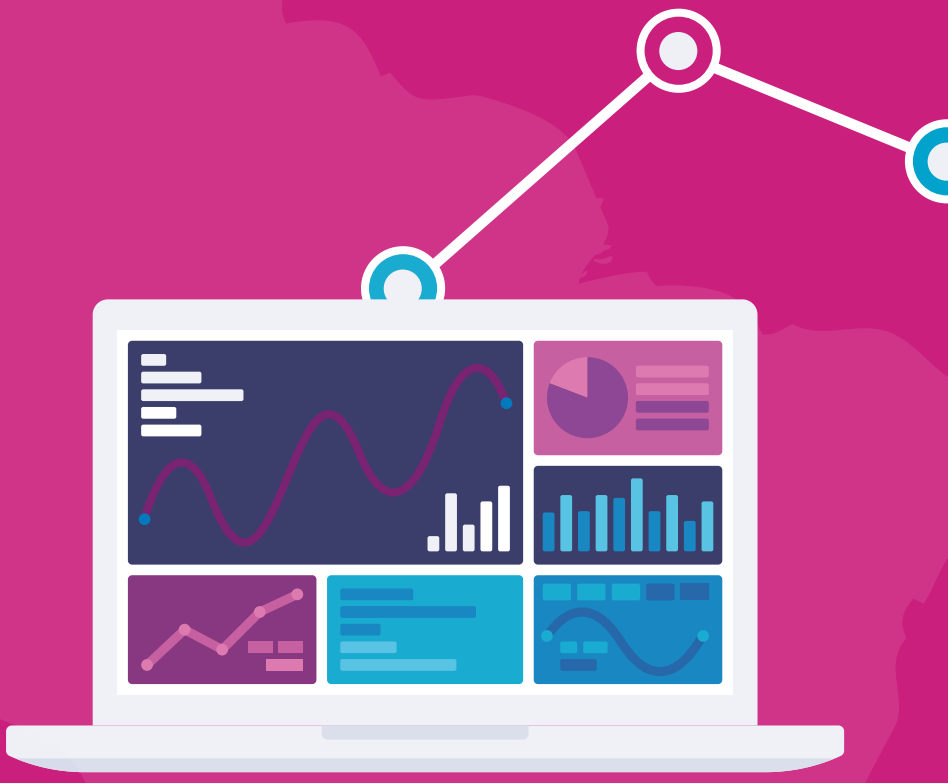
MAGE
Monitoring and Action for Gender and Equity

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



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Introduction

Improving maternal and newborn health within health systems entails ensuring that a woman and her unborn child reach their full potential for health and well-being during pregnancy, labor, childbirth, and in the postpartum period. Gender inequity impacts maternal health by affecting women's decision to seek care and her ability to access the right, needed and preferred maternal health services[1]. This brief explores key gender issues in maternal and newborn health service delivery and how they contribute to poor maternal health outcomes. It includes examples of indicators that can be adapted to achieve gender-responsive maternal and newborn health at the health system level.

In the context of maternal and newborn health, gender-responsive monitoring and evaluation (M&E) integrates women's and girls' needs, rights, and preferences, and the ways in which gender power relations and systems manifest as inequities (at all levels) to impact health and wellbeing. This can include: 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]. It is important to integrate gender-responsive indicators into M&E for maternal and newborn health because women's and girls' maternal health outcomes are disproportionately affected by gender inequities within health systems[2,3].

In relation to maternal and newborn health, service delivery refers to considerations related to quality of care, including timeliness of care, adequacy of care, content of care, and patient satisfaction. Key gender issues related to service delivery are included below.

Infrastructure and supplies

Inappropriate and inadequate infrastructure and supplies

Inappropriate and inadequate infrastructure and supplies include: dirty, noisy, disorderly, and overcrowded antenatal and delivery rooms; open and exposed antenatal care (ANC) and delivery rooms that lack curtains and doors; and lack of designated and properly resourced places for ANC and delivery[4]. For example, research showed that pregnant and postpartum women in Mexico were at a higher risk of physical harm and death in health facilities that were poorly resourced to manage obstetric complications[5]. Further, community groups in many countries reported that a limited supply of beds in maternal wards resulted in women being discharged too soon after delivery, and an increase in practices that are meant to speed up delivery such as routine episiotomies, application of excessive fundal pressure, unnecessary oxytocin injections and unnecessary Cesarean sections (C-sections)[6]. Women who undergo C-sections in settings with poor access to comprehensive obstetric care and lack of equipment to perform safe surgical procedures are more likely to experience poor maternal and neonatal outcomes[7].

Example indicators

Examples of gender-responsive indicators that could be used to measure/track the issues above[8,9]:

- % of facilities with basic uninterrupted water supply in maternity care areas (labor, birth, postnatal).
- % of facilities with basic environmental cleaning practices in maternity areas (labor, birth, postnatal), written cleaning protocols, and trained cleaning staff and providers.
- % of obstetric facilities without stockouts on delivery-related drugs in the last 12 months.
- % of obstetric facilities that meet basic standards of care.
- % of women with prolonged/obstructed labor who gave birth by C-section.
- The proportion of all pregnant women who attended the health facility who reported that it has a clean physical environment conducive for childbirth.
- The proportion of all women who gave birth in the health facility who were satisfied with the environment of the labor and childbirth area, including the cleanliness, proximity to a toilet, general lighting, and level of crowding.

Privacy and confidentiality

Lack of privacy and confidentiality

Studies show that women feel embarrassed during vaginal and abdominal examinations when they are observed from open spaces that do not have partitions and curtains in windows and doors[4,10,11]. Furthermore, women feel that their privacy is undermined when they are examined in the presence of other expectant mothers, caregivers, and numerous health workers including students[4,12]. In some settings, research shows that when maternity wards get overcrowded, mothers are forced to share beds with other women in labor, making it difficult for health workers to protect their privacy and confidentiality when conducting examinations and/or passing on health information[13]. Also, women's confidentiality may be breached when health providers disclose women's health information to their male partners and to other patients without their permission[4]. Ensuring physical privacy and confidentiality of women's personal medical information is not only a human right in healthcare provision, but failing to do so discourages women from seeking care from the formal health sector.

Example indicators

Examples of gender-responsive indicators that could be used to measure/track the issues above[8,9]:

- The physical environment of the health facility allows privacy and the provision of respectful, confidential care, including the availability of curtains, screens, partitions, and sufficient bed capacity.
- % of facilities where the physical environment allows privacy.
- % of facilities with basic sanitation available for women during and after labor and childbirth (separate toilet/latrine for women).
- The proportion of all women who gave birth in the health facility who were satisfied with the degree of privacy during their stay in the labor, examination, treatment, and childbirth areas.

Autonomy

Lack of decision-making autonomy

In many cases, pregnant and expectant mothers feel that health workers force them to accept healthcare regardless of their own preferences. For instance, in some settings, mothers are not asked for their informed consent for medical procedures such as C-sections, episiotomy and vaginal examinations[4,10,12]. Previous studies have found that health workers tend to ignore or doubt mothers' perceptions, feelings, and wishes during labor and delivery[14]. For instance, some women are not allowed to express pain in the form of screaming, crying or walking during labor[15]. Moreover, in some settings, health workers refuse to provide pain relief during surgical procedures such as episiotomy[4].

In many contexts globally, health facility policies deny women and girls birth companions of their choice[4]. In some settings, mothers are hesitant to seek facility-based care because health facilities are not responsive to their traditional norms and practices, such as a warm bath after delivery[16], privacy from male service providers during vaginal examinations, labor and delivery[17], and a lack of choice for a preferred birthing position[18]. In some settings, women's ability to seek healthcare is limited by socially accepted restrictions on their mobility, security and safety concerns, and a lack of appropriate means of transport[1,3,19–21]. It is important for women to have the right to make decisions about their reproductive and maternal health. Women's autonomy in this space can affect their decisions about where, or how much, antenatal care to seek. For example, in Nigeria, women who reported experiencing autonomy in decision-making in their healthcare choices were more likely to attend eight or more ANC visits than women who reported experiencing less autonomy[22].

Example indicators

Examples of gender-responsive indicators that could be used to measure/track the issues above[8,9]:

- The proportion of all women undergoing examinations or procedures in the health facility who reported that their permission was sought before the examination or procedures were performed.
- The proportion of all women who gave birth in the health facility who did so in the labor position of their choice.
- The proportion of all women who gave birth in the health facility who were satisfied that their choices and preferences were respected.
- % of women who reported they were given an opportunity to discuss their concerns and preferences.
- The proportion of women who attended the health facility who reported receiving attention within the appropriate time for their condition as per facility policy on triage and waiting time.
- 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 wanted and had a companion supporting them during labor and/or childbirth in the health facility.

Stigma and discrimination

Women of lower socioeconomic status and those from minority groups are more likely to receive poor-quality care. In India, the quality of treatment was found to be worse for women from low-income backgrounds compared to that of those from the middle- and upper-income classes[23]. Somali migrants and refugees in Canada with female genital cutting were expected to pay more to access to maternal health services[4]. While in Europe, women from countries that practiced female genital cutting reported experiencing poor attitudes, negative judgments, and offensive treatment by health workers[24]. Furthermore, women with pre-existing conditions such as HIV often experience delays in receiving appropriate care; for instance, evidence shows that health workers are afraid of attending to mothers with HIV when there are no protective devices such as gloves[4]. A mother's age has also been shown to prompt gender-related stigma in health facilities as expectant adolescent mothers and older women reported being judged by health workers for engaging in sexual activities[4,25]. For instance, in South Africa pregnant adolescents reported that they were treated differently from other expectant mothers, as they felt that health workers were rude since they looked at them as immature and promiscuous, and they felt that health workers didn't understand their needs[26].

Example indicators

Example of gender-responsive indicators that could be used to monitor/track the issues above[9]:

- % of facilities with written, up-to-date zero-tolerance nondiscriminatory policies on mistreatment.
- % of facilities with written accountability mechanisms for redress in the event of mistreatment.
- % 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 have an easily accessible mechanism (e.g., a box) for handing in complaints.

Mistreatment

Mistreatment and abuse during childbirth

Globally, women report experiencing various forms of mistreatment and abuse in health facilities during childbirth. These include physical abuse such as beating, aggression, rough touches, pinching, hitting, slapping using instruments and hands, tying women's legs to beds, and using mouth gags[4,10]. Women also report experiencing verbal abuse including being shouted at, scolded, or mocked[10]. Furthermore, in contexts where pregnancy is only seen as viable for married women, pregnant unmarried women tend to be judged by health workers for their pregnancies[4]. Reports have shown that some health workers threaten women by withholding healthcare or attention when they do not comply with their requests[4,14]. In other cases, some health workers blamed women for poor quality of care and poor health outcomes during and after labor and delivery[4,15]. Research shows that women have been made to clean up delivery rooms after birth and during their health facility stay while others have been told to retrieve medical supplies from other

rooms or to dispose of medical waste when they are in labor[4,15]. A study in Kenya showed that expectant women who used vouchers to pay for healthcare were treated differently from other expectant women as they were made to wait longer to receive treatment from health providers who preferred to first attend to patients with cash[27].

Example indicators

Examples of gender-responsive indicators that could be used to measure/track the issues above[8,9]:

- The proportion of all women who gave birth in the health facility who reported a positive birth experience.
- % 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).
- The proportion of women who received care in the health facility who were aware that they had the right to accept or refuse treatment.

Male partner involvement

Lack of male partner involvement in maternal and newborn health

Male partners are often gatekeepers and decision-makers for women's and children's health. Research shows that some men dislike accompanying their wives to health facilities because of the disrespect and poor attitude that they receive from health workers. For instance, some men are not allowed to join their partners in clinic rooms or ANC settings without explanation, and some health workers blame men for women's negative health outcomes[28–30]. Furthermore, there is evidence that health providers might lack the capacity and skills for male involvement in maternal and newborn health. For instance, a study among nurses in Uganda found that they were not trained, and lacked guidance, on how to integrate men into maternal and newborn health services and on how to make health facilities male-friendly[31]. Some men reported a lack of privacy and experiences of coming across unclean environments in delivery areas, which demotivated them from ever accompanying their wives to seek maternal health services[29,30].

A lack of male-friendly services during ANC, labor, and delivery makes men think that their presence at health facilities is unnecessary. For instance, there may be a lack of space to accommodate male partners, a lack of specific services targeting men, such as the prevention of prostate cancer,[29,30,32,33] and fewer opportunities for men to engage with health workers[34]. Furthermore, health facility protocols in some settings intentionally limit men's presence where a labor room accommodates more than one woman in labor, and privacy for other patients has to be maintained[35,36]. Another issue that limits men from getting involved in maternal and newborn health is their nature of work. Research shows that men who are in paid work and those in seasonal jobs may find it hard to create time to accompany their partners for ANC or labor and delivery because of the time it takes to visit the health facility, which might be long and/or have unfavorable timing in service provision, for instance where services are provided only in weekdays and morning hours[29,30].
Policies and guidelines that encourage men's involvement in maternal and newborn

health should be cognizant of women's and men's preferences while at the same time minimizing potential unintended consequences. For instance, in Tanzania, a policy that recommended male partners attend the first ANC appointment with their female partners as a strategy for HIV prevention and treatment resulted in strict health facility protocols that led to some expectant mothers who were not accompanied by their male partners being treated differently. Reports showed that health workers tended to first give priority to women who came with their male partners and in some cases, unaccompanied women were denied services[37]. Furthermore, another study showed that some health facilities in Tanzania required unaccompanied women to present a letter from a local government committee explaining why their male partner was not able to attend in order to receive services, while some women who could not be accompanied by their male partners delayed seeking their first ANC visits for fears of being treated differently or denial of health services by health workers[38].

Example indicators

Examples of the types of gender-responsive indicators that could be used to address the issues above[9,39]:

- % of men who accompany their spouse or partner to at least one antenatal care (ANC) visit.
- The proportion of all male and female companions who were satisfied with the orientation given on their role during labor and childbirth.
- Number of visits to male-focused services, by type of service such as prostate cancer prevention.

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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