

Call to address ethnic inequalities in access to RMNCH services



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In *The Lancet Global Health*, Marilia Mesenburg and colleagues present analyses of the ethnic gaps in coverage of reproductive, maternal, and child health (RMNCH) services across 16 Latin American and Caribbean countries.¹ This important study could help to address health equity problems for ethnic minority populations in these regions. The authors considered four outcomes of RMNCH services: coverage with modern contraception, antenatal care coverage, skilled birth attendants at birth, and coverage with three doses of diphtheria-pertussis-tetanus vaccine among children aged 12–23 months. In most of the countries studied, coverage with modern contraception (median coverage ratio 0.82, IQR 0.66–0.92), antenatal care (0.86, 0.75–0.94), and skilled birth attendants (0.75, 0.68–0.92) was lower among indigenous women than in the reference group. Vaccine coverage among children only showed significant gaps in three countries. The lower uptake of services for indigenous women compared with their non-indigenous counterparts persisted after adjustment for household wealth, women's education, and urban-rural residence. However, the reasons why indigenous populations are lagging behind have not yet been fully explored.

The international literature suggests that two types of factors—intrinsic or personal factors including particular socioeconomic status, cultural norms, and competence in language; and extrinsic or organisational factors focusing on geographical location, service provision, and health policies—play a part in differential access to health services and worse health outcomes among ethnic minorities.^{2,3} As the authors conclude, the differences in wealth, education, and residence considered in their work cannot completely explain the gaps in RMNCH service coverage between indigenous and non-indigenous populations. Factors such as cultural beliefs or institutional barriers are not easily measured or are rarely considered in national surveys.⁴ Without considering these factors, it might be difficult to fully understand the underlying causes for ethnic disadvantage in RMNCH use. Qualitative research can explore this phenomenon more deeply and provide more information on the barriers faced by indigenous populations in accessing health services

One important finding from Mesenburg and colleagues' work is that although people of African descent were considerably poorer than the reference groups (which were composed mainly of people of European descent), they had similar levels of RMNCH service coverage to the reference groups. The authors suggest that this might be partly because people of African descent—unlike indigenous populations—are predominantly urban in most of the countries considered in the study. Urban residence could facilitate access to health services in at least three ways. First, geographical location could be a main concern when deciding to seek care and reaching care after a decision has been made. Previous studies in both African and Asian settings have shown that women who live in remote villages are less likely to access health-care services.^{5–7} Second, some rural health facilities might be underused owing to the poor quality of their services; a negative reputation of inadequate capacity and poor service attitude could prevent people from going to a health facility, even if its location is convenient.^{4,8} Third, rural populations might have more traditional beliefs that makes their receptivity to modern medical practice less than that of urban residents.⁴ The misunderstanding caused by the conflicts between clinical practices and local norms could prevent people from seeking care.^{9,10} These three considerations seem fundamental to understand the ethnic disparities in health-care use between indigenous and non-indigenous populations. However, the authors were unable to explore them in the present study because of data limitation. Future studies focusing on service provision are needed that could benefit national or community health planning.

Another crucial finding from Mesenburg and colleagues' work is that the services delivered at community level through campaigns such as immunisation and antenatal care are less inequitable than are services that require access to health facilities (eg, contraceptives or skilled attendant at birth). Therefore, community-based health interventions including health education campaigns conducted by community health workers who understand the local culture and language could be possible ways to increase health awareness and further change care-seeking behaviours. The authors suggest that another potential reason for the ethnic inequalities in RMNCH

coverage between indigenous and non-indigenous populations is that services requiring access to health facilities might incur additional costs in user fees and transportation. The provision of small financial support such as a transportation subsidy might encourage use of health-care facilities among poorer populations. We hope that the messages from this study will not only raise awareness of the ethnic inequalities that exist in RMNCH service coverage and use, but will also motivate the conception and delivery of health-care interventions for ethnic minorities living in remote and poor communities.

The Countdown to 2030 continues to improve maternal and child health globally. Ethnic minorities who shoulder a disproportionate share of the overall burden of adverse health outcomes are the target of policies and interventions aiming to achieve country-level progress by increasing the coverage of essential RMNCH interventions. A comprehensive understanding of the reasons underlying the ethnic variation in needs and access to RMNCH services is fundamental. Mesenburg and colleagues' Article should not be seen as a final product showing the severity of ethnic inequalities, but a launch pad for future studies. We call for more works to improve the information base about ethnic minorities over the world to guide future implementation of policy initiatives.

Yuan Huang

West China School of Public Health, Sichuan University, Chengdu 610041, China and London School of Hygiene and Tropical Medicine, London, UK
yuan.huang@hotmail.com

I declare no competing interests.

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