Arab States Regional Office

Policy Brief

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Achieving Equity in Maternal Health in the Arab Region

Despite large gains in health over the past few decades in the Arab region, the distribution of health risks remains unacceptably uneven both across and within countries.[1] Today, children born in Sudan are ten times more likely, on average, to die before their fifth birthday than children born in Oman, and a woman living in Somalia faces a lifetime risk of dying due to pregnancy-related cause 30 times and 100 times higher than a woman in Egypt and Bahrain, respectively.[2]

Furthermore, data on national averages mask health disparities among population groups within countries. In Yemen, the maternal mortality ratio in rural areas is 164 deaths per 100,000 live births compared to 97 deaths per 100,000 in urban areas.[3] In Sudan, one in five married women belonging to the richest fifth of the population use modern contraception, while hardly any of those belonging to the poorest fifth do so (see Table 1). These and other disparities in maternal health are unfair—or inequitable—because disadvantaged population groups such as young girls, illiterate women, or displaced populations suffer higher levels of ill-health that are known to be preventable and avoidable.

An "equity approach" to maternal health can help reduce or eliminate differences in health outcomes resulting from structural and individual factors, such as gender inequality and lack of opportunity or access, which are avoidable and unfair.[4]

Improving maternal health is Goal 5 of the United Nations' Millennium Development Goals (MDGs), reducing maternal mortality and universal access to reproductive health services, including family planning, are the two specific targets associated with this goal. The eight MDGs, agreed on after the Millennium Summit in 2000, are interrelated and have succeeded in bringing health into development discourse around the world. The MDGs have also proved to be a successful tool for motivating governments to act and to monitor their progress. Yet, the indicators used to measure progress fell short of taking into account progress in addressing disparities among subgroups within a country. As a result, countries' progress could reflect health gains among the more privileged groups of the population while the less privileged continued to lag behind.

Table 1 - Percentage of Married Women Aged 15 to 49 Who Use Modern Contraception, by Wealth Quintile

Country	Poorest	Middle	Richest
Egypt	52	59	62
Iraq	29	33	36
Jordan	37	41	49
Libya	15	20	26
Morocco	55	59	57
Somalia	<0.5	<0.5	4
Sudan	<0.5	3	20

Notes: Wealth quintiles (five groups of equal population size) are based on an index of surveyed household assets. Data are shown for the first (poorest), third (middle), and fifth (richest) quintiles. Modern contraception includes hormonal pills, injectables, and implants; intrauterine devices (IUDs); male and female sterilization; and condoms, diaphragms and other barrier methods.

Source: Population Reference Bureau, Family Planning Worldwide 2013 Data Sheet.

With the MDG targets ending in 2015, however, the international community is mobilized to forge a more inclusive development agenda for the next 15 years. Founded on human rights, the new goals, known as the sustainable development goals (SDGs), will have ambitious targets and indicators to measure progress. The proposed Goal 3, "Ensure healthy lives and promote well-being for all at all ages," will include a target for maternal mortality: "by 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births."[5] The proposed target for reproductive health is "by 2030 ensure universal access to sexual and reproductive health care services, including for family planning information and education, and the integration of reproductive health into strategies and programmes."

With "Leave No One Behind" and "People Centered" as its mottos, the emerging global development agenda provides an opportunity for governments, including Arab governments, to embrace and promote equity as a measure of societal progress and a benchmark for a just and fair society.[6]

This policy brief examines Arab countries' global standings on maternal health, along with disparities within countries. It also describes how achieving universal health coverage and approaching reproductive health from an equity perspective are necessary steps toward improving maternal health and, more broadly, people's well-being.

Arab Countries' Global Standings in Maternal Health

A number of international agencies regularly publish reports that rank countries' standings in specific areas of development. The State of World's Mothers, published annually by Save the Children, features a Mothers' Index that combines several indicators of women's health and well-being, including maternal and child mortality, female education, women's participation in national government, and per capita income. Table 2 presents the latest rankings for Arab countries.[7] The data show wide disparities among Arab countries, with Saudi Arabia at the top regionally (38th globally) and Somalia at the bottom, both regionally and globally. While countries with higher per capita incomes tend to converge at the top and those with lower income at the bottom, a direct association between per capita income and the health of mothers does not necessarily hold for all countries. Tunisia, a middle-income country, for example, ranks 7th right after Libya and Kuwait, whose per capita incomes are three times and ten times that of Tunisia, respectively. Tunisia's standing is largely due to its strong performance on women's participation in public life, reflecting the better social conditions in which they live.

Women's lifetime risk of dying due to pregnancy-related causes is a commonly used indicator for assessing the state of maternal health. Generally, women's lifetime risk of maternal death is high in countries where fertility is high and access to services is poor. In Somalia, where women give birth to an average of 6.8 children—the highest in the region—the lifetime risk of death due to pregnancy is also the highest: 1 in 16 (see Table 2).

Maternal deaths and disabilities, however, are largely avoidable if all women have access to, and are empowered to use, quality reproductive health information and services. Family planning information and services, antenatal care, and deliveries assisted by trained health personnel are known to improve maternal health and help save the lives of mothers and their newborns. Yet, women experience higher rates of pregnancy-related death and disability in countries whose health systems fail to make quality maternal care accessible to those in need.

Maternal Health Inequities Within Countries

The targets set for MDG5 for countries are to: 1) reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio; and 2) ensure universal access to reproductive health services. The indicators used to monitor progress include the maternal mortality ratio (the number of maternal deaths per 100,000 live births); proportion of births attended by skilled health personnel; proportions of women using contraception and having unmet need for contraception; adolescent birth rate; and receipt of antenatal care. Survey data from the region, however, show systematic inequalities within countries on these measures, regardless of the countries' overall progress.

Family planning services have expanded in the Arab region, and a growing number of women are using contraception. Still, a significant number of women

have "unmet need" for family planning—that is, they prefer to avoid a pregnancy for at least two years or stop childbearing altogether, but are not using a modern family planning method. These women are at risk of having unintended pregnancies, which can jeopardize the health of the women and their children and also put a burden on society as a whole. The causes of unmet need for family planning are complex. A range of obstacles and constraints, stemming from individual beliefs to women's socioeconomic conditions, and to broader cultural, social, legal, and political factors, can undermine a woman's ability to act on her childbearing preferences. These circumstances systematically put the poorest women at a disadvantage in meeting their reproductive needs, including family planning. Figures 1 and 2 on page 4 show examples of such disparities in Syria, Egypt, Morocco, and Djibouti.[8,9,10,11]

Table 2 – Mother's Index for Arab Countries

Mother's Index Rank (among Arab countries)	Country	Maternal Health	Children's Wellbeing	Educational Status	Economic Status	Political Status	Mother's Index Rank (worldwide)
		Lifetime Risk of Maternal Death (1 in number stated)	Child Mortality Rate (deaths under age 5 per 1,000 live births)	Expected Years of Formal Schooling for Women	Gross National Income Per Capita (US$)	Participation of Women in National Government (% of seats in parliament held by women)	
		2010	2012	2103	2012	2014	2014
1	Saudi Arabia	1,400	9	16	21,210	20	*38*
2	Bahrain	1,800	10	13	14,820	19	*50*
3	Qatar	5,400	7	14	76,010	0	*51*
4	UAE	4,000	8	12	35,770	18	*52*
5	Kuwait	2,900	11	15	44,100	5	*57*
6	Libya	620	15	16	12,930	16	*58*
7	Tunisia	860	16	15	4,150	28	*59*
8	Oman	1,200	12	14	19,110	10	*69*
9	Algeria	430	20	14	5,020	26	*71*
10	Lebanon	2,100	9	13	9,190	3	*77*
11	Jordan	470	19	13	4,670	12	*95*
12	Iraq	310	34	10	5,870	25	*104*
13	Syria	460	15	12	2,610	12	*115*
14	Egypt	490	21	13	2,980	3	*117*
15	Morocco	400	31	12	2,960	11	*121*
16	Sudan	31	73	5	1,500	24	*150*
17	Djibouti	140	81	7	1,030	13	*160*
18	Yemen	90	60	9	1,270	1	*162*
19	Somalia	16	147	2	120	14	*178*

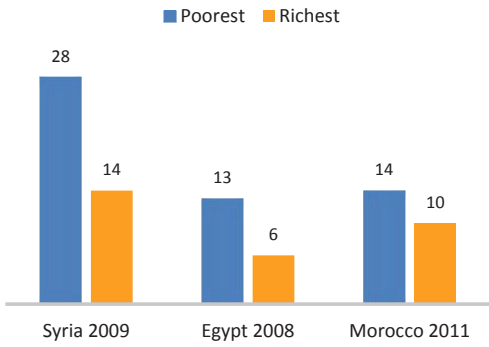
Source: Save the Children, State of World's Mothers 2014.

Antenatal care and deliveries assisted by skilled personnel are increasingly becoming the norm in Arab countries. Deliveries assisted by skilled health personnel are nearly universal—and therefore equitable—in the Gulf Cooperation Council countries, Jordan, and Palestine.[12] In Syria and Iraq, respectively, 10 and 18 percent of the deliveries by women in the poorest quintile are not attended by skilled health personnel, while it is rarely the case for women in the richest quintiles (see Figure 3, page 5).[13] The percentage not receiving professional care rises to more than 70 percent and 80 percent for the poorest fifth of the population in Sudan and Yemen, respectively.[14] And as these percentages rise, so does the gap between the poorest and the richest women.

The underlying reasons for inequity in the use of maternal health services stem from a combination of the conditions in which women live and their individual circumstances. In Djibouti, for example, women living in urban areas are twice as likely to use maternal health services as their counterparts in rural areas, where three-quarters of the population live (see Figure 4). In all countries, women's reproductive health is influenced by the strength of health systems and other factors, such as women's educational level, their families' ability to pay for transportation and health services, and women's ability to make decisions within the family.

Figure 1 – Poorer Women Have Higher Unmet Need for Family Planning

Percent of married women aged 15 to 49 who prefer to avoid a pregnancy but are not using a modren family planning method, by wealth quintile



Note: Wealth quintiles (five groups of equal population size) are based on an index of surveyed household assets. Data are shown for the first (poorest) and fifth (richest) wealth quintiles.

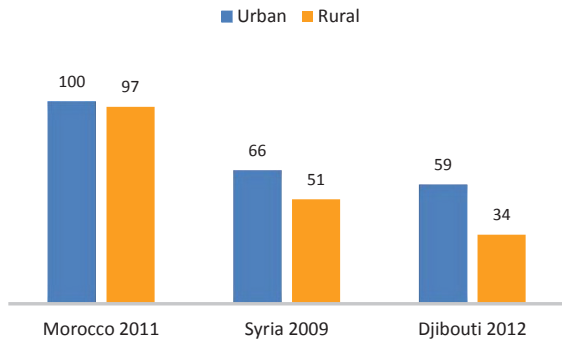
Sources: Syria Household Survey 2009, Egypt Demographic and Health Survey 2008, Morocco National Survey on Population and Family Health (ENPSF), 2011.

Morocco is considered a success story in reducing maternal mortality by more than half in a relatively short time (see box, page 6), yet disparities remain to be tackled. For example, the percentage of deliveries assisted by skilled personnel there ranges from 57 percent in Taza Al-Hoceima to 92 percent in Grand Casablanca, with 74 percent as the national average (see Figure 5). Egypt is also a success story in reducing maternal mortality and improving reproductive health, but disparities still persist. The 2014 Egypt Demographic and Health Survey, for example, reveals that antenatal care of at least four visits during pregnancy is the highest and nearly universal in Port Said Governorate, while in Matrouh Governorate, where the rate of antenatal care is the lowest, more than a third of pregnant women don't receive the minimum of four visits as recommended by the World Health Organization.

Experiences in Morocco, Egypt and other countries around the world have demonstrated the complexities of social, cultural, political, and financial factors influencing health outcomes. As a result, international health experts now recognize that reducing or eliminating health inequities requires policies and interventions that are specifically crafted to target poor and marginalized people and to address the so-called social determinants of health.

Figure 2 – Women Living in Urban Areas Generally Have More Positive Attitudes Toward Using Contraception

Percent of ever-married women aged 15 to 49 who believe it is acceptable to use contraception



Note: The surveys asked, "Would you say that in general you approve or disapprove of couples using a method to avoid a pregnancy?" and gave respondents four choices: they approve, approve conditionally, disapprove, or do not know. The percentages shown in this graph refer to women who said that they approved and those who said they approved conditionally.

Sources: Morocco ENPSF 2011, Syria Household Survey 2009, Second Djiboutian Survey on Family Health 2012.

The Health Equity Approach and the Post-2015 Agenda

Equity is at the core of the post-2015 agenda, as evident in the UN-sponsored report of the High-Level Panel of Eminent Persons, A New Global Partnership: Eradicate Poverty and Transform Economies Through Sustainable Development.[15] The Panel proposed a set of development goals and accompanying targets to replace the MDGs in 2015. The report recommends that countries continue to report on overall progress toward achieving their development targets, and also show indicators disaggregated by wealth, age, geography and education, among other factors, so that they can monitor their progress toward equity on specific targets.

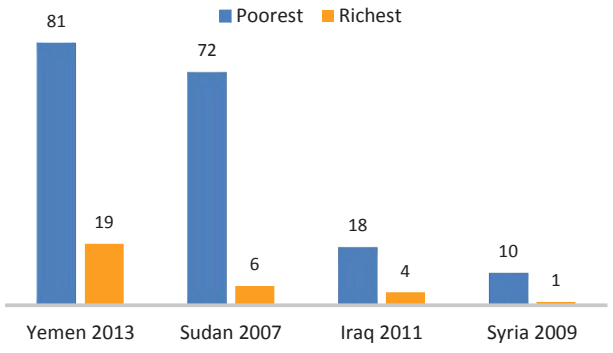
The health-equity approach that is inherent in the post-2015 agenda means that everyone should have a fair opportunity to attain their full health potential—a goal that cannot be achieved without universal health coverage. The Panel's report emphasizes that the international development community and individual countries "must make steady progress in ensuring universal health coverage and access to quality essential health services."[16] Efforts to achieve universal health coverage should entail:

- Reaching more people
- Broadening the range of integrated, essential services available to every person
- Ensuring that services are affordable to all

"Ensuring universal access to sexual and reproductive health care services" is one of the targets under the proposed goal to "ensure healthy lives and promote well-being for all at all ages." The term universal implies that every individual is entitled to access quality reproductive health services at least at the primary health care level with special attention to the needs of the most vulnerable or marginalized population groups including refugees, internally displaced populations, undocumented migrants, nomadic people or those denied birth

Figure 3: Poor Women Are More Likely to Receive Poor Maternal Health Care

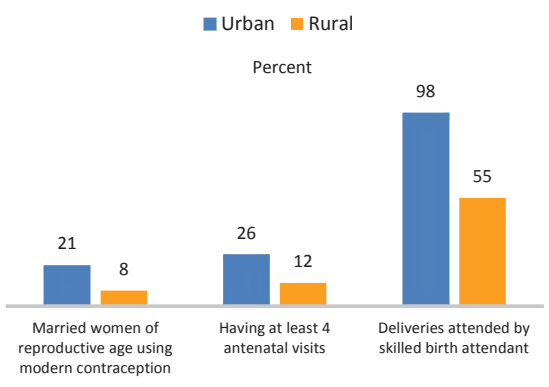
Percent of Deliveries Not Assisted by Skilled Personnel for the Poorest and Richest Fifths of the Population



Note: Wealth quintiles (five groups of equal population size) are based on an index of surveyed household assets. Data are shown for the first (poorest) and fifth (richest) quintiles.

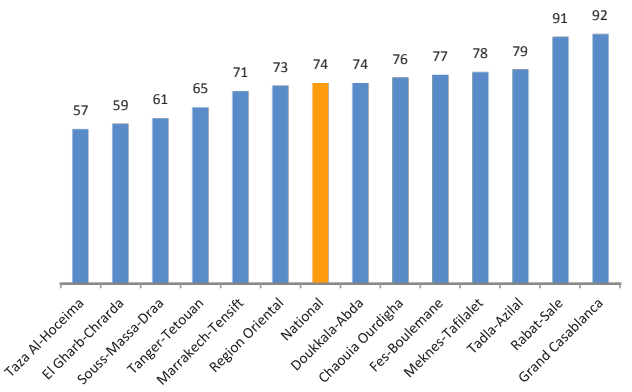
Sources: Yemen National Health and Demographic Survey 2013, Sudan Household Health Survey 2007, Iraq Multiple Indicator Cluster Survey 2011, and Syria Household Survey 2009.

Figure 4 – Women Living in Rural Areas Are Less Likely to Access Maternal Health Services, Djibouti 2012



Source: Second Djiboutian Survey on Family Health 2012.

Figure 5 - Percentage of Births Assisted by Skilled Health Personnel by Province, Morocco 2010



Source: Kingdom of Morocco, Ministry of Health, National Household Population and Family Health Survey (ENPSF), 2011.

registration. Sometimes, such vulnerable groups may be considered as lacking the legal entitlement to receiving health care.[17] This can be particularly problematic in the Arab region, where a significant number of labor migrants and large refugee populations live. International partnerships could be used to ensure universal health coverage and, by extension, universal sexual and reproductive health care, to help reduce or eliminate disparities among such population subgroups.

Another sensitive issue for Arab countries is how to go about ensuring universal access to sexual and reproductive health care for young people. Such an effort will require culturally appropriate policies and programs. In addition, the discrimination against

Improving Maternal Health in Morocco: A Success Story, But Still Inequitable

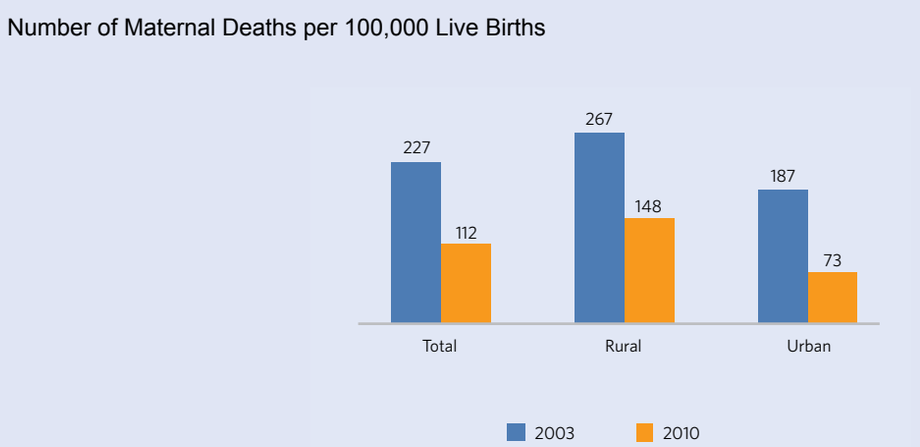
In Morocco, maternal mortality declined by more than half in less than a decade, from 227 maternal deaths per 100,000 live births in 2003 to 112 maternal deaths per 100,000 live births in 2010 (see figure below). This sharp decline came about as the result of high-level political commitment to improve maternal health, which was translated into investments in the national health system and coordinated efforts at local levels—all informed by evidence. The decline brought Morocco in line with a small group of middle-income countries in the region, such as Egypt and Jordan, which are rapidly progressing towards acheiving the MDG5 target of reducing maternal mortality by three-quarters between 1990 and 2015.

With regard to deliveries in health facilities, the 2003-2004 PAPFAM survey in Morocco revealed that inability to pay was the main obstacle: 74 percent of women who did not deliver their baby in a health facility reported inability to pay as one of the reasons; 60 percent reported distance as a problem; and 46 percent mentioned lack of transport. Also, the results of a socio-anthropological study conducted in Morocco in 2006 showed a divergence of perceptions between people and the medical profession regarding the need for supervised delivery. It pointed to a lack of communication, respect, privacy, or a supportive environment for the laboring mother, which contributed significantly to women's reluctance to use these facilities.

The Moroccan Ministry of Health used these and other data to develop a national strategy in 2008 to reduce maternal mortality. Reducing maternal mortality became a high priority, backed by financial commitment to implement the desired improvements: the health system was strengthened and measures were put in place to reduce barriers to emergency obstetric care and to improve the quality of care. The ministry also established a national surveillance system to provide accurate and timely information on maternal mortality.

As a result, maternal health has improved across the country and among vulnerable groups. Still, disparities remain wide among different population groups. Women living in rural areas, for example, are twice as likely as those living in urban areas to die due to complications of pregnancy or delivery. The post-2015 agenda provides the opportunity for Morocco and other Arab countries to reduce, and where possible eliminate, disparities in maternal health among different socioeconomic groups and across geographic areas.

Maternal Mortality Declined in Morocco, but Rural-Urban Disparity Remains



Source: Kingdom of Morocco, Ministry of Health, National Household Population and Family Health Survey (ENPSF), 2011.

girls and women in Arab countries underscores the importance of addressing the social determinants of health.[18] Achieving gender equality in Arab countries, which is key to achieving equity in maternal health, will require broad shifts in countries' cultural, social, legal, and economic environment.

The age at which girls marry, for example, is a critical social determinant of maternal health. Early marriage for girls usually means early childbearing and many pregnancies, putting the girls at a higher risk of maternal ill-health and death than those who marry at a later age. Early marriages are most prevalent in the lower income countries—Yemen, Somalia, and Sudan—where women are at highest risk of maternal death. The harmful consequences of early marriage are lifelong, because the girls generally drop out of school and are socially isolated, with limited opportunities to make decisions about their health and wellbeing.

Influenced by tradition, the practice of early marriage disproportionately affects the poorest and least educated girls. In Egypt, for example, girls from the poorest fifth of the population are six times more likely to be married before age 18 than girls from the richest fifth, and girls who marry before their 18th birthday are twice as likely to be illiterate as those who marry at a later age.[19] In Morocco, women who complete at least secondary school are rarely married before age 18, compared to 20 percent among those who have no or some primary schooling. In both Egypt and Morocco, the legal minimum age at marriage is 18. Thus, the practice of early marriage demonstrates the need for, and also the complexity of, addressing the determinants of maternal health outside the health system. Collective efforts will be required on all fronts—social, economic, judicial, religious, and political—to tackle these determinants.

The Way Forward

Arab countries now have the opportunity, particularly given the social and political transformations in the region, to make health equity central to their development goals. From childhood to old age, healthier people have a better shot at reaching their potential, while less healthy people can potentially slip into poverty.

Ensuring universal access to sexual and reproductive health care is essential for families' and individuals' health and well-being. Access to safe pregnancy and delivery care and family planning information and services should be seen as every woman's right, not privileges for only the better-off segments of the society. Thus, universal health coverage is a necessary step toward achieving equity in maternal health.

Governments need to strengthen their health systems to respond to the needs and priorities of women and girls and address all preventable causes of maternal death and disability and related reproductive disability. Governments need to place a high priority on reducing inequities, and evaluate and reform their health programming and financing strategies with a view to moving toward universal health coverage.

Achieving equity in maternal health, however, requires multi-sectoral efforts that go beyond the health system, such as encouraging girls' education, discouraging families from marrying off their daughters at a young age, and raising the status of girls and women in family and society. Policies and programs need to address the broader cultural, legal, economic, and political circumstances that limit opportunities for girls and women. Promoting gender equality and girls and women's empowerment should take a central place in such efforts, making them not only national development goals on their own, but also an integral part of all development strategies, particularly those aimed at improving maternal health.

Finally, governments need to ensure that their development strategies are informed by evidence. They should gather data, analyze, and report on maternal health by subnational and socioeconomic groups (e.g., by income level, age, place of residence, migrant status, and ethnic origin) and for the lowest administrative district, in a timely manner. Such data will not only help guide policies and programs, but also allow countries to track progress in improving maternal health across the entire population, with the goal of "leaving no one behind."

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Delivering a world where every pregnancy is wanted every childbirth is safe and every young person's potential is fulfilled