Global progress on improving maternal and child health has been hard-won and deeply uneven. Researchers supported by IDRC focus on the root causes of inequities and how health systems can better meet the needs of women and children.

According to United Nations’ estimates, in 2010, some 800 women died every day from complications of pregnancy or childbirth, 99% of them in developing countries. Some 7.6 million children died before the age of five. While these numbers are high, they do reflect considerable gains for maternal and child health since countries agreed in 2000 to a set of ambitious development targets for 2015. A closer look reveals that these gains are socially and geographically uneven. Maternal mortality is higher in rural areas and among poorer communities. Deaths in children under five are increasingly concentrated in sub-Saharan Africa and South Asia. In two-thirds of countries that have made progress on child mortality, the gap between rich and poor actually increased. This reflects inequities at many levels, and underscores the fact that health services are not reaching those who most need them.

In many regions, the inadequate care women receive stems from their low social status. From childhood on, girls have less access to education and poorer nutrition. As they grow older, they are excluded from economic and political participation, and suffer domestic violence. Too often, women are the last to eat, and the last to receive medical treatment.

Addressing the root causes of poor maternal and child health

Through its Governance for Equity in Health Systems (GEHS) program, Canada’s International Development Research Centre (IDRC) brings a unique perspective to maternal and child health in low- and middle-income countries. Going beyond a narrow focus on illness and treatment, IDRC promotes research that explores the root causes and systemic factors undermining women’s and children’s health.
While women commonly die in childbirth and pregnancy from hemorrhage or infection, the underlying causes include malnutrition, domestic violence, and their lack of education and decision-making power. These conditions find fertile ground when poverty intersects with a lack of respect for women’s rights and needs.

With GEHS support, researchers in low- and middle-income countries are addressing how effective health systems are in meeting the needs of mothers and their children. They are using social and gender analysis to understand how health care is governed and implemented, how resources are allocated, and how the systems can support the empowerment of women.

**Applying a gender lens to health policy in India**

In India’s Karnataka state, girls and women face many barriers stemming from their low social status that are exacerbated by poverty and caste. Researchers with the Indian Institute of Management in Bangalore are exploring how power dynamics within households and communities affect women’s health outcomes. Using a gender framework to explore social norms is essential, says research leader Gita Sen.

"Why would a woman with chronic pelvic inflammatory disease or severe back pain never go near a doctor? Is it because she has been socialized to believe that is the norm?"

Dr Gita Sen, Professor of Public Policy at the Indian Institute of Management Bangalore

The project features a series of studies of the underlying causes of maternal illness and death, where routine patterns of deprivation and abuse are often hidden. For example, a review of verbal autopsies — interviews conducted following a death — suggested that oversights and bias may be masking the true causes of women’s deaths. While nearly two-thirds of pregnant women in Karnataka suffer from nutrition-related anemia — which increases pregnancy risks — such common underlying conditions were not recorded. And with verbal autopsies normally conducted by a single medical officer — often one involved in the patient’s treatment — health worker errors or failure to take action in emergency situations were underreported.

The team is working backwards from data on maternal deaths to identify the prevalence of violence and its consequences. And given the rates of under-nourishment, teen pregnancy, anemia, and domestic abuse in the area, action research in 15 villages is testing interventions designed to help health workers address these potential risk factors much earlier than usual.

To ensure evidence informs health policy and practice, researchers are also working with state officials to improve maternal health services. They are creating village-level support groups and district-level advocacy for safe motherhood, and building overall awareness on maternal rights and safety. Lessons from these interventions are also being shared at the community, state, national, and international levels through existing platforms, including the Fostering Knowledge-Implementation Links Project, an effort commissioned by the Karnataka state government to strengthen the evidence base for public health.

*In rural Karnataka, a mother and newborn child are confined to a dark and poorly ventilated room. Research and advocacy efforts are helping to support new mothers while building awareness on maternal rights and safety.*
Removing cost barriers — lessons from West Africa

Despite recent progress, as a region, sub-Saharan Africa has the highest rates of maternal, infant, and child mortality in the world. From 2009 to 2012, researchers led by Niger’s Laboratoire d’études et de recherches sur les dynamiques sociales et le développement local (LASDEL) analyzed government efforts in Burkina Faso, Mali, and Niger to increase access to health care by removing user fees.

In these three West African countries, nearly half the populations live in poverty, with women and children particularly at risk. Fees were removed or reduced for treatment and prevention of HIV/AIDS and malaria, caesarean sections and other deliveries, and care of pregnant women and children under five. In Niger, contraception and cancer treatment for women were also covered.

Research confirmed that removing financial barriers clearly increased access and use of health services among the poorest women, but found that poor planning and implementation threatened the quality of services provided. How the fee exemptions were introduced created new demands on already weak health systems. In Burkina Faso, for example, staff were inadequately prepared and complained of unmanageable workloads. Communities were poorly informed about the subsidies, and there were unclear boundaries between free services and those that were partly subsidized.

One of the biggest challenges in Niger, noted researcher Aïssa Diarra, were disruptions in medical supplies:

“The analysis suggests new policies and programs must reflect on-the-ground realities. Removal of user fees is not enough; governments need to put in place the organizational, technical, and financial mechanisms required to ensure the quality of primary health care is not undermined.

LASDEL is now leading a new five-year research and training effort that targets neglected problems within West African health systems. It will focus on sensitive areas crucial to maternal and child health, such as norms of practice among midwives, and the treatment of women who have experienced interrupted pregnancies. The aim is to inform public debate and mobilize policymakers, training institutions, and unions on systemic issues which stand in the way of healthcare reforms.

Ensuring Southern input on global action

The voices and experience of developing country researchers are too often missing when international donors and decision-makers gather to address global health issues. Strengthening capacity and creating space for Southern expertise is one of IDRC’s most important contributions.

In 2011, a United Nations commission was struck to address the lack of affordable and effective treatment, tools, and medical supplies for addressing maternal and child health. To ensure input from regions most affected by these gaps, IDRC supported developing-country case studies and the participation of five Southern-based commissioners.

Published in 2012, the Report of the UN Commission on Life-Saving Commodities for Women and Children endorsed 13 life-saving products that it calculates could save more than 6 million lives if widely accessed and properly used. Recognizing the broader challenges many low-income countries face —
in governance, human resources, supply chains, and information systems — the Commission called for 10 specific actions to be linked with other initiatives to strengthen overall health systems. Making these connections is vital, as commodities are just one small part of what a strong health system should provide.

**Monitoring inequities in East and Southern Africa**

While sub-Saharan Africa struggles to improve the health of its women and children, there are great differences within and among countries. The EQUINET research network promotes and monitors progress toward health equity in East and Southern Africa. Its *Equity Watch* report series pinpoints areas and groups that are un/reached or underserved, and lays bare the social disparities undermining public health. The latest update, *Regional Equity Watch 2012*, notes widening social gaps alongside overall health progress in 16 countries. In some, nearly one in five children under the age of five dies in the poorest households. Even as overall child mortality has improved, the poor are faring worse. And while overall fertility rates are falling, they remain higher among teenage girls from poor and rural areas.

Besides tracking these trends, the report helps isolate the underlying factors that make a difference. Wealth matters of course — children from the poorest homes are three times more likely to be undernourished than those from the wealthiest. But maternal education matters even more — undernourishment varies by a factor of five between the households of the best educated mothers, and those with the least schooling.

The report points to a wide range of inequities that undermine women and children’s health: uneven access to safe water and sanitation; low and unequal coverage of early childhood education, child care, and secondary education; and inadequate access to land and other support for female food producers. In publishing these periodic reports, EQUINET monitors progress and involves, informs, and prods governments at the same time. Why, the report’s authors ask, shouldn’t all children, adolescents, mothers, and households expect the same nutrition, health, and mortality outcomes as the wealthiest and best educated?