

## Introduction

The new millennium requires new thinking about the relationship between health and development. It is not simply the turn of a calendar page that beckons us to new thinking. It is the growing conviction that, notwithstanding enormous gains in many critical areas of health over the past 50 years, the old strategies are no longer sufficient. Indeed, to a large degree, they are failing.

In many parts of the world declines in mortality have slowed or stagnated; in others they have reversed, leaving billions suffering from avoidable mortality and morbidity. Inequalities in health status and in access to healthcare are wide and deep—and they are growing. Such inequalities are linked to deep inequities—profound injustices that ultimately feed the corrosive insecurity that now plagues all societies, rich and poor alike. Conventional strategies have done little to stem these tides. They may even have contributed to them.

The old strategies are failing in another sense as well: they no longer describe reality. The field suffers from a terrible disconnect between the dominant models and the prescriptions that flow from them on the one hand and the reality that people are coping with on the other. This is a warning sign. We need to rethink. The Millennium Development Goals and the UN Millennium Project provide a strategic setting in which to do just that.

Health interventions already exist to prevent or treat the vast majority of conditions that kill children and women of reproductive age and to enable all people to protect and promote their health. Thus, the challenge in meeting Goals 4 and 5 (see the list of Goals on pages xvi–xvii) is not to discover new medical technology but to tackle the problems of implementation, of ensuring access to these interventions by means that simultaneously promote the fundamental aims of development. That challenge is social, economic, cultural, and unavoidably political, in the sense that it relates to the distribution of power and resources within and between countries.

## Health is vital to meeting all of the Goals

Power comes in many guises. Among them is the power to set the terms of the debate, to structure the patterns of thought and language, the fundamental taken-for-granted assumptions that shape our approaches to problems and solutions. If the current situation is indeed untenable, if the dominant categories no longer address the dominant problems, then these terms must be challenged and opened to new debate and directions.

The targets and indicators set by the Millennium Development Goals are framed in technical, results-oriented terms. But the response must go beyond these technical terms to address access to and distribution of power and resources within and between countries, in the structures of global governance, and in the intimate spaces of families, households, and communities. Unless we face up to the fundamental anchoring of health status, health systems, and health policy in these dynamics, our seriousness about achieving the Goals can legitimately be questioned.

Facing up to these dynamics means more than simply describing the connections among them, although that is a critical step. It requires a conscious decision to develop and pursue strategies that are honest in their efforts to confront and transform these realities of power and resource distribution while simultaneously being pragmatic about how these very dynamics so often blunt implementation of the best laid plans.

Here, where elegant theory and pristine logic meet the messy, complex reality that operates on the ground, lies the second fundamental challenge: ideology—any ideology—must not blind us to the serious operational problems that confront the health sector and to the urgent need for evidence-based actions to tackle them. Nor should our critique of current trends blind us to the important lessons that can be drawn from the truly dramatic examples of success that dot the health and development landscape. The goal of this report is to analyze problems in order to frame workable solutions to push toward as actionable an agenda as our positioning responsibly allows.

Health is vital to meeting all of the Goals. Most accounts of the relationships between health and development and between health and poverty reduction give two explanations. First, health is an intrinsic good, valuable in and of itself, and thus an important goal of development. As Amartya Sen has put it, good health enables each person to “lead the kind of life he or she has reason to value” (Sen 2001). The right to health codified in the Universal Declaration of Human Rights and in binding treaties is based on a related proposition: health is part of the very essence of what it is to be human.

Second, at the national level, health is a precondition for economic growth. Economic growth, in turn, is necessary to pull countries out of poverty traps, including the vicious circle of disease and deprivation that characterizes them (UN Millennium Project 2005a). At the individual level, serious health conditions can push already poor people even deeper into poverty when disabling illness prevents workers from earning income or the out-of-pocket cost of

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obtaining healthcare has catastrophic impact. In India, for example, 25 percent of people who went into the hospital above the poverty line came out below it (Wagstaff and Claeson 2004).

There is a third way that health and healthcare relate to poverty and development. Poverty is not just an individual state of being, it is relational. It concerns interaction with structures of power. Poverty—especially the experience of poverty—is characterized by exclusion, marginalization, voicelessness, and humiliation. This experience can contribute to or result from income poverty, and it can contribute to poor health (Krieger 2001). But even for those not catastrophically ill and those above the income poverty line the experience of exclusion, abuse, and voicelessness is a kind of poverty and must be understood unequivocally as a failure of development (Narayan 2000; Kern and Ritzen 2001).

This conception of poverty relates directly to the way we think about and address health. The health system is a core social institution, not simply a mechanical structure for delivering technical interventions the way a post office delivers letters. Health systems function at the interface between people and the structures that shape their broader society. Neglect, abuse, and exclusion from the health system are part of the very experience of being poor (Mackintosh 2001). Conversely, claims to health—claims of entitlement—are assets of citizens in a democratic society. Health actions, the choices and means that enable individuals and communities to control their health, to participate as agents, not victims, in shaping their own life circumstances are not only important for individual capabilities and the enjoyment of individual rights, they are also among the essential freedoms that shape democracy and development.

Qualitative research has demonstrated this over and over again. It is the multidimensional experience of poverty that matters to people who are poor. Although these observations about the relational nature of poverty are well documented in the literature and viscerally understood by those who work directly with the poor, current practice is remarkably thin when it comes to working through the implications for policies and programs. In response to the finding of “voicelessness” and “exclusion” come the solutions of “community participation” and, more recently, “accountability.” These are certainly important tools of good development practice, but until they are grounded in deeper systemic change, the risk is that they will breed little more than cynicism.

This disconnect between the textured experience of poverty and the thinness of policy responses to it hints at a larger set of questions about why well intentioned plans for the health sector so often fail—indeed, why the solutions favored by the development community so often become the problem that the next generation of solutions must address (Pritchett and Woolcock 2004). Some would simply call this progress. But a recent analysis of “solutions” in social sectors in which key public services are both highly discretionary and transaction-intensive—services such as curative healthcare—finds a common

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structure to the repeated failure (Pritchett and Woolcock 2004). Identifying and understanding that common structure are important preliminary steps in devising best strategies to achieve the Goals.

Starting with attempts by postcolonial states in poor countries to meet the needs of their people with a needs/supply/civil service model, Pritchett and Woolcock contend that the common structure of failed solutions is found in a kind of “bureaucratic high modernism” (Scott 1998), a push to find simple, measurable, replicable, standardized, top-down solutions—solutions that attempt to replicate the end points of successful social sectors in high-income countries without going through the often contentious, painstaking, and lengthy social and political processes that preceded such successes.

Three more examples help deepen the analysis of the common structure of failure:

During the 1990s the World Bank and other donors and international agencies promoted health sector reforms explicitly designed to address the manifest inequities of failing health systems. Why were the policies intended to address inequity so widely experienced as unequalizing? How can this repeated “redistributive failure” be explained (Mackintosh and Tibandebage 2004)?

Poverty Reduction Strategy Papers, a primary tool in current aid regimes, were proposed as a response to the perception that donors, especially international financial institutions, had emphasized economic growth without paying adequate attention to poverty reduction and had imposed new policies without ensuring country ownership. Development of a Poverty Reduction Strategy Paper was supposed to begin with a participatory poverty assessment, intended to give voice to the poor, and then proceed with deliberations involving civil society, intended to provide ownership to citizens and national governments.

But Poverty Reduction Strategy Papers have been widely criticized—even by internal evaluations of the World Bank (World Bank Operations Evaluation Department 2004) and International Monetary Fund (IMF Independent Evaluation Office 2004)—for ignoring the very processes they initiated, as outside consultants generate standardized strategies that conform to the policies of international financial institutions. Ironically, a process explicitly designed to give voice to the poor solicits but then ignores their views, confirming and reinforcing their marginalization.

It is indisputable that low-income countries need additional investment in order to make serious progress. There is an absolute scarcity of domestically generated resources. Yet studies document countless instances of failure of aid to reach precisely the services that need it most.

These examples suggest several connected dimensions to the common structure of failure.

First, context matters. The drive for technocratic, managerial fixes fails because of its inability to acknowledge that effectiveness in highly discretionary, transaction-intensive services, such as the aspects of healthcare in which

**Context  
matters, values  
matter, process  
matters, and  
acknowledging  
responsibility  
matters**

failure has been most acute, truly cannot be one size fits all. Until initiatives genuinely draw on context-specific knowledge and local capacity, health initiatives will not succeed at scale.

Second, values matter. When problems that are deeply political, that involve the distribution of power and resources, are systematically converted into managerial problems addressed by technical adjustments that avoid the heart of the problem, the result cannot be success. Standard health sector reform attempts at promoting equity are deployed around the edges of a system whose structure is profoundly inequitable. Until the structure is addressed, the solutions will not work. This does not necessarily mean that a massive, immediate overhaul is necessary. It does mean that values must play an important role in setting the direction of change, even if change is managed and gradual.

Third, process matters. Conventional views of policymaking as a linear, top-down process of agenda-setting, policy design, and implementation miss the many forces from the ground up that have the power to sabotage or neutralize such plans. They also ignore the fundamental rights of people to have a say in their societies. Superficial attempts to engage so-called stakeholders will be experienced as just that.

Fourth, acknowledging responsibility matters. To truly achieve the substance of the Goals, both sides in the Millennium Development compact—rich countries and poor countries—will have to look long and hard at how their actions block progress and at the constraints faced by those sitting across the table. This is not an excuse for the status quo. It is the first step in changing the structure of international development politics that fail hundreds of millions of citizens of the world today.

In the health sector many of these problems cluster around health systems. The central argument of this report is that dramatic, meaningful, sustainable progress toward both the spirit and the quantitative targets of the Millennium Development Goals requires a shift in perspective and mindset. This new perspective must pay close attention to systemic problems and to the problems of health systems anchored in their socioeconomic and political contexts. It must recognize the multiple ways in which health and health systems relate to poverty (table 1.1).

The conventional approach and the task force approach are not mutually exclusive. The task force approach does not claim that burden of disease assessments are useless, that market forces are irrelevant to healthcare, or that citizens with rights are not also consumers with preferences. Rather, this report sketches the framework of basic principles that the task force believes must inform—not dictate—policy, as decisionmakers at each level consider the changes necessary to meet the Goals in their specific contexts.

The goal of this report is not to propose and argue for the theoretically ideal health system. Instead, it describes the realities on the ground and in the international community in order to try to find actionable, principled ways to

**Table 1.1**  
**Task force approach**  
**to health systems**

Item	Conventional approach	Task force approach
Primary unit of analysis	Specific diseases or health conditions, with focus on individual risk factors	Health system as core social institution
Driving rationale in structuring the health system	Commercialization and creation of markets, seeking financial sustainability and efficiency through the private sector	Inclusion and equity, through cross-subsidization and redistribution across the system
Patients/users	Consumers with preferences	Citizens with entitlements and rights
Role of state	Gap-filler where market failure occurs	Duty-bearer obligated to ensure redistribution and social solidarity rather than segmentation that legitimates exclusion and inequity
Equity strategy	Pro-poor targeting	Structural change to promote inclusion

move forward. The dream of an ideal inspires and guides, and it is politically potent. It helps us defy business as usual and to think and act more boldly. But debates over ideals must not be allowed to derail concrete actions to address the actual conditions that each society faces.

The task force advocates substantial new investment in health sectors in order to meet the Goals, which cannot be met on annual per capita health expenditures of \$5–\$10 or less. But even massive new aid poured into the same old strategies will not lead to success. The Millennium Development Goals must be more than a high-stakes negotiation over the bottom line of official development assistance.

Creative, effective solutions that positively transform societies and their health ultimately grow from processes that take place within those societies. In both child health and maternal health, powerful stories of success tell us that change is possible, that the Goals need not be pie in the sky, and that leaders of change speak many languages. But we are also keenly aware that global forces both constrain and facilitate the ability of local and national actors to think and act boldly. The global community, and the wealthy nations that strongly influence it, are not rescuers of poor countries or poor communities in distress; nor are they solely responsible for all of the world's problems. But they are complicit in having created the conditions that define the dismal state of health today and they must therefore be part of the solution. Their complicity lies not just in the economic and political realm. In the health arena the global community, including multilateral and bilateral agencies, does critical work in setting technical norms and standards, generating and evaluating scientific evidence, forging consensus strategies, and facilitating or frustrating implementation on the ground. Transformative change must also be on their organizational agendas.

The 2015 target date for achieving the Millennium Development Goals should spur countries and the global community to action, to take immediate

concrete steps. But the fundamental transformations discussed here need to be part of dynamic, ongoing processes of revitalizing—sometimes recreating and rebuilding—health systems as part of broader social change. That requires new vision about where we are going and how we get there, a realization that 2015 is a stop along the way, not the final destination.

## Analytical context

This chapter provides a brief overview of the current picture of child health and maternal health, introducing the multiple perspectives that are developed in the rest of the report. It also introduces the analytic lens of health equity and links it to human rights and the multifaceted practice developing under the rubric of rights-based approaches. These perspectives provide support for the underlying premise of this report: that analysis of health conditions and interventions, as well as strategic choices of policies and programs, must be firmly rooted in their social, economic, and political contexts. Context is not only cross-sectional. Just as the choices made today have serious consequences for future conditions and decisions, so the current situation must be understood in historical context.

As an important backdrop to the chapters that follow, this chapter raises some crucial questions about the role of different kinds of evidence in the health field. The focus is on the quintessential challenge for the UN Millennium Project, namely, scale. What evidence helps us move from proof of efficacy of specific interventions (often in experimental settings) to the implementation of health sector policies and programs that meet the needs of entire populations?

### **Global health from three perspectives**

The current global health picture can be described in a variety of ways, particularly for low- and middle-income countries, where more than 98 percent of both maternal and child deaths take place. These include an epidemiological approach, which describes health status; a structural approach, which focuses on health systems; and a power-mapping approach, which charts patterns of decisionmaking. Each yields a different, vital perspective on the problem. Each tends to structure thinking about solutions in a different way. Together these approaches lay the foundation for the task force's recommendations.

**“Business as usual” will not be enough to reach the Goals**

***Epidemiological evidence reveals that progress is slowing—and even being reversed***

The most conventional way to characterize the global health picture is to describe health and disease. The picture that emerges is a grim one.

About 10.8 million children under the age of five die each year (Black, Morris, and Bryce 2003). While child mortality has steadily declined in the past two decades, progress on key indicators is now slowing, and in parts of Sub-Saharan Africa child mortality is on the rise. The great bulk of the mortality decline since the 1970s is attributable to reductions in deaths from diarrheal diseases and vaccine-preventable conditions in children under five. Other major killers of children, such as acute respiratory infection, have shown far less reduction, and malaria mortality has been increasing, especially in Sub-Saharan Africa.

The rate of neonatal mortality has remained essentially unchanged. As a result, neonatal mortality now accounts for an increasing proportion of all childhood deaths. Yet interventions and strategies for reducing neonatal mortality have remained largely unaddressed and unimplemented. This report pays particular attention to this problem and suggests that a new indicator, the neonatal mortality rate, be added to the measurement of Goal 4 (see chapter 5).

Malnutrition of children is a contributing factor in more than half of all child mortality, and malnutrition of mothers contributes to a substantial proportion of neonatal mortality. For this reason, this report pays close attention to the nutrition aspects of Goal 1.

Although some bright spots exist, sluggish progress overall makes clear that “business as usual” will not be enough to reach the health Goals. According to a World Bank study conducted in 2003, only 16 percent of countries (with only 22 percent of the developing world’s population) are on track to meet the child mortality target, and not a single country in Sub-Saharan Africa is among them. Most developing countries are on track to meet the somewhat less ambitious indicator on reducing the prevalence of underweight children. But just 17 percent of countries in Sub-Saharan Africa are on track for doing so (Wagstaff and Claeson 2004).

National trends mask deep disparities within countries. On average the poorest fifth of the population saw child mortality falling half as fast as the general population. This means the gap between rich and poor is widening (Wagstaff and Claeson 2004). A paper commissioned by this task force to analyze data from Demographic and Health Surveys and Multiple Indicator Cluster Surveys reveals that wealth is only one axis of inequality (Wirth and others 2004). Ethnic, linguistic, and other divisions are equally or more significant markers of gaps in child mortality in many countries. For some countries, particularly in South Asia, gender matters immensely: girls lag behind boys on many indicators, including the under-five mortality rate and utilization of healthcare services (Bhan and others 2005; Fikree and Pasha 2004).

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the iceberg**

For maternal mortality, progress has been even more elusive. Despite 15 years of the Safe Motherhood Initiative, overall levels of maternal mortality are believed to have remained unchanged, with the latest estimate of deaths standing at about 530,000 a year (WHO, UNICEF, and UNFPA 2004). And as with child mortality, the burden of maternal death falls disproportionately on the poor (Graham and others 2004). A handful of countries have experienced remarkable drops in maternal mortality ratio, and the Middle East and North Africa region appears to be on track for meeting the maternal mortality target (Wagstaff and Claeson 2004). But the only other region even close to being on track is Latin America and the Caribbean. In the great majority of high-mortality countries, where the great majority of maternal deaths occur, there has been little change. Indeed, in some countries in which levels of HIV/AIDS and malaria are high and growing, the number of maternal deaths as well as the maternal mortality ratio are believed to have increased (McIntyre 2003). Moreover, the half million maternal deaths are the tip of the iceberg: every year another 8 million women suffer complications from pregnancy and childbirth that result in lifelong health consequences, including obstetric fistulae (WHO 2003c).

Other aspects of maternal health present a mixed picture. While globally fertility has declined dramatically—from 5.0 births per woman in 1960 to 2.7 in 2001—an estimated 201 million women who wish to space or limit their childbearing are not using effective contraception that would enable them to do so.<sup>1</sup> The result is about 70–80 million unintended pregnancies each year in developing countries alone (Singh and others 2003).

Meanwhile, violence continues to shatter the lives of women in every part of the globe (Heise, Ellsberg, and Gottemoeller 1999). And sexually transmitted infections, including HIV/AIDS, ravage whole communities, with disastrous effects on families and societies. The 13 million children in the world who have lost one or both parents to AIDS are testament to this fact (UNICEF 2003a).

The Goals for child health and maternal health are constructed in epidemiological terms (see Goals on pages xvi–xvii). Chapter 3 examines the epidemiological picture more closely and discusses the interventions that can address the primary proximate causes of poor child health and maternal health.

***Poorly functioning health systems are a primary obstacle to meeting the Goals***

Epidemiological data form the skeleton of the picture of health status. But people's actual experience of health and disease—and, critically, of poverty itself—is inseparable from their experience interacting with health systems. In poor, high-mortality countries, those systems are in profound crisis. A second way to characterize the global health picture is thus to examine the state of healthcare in poor countries. Indicators of the crisis that has overtaken health systems across developing countries include the following:

**The problems of health systems have become a primary obstacle to meeting the Goals**

- Users routinely describe abusive and humiliating treatment by health providers.
- Health providers routinely describe dehumanizing and demoralizing working conditions, including public sector salary levels that have plunged well below a living wage.
- Huge gaps in the staffing of front-line facilities make reliable, good-quality services virtually unattainable. Many clinics stand empty; others are dangerously overcrowded.
- Ministries of health at all levels are grossly unprepared to manage the crises they face, a situation often exacerbated by rapid decentralization and a proliferation of uncoordinated, donor-driven initiatives.
- The lack of basic drugs and equipment cripples facilities' ability to function, damages the system's reputation, raises out-of-pocket costs to patients, and fuels a spiral of distrust and alienation.

The result in many countries is a mass exit from the public health system into a chaotic, unregulated, wildly diverse, and sometimes dangerous private sector (Standing and Bloom 2002) and catastrophic costs, formal and informal. These costs are borne disproportionately by the poor, leading one commentator to coin the term “iatrogenic poverty” (Meessen and others 2003).

The problems of health systems have become a primary obstacle to meeting the Goals. Chapter 4 examines health systems, not simply as mechanisms for delivering medical interventions but as core social institutions—a role that makes their improved functioning a vital element of poverty reduction strategies.

***Identifying who has the power to change health is a key step in formulating strategies***

The conception of health systems as core social institutions moves the analysis beyond a simplistic view of healthcare as a technical, biomedical fix to a recognition that both health and healthcare are deeply embedded in broader webs of social and economic forces. A third way to approach the global health picture is through power-mapping. Who makes the decisions that shape health and healthcare in poor countries, and what is the context that shapes their decisions?

At the country level, national policies obviously matter greatly. But priority must also be given to the critical decisionmaking that happens at the district level, where integrated primary health systems are needed to effectively deliver child, maternal, and reproductive health interventions. Facilities—both governmental and nongovernmental—are critical to the district health system. But so are community-based primary care activities, often linked to those facilities, especially when they truly empower the communities they serve.<sup>2</sup>

Chapter 6 examines the effect of international aid mechanisms—Poverty Reduction Strategy Papers and associated resource allocation tools, public

**A rights-based approach should ask hard questions about who has the power**

expenditure reviews, and medium-term expenditure frameworks—on countries' ability to meet the Goals. It also raises questions about the dynamics of power between the people and communities whose health is at stake and the wider social structures—including the health system—responsible for addressing it. Invoking notions of “participation” and “accountability” is almost de rigueur in the health literature. A rights-based approach should go beyond the formal mechanisms through which such notions are implemented to ask hard questions about who actually has or shares the power to effectuate change.

**First principles: equity and human rights**

If health is central to poverty reduction, then issues of equity must be central to health. In recent years, researchers, donors, and activists have taken up the call for health equity, which has become an increasingly sophisticated lens through which to document and understand disparities in health. Its power to generate or guide change could be substantially increased in many settings by connecting to the principles and evolving practices derived from human rights. These concepts are introduced here and used throughout the report to demonstrate what difference they make in actual strategic choices, policy directions, and program design and implementation—in short, for strategies for reaching the Goals.

*Health equity*

Our concern with disparities in health status and in access to healthcare reflects not simply a concern with the statistical range that exists across ungrouped individuals in a population. Rather our primary concern is with the relationship that inequality has to the socially defined hierarchies that exist in every society (Braveman, Starfield, and Geiger 2001). The report adopts the operational definition proposed by Braveman and Gruskin (2003, p. 254): “Equity in health is the absence of systematic disparities in health (or in major social determinants of health, including access to healthcare) between groups with different levels of underlying social advantage/disadvantage.” Health equity is therefore an expression of social justice.

The coincidence of multiple inequities in health and the multifaceted nature of poverty make for a very complex field. People living at the margins of society suffer numerous and overlapping inequities—in health, voice, agency, living conditions. Often their poverty and ill health keep them perpetually trapped. Just as an intervention might spare a child from malaria only to leave her to die a year later of measles, a policy change in the health sector might be successful in eliminating one source of inequity (for example, financial barriers to care) only to have another emerge or persist (for example, gender bias). Among the poor, gender inequities further increase women's vulnerability (Sen, Iyer, and George 2002). And among poor women, those of a particular ethnicity or religion may face additional stigma or marginalization.

**Public spending  
in the health  
sector dispro-  
portionately  
benefits the  
wealthier**

The idea that poverty, social exclusion, and marginalization underlie disease has deep historical roots, and has been articulated by influential health movements, such as the social medicine movement in Latin America (Tajer 2003) and the sexual and reproductive health and rights movement globally (Correa 1994). Theories of social epidemiology recognize social conditions and exclusion as fundamental causes of ill health. One of the ways these fundamental social causes translate into disparities in physical health conditions is by influencing access to the resources necessary to prevent and treat illness (Link and Phelan 1995). This often plays out in differential access to health interventions or exclusion from the health system.

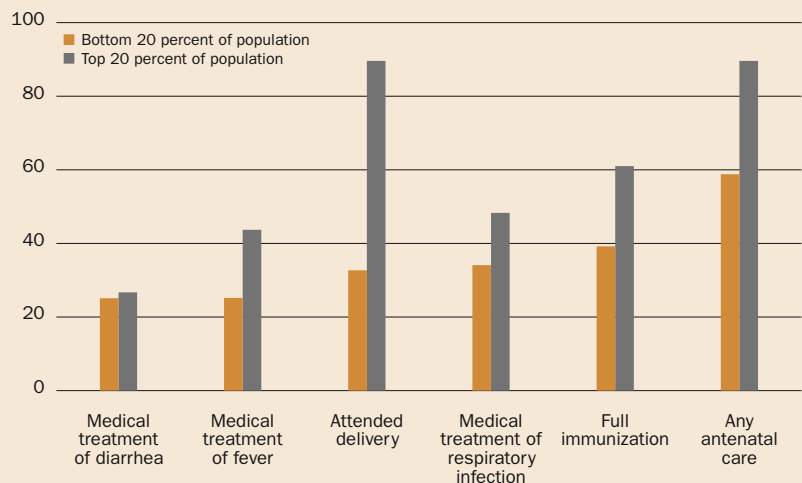
Utilization is a somewhat more complex concept, since it potentially implicates not only availability and accessibility of services but also the decision-making dynamics of users themselves. But here, too, disparities are rampant. For key maternal and child health interventions, utilization data reveal wide disparities between the lowest and highest wealth quintiles, with attendance of births by skilled health personnel—an indicator for the maternal health Goal—displaying the widest gap (figure 2.1). These are aggregate data for developing and transitional countries as a whole, but in many countries, the disparities in utilization are far wider.

Another important dimension of health equity analysis is detected through benefit-incidence studies, which measure the extent to which different segments of the population benefit from public spending (Castro-Leal and others 2000). These studies generally find that public spending in the health sector disproportionately benefits the wealthier, although the extent of the disparity varies across healthcare services and countries (Gwatkin, Bhuiya, and Victora 2004).

Much work on health equity has focused on “sounding the alarm,” pointing to widening gaps in health status between population groups. Joining with many in the health equity field, the task force maintains that it is critical to

**Figure 2.1**  
**Use of health services  
by lowest and highest  
wealth quintiles  
in developing and  
transitional countries**  
*Coverage (%)*

Source: Gwatkin, Bhuiya,  
and Victora 2004.



**The health equity literature is surprisingly silent on rights**

go beyond the mapping of disparities to pointed inquiries into determining “who and what is responsible for population patterns of health, disease, and well-being, as manifested in present, past, and changing social inequalities in health” (Krieger 2001, p. 668). As health equity research increasingly looks upstream, documenting the roots of health disparities in wider social, economic, and political conditions as they have developed over time, its potential synergy with rights-based approaches to health becomes clear (Krieger and Gruskin 2001).

***Human rights and rights-based approaches to health***

With a few exceptions, the health equity literature is surprisingly silent on rights. More often, health researchers who effectively expose and document disparities have used concepts of fairness, based on need, to work toward recommendations for policy change (Daniels and others 2000). Sometimes health equity is framed as a moral issue. Sometimes it is framed as an economic issue, premised on the fact that a healthy labor force is necessary for economic growth and that disparities raise concerns about “externalities” or “market failure.” There is little talk of entitlement or claims—and even less of violation.

Often the outcome of health equity and of rights-based analyses has been a search for so-called “pro-poor” interventions, with little attention paid to the roots of inequity or the social dynamics that reinforce it (Vega and Irwin 2004). Although “pro-poor” is rarely defined, it often refers simply to an intervention that, in theory or demonstrated fact, is used more by the poor than the wealthy (Wagstaff and Claeson 2004). Yet such “pro-poor” interventions are not necessarily pro-equity or anti-marginalization. Narrowly focused but well conceived targeted interventions are sometimes powerful short-term steps that are essential parts of a broader equity-based strategy (see chapter 4). But policies that segregate and “target” the poor can deepen and institutionalize inequality by increasing their marginalization.

Moreover, even when “pro-poor” interventions effectively combat poverty, they are generally discussed in the health literature as interventions floating free from any structure of entitlement or accountability. There is no sense that the state is obligated to provide such interventions or that the law should guarantee them. There is no sense that citizens in a country have any recourse when access is denied. This despite the fact that virtually all countries in the world have ratified at least one human rights treaty that legally commits them to addressing such disparities in health.

To effectively move from a research-oriented approach of health equity to an action-oriented agenda for meeting the Millennium Development Goals as true development goals, we need human rights. Human rights provides a normative framework that has generated exceptionally wide consensus in the international community—not least in its invocation as a central theme of the Millennium Declaration. The norms include both outcomes (obligation of

**Human rights offers a set of norms and values that have special resonance when turned to women's and children's health**

results, such as the highest attainable standard of health) and processes (obligation of means, such as participation and maximum use of available resources). Equally important, human rights offers a set of values: individual human dignity, nondiscrimination, and social justice. These values have special resonance when turned to the shameful statistics of women's and children's health.

In addition, human rights provides a language that has multiple uses beyond its analytic role. It is a tool for advocacy and mobilization: deployed in a consciously political struggle, it "crystallizes the moral imagination" (Uvin 2004, p. 134) and the commitment and action that imagination inspires.

At another level, the language and categories of human rights act as a counterweight to the hegemony of economics in development practice today. This is not a minor point. The tendency to convert every issue into a technical, measurable, cost-able, managerial problem both preserves the balance of power in particular expert groups and, by sidestepping the true issues at stake, undercuts many development projects (Pritchett and Woolcock 2004; Scott 1998; Uvin 2004). For the UN Millennium Project, no less than for health policymakers, economic analysis needs to be complemented by politics of principles and values. There is no avoiding it: there is no such thing as a value-free or objectively scientific perspective on the recommended solutions. The status quo implies acceptance of the values that currently drive health and health systems, even if those values are not often acknowledged or made explicit.

If the current state of global health is unacceptable, if the status quo needs to be transformed, then consciously identifying and addressing the values that operate in health-related decisionmaking in households, communities, districts, countries, and throughout the world—and the relationship of those values to the distribution of power and resources—will be an essential part of the transformative process. Health equity analysis reveals one panel of a picture that is unacceptable from any point of view—moral, economic, legal—and uses scientific methods to probe its origins. Human rights is ultimately about identifying the workings of power that keep these unacceptable situations as they are and then using a different vision of human well-being and a growing set of rights-based practices to demand, implement, and ensure the rearrangements of power necessary for change.

We should not be naïve, however. Human rights often comes with baggage. Some suspicion of human rights talk grows from its cynical use by those who hold power in countries both rich and poor. Too often the invocation of human rights is mere rhetorical repackaging of the same old policies or a justification for aid conditionalities that, because of their selective and inconsistent application, can seem like little more than a raw exercise of political and economic power (Uvin 2004). Other attacks on human rights challenge its claim of universality, arguing that rights are "Western" and hence inauthentic and illegitimate for non-Western societies. Such a charge is profoundly cynical and manipulative when lobbed by regimes with checkered, sometimes appalling

**Virtually every country has endorsed at least some human rights treaties**

human rights records against their own citizens, including human rights advocates who bravely stand for justice in their own societies.

In fact, virtually every country in the world has endorsed at least some human rights documents. But we must be clear: The standing of human rights treaties as international law binding on governments does not vitiate the need to build—not assume—cultural legitimacy for human rights principles (An-Na'im 1992). The health field can be especially fertile ground for that process.

Finally, it is fair to say that within the field of international health, human rights are far too often invoked as a substitute for the crucial work of evidence-based health interventions and policy development. But, as this report seeks to show, that need not be the case.

***Implementing human rights in health***

The approach to human rights used in this report and recommended by the task force begins by making a basic distinction between two concepts:

1. Human rights as formal law, including the international human rights system of treaties and reporting mechanisms (treaty bodies, special rapporteurs, and working groups) and domestic courts.
2. Rights-based approaches in development practices, in which principles and values derived from human rights are incorporated into policy and program design and implementation (whether or not the term “human rights” is used).

This distinction underscores the difference between doing human rights work on health and doing health work that uses human rights as one of its guiding principles. The distinction relates to methodologies.

Mainstream human rights organizations have pioneered a methodology that focuses on violations of applicable human rights law, using a “name and shame” or “expose and denounce” technique that is particularly effective for civil and political rights violations, such as torture and unfair trials, and sometimes for rights related to health as well. But human rights should not be conflated with this traditional methodology. The complexity and diversity of human rights problems requires a much more varied and nuanced set of human rights tools and human rights practices. Health is a good example.

The formal human rights system has taken major steps in recent years to clarify the right to health and demonstrate its applicability to specific problems. The Economic and Social Committee's General Comment 14 on the right to health and the appointment of a special rapporteur on the right to health are two important milestones. These processes need to be supported and strengthened, as they are crucial to the building of international consensus on the meaning and application of the norms.

But when it comes to healthcare workers, health activists, and health policy-makers facing concrete problems on the ground, human rights initiatives fixated

**The right to health is often misunderstood as the right to be healthy**

on and bound by chapter and verse of human rights treaties often miss the mark. In the provocative words of Peter Uvin, such legal formalism “is about as useful to on-the-ground change as knowing the lyrics to ‘We Are the World’ is to ending hunger” (Uvin 2004, p. 140). We can do much more. Rights-based approaches that build human rights principles and practices into the larger, multifaceted, and multidisciplinary endeavor of health development work and of health advocacy and activism are a central element in the strategies proposed here. Indeed, the Special Rapporteur on the Right to Health has now joined the call for this expansion of methodologies (Special Rapporteur on the Right to Health 2004).

The right to health is often misunderstood as the right to be healthy. Given the multiple determinants of health, including genetics, this would make little sense as a legal standard. No one can guarantee good health. Rather, the right to health encompasses both freedoms, such as the right to be free from torture or to have control over one’s reproductive capacity, and entitlements, such as access to healthcare or to the social and environmental conditions that make good health possible (UN CESCR 2000).

Key human rights principles include the following:

- *Entitlement and obligation.* Human rights law relates primarily—but not exclusively—to the relationship between citizens and states. With globalization, this aspect of the law has been evolving in crucial ways relating to nonstate actors (corporations, individuals, and other groups) and the growing recognition that a state can have duties outside its own borders, particularly when it is complicit in creating an extraterritorial situation that contributes to deprivations of human rights (International Council on Human Rights Policy and EGI 2003; Special Rapporteur on the Right to Health 2004). But even beyond formal law, relationships of entitlement and obligation arise throughout healthcare systems.
- *Accountability.* The concept of “constructive accountability” is used here to make clear that human rights work is not only or always about identifying violations, finding blame, and imposing punishment (Freedman 2003). Fulfillment of the right to health will mean building responsive, equitable health systems. Positive relationships of accountability—including transparency and answerability (Brinkerhoff 2004)—will be an important dynamic in making such systems function (World Bank 2003b). When properly grounded in a broader social and political framework, these ideas, together with the more conventional understanding of accountability as including mechanisms that provide recourse for violations suffered, become key parts of a rights-based approach.
- *Claims.* Principles of obligation, entitlement, and accountability translate into claims for healthcare and the social conditions critical for good health. Health claims are valuable assets that people use to wage their own battles against poverty and to exercise their citizenship rights. It is the obligation of the state to acknowledge and create the conditions for

**Obligation,  
entitlement, and  
accountability  
translate into  
claims for  
healthcare**

the effective assertion of health claims, in the broadest sense (not just through a legal malpractice system). This is a critical principle in the approach to health systems presented in this report.

- *Participation, voice.* The involvement of people in the decisions that affect their fundamental rights is an essential principle of rights-based practices. Such involvement is often promoted for instrumental reasons, because it has been shown to lead to programs with better outcomes. But participation or involvement is also the opposite of exclusion or marginalization: it has value in its own right as part of the process by which people become effective agents in their lives and their societies.
- *Respect, protection, and fulfillment.* The obligation of duty-bearers is to respect (not to violate), to protect (prevent others from violating), and to fulfill (take steps to ensure positive enjoyment of) rights. The adoption of a rights-based approach to health must not be permitted to divert attention from the steps needed to address the nitty-gritty—but not trivial—problems of functioning healthcare systems. Human rights is indeed about political action, but allowing ideological debate to derail real action on operational issues is itself a statement about the value we place on truly meeting the needs—and the rights—of the poor and the marginalized.
- *Progressive realization.* It is one thing for a state or any other responsible actor to acknowledge a right—by ratifying a treaty, for example—and quite another for it to take action to ensure that that right is enjoyed. The right to health will not be fulfilled through legal formalism, by the stroke of a pen. It takes time, money, commitment—and action. The principle of progressive realization articulated in human rights treaties requires states to take all appropriate steps to realize the right in question “to the maximum extent of available resources.”

This report uses the principle of progressive realization to highlight three critical issues:

- *Action must be concrete, deliberate, and targeted.* All states, no matter how poor, can take certain immediate, concrete measures to advance the right to health (UN CESCR 2000).
- *Budget allocations are relevant.* Allocations of budget and official development assistance are relevant to human rights. Discretionary, harmful cuts to the health budget arguably violate this right.
- *Some interventions must take priority over others.* Not all interventions are equally important for ensuring enjoyment of a right. When fundamental rights are at stake, particularly when the historical context points to a legacy of neglect, some interventions must take priority over others. This principle has been invoked in the HIV/AIDS field (Minister of Health v. Treatment Action Campaign 2002). Chapter 3 shows how it applies to maternal mortality.

**The right to  
health takes  
time, money,  
commitment  
—and action**

**The health systems crisis in historical context**

At independence most countries in Asia and Africa found themselves confronting the legacy of a colonial health system that had focused almost exclusively on urban, tertiary hospitals. Traditional providers of different kinds, unconnected to the state, were the major sources of healthcare outside the family. Newly independent states advanced a new vision of healthcare as part of the nationalist ideals that had inspired the struggles for independence (Mackintosh 2001). Into societies often marked by deep inequalities (by wealth, gender, and sometimes race and ethnicity), governments advanced a strategy that would extend basic curative and preventive services through a network of health posts or health centers in “a highly organized, supervised, and regulated publicly financed service which would cover the entire population” (Bloom and Standing 2001, p. 8).

In this scenario, households and communities would provide basic social support and voluntary labor for public health, while the state would provide specialist knowledge, drugs, and other supplies, through an extensive infrastructure of basic health posts and centers (Bloom and others 2000). To meet the daunting challenge of staffing such a system, most countries planned to train massive numbers of “medical assistants” or “health assistants” to work as government employees at the most basic level of the local health infrastructure. In addition, they planned to train “community health workers,” typically volunteers, who were expected to lead public health campaigns and provide simple preventive and curative care in their own communities. These cadres of workers were generally people with little formal education, who were given a limited amount of training. A strong supervision system in which doctors and nurses would provide regular monitoring and back-up to health assistants and community health workers was therefore an essential element of this vision.

During the 1960s and 1970s, many countries invested heavily in training and deploying community-based healthcare workers, including to underserved rural areas. The boldest, and most successful, application of this kind of system was the “barefoot doctors” program in China, which became an inspiration for international public health policymakers. In countries such as Bangladesh, these workers are crucial to strategies such as “doorstep” family planning services designed to circumvent gender-based barriers to utilization, for example *purdah* restrictions that prevent women from leaving their homes to access family planning facilities on their own (Schuler, Hashemi, and Jenkins 1995; Simmons and others 1988).

BRAC (formerly known as the Bangladesh Rural Advancement Committee), a large NGO, has been training female community health workers since the 1970s. The program grew out of frustrations with existing public and private healthcare system and experience with male paramedics. As of 2003, it had trained nearly 30,000 community health workers in as many villages (box 2.1).

### *Primary healthcare*

From this basic vision of an appropriate health system that responds to the needs of the entire population grew the concept of primary healthcare, formally articulated at the Alma Ata conference in 1978. Although primary healthcare is now often equated only with community-based, low-tech healthcare, the Alma Ata declaration very clearly recognized the importance of a facility-based health system with a strong referral network, of which outreach into communities was an integral part. As the director general of the WHO, Hafdan Mahler, said in 1981, “A health system based on primary care cannot, and I repeat, cannot be realized, cannot be developed, cannot function, and simply cannot exist without a network of hospitals” (Van Lerberghe, de Bethune, and De Brouwere 1997, p. 801).

Primary healthcare was not just a blueprint for organizing a public health system. It was a fundamental approach to health itself based on the notion that services should be delivered as close to the community as possible, in a system that the country could afford, in an integrated manner, with the participation of the community. Health was understood in its full social and economic dimensions, and healthcare was understood as an essential part of what good governance should mean. These were optimistic times: the commitment to primary healthcare and to “Health for All by the Year 2000” developed hand

#### **Box 2.1** **BRAC trains village women as volunteer community health workers**

Source: Chowdhury and others 1997; Watts 2004.

Community health workers trained by BRAC are married, middle-age women eager to work for their communities. Only a few have any schooling. They are members of BRAC-organized village organizations, groups of poor women designed to advance their social and economic well-being. Village organization members select one of their own to be trained as the community health worker for their area. These workers receive no salary from BRAC, but they supplement their income through opportunities created and facilitated by BRAC. With small loans from BRAC, they set up revolving funds for drugs, which they sell at a small mark-up. They also sell selected health products, such as contraceptives, iodized salt, oral rehydration salts, soap, safe delivery kits, sanitary napkins, sanitary latrines, and vegetable seeds, at a profit. BRAC also provides them with small loans to undertake other income-enhancing enterprises.

Community health workers receive four weeks of initial training, supplemented by one-day refresher sessions every month. They are trained to treat common illnesses, such as diarrhea, dysentery, the common cold, scabies, anemia, gastric ulcers, and worm infestation. A subset of these workers has also been trained to provide directly observed therapy, short course (DOTS) for tuberculosis and to treat acute respiratory illnesses, particularly pneumonia (Chowdhury and others 1997).

Each community health worker is assigned about 300 households, which she visits once a month. During household visits, she provides health education and treats illnesses. She also uses this opportunity to sell health products. When she encounters an illness she is not trained to manage, she refers the patient to government health centers or to BRAC facilities. While BRAC doctors and other trained health paraprofessionals provide professional supervision, the community health worker is accountable to her village organization and the community she serves.

**Primary  
healthcare  
understands  
health in its  
full social  
and economic  
dimensions**

in hand with the vision of a new international economic order that promised poor countries not only prosperity but also control over their own destiny.

Neither the optimism nor the international commitment lasted long. Some recent commentators attribute the nearly immediate reversal of primary healthcare policies to the idea that the West did not want to put priority-setting responsibilities in the hands of the developing countries (Hall and Taylor 2003). At the time, however, the main rationale for abandoning Alma Ata was affordability, as the debt crisis of the 1980s descended on many of the poorest countries of the world. Some argued that if primary healthcare was too ambitious and too expensive for immediate implementation in countries mired in debt, then a targeted approach aimed at a few of the disease conditions responsible for the highest number of deaths and for which relatively inexpensive, safe, and effective interventions already existed could be a way to have an impact on health in the short term (Walsh and Warren 1979). Much debate ensued, but this selective approach eventually won the day in the international health policy arena. Its rationale became the basis for UNICEF's Child Survival and Development Revolution, launched in 1982. The strategy was to push for massive coverage of a few key interventions that would address the most important causes of child mortality and morbidity. Known by the acronym GOBI and then GOBI-FFF, these interventions were growth monitoring, oral rehydration, breastfeeding, immunization, and then also food supplementation, family planning, and female education.

Several of these interventions have had very substantial effects on child mortality. Oral rehydration therapy has been credited with bringing about dramatic declines in diarrhea-related deaths. Immunization has had a major impact as well. But its fate is, in many ways, emblematic of the dilemmas raised by selective approaches delivered through vertical systems. The Expanded Programme on Immunization, which garnered substantial donor support in the 1980s and 1990s, using a dedicated delivery system, achieved high coverage and had a measurable impact on vaccine-preventable diseases. But even when vaccination programs attained their highest levels of performance, the overall functioning of health systems remained weak. Today, as some donors and implementing agencies withdraw from vaccination programs and turn their resources and attention to new priority diseases, such as HIV/AIDS, coverage has ceased to increase and, in some areas, is slipping.

With hindsight the effect of selective primary healthcare was particularly problematic for maternal mortality. The shift toward community-level, low-cost interventions translated into a push toward training traditional birth attendants as the primary strategy for providing safer delivery care—a strategy that eventually proved largely ineffective in reducing maternal mortality (Campbell 2001), as discussed in chapter 3. While many in the international health field shifted their attention to the community level, the budgets of many countries remained skewed toward urban tertiary hospitals. Squeezed out and

**Structural  
adjustment  
programs  
slashed  
spending in the  
health sector**

neglected were the crucial first-referral facilities, mostly health centers and district hospitals, on which reduction of maternal mortality so heavily depends (Van Lerberghe, de Bethune, and De Brouwere 1997).

As vertical programs were being deployed in the 1970s and 1980s, often quite separately from the basic health infrastructure, that infrastructure was coming unhinged. Mired in debt, many countries had little choice but to adopt stabilization and structural adjustment programs promoted by the IMF and World Bank requiring them to slash spending in all social sectors, including health. The effect of drastic cutbacks in health sector spending was magnified by the overall impoverishment and dislocation associated with economic crisis and with the policies pressed by the Bretton Woods institutions and adopted by national governments to address that crisis. In some parts of Sub-Saharan Africa, for example, not only was the health system in a state of collapse (Simms, Rowson, and Peattie 2001), “the economic context was experienced locally as a crisis of extended family support systems, a crisis to which social sectors were unable to respond” (Mackintosh 2001, p. 179).

***The marketization of healthcare***

By the early 1990s health systems were in serious disarray, particularly in Sub-Saharan Africa and parts of Asia. In some quarters of the international health policy world, primary healthcare conjured up not images of self-reliant communities engaged with committed healthcare workers and professionals in locally relevant health structures but images of empty clinics, lacking staff, drugs, and equipment, and a public system riddled with corruption, abuse, and waste (Filmer, Hammer, and Pritchett 2000).

By the 1990s the World Bank had become the leading funder of health sectors, and its view of the problems and prescriptions for solutions dominated the field. The highly influential *World Development Report 1993: Investing in Health* (World Bank 1993) introduced new priority-setting techniques for public spending and ushered in a new orthodoxy in health policy. Drawing on the neoliberal ideology that framed policies of the international financial institutions in other sectors, the core of the new orthodoxy was the view that the private sector could most efficiently meet most healthcare needs and should be allowed—indeed, actively encouraged—to do so. The public sector would be assigned the task of “gap-filling” to correct “market failures.” It would provide a set of cost-effective services determined on the basis of burden of disease measures, which would become an “essential service package” offered to the poorest through public sector facilities.

The consequence of this approach was the marketization of healthcare. In every part of the health system (whether nominally public or nominally private), healthcare—professional services, drugs, transport, basic access, and decent, humane treatment—came to be bought and sold. “The marketisation of public services has become so ubiquitous in some countries that parts of

**The  
marketization of  
public services  
has become  
ubiquitous**

the health system are more appropriately understood as government-subsidized private services than as a publicly funded service with minor problems with corruption” (Bloom and Standing 2001, p. 9). Health policy, still grounded in an idealized model of public-private sectors, was becoming dangerously disconnected from the reality on the ground.

Bloom and Standing have argued persuasively that instead of premising policy discussions (or prescriptions) on the increasingly insupportable view of discrete public and private health sectors, the situation in many—perhaps most—poor countries can be more accurately described as pluralistic and more appropriately divided into “organized” and “unorganized” categories. The choice that people confront is not between a private health system that charges for a broad menu of high-quality services and a public health system that offers essential services at no or low cost. Instead, all users, rich and poor alike, are confronted with a bewildering array of sources for healthcare, from medicine peddlers to traditional healers to highly trained specialist physicians to civil servants setting up private practices of wildly uneven quality. Indeed, in some places the community health workers who had been given minimal training with the expectation that they would be the backbone of a public health service working under the careful, supportive supervision of health professionals, actually now represent a substantial portion of private sector providers. As Bloom and Standing point out, the weakening of government supervision systems is “an important factor contributing to the de facto marketisation of health services” (Bloom and Standing 2001, p. 9).

For community health workers and other health providers faced with woefully inadequate salaries, the selling of services and even the pilfering of drugs and supplies is sometimes the only way to survive (Ferrinho and others 2004; Van Lerberghe and others 2002). Studies examining workers’ survival strategies in the face of health sector reforms help make the link between structural policies and the individual behavior that is often addressed simply as widespread corruption (Kyaddondo and Whyte 2003). (Coping mechanisms and their implications are addressed in chapter 4.)

The marketization of healthcare and the mushrooming of unorganized markets alongside collapsing organized ones have profound ramifications for health equity. Unorganized markets “do their greatest harm to the poor. They suffer the greatest information asymmetries and are much more likely to be at the purchasing end of shoddy or dangerous goods and services” (Standing and Bloom 2002, p. 7).

In societies in which inequality is deeply entrenched, the marketization of healthcare implicitly, but powerfully, legitimizes exclusion (Mackintosh and Tibandebage 2004). Any approach to rebuilding health systems—essential for meeting all of the health Goals—must confront this fact (see chapter 4).

The disintegration of the public health system—or, indeed, the failure ever to reach a functioning point from which it could disintegrate—is a core factor

**The  
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exclusion**

in the grim failure of many countries to address maternal mortality. Neither the obstetric complications that kill women in pregnancy and childbirth nor the consequences of severe pneumonia or cerebral malaria that kill children can be managed outside of a functioning health system. Even when families are willing to pay—willing to incur truly catastrophic costs (Borghi and others 2003)—women with life-threatening complications need professional, skilled healthcare and the drugs and equipment on which it depends in order to survive.

***Population and family planning: a parallel evolution***

Slow progress on reducing maternal mortality in most countries—and rapid progress in others—can also be understood from the perspective of a second narrative sketching the evolution of reproductive health policy and its implications for health systems. Historically, family planning programs have been justified and shaped by three different rationales, receiving different weights at different times and places: demography (reducing population growth), health (initially of children but also of women), and human rights (of women and men) (Seltzer 2002). The feminist-defined right of women to control fertility and family size has also had an impact across these policy rationales and in services themselves (Dixon-Mueller 1993).

Does it matter for health system functioning which rationale is the force behind a contraceptive program? Evidence from the family planning field suggests that it does.

In the 1950s and 1960s, censuses conducted in newly independent nations revealed rapid population growth. Some policymakers believed that the ability to provide (publicly funded) social services and generate savings for the investment necessary for economic development would be imperiled if declines in mortality were not accompanied by declines in fertility. International donors, influenced in part by geopolitical concerns, offered support to family planning services in an effort to hasten the demographic transition. The earliest policy and program developments were in South Asia.

Driven primarily by demographic concerns, these early family planning programs were constructed as vertical programs, with their own infrastructure of facilities, staff, logistics, and supplies. In countries such as India, where political energy was intensely focused on family planning as a primary tool of “population control,” the distortions to the health system were enormous (Visaria, Jejeebhoy, and Merrick 1999). The fate of auxiliary nurse midwives in the Indian system is a good example. Initially intended as community-based midwives who would provide skilled care for deliveries, auxiliary nurse midwives were de facto converted into family planning workers when they were held to numerical targets for bringing in “contraceptive acceptors” and monitored and held accountable for only this aspect of their job (Mavalankar 1997). While in some cases family planning enhanced the value of auxiliary nurse midwives within their communities, to a certain degree all other aspects

## Where was the M in MCH?

of women's health were accorded less importance. Moreover, the reliance on targets, on incentives and disincentives, and on the promotion of sterilization as the only method of contraception created a potentially coercive situation for patients, sowing distrust in the government system as a whole.

In some countries, particularly in Sub-Saharan Africa, health rationales dominated family planning programs and policy (Seltzer 2002). In these settings population growth was rapid, as traditional birth-spacing practices were eroding and motivation for limiting fertility was weak. Governments were concerned primarily with children's health; donors recommended and funded family planning as a child survival strategy. Strong evidence does support the important link between family planning and improved child health and survival (National Research Council Committee on Population Commission on Behavioral and Social Sciences and Education 1989). Maternal and child health (MCH) and family planning programs were the mode of service delivery adopted in many countries (Stewart, Stecklov, and Adewuyi 1999). It was not until the influential 1985 *Lancet* article subtitled "Where Is the M in MCH?" that the international health community recognized what was missing: programs that viewed maternal health primarily as a means to improve the health of children were failing to address the health system capacities necessary to avert the death of mothers (Rosenfield and Maine 1985). Indeed, international actors shared responsibility for the skewing of services. Even programs for improving delivery practices, a concern for many donors in the 1950s and 1960s, were crowded out in the 1970s and 1980s, as the WHO, USAID, and UNICEF turned the bulk of their attention to family planning and child health (Campbell 2001).

Several countries adopted broader approaches. In Malaysia and Sri Lanka family planning services developed in conjunction with an expanding primary healthcare system (including development of a cadre of professional midwives linked to and supported by that system) and a complementary set of policies and services advancing girls' education and women's status more generally. The impact on both fertility and maternal mortality, and even on child mortality, has been dramatic. Once modern contraceptive methods were introduced in these countries' primary healthcare systems, in the 1960s and 1970s, total fertility and maternal mortality fell to quite low levels. As a World Bank study explains, "it can be expected that when a health system provides credible and attractive basic services in key areas of women's health (that is, maternal health-care and contraceptive care), those services will reinforce each other. Maternal mortality and fertility declines are thus interwoven through increased uptake of both services" (Pathmanathan and others 2003, p. 52).

Human rights rationales for family planning first appeared in international documents in the late 1960s (Seltzer 2002). Although the earliest statements justified the right to decide on the number and spacing of children by its importance for population stabilization and child health (Freedman and Isaacs 1993), with the entering into force of the Convention on the Elimination of All Forms

**Maternal  
mortality and  
fertility declines  
are interwoven**

of Discrimination against Women (CEDAW) in 1981, the “right to decide freely and responsibly on the number and spacing of their children and to have access to information, education and means to enable them to exercise these rights” (Article 16.1) was codified in formal law as a woman’s human right (UN 1979). Indeed, evidence from social science research confirms the position put forward by women’s health and rights advocates that, from the perspective of women themselves, contraceptive services are an essential tool in their struggle not only to protect their own health and that of their children but also to participate as full citizens in their societies (Correa 1994; Petchesky and Judd 1998).

From this perspective, it mattered very much how contraceptive services were organized and delivered (Freedman 1995). If “health system functioning” is understood to include the experience of users interacting with that system—and not simply the technical capacity to deliver contraceptives—then a human rights rationale for family planning introduced a range of issues, from technical questions about contraceptive safety to policy questions about who should have a voice in decisions affecting health systems and services (Maine and others 1994). The rights-based, user-centered perspective was an important factor in the policy dialogue and programmatic recommendations that, during the 1980s, increasingly came to see informed choice and access to information, technically competent providers, and a range of contraceptive methods offered in a context of respectful interpersonal relations and an appropriate constellation of services as the key features of good quality of care (Bruce 1990).

By the 1990s a growing body of evidence had confirmed the importance of contraceptive services for health, for human rights, and for reduction in population growth as well. Simultaneously, a substantial research effort was devoted to the question of how best to deliver such services. That research, developed over several decades, overwhelmingly demonstrates that the mere supply of contraceptives is not sufficient to ensure that even women who want to limit or space births can or will use them. Utilization depends on many variables, including factors outside the formal health system, such as gender and age dynamics within households, economic survival strategies, and education. But utilization also depends on the very nature of the services themselves: the quality of care has been shown to have a significant impact on the level of contraceptive use (Koenig, Hossain, and Whittaker 1997; Samara, Buckner, and Tsui 1996; Seltzer 2002).

Quality of care, in turn, requires a functioning health system that can, for example, appropriately integrate an expanded range of contraceptive methods (Diaz and others 1999) or address the problems facing providers so that they can better address client needs (Shelton 2001). A particularly important question relates to the integration of family planning services with the broad set of services necessary to address a range of women’s reproductive health concerns, such as reproductive tract infections, HIV/AIDS and other sexually transmitted infections, cervical cancer, antenatal and delivery care, and gender-based violence (Berer 2003b).

**Quality of  
care requires  
a functioning  
health system**

The ferment within the family planning field reflected larger changes taking place in the post–Cold War world, including the growing recognition that women, as full citizens in their communities and countries, are essential to the development process and that sexual and reproductive health and rights are fundamental to the ability of both women and men to exercise citizenship. At the international policy level, the expanded dialogue on rights, the roles of women, participation, and development culminated in the consensus of the Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo in 1994. That consensus amounted to a paradigm shift that consolidated new thinking that had been emerging in the international health community in response to both new evidence and the growing voices of civil society movements. The ICPD paradigm shift was captured in the concept of reproductive health endorsed by the 179 countries that signed the conference declaration (box 2.2).

Reproductive health entails both an approach to health generally and a set of healthcare services aimed at improving the reproductive and sexual health status of all people (WHO 1999). As an approach, reproductive health actually shares much with the original notion of primary healthcare articulated at Alma Ata in 1978. Reproductive health is understood broadly, linking biomedical to social, economic, and political dimensions, and conceptualized as an essential part of development and a fundamental human right. Translating the commitment to human rights into reproductive health policies and programs means paying new attention to individual dignity and autonomy; to the right to make decisions free from coercion, violence, and discrimination; and to broader systemic questions of equal access and social justice (Copelon and Petchesky 1995; Helzner 2002).

This brief account has exposed the perennial tension that exists between strategies, such as primary healthcare and reproductive health, committed to the development of integrated health systems as part of equitable development on the one hand and vertical programs, such as immunization or contraceptive delivery, often supported by outside donors looking for short-term impact on discrete health outcomes, on the other. But the deterioration of healthcare systems has rendered this dichotomy almost moot. Whether due to vertical programs that draw off the resources of fragile health systems, to the impact of macroeconomic conditions and policies, to poor management, or simply to blind neglect, it is now indisputable that health systems are in deep trouble. With the resurgence of tuberculosis and malaria and the devastating rise of HIV/AIDS, this stark fact is once again laid bare. There is serious question about whether tuberculosis or HIV/AIDS can be effectively managed without strengthening health systems more generally (Buve, Kalibala, and McIntyre 2003; Mahendradhata and others 2003).

As the world swings toward addressing HIV/AIDS with a new seriousness of purpose, a new page in the narrative of global health policy is being written. The

**Box 2.2**  
**The UN**  
**International**  
**Conference on**  
**Population and**  
**Development**  
**definitions of**  
**reproductive**  
**health and**  
**reproductive rights**

Source: UN 1994.

The Programme for Action of the UN International Conference on Population and Development defines both reproductive health and reproductive rights:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive healthcare is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (paragraph 7.2).

Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized 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. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality (paragraph 7.3).

question is whether the Millennium Development Goals, and the strategies they inspire, will enable that page to be written well, to have lasting effect on all aspects of health and on the critical role that health systems will play in strengthening—or tearing apart—the fabric of society in poor countries around the globe.

**Evidence and the challenge of scaling up**

The central argument of this report is that dramatic, meaningful, sustainable progress toward improving child, maternal, and reproductive health requires a shift in perspective and mindset. The argument builds on the crucial distinction

**Health systems  
are complex  
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between an evidence-based understanding of the medical, behavioral, or public health interventions that will successfully address the primary causes of child health and maternal mortality and morbidity and an evidence-based understanding of and approach to the social, political, economic, and institutional structures that will enable societies—locally, nationally, globally—to ensure that all people have access to those interventions (Bryce and others 2003).

These are two dramatically different exercises. In recent decades much work in the public health field has focused on the first, on identifying the primary causes of poor health, including their prevalence and distribution, and developing an evidence-based understanding of the interventions that will work to address those causes. There is broad consensus on the methodology for evaluating evidence of the efficacy of interventions. The randomized controlled trial is widely accepted as the “gold standard,” though many other techniques are used to produce valuable evidence that is considered in setting health policy. That evidence base has then been extended through economic analysis of cost-effectiveness, as typified by the World Bank’s burden of disease work and the priority-setting techniques articulated in *World Development Report 1993* (World Bank 1993). Building on the concept of disability-adjusted life years (DALYs), the evidence of cost-effectiveness is used to arrive at “best buys” and the “essential service packages” that have been promoted by major international donors over the past decade.

The transition from efficacy of interventions to effectiveness of delivery strategies is where we so often lose our way. If efficacy is “proven” by techniques such as the randomized controlled trial, which screens out the noise of confounding variables, then the techniques to assess the effectiveness of delivery strategies and to set priorities for health sector policy must do just the opposite. They must take into account—they must even grow out of—precisely the messy, contradictory, dissonant noises of real life. In this sense, “delivery strategy” is a misleading term, implying a one-way flow, almost as a postal service organizes to deliver a letter. In fact, health systems and the health sector need to be approached as a dynamic, complex structure into which new interventions cannot simply be wedged. Over and over again, international strategies built on disease epidemiology simply assume that the societal structures to “deliver” those strategies exist and function. And over and over again, such strategies fail to have the expected impact. In subsequent evaluations the obstacles are identified—but the epidemiology alone yields no new strategies for surmounting them, only new strategies for avoiding them.

This will no longer work. We need to grapple with the true systemic obstacles to scaling up and to access, utilization, and equity—and so to dramatic improvements in maternal, child, and reproductive health. The ultimate solutions will include the infrastructure and resource requirements to deliver priority interventions, but that cannot be the starting point of the analysis of scaling up. Instead, a second line of inquiry, analysis, and evidence-building needs to

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be opened up—one that begins, not ends, with the social and political dimensions of health and healthcare as they are experienced by the people whose lives make up the grim statistics that are the focus of the Goals.

That analytic and evidentiary problem is distinct from the equally important exercise of identifying social, economic, and other environmental (non-physiological) determinants of health and disease. Identifying such determinants—and understanding the mechanisms through which they influence biological status and mortality and morbidity levels—provides a more accurate and refined picture of the importance of interventions outside the health sector. For example, virtually all of the health conditions identified in the Millennium Development Goals correlate with income poverty. But the solution to good health is not simply reducing poverty—full stop. Understanding the causal link is key.

For some health conditions, such as the mortality of children under five, improvements in the basic living environment—water, sanitation, nutrition—that can come with economic growth will have a powerful effect, because of the huge influence that malnutrition and infectious disease have on children's health in the postneonatal period (Black, Morris, and Bryce 2003). For other health problems, however, such as maternal mortality, improvements in living conditions will, by themselves, make very little difference, because the correlation between poverty reduction and maternal mortality reduction works through the impact that economic growth can have on the health system (Wagstaff 2002). Improved living conditions do not substantially change the chance that a woman will experience a life-threatening obstetric complication during pregnancy or childbirth, but access to a health system that can treat such complications will save women's lives and dramatically lower maternal mortality (Lule and others 2003; Maine 1991). For other aspects of maternal health, such as preventing sexually transmitted infections, poverty reduction can have a significant impact when it facilitates access to education, control over income, and a supportive legal system. Poverty reduction affects HIV/AIDS risk status in part through its effect on women's empowerment (Matinga and McConville 2002).

These multisectoral analyses are, of course, critical for improving health and must be part of overall MDG-based strategies. But the focus of this report is on the core challenge for health sector strategies. That challenge is typically characterized as one of “scaling up.” In the health literature, “scaling up” is undertheorized and underconceptualized. Often the tacit assumption is that scaling up is largely a matter of doing the same things that have been proven in small-scale demonstration projects but extending them to wider geographic areas and larger, more diverse populations. The obstacles to scaling up are identified as insufficient capacity and resources: not enough money, not enough human resources, not enough managerial skills, not enough information, not enough political will.

**Scaling up must  
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systematically**

While all of these deficiencies do indeed exist and must certainly be addressed, the aim of this report is to begin to identify and approach the problems systemically (Potter and Brough 2004). This means building a far stronger base of understanding of the complex functioning of the health system (broadly defined) in social and political life. With that foundation, the deficiencies in resources can be addressed in a context that can make strategies more pertinent and effective.