sense. However, there is a strong argument for going beyond this strict view and considering certain types of essential services or indicators of well-being as opportunities even for adults, and particularly for women. This is because the choices made by most women in LMICs – e.g. whether they should go to a hospital to deliver a baby, access pre-natal care or use family planning methods – are affected by external factors on which they have almost no influence. These include family, economic and social status, or location – circumstances that can effectively constrain the choices available to women in making these decisions. This argument is even more salient when it comes to health indicators such as anaemia and malnutrition, which are even more likely to be influenced by constraints imposed by life circumstances. As mentioned earlier, because women are a particularly vulnerable group in many situations, it is even harder for them to exercise free choice to access opportunities that are essential for their well-being.

A major focus of this report is the extent of inequalities associated with life circumstances for SSA women in reproductive and maternal health that they have no control over. Following the rationale described above (see Box 2), opportunities here will be interpreted as a "desirable situation" for a woman in terms of her reproductive and maternal health status. Thus, opportunities will refer to both health outcomes (such as being well-nourished), and the use and knowledge of essential maternal and reproductive health services (such as antenatal care, deliveries attended by skilled personnel, and family planning). This is clearly an expansive view of opportunities as it ignores the role of personal effort or decision-making by a woman in accessing these services or adopting healthy practices

(in diet, for instance) and instead considers a lack of any of these "desirable situations" to be an absence of opportunity.

The expansive view of what qualifies as opportunities has the disadvantage of ignoring the role of individual responsibility. However, this criticism is less relevant for the purposes of this report, which focuses on quantifying how opportunities are distributed by circumstances, as opposed to finding causal explanations for these inequalities. Accordingly, the findings of this report should be interpreted as a description of the extent to which women's opportunities, in maternal and reproductive health are differentiated by life circumstances, and not as causal relationships pointing to the underlying reasons for these inequities, some of which could very well relate to individual behavioural patterns driven by intrinsic preferences and cultural norms.

Whilst other studies have analysed maternal and reproductive health inequalities in the past, showing that almost all indicators are unequally distributed among population groups – with different wealth characteristics, areas of residence or educational levels[13] –, this report aims to go one step further by considering all such health determinants simultaneously, to assess the magnitude and sources of inequality for different indicators of access to health care and health outcomes. Following the SDGs trend, and aligned with the SDG framework that advocates for strengthened stakeholder engagement and keeping pace with policy developments from an inter-sectorial perspective, we include many different factors in the same analysis to account for all possible inequalities. This is done using the Human Opportunity Index (HOI), a methodology developed by the WBG.

The HOI is a measure of the coverage rate of an opportunity, discounted by inequality in its distribution across circumstance groups – sets of individuals with the same circumstances. It summarises two elements in a composite indicator: how many opportunities are available (the coverage rate), and how equitably those opportunities are distributed. If the coverage rate is close to the HOI, the distribution of the opportunities is equitable; when the HOI is lower than the coverage rate, the gap between them suggests inequality[9]. Interestingly, this methodology allows us to disaggregate the HOI into the marginal contribution (or weight) of each circumstance to the inequality of opportunity, meaning that data become available about which circumstances generate the highest inequalities between groups of individuals.

The HOI is comparable across countries and indicators, and allows for the contributions or weights of different characteristics to be quantified. This report uses recent Demographic Health Surveys (DHS) data (year 2010 or later) to cover around 79 percent of the SSA population, allowing for comparisons across countries and analyses for the region as a whole.

A more detailed discussion of the concepts underlying the HOI can be found in Chapter 2, methodological section.

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