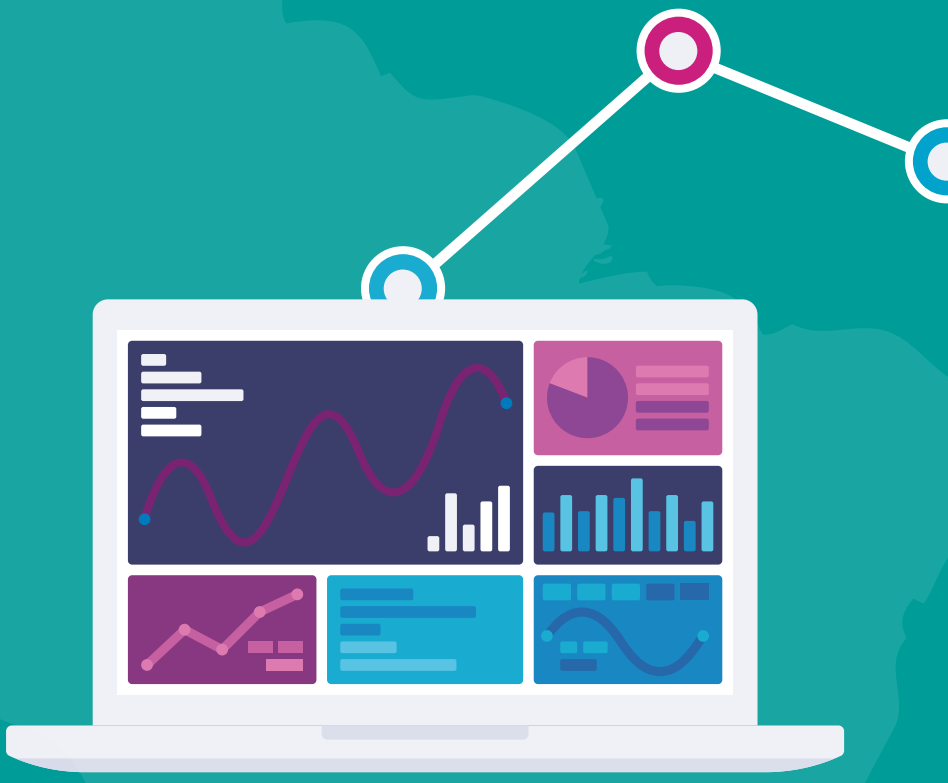
MAGE
Monitoring and Action for Gender and Equity

Gender and maternal and newborn health financing: Key issues for monitoring and evaluation (M&E)



Johns Hopkins Bloomberg School of Public Health

Global Financing Facility

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Introduction

Health systems should ensure that women and their unborn children reach their full potential for health and well-being during pregnancy, labor, childbirth and postpartum. However, gender inequity impacts women's decision to seek, and their ability to access the right, needed and preferred maternal health services[1]. This brief explores key gender issues within health financing for maternal and newborn health at the health systems level, and how they contribute to poor maternal health outcomes. It includes examples of indicators that can be adapted for monitoring and evaluation to achieve gender-responsive maternal and newborn health.

Gender-responsive monitoring and evaluation (M&E) integrates women's and girl's needs, rights, and preferences[2]. It takes account of the ways in which gender power relations and systems manifest as inequities (at all levels) to impact health and wellbeing. This includes inequitable: access to resources; roles and practices; norms, values and beliefs; and decision-making power and autonomy[2]. It ensures that target groups are involved and represented in the whole project cycle (development, implementation and evaluation processes)[2]. Women's and girls' maternal health outcomes are disproportionately affected by gender inequities within health systems and M&E can track the extent to which outcomes are being achieved[2,3].

Health financing includes women's and girls' ability to pay for services, including the availability of health insurance, the presence of user fees and related inequities between and among women and men.

Existence of user fees

User fees include out-of-pocket expenses for consultations, admission, drugs and supplies[4,5]. Where there are no user fees, research shows that women can incur indirect costs for maternal and newborn health services and costs for bribes to access and utilize quality health services[4–6]. For instance, a study in Ethiopia showed that women incurred costs for gloves, syringes, needles, and intravenous fluids and catheters despite the existence of a policy to deliver maternal health services to women free at the point of use[7]. Another study in India showed that women who were asked to pay bribes received fewer health checks during all stages of labor and delivery and were more likely to experience complications[8]. In Kenya, research showed that mothers who could not afford to pay bribes were made to wait for long hours in queues as providers first attended to those who could afford to pay to skip lines[9]. Furthermore, some women are detained in health facilities for not being able to finance their health care and that of their children after receiving treatment[6,10], while others are punished by health providers[7].

Other indirect costs that women incur in low- and middle-income countries include payment to use toilet facilities while at the hospital in Benin, purchasing of essential baby items and meals in Ghana, and purchasing personal hygiene essentials during health facility stay in Nepal[7]. Where fee structures are not clear, mothers are more likely to be charged for services that are supposed to be free, or overcharged for subsidized services[9]. In some low- and middle-income countries, health facilities with delivery services require a fee to be paid in advance for an obstetric emergency[7], which can be a limiting factor for access to health services among poor women and girls.

Research shows that while the removal of user fees can improve utilization and access to maternal health services, increasing the demand for services without addressing supply-side constraints might have gender-related implications related to quality of care[4]. For instance, an impact evaluation of user fee removal policies on maternal health services in Kenya showed that health workers became overwhelmed by the increased demand for health services resulting in longer waiting times when service providers took tea breaks and during shift changes, inadequate equipment, insufficient drugs and poor diagnostics[11]. Congestion and limited equipment resulted in some women delivering on the floor, more women sharing beds, and quicker discharges to create space for other incoming patients[11]; while young mothers reported an increased likelihood of mistreatment such as being neglected and abandoned[11].

Other findings

Other findings from Kenya showed reports of poor quality of delivery items such as soap and sanitary towels, while some mothers reported being told to purchase supplies from specific suppliers and some women experienced a lack of confidence to ask questions because they were receiving free services[11]. In Ghana, findings showed that the removal of user fees for maternal health services at health facilities resulted in stockouts of drugs and supplies that prompted some health facilities to reinstate user fees, and a lack of change in the quality of delivery services in some health facilities as poor quality did not improve[12]. Findings in Nigeria and Burundi showed that the removal of user fees for maternal health services resulted in persistent frequent stockouts of essential drugs and supplies such as oxytocin and blood, demotivation of health workers, disruption of referral systems, increased occurrence of post-operative infections, and consequently reduced quality of services[12].

Example indicators

The following indicators are examples of the types of gender-responsive indicators that could be used to address the issues above [13,14]:

- The proportion of women who attended the health facility who were refused care because of their inability to pay.
- The fee structures for maternity and newborn care are equitable, affordable, and clearly displayed in health facilities.
- The proportion of women who received care in the health facility who were aware that they had the right to accept or refuse treatment.
- % of women who reported receiving dignified and respectful care during maternity visits.

- % of women who gave birth in the facility who reported physical or verbal abuse to themselves [or their newborns].
- % of facilities with written, up-to-date policy and protocols that outline women's and families' right to make a complaint about the care received and has an easily accessible mechanism (e.g., a box) for handing in complaints.
- Availability of essential life-saving medicines (oxytocin, magnesium sulfate, dexamethasone, vitamin K, injectable and oral amoxicillin, benzyl penicillin, gentamicin, ceftriaxone, metronidazole, antimalarial drugs, antiretroviral drugs and vaccines against tuberculosis, hepatitis B, poliomyelitis) in the past three months.
- The proportion of unmet need for cesarean section as a result of lack of supplies or staff trained to conduct cesarean section.

Insurance packages

Lack of maternal and newborn services in health insurance packages

Not all essential and routine maternal and newborn services are covered in health insurance packages[6]. In Ghana, a study showed that a Community-Based Health Insurance (CBHI) scheme only covered complicated deliveries that required hospitalization[15]. In other cases, services covered under a specific type of health insurance might not be available in all health facilities. For instance, in Kenya, research showed that mothers in rural areas with vouchers were forced to walk long distances to reach facilities that offered free services[9], which can make it difficult for mothers to access timely care and treatment, especially during emergencies. Furthermore, in some settings, health facilities that accept vouchers have been found to be inconsistently open for services[16]. Mothers might also not be aware of all maternal health and newborn services covered by health insurance. For instance, in Mali, some health facilities did not provide services for CBHI schemes[15].

In addition, gender-specific barriers might limit women's access to participate in free healthcare schemes. For example, many women in low-income countries do not possess a birth registration card or other form of government identification that is necessary for health insurance registration[17]. In India, a requirement for one's name to appear on the family ration card as a condition for eligibility for the publicly funded Chief Minister's Comprehensive Health Insurance Scheme in a southern State in Tamil Nadu limited unmarried women who did not possess the card, and married and newly married women whose names were not yet included on the card[18].

Example indicators

The following indicators are types of gender-responsive indicators that could be used to address the issues above[19]:

- Health expenditure on reproductive health as % of current health expenditure.
- Policy on free access to health services for pregnant women.
- Availability of user fee exemptions for postnatal care mothers.

About the MAGE Project

The Monitoring & Action for Gender & Equity (MAGE) project is a partnership between Johns Hopkins University (JHU) and the Global Financing Facility for Women, Children and Adolescents (GFF), a multi-stakeholder global partnership housed at the World Bank that is committed to ensuring all women, children and adolescents can survive and thrive. Supported by the Bill and Melinda Gates Foundation, MAGE aims to advance and strengthen the capacity and execution of gender- and equity-intentional monitoring and evaluation and build sustainable systems and capacity for the use of data to improve gender equality and RMNCAH-N outcomes for women, children, and adolescents in GFF partner countries and beyond.

Suggested Citation

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