



FEATURES

Neglect and Excess: The Two Faces of Maternal Health Inequity in South Asia

Photo courtesy of UNICEF

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Introduction

South Asia's maternal mortality story is one of both success and stubborn inequity. As the world's most populous region—and home to nearly a third of all global maternal deaths—it offers urgent insight into how inequity can persist even amid progress. Between 2000 and 2023, the region achieved a 71% decline in its maternal mortality rate, from about 405 to 117 maternal deaths per 100,000 live births, one of the steepest reductions globally (World Health Organization, 2025). However, that progress is deeply unequal across socioeconomic status. Women in remote areas, lower-income households, and marginalized communities continue to face preventable death during childbirth due to gaps in care. At the same time, wealthier urban women increasingly experience the opposite problem: the over-medicalization of birth, including the widespread implementation of unnecessary caesarean sections (C-sections). Fragmented health systems in South Asia, driven by unequal public investment and unregulated private expansion, create a dual crisis in maternal care:

the neglect of marginalized women and the exploitation of those with access to private medicine.

Underuse of Life-saving Care: Neglect

Since public investments remain focused on urban hospitals while rural facilities lack resources, many women in poorer and remote communities still struggle to obtain even the most basic maternal care. Improvements in survival have largely benefited women who are wealthier, urban, and more socially privileged. A recent study found that women in the lowest income quintile in South Asia are two to three times less likely to receive key maternal services—such as antenatal care, skilled birth attendance, or postpartum checkups—compared to their wealthiest and urban counterparts (Rahman et al., 2024). In Bangladesh, increases in hospital births have occurred mainly among affluent, urban populations, while women in remote districts still rely on home deliveries with minimal support (Nagesh et al., 2024). A similar urban bias emerges across borders: The Pakistan Demographic and Health Survey (PDHS) highlights enduring rural–urban disparities in access to emergency obstetric services (Mumtaz et al., 2017). Even within India, these inequalities

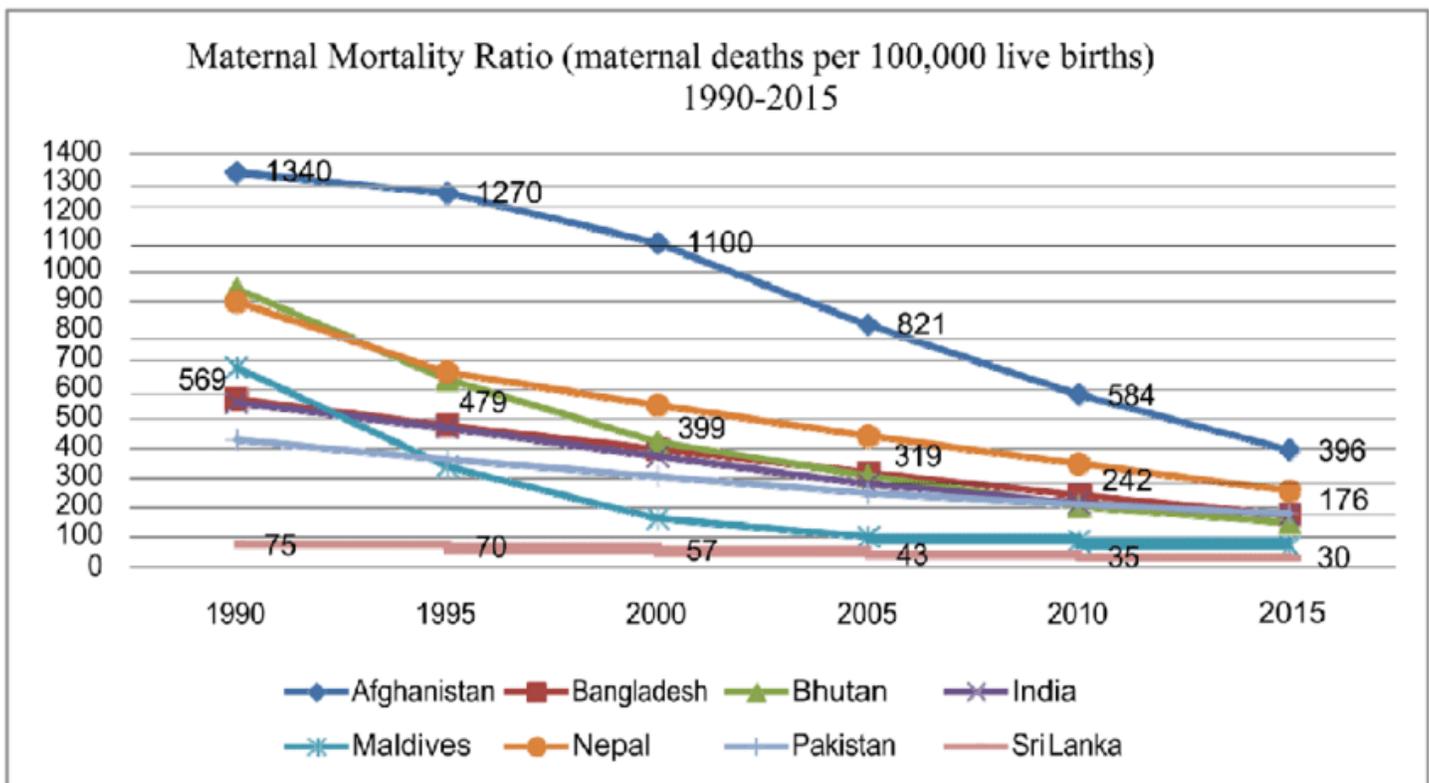


Figure 1. Trends in maternal mortality ratios across South Asia (1990–2015): Despite substantial regional declines, the figure shows wide cross-country disparities driven by differences in public investment, health system capacity, and social inequality. The contrast between low-mortality countries (Sri Lanka, Maldives) and high-mortality ones (Afghanistan, Pakistan) mirrors the structural inequities at the center of South Asia’s maternal health landscape.

persist at the state level. The Sample Registration System (SRS) Special Bulletin (2020–22) shows that the state of Assam—one of India’s poorest states by per-capita income—has a maternal mortality ratio nearly three times higher than Kerala, a southern state known for its robust public health infrastructure and high female literacy. These differences in treatment are not incidental; they reflect broader structural and institutional inequalities (Dutta et al., 2023).

The principal causes of maternal death in South Asia—postpartum hemorrhage, hypertensive disorders such as pre-eclampsia and eclampsia, obstructed labor, sepsis, and indirect sources like anemia, cardiovascular disease—are well-documented (Souza et al., 2024). In principle, these conditions are preventable or treatable with interventions such as uterotonics, safe blood transfusion, magnesium sulfate therapy, timely surgical intervention, antibiotics, and quality antenatal screening. However, they are often unavailable or inaccessible when they are most needed—especially for the women at highest risk.

A helpful framework for understanding this phenomenon is that of the “three delays”: delay in seeking care, reaching care, and receiving appropriate care upon arrival. These delays are exacerbated by poverty,

inadequate transportation, weak referral networks, gendered decision-making constraints, and limited health system capacity (El-Saharty et al., 2015).

Importantly, underuse is not simply the absence of care. Rather, it also implicates the poor quality of routine services. In some facilities, staff shortages, stockouts of essential supplies (e.g., blood and magnesium sulfate), or lack of surgical capacity turn “institutional delivery” into a false promise of safety, given that these deficiencies result in a reduced capacity to manage emergencies. Reports from parts of Bihar, Sindh, and rural India document this inequity within facilities (Nagesh et al., 2024). Thus, the first face of maternal health inequity in South Asia is structural neglect: when geography, socioeconomic status, caste, and gender govern whether a woman receives timely, life-saving care. As a result of this disparity, it is vital to redesign referral networks, strengthen quality and emergency readiness, and tackle social and logistical barriers.

Overuse of Unnecessary Care: Exploitation

C-section rates have surged across South Asia’s urban and private hospitals, often far exceeding medical need. In Bangladesh, for example, C-sections climbed from

just 3.5% of births in 2004 to 32.8% by 2017. Pakistan saw a similar rise from 2.7% to 22.3% over two decades (Rana et al., 2024). These increases are concentrated among wealthy, urban populations: C-section usage in Bangladeshi and Pakistani cities is roughly double that of rural areas (approximately 27% versus 13%; Rana et al., 2024). Private facilities amplify this trend. In Bangladesh, women delivering in private hospitals have nearly five times the odds of receiving a C-section compared to those in public facilities; in Nepal, the odds are roughly twice as high (Rana et al., 2024). India likewise exhibits stark disparities, with nearly half of the deliveries in private hospitals being C-sections versus roughly 14% in public facilities (Dutta et al., 2023). As a reference point, the World Health Organization has suggested an “ideal” C-section rate of around 10%-15% for optimal outcomes. The fact that this threshold has now been surpassed in many South Asian settings suggests that C-sections are increasingly being driven by non-medical factors rather than genuine clinical need.

Financial incentives and convenience have become major drivers of rising C-section rates in private urban care. Underpaid doctors may push elective C-sections to increase income, and scheduled operations are more convenient than unpredictable labor (Rana et al., 2024).

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Among educated and affluent women, C-sections are often seen as more modern, safer, and less painful than a vaginal delivery and are sometimes even considered a mark of status and high-quality care (Filipovic, 2014). These misconceptions can lead women to prefer unnecessary surgery (Rana et al., 2024). Family influences and media portrayals—such as television dramas and YouTube birth vlogs that frame C-sections as modern, painless, and convenient—also contribute to a cultural shift toward “planned” births (Veparala et al., 2025).

Though life-saving when indicated, unwarranted surgeries heighten risks of infection, hemorrhage, anesthesia complications, and future pregnancy problems. One analysis by Negrini et al. (2021) noted that unwarranted C-sections can triple the risk of maternal death and lead to a higher incidence of placental disorders in subsequent pregnancies. Babies delivered by C-section

without an evident need may suffer respiratory issues and have higher chances of neonatal ICU admission (Negrini et al., 2021).

Economically, C-sections cost far more than vaginal births. In the U.S., they cost about 30% more, with similar disparities in South Asia where most families pay out-of-pocket (Negrini et al., 2021). Such unnecessary procedures deepen inequities: Affluent families pay high prices for interventions of limited benefit, while scarce health funds are diverted from improving essential maternal care. Beyond the financial consequences, over-medicalization also erodes trust. The suspicion that providers may recommend surgeries for profit or convenience rather than medical need can fuel deep mistrust and dissatisfaction (Rana et al., 2024). On a broader scale, communities may become wary of institutional care, weakening the patient-provider relationship and discouraging women from seeking care altogether.

Structural Causes of the Two-Sided Inequity

The coexistence of underuse and overuse of maternal healthcare in South Asia is rooted in deeper structural flaws. As aforementioned, on one side, poor rural women receive too little care; on the other, affluent urban women are overtreated. Most South Asian governments allocate very little public funding to healthcare, resulting in weak rural infrastructure. Public health spending in the region is among the lowest in the world—for example, Bangladesh spends only about 0.4% of its gross domestic product on health, whereas even a small country like the Maldives spends about 8% (Bloch, 2020). Across countries like India, Pakistan, Nepal, and Bangladesh, government funding covers barely half, or less, of total health expenditures, leaving households to pay the rest out-of-pocket (Bloch, 2020). As a result, many rural clinics lack staff, supplies, or emergency obstetric care, and poor women often give birth in the absence of skilled attendants. In contrast, countries like Sri Lanka and the Maldives, which prioritize public health investment, have achieved much lower maternal mortality rates (Bloch, 2020). In the Maldives, where the maternal mortality ratio has declined to around 32 per 100,000 live births, and in Sri Lanka, at about 18 per 100,000 live births, strong public-health investment correlates with lower maternal death rates (World Bank Blog, 2023).

Meanwhile, the rapid but weakly regulated growth of the private sector has transformed urban maternity care. Concentrated in cities and catering to those who can pay, private hospitals often prioritize profit over patient welfare. A recent review by Veparala et al.

(2025) identifies private sector dominance and weak regulatory frameworks as key system-level drivers of rising C-section rates across South Asia. Private hospitals often have financial incentives to offer more procedures and face few penalties for excessive intervention, and insurance schemes may further encourage surgical

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deliveries by reimbursing them at higher rates. The result is an oversupply of care in privileged settings—wealthy, medically low-risk women subjected to unnecessary procedures driven by commercial rather than clinical motives.

Deep-rooted social hierarchies determine who gets neglected and who gets overtreated. Gender norms in South Asia have historically undervalued women's health, especially for the poor. In rural areas, women from lower castes or disadvantaged ethnic groups are further marginalized—not only because caste discrimination limits their access to quality care, but also because caste and class often overlap, concentrating poverty among these groups and leaving them dependent on under-resourced facilities or home delivery. This Pattern aligns with former Harvard physician-anthropologist Paul Farmer's (2010) concept of structural violence, where social structures (e.g., poverty, inequality, patriarchy) systematically harm certain groups' health. The notion that normal childbirth is for the poor, while the elite opt for surgery has been observed not only in South Asia but also in other countries, capturing how birth and quality of treatment have become a marker of status rather than a medical need (Filipovic, 2014). Regardless, women's autonomy remains constrained: The poor are denied adequate care, while the wealthy are steered towards needless procedures.

Conclusion

Overall, these dynamics expose a dual injustice at the heart of South Asia's maternal health landscape: the neglect of marginalized women and the over-medicalization of those with greater means. Similar inequities appear

wherever health systems are segmented. For instance, Brazil's maternal care system shows a familiar split: Low-income women depend on the public sector (with higher rates of natural birth), whereas private hospitals serving the rich have C-section rates of 80% to 90%, far above the recommended 15% (Filipovic, 2014). There, too, C-sections have become "modern and elegant," and vaginal birth is disparaged as something "poor women are supposed to endure" (Filipovic, 2014). By contrast, countries that have strong, well-regulated public health systems manage to avoid such extremes. Many high-income nations ensure more uniform maternity care; for example, in much of Western Europe, robust public provisioning and clinical guidelines keep overall C-section rates moderate and minimize gaps between population groups. Even within South Asia, Sri Lanka stands out as an example of more equitable maternal healthcare. Long-term public investment—including rural midwife networks and free universal maternity care—has led to high coverage of essential services and relatively low maternal mortality (Bloch, 2020). These comparisons underscore that South Asia's two-sided maternal health crisis is not inevitable, but rather the predictable result of policy choices and power structures. Adopting a structural lens—what Farmer (2010) terms a "*pathology of power*"—reveals that the exploitation of some women and the neglect of others are two symptoms of the same underlying problem: a health system stratified by wealth, geography, and social status. Addressing this will require systemic reforms, including greater public investment in underserved areas, regulation of private care to curb profiteering, and efforts to challenge the gender and class biases that have become deeply ingrained into the fabric of the health system.

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