TAKING A BROADER VIEW:
ADDRESSING MATERNAL HEALTH IN THE CONTEXT OF FOOD AND NUTRITION INSECURITY AND POVERTY

Narimah Awin
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INTRODUCTION

Health of individuals, families, and communities is influenced by a multitude of social determinants, including poverty and food security. The Commission on Social Determinants of Health (CSDH) under the World Health Organization (WHO) published in 2008 the report, *Closing the Gap in a Generation: Health Equity through Actions on the Social Determinants of Health*, which critically studied the reasons behind inequities in health and challenged the conventional view of public health. The report asserts that health inequity is not natural and is avoidable, being influenced by the circumstances in which people grow, live, work, and age, and the systems put in place for them to deal with illness. These circumstances are shaped by political, social, and economic forces.

The Commission made several recommendations in three domains: (1) improving daily living conditions; (2) tackling inequities and distribution of power, money, and resources; and (3) measuring and understanding the problem and assessing the impact of action. In 2010, the Priority Public Health Conditions Knowledge Network under the Commission published the document “Equity, Social Determinants, and Public Health Programmes” that serves as a guide for those responsible for health programmes to work with other sectors to translate these recommendations to concrete actions. Of the many social determinants of health and maternal health, poverty is one of the strongest. Often but not always consequent upon this is the role of food and nutritional insecurity. While the link between poverty and food security is established, the link between them and maternal health has not been sufficiently studied or addressed. This link needs to be understood in a comprehensive and critical manner for appropriate interventions, including formulating appropriate policies to ensure optimal maternal health through alleviating poverty and ensuring food security.

This thematic paper starts with an overview of the foundation and scope of maternal health and global initiatives to improve maternal health, including the Millennium Development Goals (MDGs). It includes a brief background on poverty and food security and the link between them, as well as how they are impacted upon by current global politics and neoliberal economics. A discussion on poverty and food security as two key social determinants of maternal health follows to establish linkage in this triad. Because gender inequality and the tradition of patriarchy are also social determinants of poverty, food security, and maternal health, these are also covered. The issue of groups especially vulnerable to poverty, food insecurity, and especially, poor maternal health is also addressed. Before concluding, this paper suggests some needed general responses covering all sectors to address the social determinants of maternal health, followed by responses to address inequities, specific
recommendations for responses by the health sector, and finally responses for ensuring that poverty eradication, food security, and maternal health are captured in the post-2015 human development agenda.

OVERVIEW OF MATERNAL HEALTH

Foundation and scope

The traditional view and scope of maternal health is the health of women in the reproductive age group (15-49 as identified by the MDGs), while they undergo the physiological state of pregnancy, followed by childbirth, and the postpartum period. This is the foundation of maternal health policies, programmes, and services.

Maternal health services are always provided along with infant and child health, recognising the intricate and inseparable link in the mother-child dyad; and are usually called maternal and child health (MCH) services, which in many countries, is the foundation of the overall health services. With new knowledge and realities, the scope of maternal and child health services is now considered too narrow. Neonatal or new-born child health and medicine has evolved considerably in the past several decades; programmes have now expanded to maternal and new-born child health (MNCH) programmes. Also, with increasing recognition of the importance of adolescent sexual and reproductive health, many maternal health programmes today encompass this stage of the life course as well, and are referred to as maternal new-born, child, and adolescent health (MNCAH) programmes. There is also new knowledge on the importance of the pre-pregnancy or pre-conception period and its impact on pregnancy. Several countries have developed programmes for this. For example, Malaysia's Ministry of Health in 2002 developed its guidelines for pre-pregnancy care.1 WHO has begun several consultations on this important service and a document has been published on the report of a consultation in 2012.2 Some of the important components of pre-conceptual care included food and nutrition.

There is also need to view maternal health within the broader ambit of sexual and reproductive health (SRH). In the WHO Global Strategy for Reproductive Health, maternal health is listed as the first of the five components of reproductive health and is expressed as “improving antenatal, delivery, post-partum, and new-born care”. The five components of reproductive health are:

1. Improving antenatal, delivery, post-partum, and new-born care;
2. Providing high quality family planning including infertility services;
3. Eliminating unsafe abortion;

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1 See the Perinatal Care Manual published by the Division of Family Health Development, Ministry of Health, Malaysia in 2002. Section 1 is on Pre-pregnancy Care. A second edition was published in 2010.
2 See the meeting report and packages of interventions Pre-conception Care to Reduce Maternal and Childhood Morbidities and Mortalities published by WHO, 2012.
4. Combatting sexually transmitted diseases, including HIV and AIDS, reproductive tract infection, cervical cancer, and other gynaecological morbidities; and

5. Promoting sexual health.

This global strategy serves as a guide to member states to design appropriate programmes and services for optimal reproductive health. For the optimal delivery of reproductive health services, the authority responsible must take into consideration the barriers to accessing these services, which may be demand-side barriers (such as poverty or remoteness) or service-side barriers (such as fee for service or poor quality care), and put appropriate interventions in place.

The direct causes of maternal deaths are clinical in nature. The leading causes are postpartum haemorrhage, hypertensive disorders manifested as pre-eclampsia and eclampsia, sepsis (especially due to unsafe abortion), obstructed labour, and medical conditions made worse by the pregnancy. However, what is important to acknowledge is the role of the factors underlying these direct causes of maternal deaths, the social determinants. This recognition will allow policy makers to design appropriate interventions to save women from dying during pregnancy and childbirth. The low social status of women in developing countries limits their access to economic resources and basic education, and their ability to make decisions relating to their health and nutrition. Some women are denied access to care when it is needed, either because of the cultural practise of seclusion or because decision-making is the responsibility of the other family members. Lack of access to and use of essential obstetric service is a crucial factor that contributes to high maternal mortality. Lack of decision-making power and alternative opportunities relegates women to a life of repeated child-bearing. Excessive physical work and poor diet contribute to poor maternal outcome (Reduction in Maternal Mortality, 1999).

**Global initiatives on maternal health**

In 1985, at the end of the International Decade for Women, maternal deaths were highlighted as an issue, with more than half a million women dying each year while giving life. In addition, it was observed that maternal and child health programmes placed emphasis on child health, thus raising the question, “Where is the M in MCH?” To address these issues, the Safe Motherhood Initiative was launched in Nairobi in 1987 to get attention of the world on the unacceptable magnitude of maternal deaths.

The International Conference on Population Development (ICPD) in Cairo in 1994 was a watershed for sexual and reproductive health rights (SRHR) and maternal health, where calls were made to recognise and respond to the influences of the broader socio-economic and political determinants of SRHR and maternal health, and where the human rights and gender perspectives were emphasised. These calls reverberated at the Fourth World Conference on Women in Beijing in 1995. The follow-up on recommendations made at these two conferences with their respective Programmes of Action and Platform for Action were examined every five years thereafter, culminating in the reaffirmation of the ICPD Programme of Action in a UN General Assembly Session on ICPD beyond 2014 and a review of the Beijing Platform for Action in 2015 at the 59th session of the Commission on the Status of Women (CSW).
The MDGs was another milestone for maternal health. The eight goals in the MDGs are interrelated, aimed to work in consonance with achieving human development. MDG5 is to improve maternal health. The first of the two targets is reducing maternal mortality by three quarters (75%) between 1990 and 2015, with indicators: (1) maternal mortality, and (2) the proportion of births attended by skilled health professional. The second target of MDG5, “achieving universal access to reproductive health” was added in 2005, after advocacy and insistence from several movements and stakeholders including civil society, to ensure that the MDGs do not fall short of the aspirations made in the 1994 ICPD Programme of Action. The indicators for this target are:

- contraceptive prevalence rate,
- adolescent birth rate,
- antenatal coverage (at least one visit), and
- unmet need for family planning.

In the context of this thematic paper, it is pertinent to view MDG5 as linked to the MDG1, which is “to eradicate extreme poverty and hunger.” Its first target is “to halve between 1990 and 2015 the proportion of people whose income is less than one dollar a day,” which is to be measured by the three indicators, namely: (1) proportion of people earning less than one dollar a day; (2) the poverty gap ratio; and (3) share of the poorest quintile in national consumption. The second target of this MDG is “to halve between 1990 and 2015 the proportion of people who suffer from hunger,” to be measured by: (1) the prevalence of under-weight children under 5 years of age; and (2) the proportion of the population below minimum level of dietary energy consumption.

It has become clear that MDG5 is the goal that has made the least progress, and is unlikely to be achieved if the current situation persists. In response, the Global Strategy on Women’s and Children’s Health was launched by the UN Secretary General in September 2010, aimed to prevent 33 million unwanted pregnancies, 570,000 deaths in women from pregnancies and childbirth, and 15 million deaths in children under 5 years old (UN, 2010). Under this strategy, two commissions were established. The Commission on Information and Accountability (COIA) is to ensure that pledges and commitments among member States are honoured, and that more reliable information is obtained to track results and resources. The Commission on Life-saving Commodities for Women and Children is to address the problem of cost-effective high impact health commodities not reaching the women and children who need them, because of several barriers, poverty being the major reason.

Reports on the progress of the MDGs made the headline of the Wall Street Journal of 3 August 2013. The headline read, “Countries Met Poverty Reduction Goal but Trip on Maternal Health” and the report highlighted that the world has achieved MDG1. This achievement means that the proportion of people living on less than USD1.25 a day in 2010 has declined as targeted—it is now 22% compared to 47% in 1990, thus achieving the target of halving this proportion. It should be noted, however, that civil society groups have opposed the poverty measurement of USD1.25 a day, calling it as a “starvation indicator,” and therefore much more remains in eradicating poverty and hunger.

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This was proposed in the Asia-Pacific Regional CSO Engagement Mechanism (AP-RCEM) submission: Taking Stock of SDGs and Post-2015 Development Agenda: Demanding Our Call for Development Justice.
For MDG5, the picture is dismal. Though the MDG report of 2014 indicated that the maternal mortality ratio dropped by 45% between 1990 and 2013, from 380 to 210 deaths per 100,000 live births, this significant progress is still way below the targeted 75% reduction by 2015. A closer look at this figure would indicate that maternal mortality in developing regions is 14 times higher than in developed regions with 230 per 100,000 live births compared to 16 per 100,000, respectively in 2013. The report further showed that there were an estimated total of 289,000 maternal deaths in 2013 due to pregnancy and childbirth. Further, Sub-Saharan Africa registered with the highest incidence of maternal death with 510 per 100,000 live births. Since maternal death can be prevented, the report suggested a concerted effort to ensure that there is universal access to both antenatal and effective interventions like family planning and access to information and services. Also, the report noted that monitoring efforts should be strengthened to “ensure that effective actions are taken” (UN MDGs Report, 2014).

The ICPD beyond 2014 process has provided opportunities and impetus for analysing and addressing the challenges that have hampered the achievement of the goals set in the Programme of Action. Additionally, deliberations are ongoing on the framing of the next set of goals for human development for the post-2015 period.

POVERTY AND FOOD SECURITY AS DETERMINANTS OF HEALTH

Poverty

Countries of the world are classified in terms of wealth using several approaches and methods, such as Gross National Income (GNI). However, income and especially the use of poverty line income (PLI) as the cut-off point to identify poor people and households is an inadequate measure of economic well-being. Therefore, the Multidimensional Poverty Index (MPI), a broader concept taking into account other variables such as living standards, health, and education, is preferred because it takes into account other relevant variables besides mere income. Poverty is not a simple lack of income; it is the lack of capabilities and functioning of individuals at some minimal level as they see fit.

Generally, in countries including those in the Asia-Pacific and South Asian regions, the proportion of the population that is MPI-poor is lower than the proportion of population that is income-poor. In other words, despite having low income, households have access to health, education, and basic living amenities. To illustrate, in Vietnam, although 38.5% of the population is income-poor (living on less than USD2 per day), only about half of them (17.7%) is MPI-poor, suggesting that people in Vietnam do have the basic health, education, and living standards despite having low income. In some countries, the difference is smaller, as in Cambodia (56.5% vs. 52%), Lao PDR (66% vs. 47.2%), and India (75.6% vs. 53.7%), suggesting that besides having low income, a large number of the people also have access to health, education, and amenities for a decent living standard.
In the Asia-Pacific, there are 1.8 billion people below the poverty line living on less than USD2 per day, and 903 million survive on less than USD1.25 per day; the region is home to two-thirds of the world’s poor (Raghuram, 2012). Poverty is highest in South Asia, with more than 40% of people in Bangladesh, India, and Nepal living in poverty. The lowest poverty rate is reported by Maldives, Malaysia and Sri Lanka (Ravindran, 2012).

This profile does not tell the full story; it has to be critically studied to elicit the conditions that may explain these differentials, many of which are policies of governments themselves, policies that are not designed to alleviate poverty, or factors that have made poverty alleviation a failure. It has to be recognised that while economic growth is important for human well-being (since it provides opportunities for resources for investment to improve lives), growth alone is not enough. Social policies are needed to ensure reasonable fairness in the way its benefits are distributed. The achievement made by two low and middle income countries—Malaysia and Sri Lanka—in reducing maternal mortality has a lot to do with social policies that are more embracing, including ensuring education and literacy, and use of limited resources through prudent prioritisation supported by strong political commitment to the issue.

**Food security**

Food security is defined as “all people at all times have physical and economic access to sufficient, safe and nutritious foods to meet their dietary needs and food preferences for an active healthy life” (FAO, 1996). It has three pillars:

- Availability—sufficient quantities of food are available on a consistent basis;
- Affordability—having sufficient resources to obtain appropriate food for a nutritious diet; and
- Use—appropriate use based on basic knowledge of nutrition and care, along with adequate water and sanitation.

Under the third pillar, “use”, it is possible that even if an individual can avail of and afford food (which is often compromised by poverty), he or she may decide not to consume it for some reason (usually not related to poverty), and therefore faces what is termed as “nutrition insecurity.” This concept is extremely important in maternal health, especially when we examine the change in appetite of pregnant women who suffer from morning sickness and hyperemesis gravidarum. More importantly, the influence of cultural norms on the diet and eating behaviour of pregnant and lactating mothers can threaten their nutrition security. Food safety is another relevant and related issue; bearing in mind that some food-borne diseases have impact on maternal health, and more broadly that women are almost always responsible for ensuring the safety of food for the family.

**Global politics impacting on poverty and food security**

So basic and so important is the link between poverty and food security that the first and driving goal of the MDGs is to eradicate extreme poverty and hunger, and the targets are on income and on hunger. Indeed the term “food poverty” is sometimes used, an apt portrayal of a dual deprivation—that of money/material and of food. The cut-off point of one dollar a day has been found to be grossly inappropriate, and monitoring of the
MDG uses USD\textdollar{}1.25, which is still unrealistically low as already noted above.

The role of poverty in causing food insecurity and under-nutrition is well-known, and easy to understand; it is a proximate factor. However, the real underlying cause is the global politics and the national policy environment created by the state that not only initiates, but also perpetuates poverty. In today’s world where food is aplenty, the reasons for hunger and food insecurity have political undertones. Globalisation and neo-liberal policies and economies have not reduced poverty; indeed, many more people have been impoverished by them. This theme has been extensively addressed by several writers. Danguilan, in her paper “Food for Thought: Why Millions Go Hungry in the Midst of Plenty,” points out the negative effects of transnational corporations (TNCs) on the food supply and distribution system; the failure of the Agreement on Agriculture under the WTO, which lacks political commitment and integrity of the developed nations at the expense of poor developing nations; the quest for biofuels, which exerts pressure on agricultural system; the impact of food speculation, which has led to increases in food prices, and which are often against market logic and fundamentals; and not least the impact of climate change on food availability. All these will finally leave their mark on women and on maternal health.

The concept of food security emphasises adequate food for all, without giving consideration to the source of the food, and therefore, does not recognise the role and rights of the individuals who produce, distribute, and consume food in the food system, in which they are an integral part. This is the basis of food sovereignty. Big corporations using increased productivity and enhanced efficiency as a rationale have taken over this right, creating what can be termed as the “corporate food regime.” This has effectively resulted in the dispossession of small-scale and individual farmers and producers. In addition, this trend has also led to ecological degradation. While the issue of food sovereignty has implications and impact on health and economic capacity of all individuals particularly in developing countries, it equally impacts on women of reproductive age, including pregnant and lactating mothers. In many countries of the Asia-Pacific region, the introduction of foods and diet habits are imported from other cultures, to the extent that nutritious, cheap and easily available foods are not consumed or sparingly consumed.

In her article “Food Sovereignty: Power, Gender and the Right to Food,” Patel (2012) highlights that understanding hunger and malnourishment requires an examination of what and how food systems and institutions hold power over food, and that the concept of food security should capture the notion of hunger not only as a deficit in calories but as a violation of a broader set of social, economic, and physical conditions. The article also emphasises that gender is key to food insecurity and malnutrition, as women and girls are disproportionately disempowered through current processes and politics of food production, consumption and distribution; and that women’s

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5 Food sovereignty. Wikipedia.
rights are central to food sovereignty. Ravindran (2014) emphatically points out that “neoliberal economic policies run contrary to measures essential for substantial and sustained poverty reduction.” She eloquently analyses the consequences of free trade and liberalisation as contained in the respective instruments of the World Trade Organization (WTO), especially Multilateral Agreements on Investments (MAI) and General Agreement on Trade in Services (GATS), which along with the economic crisis of the late 1990s, have pushed several Asian economies to the verge of collapse.

Mothers and children are vulnerable to the loss of food sovereignty in one specific context—breastfeeding. Breastfeeding rates have declined in many countries due to the aggressive approach of the multinational manufacturers and marketers of infant formula, which has led to the gradual disempowerment of women in developing countries to breastfeed their infants. To bring back the culture of breastfeeding, which is the inherent culture in almost all countries of the Asia-Pacific, governments need to do more to protect and promote breastfeeding, including enacting and enforcing legislations and codes of ethics on the promotion and sale of infant formula, and in providing facilities for working women to breastfeed.

Because the most often cause of food insecurity and hunger is poverty, there have been efforts at establishing food banks and providing food subsidies to the poor. This is sometimes a contentious issue; besides the high costs, food aid of this nature cannot in reality be indefinite, and after a time people should be expected to become self-reliant. The difficulties can be seen in a previous debate in India on the National Food Security Act (NFSA) that gives food grains at subsidised price to 70% of India’s population of 1.2 billion, and that will cost USD2 billion for the fiscal year 2013-2014 alone. India produces a huge amount of food, but millions go hungry for a complex web of reasons, including weak governance. Mahr (2014) commented that few would argue against getting food to poor Indian households, but not all agree that the NFSA is the way to do it. The gargantuan costs that will increase with succeeding years are seen as a burden to government with a large fiscal deficit and weakened currency. Moreover, the distribution of the grains will depend on the system and machinery in the states, which is notorious for inefficiency and corruption. Even in existing food aid programmes in India, nearly 60% of the grain did not reach the target beneficiaries (Mahr, 2014).

The same contention has been put forward for free water and electricity; it is further argued that it takes away the value of these amenities. Instead, a balanced, mutually reinforcing mix of policies and programmes are needed to raise real income of people and free them from hunger, but these must not promote or endorse the neoliberal development framework of globalisation, which traps people further into the poverty cycle.

The provision of health and education by the state as free is grounded upon a different premise. Healthcare and education (unlike food which is a physical commodity that may need to include perishable items) are more easily provided for free by a cadre of salaried providers as a social service by the state. Low and middle income countries such as Malaysia and Sri Lanka have reaped the dividends of free maternal and child healthcare. Malaysia, in addition, had put in place the “Programme for the
Rehabilitation on Undernourished Children from Hard-Core Poor Families, loosely referred to as the food basket programme, in which the eligible family is given a food basket monthly by the government through the health sector containing eight food items with calorie value 125% to 250% of Recommended Dietary Allowance (RDA). The programme is founded on three principles, namely: (1) parental involvement in the rehabilitation of the child; (2) sectoral and inter-disciplinary approach; and (3) sustainability. Sustainability is assured with the budget having been incorporated into the regular annual budget of the Ministry of Health. The related sectors are responsible for taking these families out of poverty, as in providing adequate and decent housing, creating income-generating activities, providing micro-finance schemes and looking after the needs of people with disability.

POVERTY AND FOOD SECURITY AS DETERMINANTS OF MATERNAL HEALTH

Poverty and maternal health

Maternal health, as a component of the broader area of sexual and reproductive health (SRH), which in turn is a crucial and integral part of health, is influenced by the wide range of social, economic, and political determinants identified in the report of the Commission on Social Determinants of Health (CSDH). Among these, poverty is a major determinant. One of the most often repeated truths in the past decade is that 99% of maternal deaths occur in poor developing countries. Besides being the evidence of the role of poverty in maternal health, more significantly, it is a reflection of inequality between the rich and poor and gross injustice towards women. While poverty is not the only determinant of poor maternal health, its role is evidently significant. The per capita health expenditure, along with the proportion of skilled attendance at birth, accounts for 90% of inter-country differential on maternal mortality (Malacher, et al, 2012).

The report of the Maternal Mortality Estimation Interagency Group (MMEIG), *Trends in Maternal Mortality 1990 to 2010* (2012), shows the number of maternal deaths and the MMR of 181 countries for five time periods (See Table 1). The largest number of maternal deaths has been in India, which reported 56,000 maternal deaths in 2010, comprising 19% of the world’s total. The second in the ranking was Nigeria with 40,000 maternal deaths. The two poorest regions of the world, Sub-Saharan Africa and South Asia accounted for 85% of total maternal deaths in 2010, 56% for the former and 29% for the latter. However, when expressed as maternal mortality ratio, the MMR for India was only 200 maternal deaths/100,000 live-births, slightly lower than the world figure (210) while the MMR for Nigeria was 630. Notwithstanding this, it is a stark reality that maternal deaths are highest in poor countries. The lifetime risk of a maternal death is 1 in 29 in Nigeria, and 1 in 73 in India; as compared to 1 in 18,200 in Austria and 1 in 8,100 in Australia.

In general, within a span of two decades, the maternal mortality ratio improved from 400 in 1990

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6 From Chen & Parman’s Report of the evaluation of the “Programme for the Rehabilitation of Under-nourished Children from Hard-Core Poor Families.” Personal communication.
to 210 in 2010 for the whole world. This presents a decrease of 47.50%, which is still short by 27.5% of the goal set by 2015 to reduce maternal mortality ratio by 75%. The last column in Table 1 below shows the gains made of MDG5 on maternal mortality ratios from 1990 to 2010.

There are differentials in maternal mortality between the richest and the poorest segments within most countries. In Peru, the MMR in the richest quintile is 80/100,000, while in the lowest quintile it is 130/100,000. In Indonesia, the difference is three to four times more (Paruzzolo, 2010). In the article “Maternal Health Situation in India: A Case Study,” Vora and Mavalankar (2009) presented data of selected service indicators and compared the results according to maternal wealth status.

Table 2 shows that only 13% of women with low economic status avail of institutional deliveries and 19% of the lowest quintile avail of post-natal care. According to the article, this is an indication that the public healthcare system fails to address the

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**TABLE 1: TRENDS OF ESTIMATES OF MATERNAL MORTALITY RATIO (MMR) BY 5-YEAR PERIODS 1990-2010, BY WORLD BANK REGION AND INCOME GROUP**

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<tr>
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</thead>
<tbody>
<tr>
<td>Low income</td>
<td>810</td>
<td>740</td>
<td>630</td>
<td>520</td>
<td>410</td>
<td>49.38</td>
</tr>
<tr>
<td>Middle income</td>
<td>360</td>
<td>320</td>
<td>180</td>
<td>230</td>
<td>190</td>
<td>47.22</td>
</tr>
<tr>
<td>Lower middle</td>
<td>560</td>
<td>480</td>
<td>420</td>
<td>330</td>
<td>260</td>
<td>53.57</td>
</tr>
<tr>
<td>Upper middle</td>
<td>120</td>
<td>91</td>
<td>76</td>
<td>63</td>
<td>53</td>
<td>55.83</td>
</tr>
<tr>
<td>Low &amp; middle income</td>
<td>440</td>
<td>400</td>
<td>350</td>
<td>290</td>
<td>230</td>
<td>47.73</td>
</tr>
<tr>
<td>East Asia and Pacific</td>
<td>220</td>
<td>160</td>
<td>130</td>
<td>100</td>
<td>83</td>
<td>62.27</td>
</tr>
<tr>
<td>Europe, Central Asia</td>
<td>70</td>
<td>61</td>
<td>49</td>
<td>36</td>
<td>32</td>
<td>44.28</td>
</tr>
<tr>
<td>Latin America, Caribbean</td>
<td>140</td>
<td>120</td>
<td>110</td>
<td>89</td>
<td>81</td>
<td>42.14</td>
</tr>
<tr>
<td>Middle East, North Africa</td>
<td>220</td>
<td>170</td>
<td>130</td>
<td>98</td>
<td>80</td>
<td>63.64</td>
</tr>
<tr>
<td>South Asia</td>
<td>620</td>
<td>500</td>
<td>410</td>
<td>300</td>
<td>220</td>
<td>64.52</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>850</td>
<td>820</td>
<td>740</td>
<td>630</td>
<td>500</td>
<td>41.18</td>
</tr>
<tr>
<td>High income</td>
<td>16</td>
<td>14</td>
<td>13</td>
<td>13</td>
<td>14</td>
<td>12.50</td>
</tr>
<tr>
<td>World</td>
<td>400</td>
<td>360</td>
<td>320</td>
<td>260</td>
<td>210</td>
<td>47.50</td>
</tr>
</tbody>
</table>

**TABLE 2: ACCESS TO MATERNAL HEALTHCARE ACCORDING TO MATERNAL WEALTH STATUS**

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>POOREST</th>
<th>RICHEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal care</td>
<td>59%</td>
<td>92%</td>
</tr>
<tr>
<td>Institutional delivery</td>
<td>13%</td>
<td>84%</td>
</tr>
<tr>
<td>Postnatal care</td>
<td>19%</td>
<td>79%</td>
</tr>
</tbody>
</table>
needs of the poor because of the inability to reach out to them. In addition, statistics show that of the women who availed of antenatal care, only 44% have completed three antenatal visits despite government’s effort to emphasise the importance of antenatal care and almost half have not availed of antenatal care at all. There is a wide range of factors that explain this which is beyond the ambit of this paper. Suffice it to say that politics, culture, and ideology of a country play significant roles. The case of Kerala in India and Sri Lanka, where high premium is paid to literacy and education and where the government has put in place good social policies, serves as an illustration.

Maternal health cannot be seen separately from child health in view of the intricate mother-child dyad. In the chapter on health and nutrition of children by Barros, et al (2012) for the publication Equity, Social Determinants, and Public Health Programmes, the writers highlight that poor children are more likely to be exposed to disease-causing agents. Once they are exposed, they are more vulnerable to lower resistance and low coverage with preventive interventions; and once they acquire a disease that requires medical treatment, they are less likely to have access to services, the quality of services are likely to be of lower, and life-saving treatments are less readily available. The paper also points out that most deaths in children below 5 years globally are caused by a few conditions: neonatal causes, pneumonia, diarrhoea, measles, and HIV and AIDS, with malnutrition as an underlying cause in a third of these deaths.

In the report, Closing the Gap in a Generation: Health Equity through Actions on the Social Determinants of Health, evidence is provided on the use of service by the lowest and highest quintiles in a study conducted in more than 50 countries, as shown in Table 3.

In many countries, maternal healthcare cost is high and unpredictable, a barrier to utilisation of services, and potentially catastrophic to the poor. In a recent study in Indonesia, it is reported that delivery can cost up to USD200. Among the poorest quintile, 68% of households spend 40% of disposable income on health. In Bangladesh, cost of normal delivery is USD32 and caesarean section is at USD115. There are also informal costs. In a study in rural India, it was found that in a supposedly “free” clinic, women paid as much as in a private clinic. There are also other associated costs, especially travel and transport. Studies in Nepal and Tanzania show that travel cost takes up 50% of total cost of the health service. In Ghana, by reducing distance travelled by half, the utilisation rate doubled.

The role of poverty in poor maternal outcome is the main reason for the introduction of the many demand-side financing schemes to improve the use of maternal health services, such as health equity fund, subsidies, vouchers, direct cash payment, and conditional cash transfers (CCT), among others.
These schemes have focused on maternal health as those in Bangladesh, India, and Nepal. There are also supply-side incentives especially to quality of services, such as pay-for-performance schemes for health providers as have been introduced in Cambodia and India. It is not within the scope of this paper to elaborate on these.

Poverty, and its reverse, wealth, can be applied to individuals, families, communities, and countries. While poverty is the main underlying cause of maternal deaths, this applies to the individual and family levels as well. At the national level, there are examples to show that relatively poor countries, with political commitment and determination, have succeeded in reducing maternal deaths. The most often cited examples are Malaysia and Sri Lanka; and now several others have entered the same league, such as Egypt, Honduras, Indonesia, Thailand, and Zimbabwe. In the World Bank publication, *Investing in Maternal Health: Learning from Malaysia and Sri Lanka*, Pathmanathan, et al (2003) stated that these two countries experienced rapid declines in maternal mortality in the 15 years after the Second World War, in spite of being poor in terms of the proportion of their population living below the per capita GNI. What is significant to take note of is the fact that the absence of wealth does not preclude health-enhancing policies; and conversely, wealth in the absence of good policies will not create health. For example in a high-income country, if a specific service, such as emergency obstetric care, is not provided, then even the well-to-do will not have access to life-saving care.

Poverty in developed nations can occur, usually in pockets within the country, and the people therein are often marginalised. In the USA, a developed country, pregnancy outcome is worse than in other developed countries; the main factor is high poverty rate in the USA. Indeed, poverty in the USA has led to a huge proportion of Americans not covered by health insurance. A study on poverty, maternal health, and adverse pregnancy outcome by Nagahawatte and Goldenberg (2008), showed association between poverty and utilisation rate of appropriate prenatal and delivery service and pregnancy outcome.

The relationship between poverty and family size and fertility works both ways. High fertility can be a cause of poverty; households with a large number of children tend to be poor, with more mouths to feed. High fertility can also result from poverty; in the simplest view, poor couples have less access to family planning services especially if there is a fee required. But in South Asia, increased fertility as a result of poverty is linked to the desire of couples from poor households to want more children, as a security in case some children die, and for old age security. Gupta and Dubey (2003) stated that poor households in developing countries choose to have larger families because children are considered current and future economic assets to a family in the absence of adequate social insurance. The implication of this on maternal health is obvious; poorer women with repeated pregnancies will have poorer maternal and foetal outcomes.

Besides poverty being a barrier to the access and use of maternal and reproductive healthcare, it is also a determinant of the quality of care to those who do use the service. A study conducted in north India found that of the women who were seen by a doctor for antenatal care, only 54% had their blood pressure measured, and the percentage for those seen by a nurse was even lower at 20%. They also observed the regional difference—a similar study done in south India—showed the corresponding percentages as 93% (doctor) and 48% (nurse).
Further illustrating the role of state policies, it was found that the quality of care of service provided to women in the highest wealth quintile in north India was found lower than that for women in the lowest quintile in south India.

Food security and maternal health

Food insecurity and poor nutritional status is of particular importance in women of child-bearing age and in the achievement of optimal maternal health. Calorie requirements depend on well-known variables, one of which is physiological states, especially pregnancy and lactation. A pregnant woman of average size and physical activity would require 2,500 calories a day. The requirement pregnant women for micro-nutrients is an important aspect; the prevalence of anaemia in pregnancy, mostly nutritional anaemia in countries of South Asia, is high. Repeated pregnancies deplete whatever little body reserve is available. Women who experience blood loss during childbirth face the risk of dying; post-partum haemorrhage is the most common cause of maternal death in developing countries. Under-nourished mothers are also at higher risk of pre-term birth, resulting in a premature infant; and even if the birth is full-term, the babies are more likely to be of low-birth weight.

Poor nutrition before and during pregnancy contribute in a variety of ways to poor maternal health, obstetric problems and poor pregnancy outcomes. Stunting during childhood and short stature in women leads to cephalo-pelvic disproportion, which is the most common cause of obstructed labour. Nutritional iron-deficiency anaemia is extremely common in pregnant women especially in South Asia, often made worse by chronic parasitic infestation. Vitamin A is needed for embryonic development, and Vitamin A deficiency is linked to obstetrics complications; iodine deficiency causes hypothyroidism placing the pregnant woman at risk of stillbirth and abortions; inadequate dietary calcium is a risk factor for pre-eclampsia and eclampsia. The role of pre-conceptual folic acid in preventing neural tube defect (NTD) should not be ignored.

For many women, dietary deficiencies start in childhood, and this affects their whole life course. Experience in prenatal life and early childhood, including nutrition and education lay down the foundations for the entire life course. Girls who receive chronically inadequate diets grow into malnourished women who suffer from protein energy malnutrition and micronutrient deficiencies especially for iron and folic acid (leading to anaemia) and iodine (leading to iodine deficiency disorder).

Because of the effects of foetal programming, also called the intrauterine origin of disease and the link between hunger and chronic disease; and since under-nutrition and hunger can have their origins long before reproductive age, it is important that the problem is addressed throughout the life course, spanning foetal life to adulthood.

To respond to the extra nutritional requirement of the pregnant and lactating mother, maternal health programmes often design specific interventions, especially to prevent nutritional anaemia in

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7 The foetal programming or intrauterine origin of diseases theory suggests that diseases such as cardiovascular disease and non-insulin dependent diabetes mellitus originate in foetal life when the foetus is under-nourished (leading to low-birth weight, small for gestational age, and short in length) through adaptation which may be vascular, metabolic, or endocrinal; it permanently changes the function and structure of the body in adult life.
pregnancy. Besides the usual iron and folate tablets, many maternal health programmes in developing countries provide supplementary feeding or food commodities (usually full cream milk) to pregnant mothers. However, some of these programmes have not seen much success. Iron-folate supplementation programmes in many developing countries have been in place for several decades to treat nutritional anaemia but very few of these have shown improvement in prevalence of anaemia in pregnancy. The reasons for this have been extensively studied and include poor acceptability of the oral tablets, mainly due to side effects such as constipation, poor appreciation of the value of the supplements especially when they are provided free, and low level of awareness and poor knowledge among pregnant women. This has led to trials with alternate approaches such as oral supplementation with less frequency (instead of daily) and intravenous iron formulations.

In children, reference has been made earlier to the differentials between children from poor and from well-off families in exposure, access to care, and getting adequate quality care including medical treatment for life threatening conditions such as pneumonia and diarrhoea. The same can be said for food security and nutrition. Barros, et al (2012) provides references on evidences that link wealth quintiles to the prevalence of micronutrient deficiencies especially anaemia among children. They also show evidence of the association between low-birth weights and wealth; and underscore the fact that underweight and stunting are more prevalent in the poorer regions of the world compared to the developed and richer regions, by as much as a factor of 2. It is to be noted though that for many developing countries undergoing the epidemiological transition and having the double burden of disease, malnutrition in the form of over-nutrition manifested by over-weight and obese children, has begun to emerge.

Food security must also consider food safety. In the context of maternal health, some food-borne diseases can have deleterious effects on the pregnant woman and the unborn child. Some infectious diseases, while they affect all in the population, can have special implications for women of child-bearing age, and some of these may be due to consumption of unsafe or contaminated foods. The most well-known is viral hepatitis E, which for reasons not very well understood affect pregnant women in a much more serious manner than in non-pregnant women or in men.

It is important to bear in mind that the components of food and nutrition security apply to maternal health as they apply to the general population. This means that food security for maternal health requires the ability of the women to acquire food; that food acquired is safe, nutritionally adequate, personally, and culturally acceptable; that food is sufficient in quantity and quality to sustain health and growth and prevent illness; that food is obtained in a manner that upholds human dignity; and that food is produced, processed and distributed in a manner that does not compromise environmental sustainability. Moreover, it should uphold the tenets of food sovereignty.

OTHER SOCIAL DETERMINANTS:
GENDER INEQUALITY AND PATRIARCHY

While freedom from poverty and food security can enhance health and survival of women and mothers, there are other interrelated social issues that
impact on the triad of poverty, food security, and maternal health. Two such determinants are the interrelated gender inequality and the tradition of patriarchy, which are prevalent in South Asia.

The impact of poverty on maternal health is direct and clear, since it is women who undergo pregnancy and experience childbirth. Poverty is more prevalent in women than in men; the reasons are many and these are closely linked to the entrenched patriarchal traditions. A male-dominated and patriarchal society leads to girls and women being deprived of educational and income-generating opportunities. In addition, patriarchal systems and traditions have laws detrimental to women, such as inheritance laws and rights of divorced women. Single women are more disadvantaged than married women, and female single-headed households are much poorer than other households.

Patriarchy also has negative impact on maternal health. In patriarchal contexts, including in South Asia, women are often not empowered to decide on how many children they want, how to space their pregnancies, what family planning method to use (if at all she is empowered to use contraceptives), or what maternal health service (e.g., public or private, modern or traditional) to use (if at all she is allowed to be given such service). Even when she encounters a life-threatening complication, a pregnant woman can be deprived of life-saving measures, because in a patriarchal society, the value placed on the life of women is lower than that of men.

Patriarchal customs can also determine if the pregnant woman is given the right amount and the right kinds of food. In some societies in South Asia, women and girls eat only after men and boys. Women bear the brunt of household chores including fetching water and preparing food, and in most male-controlled communities, pregnant women are not freed from these chores, which can affect her health and endanger her life.

There are gender differentials in service use; generally, men are more likely to avail of healthcare than women. Paruzollo, et al (2010) cites studies in Bangladesh, which showed the use rate of health service in men is 1.73 times more than in women, and in South India, which showed that of the one-third of households that could access healthcare without going into debt, use of health service is rationed by gender, and this difference is more so among the very poor.

One of the pernicious impact of patriarchy, especially rampant in South Asia is sex selection due to son preference. There is evidence that in India, this practice transcends class barriers. The Indian government has enacted a law against sex determination of the foetus. However, it is reasonable to assume that the enforcement of such laws is extremely challenging. Moreover, the implications on the pregnant woman is no less significant. She may not be the decision maker in these procedures of sex selection; this is also happening in a society which values men more, and where a woman’s status and value depends on her giving birth to a male child.

In the area of food security, the role of gender and women’s empowerment is comprehensively and extensively dealt with in the publication by the FAO and ADB (2013). The publication discusses the role of women in food production and preparation, and the constraints and inequities they face in these roles; and how women have relevance to the three current global crises (food price crisis, financial and economic crisis, and the ecological crisis).
Furthermore, it highlights gender differentials in three main domains, and makes appropriate recommendations for:

- Better availability—improving the productivity of women and food production (access to land, input, technology, service, markets);
- Better access to food through decent rural employment in two settings—waged employment on farms, off-farm employment; and
- Better access to food through social protection (cash transfer, public works, asset transfer, school feeding, voluntary insurance).

INCREASED VULNERABILITY TO POVERTY, FOOD INSECURITY, AND POOR MATERNAL HEALTH

Maternal health and its links to poverty and food security have to take into account vulnerable groups. Poverty, especially extreme poverty, makes one marginalised, and the case of the poor in USA, as described in the study by Nahawatte and Goldenberg (2008) earlier, shows that the poor are mostly from ethnic minority groups. This section will focus on the maternal health dimension, but it will become clear that within this dimension, there is relevance of poverty and food insecurity in particular groups of women.

Unintended and unwanted pregnancy

Poverty is linked to unplanned, unintended, and unwanted pregnancies. Vulnerability to unintended pregnancies, whether among married or unmarried women, is influenced strongly by access to contraceptives. Poor women are also more likely to face the negative consequences of an unwanted pregnancy such as unsafe abortion. The report by Malacher, et al (2010) shows that from the limited data available, the writers are able to infer that unintended pregnancies are more likely to occur among the poor, adolescents, the unmarried and migrants. A detailed analysis is shown comparing the number of children desired by women (ideal family size) among different wealth quintiles in selected countries, and comparing this to the total fertility rate of that country. There is greater discrepancy between the ideal family size and the total fertility rate among women from poorer household. The most common consequence of an unwanted pregnancy is voluntary abortion, which in poor women is mostly unsafe putting the woman to sepsis, bleeding, and even death. The consequence of unintended pregnancy that is taken to term is unwanted child-bearing with its several implications, including lack of antenatal care, maternal depression, lower breastfeeding rate, and overall child morbidity. The report by Malacher, et al states that “children who are the result of unintended pregnancies are at increased risk of infant mortality compared to children resulting from intended pregnancies.”

Young girls and child marriage

Young girls are biologically, emotionally, and socially not ready for child-bearing, and all countries have a legal framework for disallowing child marriages (often using 18 years old as the legal age of marriage). Early marriage occurs mainly in Sub-Saharan Africa, and South Asia especially in India, where one-third of the world’s child brides live.
There have been numerous studies on early marriage in India. A 2012 report by the Annual Health Surveys (AHS) of India stated that while the incidents of child marriage has declined over the years, it is still occurring, to some extent, in some states, especially in the Empowered Action Group (EAG) States. The highest proportion of girls below 18 years old who were married is highest in Rajasthan (22%), followed by Bihar (20%). Meanwhile, a study by the Centre for Social Research India (CSRI) showed that while there has been some decline, the number of child marriages is still unacceptably high, despite the existence of legislations criminalising it. The percentage of girls in India aged 20-24 who were married before they were 18 years old over three time periods are: 54.2% in 1992-1993, 50% in 1998-1999, and 44.5% in 2005-2006. The practice is most common in some states: Uttar Pradesh, Madhya Pradesh, Bihar, Rajasthan, and Andhra Pradesh report the highest number of child marriages. The north-south divide is clear: the percentage of girls married before the age of 18 years is 71% in Bihar and 68% in Rajasthan, while in Kerala, it is 17%, and in Tamil Nadu, 25%.

The causes for early marriage are many: girls are married off early for economic reasons (to lessen the family’s burden of having one more mouth to feed for the girl’s family, and an extra pair of hands for labour in the boy’s family) and for cultural reasons (forging family alliances before the opportunity is lost, to avoid having to educate them, and to assure virginity at marriage). The consequences are many. Socially, the major consequence is deprivation of education and employment opportunities for the girls. In the area of SRHR and maternal health, the consequences are risk of complications and death in pregnancy and childbirth (in 15-19 year old, the risk of maternal death is 24 times that of older women); death of the baby (risk of infant mortality is 60 times higher if mother is below 18 years old); domestic violence (the young girl, often from poor families, is at the mercy of the older husband and his family); and increased risk of sexually transmitted infections (the husbands are often very much older), amongst others.

Remote, difficult-to-reach women

This is a common risk factor for poor maternal health status and pregnancy outcomes. The first delay (the decision not to seek care) and especially the second delay (the inability to reach the point of care) of the three-delay model is often explained by geographical barrier, aside from poverty and lack of awareness. South Asia countries have a large proportion of population in rural areas, many of these are remote, with poor transport and other facilities. Where static health facilities are not provided, for several reasons, health authorities usually provide outreach services, by mobile clinics and other modalities. An example is the flying doctor health service by the Ministry of Health for the remote areas in the states of Sabah and Sarawak. In South Asia, many forms of outreach and mobile maternal health services are available for remote communities. For example, in Pakistan, a project in 2005 provided mobile clinics for poor rural pregnant women and guidance for delivery.

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8 The Ministry of Health and Family Welfare of India established the EAG in 2001 to allow for special focus to attain national health goals on states that are demographically lagging behind. EAG states include Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Uttar Pradesh, Uttarakhand, Orissa and Rajasthan.

helped with post-miscarriage complications, and referred for assisted delivery and caesarean section. By 2008, the service had reached 85,000 women. Coverage of antenatal care was 43%, which is 12% higher than the national average. It would be useful for this to be followed up to assess its sustainability, which is difficult to attain on a project basis unless it gets transformed into a full programme.

Groups at risk of social exclusion and inequity

Two groups are at risk of inequity: ethnic or tribal minorities and migrants.

The marginalisation of minority groups is a well-known phenomenon. Mention was made earlier of the poor in USA, who mostly are also from ethnic minorities. In her article “Racial and ethnic disparities in infant and maternal mortality,” Anachebe states, “Despite the dramatic decline in infant and maternal mortality during the 20th century, one of the greatest challenges facing the USA is disparity among ethnic groups; not only among blacks, but also native Alaskans, American Indians, Hispanics.” Similarly in the UK, it has been reported by the British Medical Journal that the risk of severe maternal morbidity among white women is 80/100,000 and 120/100,000 among non-white women (Knight et al, 2009).

In South Asia, the situation of tribal groups and Dalits has also been extensively studied. The recent case of the tribal woman denied treatment in Barwanidistrict in Madhya Pradesh, and the legal tussle between the government and women activist groups, following the imprisonment of a social activist, is a glaring example. On a more positive note, certain enabling conditions do exist to improve the plight of tribal women in India. These include the emerging tradition of judicial activism, an independent media, a strong civil society, and existence of ombudsperson agencies, such as the National Human Rights Commission, National Women’s Commission for Minorities, Scheduled Castes and Scheduled Tribes, and Commission for Dalits and Minority Groups (WHRAP South Asia, 2008).

Migrants are also at risk of inequity and social exclusion. Migration, either internal or crossborder, has become a reality in today’s world. Globalisation, climate change, civil strife and wars, often are accompanied by mass mobilisation of population groups that has implications on maternal health, besides the clear implications on poverty and food security. Voluntary migration for purposes of employment, for both men and women is becoming a common activity especially in the recent decade, and countries of the Asia-Pacific region and South Asia are involved in this, both as a supplier and as a receiver of foreign workers. There may be government policies including fee-for-service for migrants and non-citizens for services given free to citizens. Malaysia provides a good example of the situation of migrants. For economic reasons, Malaysia attracts migrants from neighbouring countries, as well as refugees who are displaced from their homes because of political upheaval. The Malaysian government curbs illegal migration, including through strategies including charging a fee for service and requiring health staff to report to enforcement authorities. These unfortunately have serious health implications, including poor access to care because of unaffordable costs of services and fear of enforcement agencies; and conflict faced by health professionals and service providers whose professional code of ethics requires them to provide health care to those in need, and especially to save lives. Aside from
inter-country migration, there is also migration within a country, such as from rural to urban areas. This important issue has been extensively explored by ARROW, and the reader is advised to refer to the several publications of ARROW on this."

Displaced women (during and post-disaster)

Physiological functions like childbirth and lactation cannot be postponed, and women who are displaced while pregnant face challenges in getting prenatal care and skilled care at delivery. The experiences during the Asian tsunami of 2004 and Nargis cyclone in 2008 provide useful lessons for the management of SRHR, including maternal health, during times of disaster. Some governments have done well in providing some aspects of SRHR services post-disaster. For example, the government of China gave high priority to family planning and maternal health post-2008 earthquake (ARROW, 2008b).

Women with disability

It is undeniable that there are several physical disabilities that can affect sexual functioning and reproductive health including maternal health, and have a negative effect on well-being and quality of life. It is important to recognise that if women with disability get pregnant, they will require extra and special care depending on the type and extent of their disability.

THE NEEDED RESPONSE

- Understanding the linkages between poverty and food security (including food sovereignty) and maternal health, has become clear—not only the importance of the role of social determinants of maternal health, particularly of poverty and food security, but also the issue of inequity in terms of opportunities, exposure, vulnerability, and maternal health outcomes and consequences. It has underscored the need for maternal health to be perceived, understood, and managed not only as a health issue within the purview of the health authority alone, but also as an inter-sectoral matter. With this as the premise, the suggested responses are discussed under five areas, namely:

  - general responses to address social determinants;
  - addressing inequities in general;
  - addressing specifically the needs of the vulnerable;
  - specific responses by the health sector; and
  - suggestions to ensure that poverty, food security, and maternal health “do not fall between the crack” in the new post-2015 development agenda.

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ARROW. (2013). ARROW for Change: Labour, Migration, Gender, Sexual and Reproductive Health and Rights. Vol 19 No 1, ISSN 1394-4444
General responses to address social determinants

Maternal mortality is not only a “health divide;” it is a “social divide.” Health, social and economic interventions are most effective when they are implemented simultaneously. Safe motherhood should be in the broader context of health programmes, including nutrition advice and micro-nutrient supplementation, water and sanitation, and family planning, among others. The responses need several and diverse actors and stakeholders, and as highlighted at the beginning, the cohesion and cooperation that was generated by ICPD 1994 seemed to have waned, and efforts have been expended in a fragmented manner. Therefore, the first step in the responses is to ensure that the different actors—governments, international development partners, civil society, and individuals—work in a coherent and coordinated manner.

In this regard, MDG8 “to develop global partnerships for development” has relevance. The responses will be needed at the various levels: international and regional level, national and sub-national level, and the community and family levels. The recommended actions to be taken will be a long list to respond to the several challenges that have impeded the achievement of MDG 5 on improvement of maternal health. An important lesson learned over the past two decades has been that interventions to reduce maternal deaths cannot be implemented as vertical, stand-alone programmes; they have to be holistic and inclusive. There is need to pay more attention to the human rights aspects of safe motherhood and to ensure that all relevant rights are respected, including rights relating to life, liberty, and security of person; the foundation of family and family life; healthcare and benefits of scientific progress, including health education and information, as well as sexual and reproductive health and rights; and equality and non-discrimination.

Addressing inequities

The report Closing the Gap in a Generation: Health Equity through Actions on the Social Determinants of Health puts forward recommendations in three categories:

- To improve daily living conditions, there is need to ensure equity early in the life course; healthy place for healthy people; urban living, livelihood, land rights, rural infrastructure; fair employment and decent work; social protection; universal healthcare;

- To tackle inequities and distribution of power, money and resources, there needs to be put in place health equity in all policies and programmes; fair financing; market responsibility; gender equity; political empowerment; and good global governance; and

- To measure and understand the problem and assess the impact of action, there needs to be research and training, and a surveillance system.

As pointed out earlier, inequities in wealth, food insecurity and maternal health are more pronounced with more harmful consequences in

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Specific actions are suggested under each category. See Closing the Gap in a Generation: Health Equity Through Actions on the Social Determinants of Health.
communities and individuals who are more vulnerable or are marginalised. As elaborated earlier, these are young girls who are exposed to pregnancy and child bearing; women with unwanted and unintended pregnancies; remote, difficult-to-reach women; ethnic/tribal minorities; persons with disability; and migrants and displaced persons. All sectors and agencies including the health sector must have policies, strategies and programmes to ensure these are protected against poverty, food insecurity, and poor maternal health.

**Specific responses by the health sector**

In the report *Equity, Social Determinants, and Public Health Programmes*, several recommendations for action for the health sector are made under five levels of socio-economic differentials, which can serve as entry points for responses. These are reproduced below with adaptation to poverty, food security, and maternal health:

**Entry point level 1: Socio-economic context and position**

- Provide setting-specific, timely, and relevant evidence on the relationship between poverty, food security, and maternal health.

- Undertake health impact assessments, research and analyses, and provide examples of good practices.

- Support advocacy and action groups to engage in public debate and convince politicians, legislators, and regulators.

**Entry point level 2: Differential exposure**

- Work with and support civil society and public opinion makers, and influence the Ministry of Health to pay attention to upstream policies.

- Encourage direct and active participation by individuals and communities as in education, advertising, taxation, and others.

**Entry point level 3: Differential vulnerability**

- Take the lead to identify vulnerable populations, and the specific causes for vulnerability, work with other sectors to address these.

- Ensure that the health delivery system is in line with social norms to sensitise the vulnerable groups to benefits of health programmes.

- Reduce barriers to extend coverage of use by vulnerable populations.

**Entry point level 4: Differential care outcomes**

- Take the lead to identify sources of differential health outcome.

- Review and influence priority setting that influence infrastructure, service, financing, and revitalise primary healthcare.

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For details, see *Equity, Social Determinants, and Public Health Programmes*. 

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TAKING A BROADER VIEW: ADDRESSING MATERNAL HEALTH IN THE CONTEXT OF FOOD AND NUTRITION INSECURITY, AND POVERTY
Work with media and public opinion makers to create awareness.

Entry point level 5: Differential consequences

- Take the lead in identifying and analysing differential consequences.
- Develop and strengthen standard referral and follow up procedures across the health system.
- Work with patient groups and other partners including NGOs to facilitate appropriate responses.

Over and above these specific actions at these entry points, it is also imperative for the health system to address the following:

- Reduce cost and eliminate financial barrier (eliminate user fee, introduce and/or strengthen/expand financing schemes for maternal health such as vouchers and conditional cash transfers).
- Expand service and improve quality of service (ensure women-friendly services, provide incentives to health providers based on performance, try out innovative approaches such as getting the private sector to complement the public sector).
- Strengthen health system and MCH (increase coverage for the poor, improve quality of service, sensitise health workers to social issues).
- Strengthen social and community interventions (mobilise community resources, optimise the capacity and potential of families and communities, engage local NGOs and women’s groups more).

Ensuring maternal health as a target in the post-2015 human development agenda

There is, rightly so, a global emphasis on universal health coverage that is likely to underscore the new development agenda. In this context, the universal access to and coverage of maternal and sexual and reproductive health services should be given due attention, and there have to be specific imperatives to ensure this goal is met.

In trying to deliberate on the steps to be taken to ensure that poverty, food security and maternal health will continue to be given attention to the sustainable development goals after 2015, the thought processes should focus on three main issues: (1) what represents a suitable goal for “human development,” which will have to be a broad goal; (2) where is health in this broad goal, and how should it be positioned so as it remains a priority; and (3) how can maternal health be positioned within this wider framework.

In doing this, the main response is for all parties (development partners, national government, and civil society) to advance the cause and carry out advocacy. The arguments for maintaining maternal health in the post-2015 agenda will be centred not only on the role of maternal health and food security in reducing poverty (as much as poverty reduction will improve maternal health and food security). It should also highlight the importance of addressing the “unmet agenda”—the fact that MDG5 is the MDG that had made least progress.

Unnecessary death of women from pregnancy and childbirth is unacceptable and unjust, when we have
the means to save them. The post-2015 goals should therefore focus on the will and stronger commitment to see maternal health through the human rights lens.

Overall, it can be noted that many responses have been and are being put in place and what is needed at this stage is for the stakeholders to:

- Consolidate the successes achieved and document best practices;
- Strengthen demand-side financing schemes to reduce financial barriers;
- Support enactment of laws;
- Identify newer approaches for specific problems (better quality of service, better information systems to generate reliable information on maternal health and maternal mortality, especially to encourage national civil registration, disaggregate data); and
- Suggest innovative approaches to solve long-standing persistent problems (how best to reduce the negative features and consequences of patriarchy, to reduce child marriage in South Asia).

In doing these, political commitment is needed, especially when it involves the enactment of new legislations and formulation of national policies. In addition, research will be needed to generate evidence for action, and equally important for existing and available evidence to be used optimally.

CONCLUSION

The unequal distribution of health-damaging experiences is not a natural phenomenon, but a result of poor social policies and programmes, unfair economic arrangements and bad politics. While this general truth applies to health overall, it is equally, if not more evident in maternal health. It has become increasingly clear that social determinants play an important role in ensuring maternal outcomes, in reducing vulnerability and risk to both maternal morbidity and mortality. Poverty is one of the strongest determinants; poor women are especially vulnerable because they are less likely to avail of maternal healthcare and to avail of a skilled attendant at birth, and even when they do have the care, the quality of care is inferior compared to that provided to richer women. Some women are more vulnerable, such as the young, those with unwanted pregnancy and migrants. Food and nutritional security is critical for optimal maternal health, and in the absence of this (often but not always linked to poverty), women will have increased risk of poor maternal outcomes.

The Commission on Social Determinants of Health, based on evidence, believes that achieving equity in health, including maternal health within a generation, is not only possible, but is the right and urgent thing to aspire for. The needed responses to alleviate the pernicious impact of social determinants (especially poverty, food insecurity, gender inequality) are technically, socially, and economically within the reach and capability of all governments and other partners responsible for maternal health. With political commitment, the vicious cycle of poverty and poor health can be broken. Therefore, not to do anything is not an option in the name of justice and human rights.
In any new approach to human development, health and health equity may not be the deliberate aim of all social policies, but they must be the fundamental result of all policies. Action on the social determinants of health (and maternal health) must involve all constituencies, such as government, civil society, local communities, global partners, and businesses. All of them must embrace all the key sectors of society not just the health sector. Comprehensive, holistic, and inclusive actions need to be taken coherently by all concerned sectors in a coordinated and mutually supportive manner.

It is important, indeed critical, that all stakeholders look back at the promises made at ICPD, and analyse the reasons why MDG5 is making slow progress and is not likely to be achieved, so that remedial actions can be taken. To do this, maternal health needs to be seen and analysed in its link with poverty reduction and food and nutrition security, so that a more coordinated approach can be adopted. The understanding of this link will also contribute towards ensuring that these three components of sexual and reproductive health and rights—poverty reduction, food and nutrition security along with food sovereignty, and maternal health—will continue to be given priority in the next generation of human development goals.

Improving maternal health through alleviation of poverty and freeing people from hunger is not only possible, but possible within one generation.

REFERENCES

ANNEX: DEFINITIONS

Reproductive Health

Reproductive health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice, and to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of a healthy infant (WHO).

Reproductive Rights

Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (ICPD).

Sexual Health

Sexual health implies a positive approach to human sexuality and the purpose of sexual healthcare is the enhancement of life and personal relations, as well as counselling and care related to reproduction and sexually transmitted diseases (adapted, UN).

Sexual Rights

Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services; seek, receive, and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; decision to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life (WHO working definition).

ARROW is a regional non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, evidence generation, advocacy, capacity building, partnership building and organisational development.

ARROW envisions an equal, just and equitable world, where every woman enjoys her full sexual and reproductive rights. ARROW promotes and defends women's rights and needs, particularly in the areas of health and sexuality, and to reaffirm their agency to claim these rights.

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