EPI-4

Evidence for Policy and Implementation

Inequity in Maternal Health in Gujarat

A study that analyzed district-level health survey data in order to help policy-makers focus efforts. It identified the most disadvantaged populations in relation to maternal health in Gujarat and showed wide disparities in access to maternal health services, particularly related to poverty and caste.

Keywords
Access, antenatal care, Gujarat, health care utilization, inequity, maternal health, poverty, skilled birth attendance, social class

Results

Poverty & social class as main sources of inequity in maternal health

The most significant source of inequity in relation to use of maternal health services in Gujarat is poverty. The poor, regardless of caste, are almost six times less likely to access antenatal care services in Gujarat. Amongst the non-poor, women from scheduled tribes, scheduled castes and socio-economic backward castes were two times less likely to use antenatal care services. Furthermore, the effects of poverty and caste on use of maternal health services are independent of age of mother, age at marriage (before or after 18), and place of residence, indicating that these differences cannot be explained by the poor being more likely to marry young or to live in rural areas. Although almost half (47%) of the mothers in the survey experienced problems during delivery, only 59% received a postnatal care (PNC) check within 48 hours of delivery. The socio-economic inequalities in use of PNC among these mothers were high, with the rich-poor ratio being 2.62.

Policy considerations

- Review & refocus existing policies in order to reduce inequalities in maternal health.
- Assess health deprivation among the poor: Availability of maternal health services alone may not be sufficient, unless they are supported by a policy of greater subsidization.
- Initiate targeted interventions for better delivery of services and tools directly to the people in need.
- Take decisions on resource allocation for public health need along with related topics like poverty and girls education. It will affect the efficacy of the policy matrix in total.
- Invest in health and education. They are complementary in nature and, if combined, will produce large individual and social benefits.

“Effects of poverty and caste on use of maternal health services are independent of age of mother, age at marriage and place of residence.”
Rationale of the study

Maternal health in India and Gujarat

India has committed to achieve Millennium Development Goal (MDG) 5 to reduce maternal mortality by three-fourths between 1990 and 2015. The government has placed high priority on safe motherhood in recent years and has devoted substantial attention and funds in its flagship program National Rural Health Mission. However, there is evidence that wide disparities exist in access to and use of maternal health services in India on the basis of socioeconomic status, caste, ethnicity, education, gender and age (1).

Gujarat, often termed as India’s economic growth engine, is one of the wealthiest states in India with 42.6% of its population living in urban areas as compared to the national average of 31.6% (46% in Tamil Nadu and 45% in Maharashtra) (2). The state has a growth rate of more than 10%. The state has shown improvements in overall health status with the state being ahead (78.1%) of the national average (72.9%) in the proportion of mothers with institutional delivery. The maternal mortality ratio in Gujarat is estimated to be 148 per 100,000 live births (compared to the national average of 200), but the downward trend in maternal mortality seems to be slowing. (3).

Accelerating the reduction of maternal mortality

The Government of Gujarat has taken action to accelerate the reduction of maternal mortality through improving the functioning of health care systems for obstetric and neonatal emergencies with public-private partnership voucher schemes like Cheerenjevi yojana and Bal sakha Yojna. These measures have been complemented by investments in health facilities, supply of essential drugs, the availability and skills of doctors and midwives, and the development of procedures for ensuring quality of care, transferring women, and managing obstetric complications. Strengthened health information systems like e mamta support implementation.

Expanding public health provision through health programmes can yield big gains, especially in reducing maternal mortality. Once these “low hanging fruits” have been collected, however, the problem becomes more concentrated in populations that are harder to reach, more vulnerable and less accessible to public policy interventions.

Methods

Secondary data analyses were conducted on raw data of the Gujarat District Level Household and Facility Surveys (DLHS) from 2005-06. Information from a total of 24,513 ever married women age 15-49 years were included in the survey (4). The analyses were based on the Social Determinants of Health framework (5). The structural determinants selected for the present study were education, caste and wealth index. The intermediary determinants were age, place of residence of mother and age at marriage of mother. The outcome variables represent three important components of optimal maternal health care: institutional delivery, use of any modern contraceptive method, and at least 3 antenatal care (ANC) visits.

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Selected literature