**Addressing invisibility, inferiority, and powerlessness to achieve gains in maternal health for ultra-poor women**

The Lancet

Corrected final proof

Available online 2 October 2013

Published version:

<https://www.clinicalkey.com/playContent/1-s2.0-S0140673613616463>

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Despite a continued stated commitment to social justice and equity—the guiding spirit of the Millennium Declaration in 2000 [1](https://www.clinicalkey.com/#bib1)—concerns have arisen that this focus has often been diluted in efforts to translate the Millennium Development Goals (MDGs) into actions.[2](https://www.clinicalkey.com/#bib2)Nowhere is this more apparent than in relation to MDG 5. Analyses of national survey data and local programme assessments show that policy directives and interventions often fail to reach the poorest women within local populations. In Pakistan, for example, a ten-district intervention aimed at upgrading health facilities while simultaneously increasing demand through behavioural change resulted in a rise in institutional deliveries in the highest wealth quintile (from 62% to 74%), but no change in the poorest (remaining at roughly 18%).[3](https://www.clinicalkey.com/#bib3)Meanwhile, a cross-national analysis [4](https://www.clinicalkey.com/#bib4)identified large inequalities between wealth groups in access to skilled birth attendance [5](https://www.clinicalkey.com/#bib5)and antenatal care uptake in many countries. Thus, despite repeated assertions that reducing inequity is a top priority, international organisations, donor agencies, and country-level policy makers continue to fail to address the obstacles to care faced by the poorest women. Furthermore, despite reductions in maternal mortality in several countries, comprehensive reviews [6](https://www.clinicalkey.com/#bib6)[7](https://www.clinicalkey.com/#bib7)of progress towards MDG 5 conclude that the pace is slow and that no overall evidence of acceleration exists, suggesting that unless concerted action is taken to understand and address the needs of the most vulnerable women, the aggregate goal will remain elusive in many countries.

The structures and processes restricting poor people's access to resources, including health care, are complex and intractable. The notion of structural violence, usually attributed to Johan Galtung in the 1960s, [8](https://www.clinicalkey.com/#bib8)drew attention to the way in which embedded social structures supported by normalising ideologies systematically oppress and exploit particular groups within societies resulting in poor health and short life-spans within these populations. [9](https://www.clinicalkey.com/#bib9)Naila Kabeer [2](https://www.clinicalkey.com/#bib2)has used the notion of intersecting inequalities to describe how several and interlocking processes—poverty, ethnic origin, caste, and religion—converge with sex to place some women in very marginalised positions. Our research [10](https://www.clinicalkey.com/#bib10)in rural Punjab, Pakistan, has documented an entrenched caste-based social hierarchy in which the lowest caste, the Kammis, experience chronic intergenerational poverty, social stigma, and poor health and nutrition. We suggest that such women can usefully be identified as “ultra-poor” in south Asia since the convergence of social stigma and economic poverty places them in a very marginalised position. Importantly, we noted low uptake of maternal health-care services and very high rates of maternal mortality in these ultra-poor, socially marginalised women. Drawing on our empirical work, we emphasise key characteristics of the lives of socially marginalised women that directly affect their access to health services and resources, which, although specific, are also evident in diverse contexts around the world.

Ultra-poor, socially excluded women are often invisible to both more advantaged local people and to service providers. While living in our Punjabi village, the identification of all the low caste women took us 6 months. Our requests to local people to provide help to locate the poor did not identify any Kammi families. Higher-caste villagers chided us for our interest in Kammi women, and Kammi women themselves conformed to the normative expectation of remaining at the margins of society: silent and unseen. So invisible were these women that even a private non-governmental organisation working for gender empowerment and human rights in the village had overlooked them in its projects. Kammi women working as bonded labourers in nearby brick kilns were wholly excluded from state-funded door-to-door outreach maternal and child health services because the demarcation of Lady Health Worker catchment areas does not include these areas. [11](https://www.clinicalkey.com/#bib11)

Economic hierarchies are often closely aligned with social hierarchies with poor women occupying stigmatising social positions. In our field site, the inferior social status of the Kammis was symbolised in their caste label, “kam”, which translates as less and signals the widely held belief that they have a low level of virtue and moral character. One common result of social inferiority is that such women are poorly treated by health-care providers, which acts as a great deterrent to the seeking of care. Kammi women reported that government health staff ignored and abused them, calling state hospitals “butchers”, and preferring to “die at home” rather than seek such care. And, although our field site had geographically available and reasonably well functioning public-sector and private-sector maternal health services, less than a quarter of Kammi women had ever sought care from these facilities compared with near universal use by the upper castes.

Socially excluded groups are often denied participation in the decision-making processes of their communities and societies and their formal entitlements to state resources can be usurped by more powerful groups. We noted that despite formal criteria for the dispersal of funds from the INTER REF Benazir Income Support Programme, in practice resource allocation was decided by the local elected government representative and recipients were not the poorest, low-caste families. Moreover, Kammi women internalise their caste-based inferiority, have little sense of entitlement, and no means to challenge their exclusion from these resources. Kammi families have few productive assets, unpredictable income, and are often highly dependent on asymmetrical relationships with higher caste families. We noted that, despite an awareness of the possibility of birth complications, systematic exclusion from opportunities to accumulate savings precluded any chance for Kammi families to prepare for such eventualities and often resulted in life-threatening delays in seeking of treatment.

Similar patterns of invisibility, inferiority, and powerlessness have been documented for poor women in many parts of the world. The complex interplay of social, political, cultural, and economic marginalisation, and therefore the need for improved understanding of the experiences and relationships lived by poor people on a daily basis, has been well documented in social development literature. [12](https://www.clinicalkey.com/#bib12)[13](https://www.clinicalkey.com/#bib13)Furthermore, the high profile work of the WHO commission on social determinants of health has identified three causes of health inequities: differential power and influence associated with income inequality and social status, differential exposures to stress and other adverse conditions, and differential results associated with discrimination and unequal access to services. [14](https://www.clinicalkey.com/#bib14)So far, however, the global maternal health community has paid very little attention to these stark realities. And, although the recent “ *Manifesto for maternal health post-2015*” [15](https://www.clinicalkey.com/#bib15)offers some promise and emphasises the need to focus on “unseen women” and the social determinants of health, several substantial obstacles must be overcome for such a focus to emerge in practice.

First, in relation to knowledge generation, despite the rich insights provided by medical anthropology and development studies, so far, few researchers have sought to link an understanding of the realities of the lives of ultra-poor women directly to maternal health service provision. Too little research is seeking to answer questions about how health systems can be shaped so that they mitigate, rather than exacerbate, the disadvantages faced by marginalised women in wider society. Maternal health research tends to view poverty as simply a scarcity of material resources rather than recognising these intersecting inequalities, or worse still focuses predominantly on the technical aspects of service delivery. This situation shows the persistent dominance of a medical model of health and illness and emphasises the urgent need for increased interdisciplinarity in maternal health research.

Second, substantial obstacles exist in relation to the application of knowledge to policy and practice. Our experience shows that policy makers and programme planners can be resistant to new knowledge with respect to ultra-poor people when this knowledge challenges deeply-held beliefs about the nature of their society, goes against the accepted wisdom about “what works” for poor people, or implicates them and their social group in the oppression of marginalised people. For instance, the resistance of policy makers to accept that the caste system persists in Pakistan has been noted by several commentators. [16](https://www.clinicalkey.com/#bib16)[17](https://www.clinicalkey.com/#bib17)More generally, policy makers must accept that responsibility for improving reproductive and maternal health extends beyond the provision of services to ensuring the equitable uptake of those services by all sections of the population and to working with other sectors to address the wider determinants of poor maternal health. Our present experience in Pakistan is that policy makers and managers of maternal health are reluctant to accept that poverty and social exclusion are within the remit of the Ministry of Health. We must find ways to support and challenge policy makers to address the wider structures and processes that perpetuate poor outcomes for ultra-poor women for as Ana Langer, Richard Horton, and Guerino Chalamilla [15](https://www.clinicalkey.com/#bib15)note “maternal health will not be improved to its full potential by focusing on maternal health alone”.

Additionally, tight project timelines and a focus on aggregate outcome indicators militate against concerted efforts to understand and address the needs of the most marginalised women. Bilateral and multilaterial funding agencies (donors) in particular often exert pressure to show quick success, inadvertently encouraging programme managers and service providers to focus their efforts on women who are more readily accessible. Needs assessments and monitoring systems that incorporate appropriate measures of inequity and capture incremental progress towards the engagement of ultra-poor people are needed.

The Women Deliver 2013 meeting in Kuala Lumpur was an important landmark and rightly celebrated progress towards female empowerment and gains in maternal health around the world. However, we identified little evidence that the global maternal health community is really getting to grips with the realities of life for ultra-poor women. As the insights and recommendations from the meeting are taken forward, we challenge those charged with developing the post-2015 health and development agenda to place the unmet needs of ultra-poor people at centre stage. Without a resolute effort to emphasise, understand, and counter the deeply ingrained structures and processes—operating both within and beyond health-care systems—that perpetuate invisibility, inferiority, and powerlessness, progress towards equity in maternal health will remain elusive. Furthermore, in many parts of the world, continued neglect of the needs of these most marginalised women will also mean failure to achieve MDG 5.

**Contributors**

ZM conceived the development of the Viewpoint, collected and analysed the data, and wrote the Viewpoint. SS conceived the development of the Viewpoint, analysed the data, and wrote the Viewpoint. AB collected and analysed the data. LM contributed to the writing of the Viewpoint.

**Conflicts of interest**

We declare that we have no conflicts of interest.

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