

Exploring socioeconomic inequalities in maternal and child health coverage in Latin America and the Caribbean

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Abstract

Background. Maternal and child health have shown important advances in the world in recent years. However, national averages indicators hide large inequalities in access and quality of care in population subgroups. We explore socioeconomic inequalities affecting health coverage and interventions in reproductive, maternal, newborn, and child health in Latin America and the Caribbean.

Methods. We analyzed representative national surveys from 15 countries conducted between 2001 and 2016. We estimated maternal-child health coverage gaps using the Composite Coverage Index – a weighted average of interventions that include family planning, maternal and newborn care, immunizations, and treatment of sick children. We measured absolute and relative inequality to assess gaps by wealth quintile. Pearson's correlation coefficient was used to test the association between the coverage gap and population attributable risk.

Results. The Composite Coverage Index showed patterns of inequality favoring the wealthiest subgroups. In eight countries the national coverage was higher than the global median (78.4%; 95% CI: 73.1-83.6) and increased significantly as inequality decreased (Pearson $r = 0.9$; $p < 0.01$).

Conclusions. There are substantial inequalities between socioeconomic groups. Reducing inequalities will improve coverage indicators for women and children. Additional health policies, programs, and practices are required to promote equity.

Background

Reproductive, Maternal, Newborn, and Child Health (RMNCH) has been a global health policy priority for the past decade [1]. The Millennium Development Goals (MDGs) contributed enormously to the health of women and children, managing to reduce maternal and under-five years' old mortality and improved other indicators such as access to contraceptives, skilled attendance at childbirth, and measles vaccination [2]. Despite the progress, most regions did not reach the proposed goals, showing uneven progress that has left gaps between countries, especially in Latin America and the Caribbean (ALC) [3] [4].

The 2030 agenda for Sustainable Development Goals (SDGs) broadens the scope of the MDGs, assuming the commitment to leave no one behind. The SDG-3.8 promotes universal health coverage in terms of access to quality healthcare services, medicines, and vaccines for all [5]. More granular analysis of indicators can show whether all subgroups of the population will benefit from national progress or not [6]. Monitoring inequalities allow identifying vulnerable groups and prioritizing interventions in those who need it the most, thus promoting health coverage through equity [7]. We analyzed the Composite Coverage Index (CCI) as an indicator of universal healthcare coverage gaps in women and children. The index combines preventive and curative interventions throughout the continuity of care, family planning, maternal and newborn care, immunization, and treatment of sick children and has been used to monitor SDGs progress [8] [9].

Previous studies have emphasized the socioeconomic inequalities between countries implementing the CCI, but only a few have focused on the LAC situation [10] [11] [12]. Therefore, the scope of health interventions and the level of improvement needed to narrow the gap needs to be adequately defined. This study explores socioeconomic inequalities in RMNCH care coverage and its impact on reducing the gap in the LAC countries between 2001 and 2016.

Methods

This was an observational study based on secondary RMNCH coverage data obtained from Demographic Health Surveys (DHS) and Multiple Indicators Cluster Survey (MICS). These indicators have been defined in the Health Equity Monitor Database from World Health Organization (WHO) [13]. The surveys carried out national representative and standardized interviews with women 15–49 years old. We included 15 of 22 countries with surveys conducted between 2001 and 2016 based on the availability of recent data on the Composite Coverage Index and wealth quintile.

The CCI is a weighted score based on aggregate estimates of eight essential interventions for the continuing of care for women and children, from before pregnancy to delivery, the immediate postnatal period, and childhood [14]. The index is calculated using the formula:

$$CCI = \frac{1}{4} \left(DFPS + \frac{ANC4 + SBA}{2} + \frac{BCG + 2DPT3 + MCV}{4} + \frac{ORS + CPNM}{2} \right)$$

where DFPS = satisfied demand for modern family planning methods; ANC4 = prenatal care (at least four visits); SBA = deliveries attended by qualified personnel; BCG = one dose of Bacillus Calmette-Guérin vaccine; DPT3 = three or more doses of diphtheria-tetanus-pertussis vaccine; MCV = at least one dose of measles vaccine; ORS = children with diarrhea receiving oral rehydration therapy and continuous feeding; NSCLC = children with pneumonia symptoms taken to a health center [15].

We calculated CCI's mean, median, and standard deviation for each country. We analyzed socioeconomic inequality using the wealth index, which is an estimate based on the ownership of selected assets, housing construction materials, and access to basic services. The details of wealth index estimation have been previously described [16]. Households are classified from the poorest (Q1) to the richest (Q5) [17].

To compare patterns of inequality between and within countries, first, we calculated the coverage difference to show the magnitude of absolute inequality (Q5-Q1); second, the coverage ratio to show proportional differences between groups (Q5 / Q1) and third, the ratio of differences between coverages in lower (Q1-Q2) and higher quintiles (Q4-Q5). Finally, we use population attributable risk (PAR) to show the possible improvement if the general population hypothetically had the same coverage level as the wealthiest quintile (CCI-Q5). We estimated the PAR percentage (PAR%) to show the proportion of improvement in national coverage if socioeconomic inequality would have been eliminated (PAR / CCI * 100) [18]. We used Pearson correlation to measure the degree of relationship between the CCI and the PAR%. The analyses were performed using Microsoft Excel.

Results

Table 1 shows the average coverage by wealth quintile for each of the maternal and child health interventions. The coverage gap tended to be smaller as the income level improved. National coverage was greater than 78% in all interventions except family planning and treatment of sick children. The greatest inequality occurred in skilled attendance at birth and prenatal care, where the difference between the wealthiest and the poorest was 26.4% and 17.3%, respectively. The difference was relatively smaller in the immunization indicators, where the absolute inequality was more pronounced in the coverage of DTP3 than in BCG and measles. The difference ratio was well over 1.0 for most of the interventions, showing a wide gap to the detriment of the poorest quintile, except in the vaccination against measles.

Table 1
Mean coverage of inequality gaps in interventions by wealth quintile, LAC 2001–2016.

Indicators	Coverage gap by wealth quintile (%) [SD]						Equity measure		
	National	Q1	Q2	Q3	Q4	Q5	D	R	RD
Satisfied demand for modern family planning methods	67.2 [19.3]	63.6 [19.8]	70.7 [18.5]	72.6 [16.6]	75.7 [15.5]	78.8 [15.0]	15.2	1.2	2,3
Prenatal care (at least four visits)	88.4 [9.0]	77.7 [14.5]	85.8 [11.3]	88.3 [8.2]	91.7 [5.7]	95.0 [3.5]	17.3	1.2	2,5
Births attended by qualified personnel	86.7 [15.9]	71.6 [25.5]	86.3 [20.5]	91.9 [14.8]	95.3 [10.0]	98.0 [4.6]	26.4	1.4	5,4
Tuberculosis vaccination in children under one year of age	96.1 [4.0]	94.0 [6.7]	96.1 [4.2]	96.4 [4.7]	97.4 [2.3]	98.4 [1.5]	4.4	1.0	2,1
Vaccination against Diphtheria-tetanus-pertussis in children under one year (three doses)	84.2 [11.9]	80.9 [14.4]	83.8 [13.7]	84.6 [13.9]	86.5 [9.5]	88.0 [8.9]	7.1	1.1	1,9
Vaccination against measles in children under one year	78.1 [11.1]	77.0 [12.7]	77.4 [14.0]	76.3 [13.6]	80.0 [10.2]	82.0 [7.9]	5.0	1.1	0,2
Children under five with diarrhea receiving oral rehydration therapy and continuous feeding	53.7 [15.4]	49.3 [13.7]	53.7 [19.7]	54.6 [15.6]	57.8 [17.6]	60.0 [14.0]	10.7	1.2	2,0
Children under five with pneumonia symptoms taken to a health center	70.5 [14.0]	64.7 [16.3]	68.8 [19.5]	65.3 [16.0]	74.9 [17.8]	77.0 [15.0]	12.3	1.2	2,0
Source: Own elaboration based on study data.									
SD: standard deviation; D: difference; R: Ratio; RD: Ratio for differences.									

Table 2 shows the coverage gaps and inequalities by wealth quintiles for each country. The national median was 78.4% (Range: 49.8% [Haiti] – 86.6% [El Salvador]) and from 71% for the poorest quintiles and 82% for the wealthiest. In three countries - Haiti, Bolivia, and Guatemala - wide differences (> 21 percentage points) were observed between the wealthiest and poorest quintiles. Guyana, Costa Rica, and Paraguay were the only countries with the lowest coverage in the wealthiest quintile. Belize, Costa Rica, the Dominican Republic, El Salvador, Guyana, Honduras, Mexico, and Paraguay showed low levels of inequality, where the difference between the wealthiest and poorest quintiles was 10 percentage points or less. Haiti was the country with the highest level of relative inequality, with coverage in the wealthiest quintile that exceeds that of the poorest by a factor of 1.7. The ratio of differences between the lowest and highest quintiles was greater than 1.0 in nine countries, showing a predominant pattern of higher inequality where the wealthiest quintile had disproportionately less coverage than all the other quintiles, led by Colombia. Reducing wealth-related inequality had the potential to narrow the national gap between 0.4% (Costa Rica) and 31% (Haiti). If all countries could reach the median overall coverage for the wealthiest quintile, the gap would decrease by 3.9 percentage points (95% CI: 1.4–6.3).

Table 2
Inequality gaps in CCI by wealth quintile, LAC 2001–2016.

Countries	Coverage gap (%)			Equity measures									
	Survey	Year	National	Q1	Q2	Q3	Q4	Q5	D	R	RD	PAR	PAR%
Belize	MICS	2015	77.3	71.2	77.1	79.8	77.6	81.0	9.80	1.1	1.7	3.7	4.8
Bolivia	DHS	2008	61.7	49.4	58.0	64.1	68.8	73.8	24.4	1.5	1.7	12.1	19.6
Colombia	DHS	2010	81.1	73.8	81.9	84.0	84.4	84.7	10.9	1.1	27.0	3.6	4.5
Costa Rica	MICS	2011	84.7	81.4	88.2	80.4	86.0	85.1	3.70	1.0	-7.6	0.4	0.5
Dominican Republic	MICS	2014	78.4	74.3	78.2	80.5	78.3	82.2	7.90	1.1	1.0	3.8	4.8
El Salvador	MICS	2014	86.6	84.1	86.5	87.5	86.5	89.1	5.00	1.1	0.9	2.5	2.9
Guatemala	DHS	2014	68.9	58.7	64.2	70.7	75.9	80.1	21.4	1.4	1.3	11.2	16.3
Guyana	MICS	2014	73.7	70.6	73.3	71.6	78.5	72.7	2.10	1.0	-0.5	-1	-1
Haiti	DHS	2016	49.8	37.9	43.8	51.6	58.3	65.3	27.4	1.7	0.8	15.5	31.1
Honduras	DHS	2011	79.7	74.1	78.8	81.3	82.2	83.6	9.50	1.1	3.4	3.9	4.9
Mexico	MICS	2015	81.3	79.4	78.8	78.6	85.4	86.7	7.30	1.1	-0.5	5.4	6.6
Nicaragua	DHS	2001	75.3	63.6	75.9	79.2	79.8	82.2	18.6	1.3	5.1	6.9	9.2
Panama	MICS	2013	79.0	65.2	83.8	81.0	89.0	83.8	18.6	1.3	-3.6	4.8	6.1
Paraguay	MICS	2016	81.5	78.9	81.5	83.3	82.3	82.8	3.90	1.0	5.2	2.3	2.8
Peru	DHS	2016	74.3	65.4	74.2	75.2	79.0	80.8	15.4	1.2	4.9	6.5	8.4
Median			78.4	71.2	78.2	79.8	79.8	82.2	9.80	1.1	1.3	3.9	4.9
95% CI for the mean			73.1–83.6	64.2–78.1	71.7–84.6	74.7–84.8	75.5–84.0	78.8–85.5	5.3, 14.2	0.9–1.2	1.4–6.8	3.1–7.8	3.6–12.7
Source: Own elaboration based on study data.													
CI: confidence interval; MICS: Multiple Cluster Indicator Survey; DHS: Demographic Health Survey; D: difference; R: Ratio; RD: Ratio of differences; PAR: Population attributable risk; PAR%: Percentage of population attributable risk.													

Figure 1 shows the relationship between the CCI gap and PAR% in the study countries. It was observed that healthcare coverage increased significantly as inequality decreased (Pearson $r = 0.9$; $p < 0.01$). To achieve equality in the distribution of RMNCH interventions, Haiti (31.1%), Guatemala (16.3%) and Bolivia (19.6%) would need to make a greater effort to reduce the ICC gap at their respective levels.

Discussion

The LAC region has experienced a considerable improvement in maternal and child health post-2015 sustainable development agenda [7]. Despite the progress, it is currently considered the most unequal region in the world, which represents a major challenge for the SDGs [19].

We explore current socioeconomic inequalities in RMNCH coverage in 15 LAC countries. Our findings reveal important inequalities in maternal and child health interventions, pointing out that in some groups of the population women and children are lagging.

As shown in this study, essential preventive and curative interventions showed a monotonous pattern with lower levels in the poorest quintile. The inequality gap was greater in interventions that required a functional health system and recurrent interaction with

interventions, coverage of RMNCH interventions was lower than that in more than half of the poorest countries. Only Costa Rica and El Salvador reached this level in the poorest quintile. The difference between the wealthiest and the poorest was at least 9.8 percentage points in more than half of the countries. Haiti, Bolivia, Guatemala, Peru, and Nicaragua showed lower national coverage and absolute inequality above the regional median. Colombia showed greater inequality of coverage in the top quintiles despite not having a wide gap like other countries. These findings imply the need for health systems that prioritize adequate care to reduce the gaps in women and children from the poorest households [7] [10]. Although the countries of the region have indeed implemented reforms to provide health services without the risk of impoverishment, an approach of social determinants and human rights that considers the dimensions of inequality is still required: income, gender, place of residence and education, among others [20] [21].

Achieving equity represents a much greater challenge for Colombia, Costa Rica, Haiti, Honduras, Mexico, and Panama than for other countries in the region, since they are part of the ten most unequal countries in the world [22]. If socioeconomic inequalities were eliminated, most countries could achieve coverage of RMNCH interventions of more than 82%. The relationship between CCI and PAR% suggests that to reduce the gap in coverage of health services, the implementation of policies and programs can be effective in addressing inequalities within each country [11]. Policies should be focused on five areas: (i) development of health infrastructure; (ii) health promotion; (iii) health human resources; (iv) healthcare financing, and (v) quality of care [23] [24] [25].

There is a political commitment to understanding inequalities, encompassing efforts to support the monitoring and evaluation of inequities, health policies, and systems. However, the possibilities of achieving the SDG goals will depend on the ability of countries to accelerate and maximize their achievements in well-being [26]. The study, publication and discussion of the determinants of equity in the coverage of interventions and their impact on health contribute to increases in the effectiveness of public policies [27].

This study has several limitations. Coverage estimates are based on reanalyzed data from demographic surveys with a cross-sectional design. The analysis is limited to the availability and quality of data in each country. The strong correlation between CCI indicators does not allow us to calculate the standard error [7]. The household ranking of the wealth index may vary by year and country. The results of this study should be interpreted in the context of each country, so they should be taken with caution. Despite the limitations, our findings are based on the best method to explore gaps in care coverage between rich and poor [28].

Conclusions

Overall, our results suggest that women and children from the poorest households in LAC are far from achieving universal health coverage due to inequalities. Our findings show how RMCNH coverage could improve if inequalities were eliminated. Overcoming inequalities will substantially reduce the extreme poverty gap, maternal and child mortality, and promote sustainable development. Future research is needed to monitor inequalities as a critical component tracking the progress of the SDGs so that no one is left behind. We hope that our findings contribute to the design of public policies and strategies to reduce inequalities for women and children in the LAC region.

Abbreviations

ALC: Latin America and the Caribbean; ANC4: prenatal care (at least four visits); BCG: one dose of Bacillus Calmette-Guérin vaccine; CCI: Composite Coverage Index; CI: Confidence interval; D: difference; DFPS: satisfied demand for modern family planning methods; DHS: Demographic Health Survey; DHS: Demographic Health Surveys; DPT: three or more doses of diphtheria-tetanus-pertussis vaccine; MCV: at least one dose of measles vaccine; MDGs: Millennium Development Goals; MICS: Multiple Cluster Indicator Survey; NSCLC: children with pneumonia symptoms taken to a health center; ORS: children with diarrhea receiving oral rehydration therapy and continuous feeding; PAR: Population attributable risk; PAR%: Percentage of population attributable risk.; R: Ratio; RD: Ratio for differences; RMNCH: Reproductive, Maternal, Newborn, and Child Health; SBA: deliveries attended by qualified personnel; SD: standard deviation; SDGs: Sustainable Development Goals

Declarations

Ethics approval and consent to participate

All analyses are based on publicly available data from demographic surveys.

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Consent for publication

Not applicable.

Availability of data and materials

The datasets used in this article are available in the WHO Health Equity Monitor Database repository at <http://apps.who.int/gho/data/node.main.HE-1540?lang=en>.

Competing interests

The authors declare they have no competing interests.

Funding

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Authors' contributions

MC conceived and designed the study, carried out the statistical analysis, and drafted the paper; JD and AG analyzed the data, interpreted the results, and contributed to drafting the manuscript. All authors read and approved the final manuscript.

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Figures

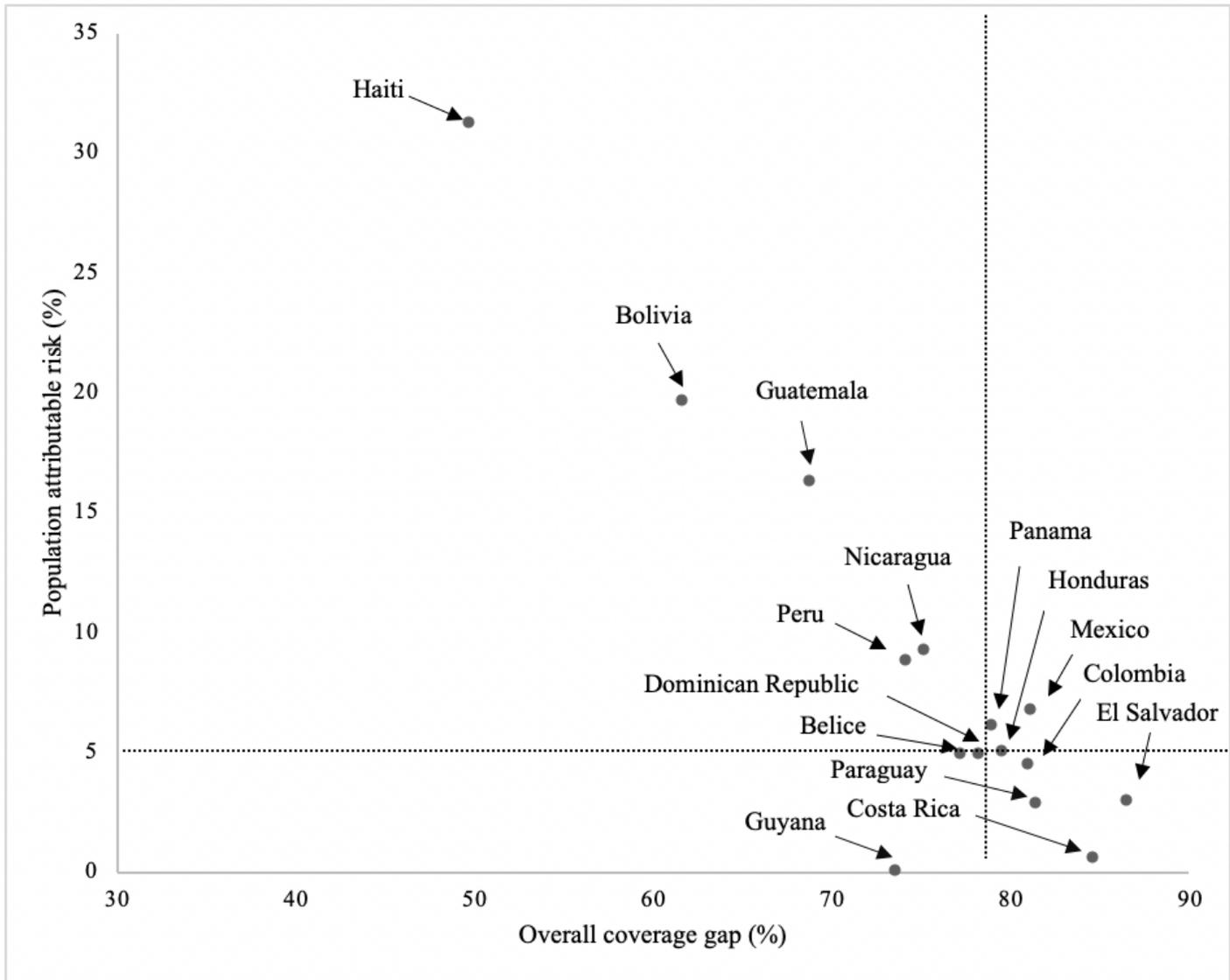


Figure 1

Coverage gap at the national level versus population attributable risk in LAC countries, 2001–2016. a Source: Own elaboration based on study data. a Dashed lines indicate the median.