

## Chapter 2

**Abstract** Multilateral agencies define and operationalize health and development in a variety of ways. The World Health Organization (WHO) and the World Bank are two dominant actors in health and development. Each espouses a different ideal of health as it relates to the process of development. The WHO defines health as a human right, and focuses on health outcomes as inputs to and the result of development. The World Bank's approach to development focuses largely on macro-economic growth. Despite this, the World Bank became a leading actor in international health policy in the 1990s when it operationalized health as an outcome of financial and health care systems. This chapter looks at programming efforts by the WHO and the World Bank, specifically at primary health care and macro-economic adjustment (Structural Adjustment Programs), and finds mixed results. Efforts to improve primary care were successful in improving health outcomes of children under five, but made little impact on maternal mortality. Structural adjustment programs achieved moderate success with medium- to long-term economic growth but increased health inequities. Subsequent health reforms have also met with mixed success.

Health and development are central concerns for national and international governance because the preservation and improvement of health and the improvement of economies and capabilities that define development contribute to stability and prosperity of nation-states as well as the regional and global communities of which they are a part. Investment in health and development is predicated upon the assumption that the constituents of the nation-state, that is its territory, people, culture and way of life, are to be maintained and preserved as they contribute to the bodies politic and economic. Competing priorities and strategies that address economic growth, state security, human security and population health suggest that the relative import of health or development, and the impact each has on the other, remains contentious and forms what can best be described as the 'chicken or the egg' debate: Is development a necessary precursor to improvements in human health, or is human health necessary to achieve development? The position an institution or nation-state takes in this debate will dictate its policy approach. The implications are clear. If one

believes that development is a precursor to health, then one accepts that resources should be put into growing the economy, alleviating poverty, and building institutions and structures that further political stability from which human development will follow. If, on the other hand, one adheres to the latter ideal, then investment in methods to improve the human condition would be at the forefront. Once a critical threshold in population health is achieved, then economic and other forms of development will follow.

## **2.1 Health and Development as Concepts in the International System**

How one defines and understands health or development will have significant bearing on programmatic operations. The conceptualization of health varies across institutions, actors and time, but is broadly interpreted in one of three ways. One understanding of health considers it to have intrinsic or independent value. Such a perspective sees health as an inalienable right of human beings. A second understanding of health defines its value based on it being an input or contributing factor to other goals, such as economic development or state security. Within this framework, population health directly impacts economic growth by producing healthy workers who perform effectively and efficiently without creating a financial drain on the health care system. A healthy population further contributes to economic well-being by creating opportunities for children to be educated. If children are likely to live into adulthood, parents are more likely to invest in education. The education in turn translates into increased future earning potential for the children, their households, and broader society because better educated populations can command higher salaries and can attract greater investment. A healthy population contributes to state security because it is able to attend to its basic needs. If a population can work (assuming there are employment opportunities), then citizens can provide for basic needs such as housing, food, and other material goods and thereby cause a reduction in absolute poverty. Where famine, malnutrition, or gross inequalities in other health aspects of a population do not exist there may be less probability of social cleavage, discontent, political and social instability. Thus, internal threats to state security decrease. When states function rather than fail, there is regional and global stability and peace. A healthy population produces young men and women who are physically able to serve in the military, thereby contributing to military preparedness and strength.

The final notion of health views health as an outcome of physical, social and institutional factors. It is thus a malleable state that must be built by adopting multiple avenues of influence and including multiple sectors within the scope of health-oriented policy. Each of the three interpretations of health implies a different notion of what policy actions contribute to good or poor health, and will therefore influence policy formulation.

These conceptions of health are neither stagnant nor are they mutually exclusive in that international actors may subscribe to one or several of these notions of health when defining agendas and prioritizing actions. The dominant understanding of health within an institution may shift over time as we will see in this chapter. Given the variability of goals within both the health and development communities, such change in definition and utility is not surprising. Neither the project of improving population health nor engaging in development is stagnant. As agendas are set and policies implemented, knowledge continues to grow through information gathering, program and policy assessment. Such assessment entails learning from what has and has not been successful. Both failures and achievements are utilized to craft new approaches to the continuing goal of betterment of society, options and capabilities. The conceptualizations of health utilized in the global community since the mid-twentieth century reflect the history, tensions and dominant concerns of the international community.

Development, like health, is interpreted in a variety of ways. At its most basic understanding, development means economic growth and poverty alleviation. Actors who used this definition focus policy on finances and economic growth. Health, thereby, may flow out of economic growth, the rationale being that increased national income translates into increased fiscal resources to invest in health inputs such as sanitation projects, improved food, health systems and so forth. However, a more holistic understanding of development sees *human* development as “the process of enlarging people’s choices, by expanding human functionings and capabilities.” (UNDP 2000, p. 17). The publication of the first Human Development Report by the United Nations Development Program (UNDP) in 1990 was an international call to more broadly acknowledge the ideal of human development and human capacities. This more holistic interpretation suggests economic growth is only one foci of development and that other sectors such as education, health, and environment are equally important. Sustainability of these sectors, and indeed the ability to offer equal options to current and future generations, continues to be an important factor in sustainable human development.

At the macro- and meso-level of nation-states and global governance there are competing views as to whether economic growth or human well-being is of higher priority. The competing models offer two very distinct approaches to attainment of either health or development; one argues economic growth comes first, the other suggests that health does. The relative prioritization informs policy focus and action.

While it is broadly accepted that development, in its many manifestations, and investment in health are necessary for stability and prosperity of nation-states and the broader global community, there remains a division in policy and action across global actors. This division forms the basis of this chapter in which we will examine how health and development have been broadly defined by international actors since the twentieth century, and how such definitions were used to formulate distinct policy approaches espoused by international organizations (IOs). We will examine the formation of global governance following World War II by first looking at the political forces that informed the United Nations Charter. We will

then examine how political forces and norms influenced and reformed the focus, scope, and actions of the WHO and International Bank for Reconstruction and Development (IBRD, a.k.a. the World Bank). We will conclude by looking at the impact of maternal-child health programs, a tool in delivering primary health care, and structural adjustment programs as a policy for obtaining macro-economic equilibrium.

### ***2.1.1 International Health Before WWII***

Infectious disease had long been a concern for international and domestic security, a concern which spurred the creation and coordination of specific codes to limit the spread of disease and mitigate its human and economic impacts. *Yersinia pestis*, plague, presented one of the early challenges to international health. Plague is believed to have originated in Asia. It ravaged Asia, the Middle East, and Europe between the 1300s and the 1800s, and remains endemic to parts of Asia, Africa, Europe and the Americas even today. The worst recorded epidemic, the Black Death, peaked in Europe between 1347 and 1351 and killed between one quarter to one third of the population in Europe and the Middle East (McNeill 1976; Watts 1997). The disease spread along trade routes over land and sea. In addition to being one of the earliest recorded pandemics, plague was also one of the earliest documented agents of biological warfare. In 1346, the Tartars laid siege to the city of Caffa. The Tartar community had suffered from the plague. They engaged in battle against the Genoese, who were secured in the walled city of Caffa. The Tartars reportedly catapulted plague-ridden bodies over the city walls hoping to disable their enemy with disease (Wheelis 2002). As the Genoese returned home to Italy, they carried the plague with them. The disease quickly established a foothold and spread throughout Europe.

Public authorities took action to limit the spread of plague. Actions included the use of isolation and quarantine to control. **Quarantine**, derived from the Italian *quaranta giorni*, or forty days, is the separation of individuals who have been exposed to a disease but have not yet developed symptoms from contact with other unexposed individuals. **Isolation** refers to physically separating people who develop a specific disease from contact with others. The city-states of Italy established Public Health Councils to address the health threat posed by plague (Gomez-Dantes 2001; Watts 1997). The City of Venice instituted a formal quarantine system. Under the quarantine law, incoming ships had to remain at anchor for forty days before they would be allowed to dock. Health regulations in Italy included sanitation (disposal of bodies), limiting movement of infected and exposed individuals, financing medical care, and economic support for those impacted by market closure (Watts 1997). Proscriptions against population movement were adopted throughout plague-ridden areas. Other actions included closing marketplaces and cordoning off entire cities, and limiting trade and domestic and international mobility. Over time, quarantine

regulations became the most powerful tool the international community had to limit the spread of infectious disease. Quarantine and isolation were used against such diseases as cholera and yellow fever in the 1800s.

The growth of interstate commerce and travel during the Industrial Revolution along with the coalescence of modern nation-states, contributed to a growing call for international coordination of health responses. The European cholera epidemic (1830–1847) led to the first International Sanitary Conference in 1851. Representatives from 11 European nations developed transnational quarantine policy (Stern and Markel 2004). Interamerican cooperation solidified under the aegis of the Pan American Sanitary Bureau (Stern and Markel 2004). In Europe, the *Office International d'Hygiène Publique* (OIHP) in Paris became the chief coordinator of public health activities, such as monitoring and assessing disease occurrence and possible risk factors, providing technical advice to address health risks and improve health outcomes, and coordinating different actors to address specific health threats. Additionally, the OIHP had the authority to convene meetings, draw up international conventions, and administer quarantines (Gomez-Dantes 2001; Stern and Markel 2004). The League of Nations Health Organization (LNHO) formed in 1922, providing health supports which were parallel to the OIHP. In the years following the first world war, OIHP came to dominate quarantine policy while the LNHO began looking at disease prevention and health promotion. The LNHO also began efforts to address social determinants of health, and the specific vulnerabilities of motherhood, childhood and poverty (Gillespie 2002; Gomez-Dantes 2001; Stern and Markel 2004).

Interest in social medicine grew in the early part of the 1900s (Rodríguez-Ocaña 2002; Weindling 2004). **Social medicine** holds that social forces such as income, ethnicity, and institutional arrangements create social inequity from which health inequity follows. This perspective represents a broad reinterpretation of public health etiology in which disease comes about via a three-way relationship between agent, host, and environment. It was a subject of debate in the late 1800s and then re-emerged in health rhetoric following World War I, challenging the exclusivity of focus as practiced by adherents of bacteriology and germ theory. A division in the health community emerged between those who focused on the individual causes of ill health and those who focused on social causes. This division influenced rhetoric and policy throughout the twentieth century into the twenty-first century.

During the 1920s and 1930s, the LNHO, under the leadership of Ludwik Rajchman, expanded the organization's scope of concern beyond that of disease control, medical nomenclature and drug standardization to include emphasis on economic needs, employment, nutrition and social insurance as important constituents of good health (Gillespie 2002; Kunitz 2007). Social insurance was more than state-sponsored insurance, which had been gaining adherents at the turn of the century. **State insurance** provided for government-funded medical care of the poor and sick through municipal clinics, free hospitals and convalescent homes. Countries such as Germany, France and Russia were early innovators in such practice. Despite such efforts, however, care was fragmentary. State efforts were frequently small

compared to private care provided by charitable or religious organizations or private fee-for-service care that precluded the poor. **Social insurance**, or social welfare, expanded the notion of state insurance to include other social aspects. It is a social safety net which includes income support, nutritional support, provision of housing and access to medical care for highly vulnerable populations such as the elderly (who no longer earn income), women, children and the poor whose physical or social circumstances prevent equal ability to access essential goods. Deficiencies in these goods make people more susceptible to death and disease; those highly vulnerable groups have fewer resources with which to mitigate harmful outcomes. In some cases, they are less able to respond to risks because of physical reasons. For example, women of childbearing age may be particularly vulnerable to physical conditions associated with childbearing, such as nutritional deficiencies, which can compromise their immune systems and make them susceptible to other diseases. These populations may be more vulnerable because of social or institutional structures as well. Consider the legal status of women following World War II. In some places, women were not allowed to enter the work force either because of formal rules or informal social norms. In other regions, women who had engaged in work as part of the war effort were expected to return home at war's end. Their means of economic support was tied to spousal income or family wealth. In still other regions, women were not allowed to own property. With no independent means of support, women were dependent upon the largess of men or upon social policies which would provide access to material support.

Progressives argued that societal obligations include the provision of social safety nets for these populations and for broader society. The growth of social medicine, state insurance and social insurance was a countervailing force to the biomedical perspective that concentrated on a specific disease and a pharmacopic or biophysical cure. In social medicine, health became entwined with labor, employment, and the political economy—in other words with the broader development landscape. Although full agreement as to the inclusion of social insurance within the health policy domain and purview of LNHO was never fully accepted, the debate about the appropriate catchment area for health had begun. The LNHO, the International Labor Organization (ILO) and a number of nation-states entered the fray. Support for social insurance was especially strong in a number of European states. The role of government in providing access to health care and social welfare continues to be debated in international and domestic spheres even today.

The LNHC was joined by the ILO and the International Red Cross in this expansive understanding of health that would play an important role in establishing the mission of the WHO in the latter part of the century (Gillespie 2002; Gomez-Dantes 2001). Neither the OIHP nor the LNHC were able to operate during World War II, and fell apart thereafter. In the power vacuum which followed the close of war, public health campaigns focused on humanitarian aid efforts (even before such a term had been coined) and were delivered piecemeal. It is in the power void that the story of current intergovernmental organizations (IGOs) engaged in health and development began.

### ***2.1.2 The United Nations and the Modern Story of Health and Development***

The modern story of health and development at the international level begins at the close of World War II with the formation of the United Nations (UN) and its agencies. The UN has proven to be the pre-eminent institution for cohesive global governance despite the challenges it faces. The UN was founded as the successor to the League of Nations in 1945. At the time of its founding, the global community was recovering from two bloody conflicts and a global depression. The international community had to address rebuilding regional and global economic and social structures. In addition, the global community had to address its own complicity in creating the conditions which led to war. It would do this by creating a system with universal membership for nation-states to work together to ensure global security. Collective action would be used to mitigate social and economic conditions which could lead to regional or global conflict. Internationally accepted norms were created which included the pre-eminence of sovereignty in domestic affairs, the responsibility of collective action, and the duty of nation-states to strive to protect peace.

At the end of the Second World War, the global community engaged in institution building with the intent of creating global prosperity and limiting the potential for another global conflict. The foci of these endeavors included peace-building, conflict mitigation, economic growth, state and international security, and human prosperity. The global community faced the short-term challenge of rebuilding vast regions that were physically and economically devastated. Such reconstruction entailed addressing the immediate needs of people and states as well as the longer term needs for political, economic and social stability. Defeated nations could not be subject to punitive or solely extractive economic and social policy, nor could they be left to attempt redevelopment on their own without risking a recreation of the desperate conditions which led to the Second World War. Development and reconstruction required short term responses and emergency aid, as well as long term planning for global security which would be predicated upon state and human security. The UN was formed to provide a global forum of diplomacy and create governance tools in the interest of maintaining world peace and security.

The United Nations Charter was adopted on June 26, 1945 with the goal “to save succeeding generations from the scourge of war.” (United Nations 1945) To do this, the UN Charter provided rules to respect human rights, rules to respect the rights of sovereign, peace-loving nations, and an international forum for grievances and conflict mitigation. With the formation of the UN, the ideal of collective responsibility in protecting internationally defined norms was put forward. It was followed three years later with the Universal Declaration of Human Rights which defined social, civil, economic and political rights of individuals and charged nations-states to collectively protect these rights. Among these rights is the right to health and the attainment of the same. The Universal Declaration of Human Rights (UDHR), adopted on December 10, 1948, reads:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection. (Universal Declaration of Human Rights Article 25)

The specific representation within the UDHR focuses on a holistic understanding of that which is necessary for overall physical and social well-being, including clothing, housing, food, employment and control over monetary and material resources necessary for an adequate standard of living. It speaks to the promise not only of health, but of a minimal status of human well-being or development. Health is not limited to the ability to access medical care or be free from sickness. Mothers and children are singled out as requiring special recognition and protections because of physical, social, economic and political factors which make them more vulnerable to illness, disease, and social insecurity. The UDHR definition suggests that health cannot be separated from being human, nor is it understood to exist in a single, natural state. Rather, by defining health within a broader scope of living standards, it is implicit that health can be produced and altered by external forces. It is also implicitly linked to some level of economic development in that housing and employment inform the basic rights and inputs for health.

The UN would also disseminate information and resources to assist members in building social and economic conditions which would ensure prosperity and deter future conflict. The charter pledges to “promote higher standards of living, full employment, and conditions of economic and social progress and development.” (United Nations 1945) In other words, part of the UN mission is to engage in the project of development.

The UN Charter entailed the creation of specialized sub-committees and units which focus on specific concerns. The principal organs of the UN include the General Assembly, Security Council, Economic and Social Council, Trusteeship Council, International Court of Justice, and the Secretariat. The UN Economic and Social Council (ECOSOC) is the main body responsible for coordinating economic and social work. In addition, numerous departments and programs exist to address specific aspects of the greater UN charter. Box 2.1 contains a brief description of a number of UN agencies. Among those programs working on issues of health and development are the United Nations Development Program (UNDP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Human Settlement Program (UN-Habitat), the World Food Program (WFP), United Nations Population Fund (UNFPA), and the United Nations Environmental Program (UNEP). Together, these bodies monitor global trends germane to social and economic conditions, identify needs and strategies to address the same, and provide technical assistance and resources to implement change. The agencies also coordinate diverse actors and resources. The UN further has the power to create specialized agencies.

**Box 2.1 PRINCIPAL ORGANS of the United Nations**

Trusteeship Council supervises the administration of Trust Territories; suspended operation on November 1, 1994. ([www.un.org/en/mainbodies/trusteeship](http://www.un.org/en/mainbodies/trusteeship))

Security Council, consisting of 15 Member States, is responsible for the maintenance of international peace and security. ([www.un.org/sc](http://www.un.org/sc))

General Assembly has representatives from all 192 Member States and is the primary deliberative and policymaking organ of the UN. ([www.un.org/ga](http://www.un.org/ga))

Economic and Social Council coordinates the international economic, social, cultural, educational, health and related work of the 14 UN specialized agencies, functional commissions and five regional commissions. ([www.un.org/en/ecosoc](http://www.un.org/en/ecosoc))

International Court of Justice is the judicial organ of the UN, whose role is to settle legal disputes and give opinions in response to legal questions. ([www.icj-cij.org](http://www.icj-cij.org))

Secretariat consists of the Secretary-General and other staff and carries out the day-to-day work of the UN, including the administration of policies and programs. ([www.un.org/en/mainbodies/secretariat](http://www.un.org/en/mainbodies/secretariat))

**PROGRAMS AND FUNDS**

UNCTAD (United Nations Conference on Trade and Development) helps developing countries integrate into the world economy by acting as a forum for intergovernmental negotiations, conducting research, policy analysis, and data collection, and providing technical assistance. ([www.unctad.org](http://www.unctad.org))

ITC (International Trade Centre), a joint agency of the World Trade Organization and the United Nations, helps developing countries achieve sustainable development through small business exports. ([www.intracen.org](http://www.intracen.org))

UNODC (United Nations Office on Drugs and Crimes) assists Member States in their efforts to counteract illicit drugs, crime, and terrorism through field-based technical cooperation projects, research and analysis, and support in the ratification of international treaties and the development of domestic legislation. ([www.unodc.org](http://www.unodc.org))

UNEP (United Nations Environment Program) provides leadership in caring for the environment by assessing environmental conditions and trends, developing international agreements, strengthening institutions, integrating economic development and environmental protection, and facilitating the transfer of knowledge and technology. ([www.unep.org](http://www.unep.org))

UNICEF (United Nations Children's Fund) seeks to protect the rights of children and promote children's full potential by addressing such issues as poverty, violence, disease, and discrimination. ([www.unicef.org](http://www.unicef.org))

UNDP (United Nations Development Program), works with countries to build and share solutions to development challenges, including democratic

governance, poverty reduction, crisis prevention and recovery, environment and energy, and HIV/AIDS. ([www.undp.org](http://www.undp.org))

UNIFEM (United Nations Development Fund for Women) seeks to advance women's rights and gender equality and works primarily in the areas of women's economic security and rights, violence against women, HIV/AIDS, and gender justice in democratic governance. ([www.unifem.org](http://www.unifem.org))

UNV (United Nations Volunteers) contributes to peace and development globally by promoting volunteerism and advocating on behalf of volunteers. ([www.unv.org](http://www.unv.org))

UNCDF (United Nations Capital Development Fund) provides investment capital, capacity building, and technical advisory services to Least Developed Countries (LDCs) to promote microfinance and local development. ([www.uncdf.org](http://www.uncdf.org))

UNFPA (United Nations Population Fund) promotes health and development by helping countries use population data to develop policies and programs. ([www.unfpa.org](http://www.unfpa.org))

UNHCR (Office of the United Nations High Commissioner for Refugees) coordinates international activities to protect the rights and well-being of refugees and resolve refugee problems. ([www.unhcr.org](http://www.unhcr.org))

WFP (United Nations World Food Program) provides food aid to fight hunger in emergencies and to reduce chronic hunger and undernutrition. ([www.wfp.org](http://www.wfp.org))

UNRWA (United Nations Relief and Works Agency for Palestine Refugees in the Near East) carries out direct relief and works programs as well as advocacy for Palestine refugees. ([www.unrwa.org](http://www.unrwa.org))

UN-HABITAT (United Nations Human Settlements Program) promotes the development of socially and environmentally sustainable towns and cities with the goal of providing adequate shelter for all. ([www.un-habitat.org](http://www.un-habitat.org))

### **SPECIALIZED AGENCIES**

ILO (International Labour Organization) promotes labor rights, social justice and protection, and opportunities for decent employment for men and women worldwide. ([www.ilo.org](http://www.ilo.org))

FAO (Food and Agriculture Organization of the United Nations) seeks to achieve food security by improving nutrition, agricultural productivity, and the lives of rural populations, and by contributing to the growth of the world economy. ([www.fao.org](http://www.fao.org))

UNESCO (United Nations Educational, Scientific and Cultural Organization) promotes international cooperation and dialogue in the fields of education, science, culture and communication. ([www.unesco.org](http://www.unesco.org))

WHO (World Health Organization) is the health authority within the UN system and is responsible for providing leadership on global health matters, establishing health norms and standards, promoting evidence-based health policies, providing technical support, and monitoring health trends. ([www.who.int](http://www.who.int))

World Bank Group's mission is to fight poverty by providing resources, sharing knowledge, building capacity, and creating partnerships in the public and private sectors. ([www.worldbank.org](http://www.worldbank.org))

IBRD (International Bank for Reconstruction and Development), a lending arm of the World Bank, aims to reduce poverty by providing loans, guarantees, risk management tools, and analytical and advisory services to middle and low income countries. ([www.worldbank.org/ibrd](http://www.worldbank.org/ibrd))

IDA (International Development Association), a lending arm of the World Bank, aims to reduce poverty by providing interest-free credits and grants for programs that increase economic growth, reduce inequalities, and improve living conditions. ([www.worldbank.org/ida](http://www.worldbank.org/ida))

IFC (International Finance Corporation) promotes the development of the private sector in developing countries through investments and advisory services. ([www.ifc.org](http://www.ifc.org))

MIGA's (Multilateral Investment Guarantee Agency) promotes foreign direct investment (FDI) into developing countries by providing guarantees to the private sector. ([www.miga.org](http://www.miga.org))

ICSID (International Centre for Settlement of Investment Disputes) provides a space for the arbitration of international investment disputes. ([www.worldbank.org/icsid](http://www.worldbank.org/icsid))

IMF (International Monetary Fund) fosters global monetary cooperation, exchange rate stability, and international trade growth, and helps member countries to achieve balance of payments and poverty reduction. ([www.imf.org](http://www.imf.org))

Fifty-one nations constituted the original UN membership. By 1974, the number was 138. Today, there are 192 members recognized as sovereign states by the UN. Of particular import is the increasing number of developing countries with UN membership. The number increased as colonies and territories gained independence or organized into independent states. Developing countries did not have individual political or economic power, but en masse controlled a newly empowered voting block which questioned the prevailing economic and political ideologies of development. After three decades of development, 70% of the world's population resided in developing countries, but these countries controlled only 30% of global income (United Nations 1974).

During the post war period, the global community engaged in reflection surrounding the collapse of global empires and independence of former colonies. As

independence movements took hold, questions arose not only about nation-building, but also about how to improve the quality of life across disparate topographical, political and social milieus, and about how best to achieve global security. The self reflection begged the question as to why certain areas of the world prospered and achieved certain standards of living, whereas other parts of the world did not. Development economics and development studies grew out of these post-war and post-colonial concerns. Development studies were initially dominated by western intellectual traditions and a conceit that the standards and norms achieved in the western world were highly desirable and should be replicated throughout the world. This intellectual bent has influenced and continues to exert pressure on international norms and the development agenda in the IOs. Neo-Marxism, post-modernism, and feminism have posed modest challenges to this tradition, but by and large development programs remain firmly entrenched in Western economic and political thought.

## 2.2 The World Health Organization

The WHO is the unique IGO charged with global monitoring and evaluation of health trends. The WHO is a specialized agency within the United Nations system which directs health policy/priorities and coordinates health-related action. The need for a global health authority was rooted in the tradition of international coordination of public health campaigns to combat the spread of infectious disease. This was a role previously filled by the LNHO and OIHP which collapsed during WWII. The UN Relief and Rehabilitation Administration provided emergency health care and food following the end of the war, but had a short-term charter for such provision. The need for a new coordinating agency in the ruins of war was clear, but the new agency's structure, powers and purview needed to be negotiated. In 1946, U.S. Surgeon General Thomas Parran and Sir Wilson Jameson of the British Ministry of Health initiated the planning process for the new health agency under the aegis of ECOSOC (Gillespie 2002). Representatives of regional, national, and international health organizations were invited to participate, but the process itself was dominated by the United States and European powers as these nations had both experience in issues of international public health and had established health offices around the world. Because ratification by 26 states was necessary to establish a specialized agency within the UN system, the Interim Commission for the World Health Organization was careful to define the scope of the agency in a manner which would attract both socially liberal and more conservative signatories. Ratification by the U.S. was critical to ensure financial support of the WHO and make the agency viable immediately and into the future (Gillespie 2002). The United States thus became one of the most influential powers in shaping policy, programs and actions. The WHO Constitution was adopted by 61 states on July 22, 1946 and entered into force on April 7, 1948.

The writing of the WHO constitution was littered with controversy as to the scope of both the agency's power and the scope of understanding as to what makes for good health. The controversy had its roots in a division among medical and policy leaders which pre-dated WWII, but was exacerbated by the post-war balance of power and growing division between capitalist and communist nation-states.

Given the international interest in defining and redefining the state's role in health creation, it should be no surprise that social insurance proved to be a contentious issue during the formulation of the WHO charter. The WHO's predecessors defined health in terms of specific diseases and had therefore limited its operations to disease monitoring and control, and dissemination of best practices (Gillespie 2002). Rajchman and his adherents' reconceptualization of health to include the political economy challenged national sovereignty and market liberalism. Critics saw social insurance as an unwelcome tool of state intervention in markets in areas where free-market capitalism was embraced (Gillespie 2002). The opponents of social insurance argued that it related to politics, the market, and labor more directly than to health. The question became whether or not the new international health agency should be given a charter which may permit clear authority in sectors not traditionally considered part of public health. The strongest opposition to including social insurance within the scope of the WHO came from the United States and Britain (Brunton 2004; Gillespie 2002; Kunitz 2007; Weindling 2004; Worboys 2004). Given the political brinkmanship necessary to obtain the U.S. vote, the focus on social medicine and social insurance was attenuated (Gillespie 2002). But the U.S. was not the only vote needed to ensure longevity of the WHO. Language that defined health as a confluence of the physical, social and mental spoke to a number of the European powers' concern for social medicine. Concessionary provisions in the articles of the constitution left room for reinterpreting the agency's focus and definition of 'health' in the ensuing decades.<sup>1</sup>

The definition of health contained within the WHO charter represents both a challenge to medical imperialism rooted in a Western biomedical basis and a mandate for the WHO to work on a social agenda which included social constituents of health.

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (WHO 2008c)

This definition validates both Western and traditional interpretations of health, and provides for mandates to focus not merely on the single body, but also on broader socioeconomic conditions which act upon health and create inequalities across diverse groups. The WHO Constitution provided for a broad purview in the topics which the agency could investigate as related to health and its determinants, but a modest role in terms of actual powers to implement policy.

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<sup>1</sup> Gillespie points to a concession that allows the WHO to study social security in conjunction with other agencies as another action that was necessary to secure votes from European countries.

The mission is to provide leadership in shaping health policy and setting the global health research agenda and to provide technical expertise on global health through monitoring and assessment of health trends, dissemination of information, establishment of norms and standards, and technical support for member states. While the WHO has the power to adopt conventions, agreements and international health regulations, it lacks enforcement power. The WHO can make recommendations and advocate specific policy approaches and research agendas and can call for international conventions and proffer binding treaties, but power to act upon recommendations remains the sovereign right of nation-states. Rather, the WHO provides technical guidance on public health issues, and coordination of actors and institutions. The WHO also coordinates donor-funding for special programs. The organization and operation of professional medicine is also outside of the WHO's scope. Although the WHO defines diseases and response protocols, it does not regulate medical practice or offer professional accreditation. Its purview is very much that of public health rather than biomedicine. The WHO's power is further hobbled by financial constraints, which allow for only modest investment in research and implementation. The agency's annual budget of US\$ 4,277 million in 2008–2009 is funded by voluntary donations, and is but 1/6th the World Bank's annual lending (WHO 2009b; World Bank 2009a).

### ***2.2.1 WHO Early Years: Health as a Biomedical Condition***

The WHO was a traditional public health authority in its early years. Its mission was much like the LNHC before it: to monitor and analyze international health threats, to standardize professional nomenclature, and to provide technical guidance for disease management. The ideal of the intrinsic value of health was always at the forefront of the WHO mission; programmatically, however, the WHO focused on health as a narrowly defined outcome of human and infective agents. Even before the final charter was signed, the Interim Commission of WHO identified communicable diseases as the primary threat to global health (Gomez-Dantes 2001). Malaria was first among these concerns, followed by tuberculosis and 'venereal disease' (Gomez-Dantes 2001). During the 1950s and 1960s the WHO embraced the health revolutions provided by technological advancement and focused on the eradication of specific diseases to the exclusion of economic or social constituents of health. Vaccination, antibiotics, and insecticides became the tools for global campaigns to combat infectious disease. The focus provided mixed success. An anti-yaws campaign proved highly successful. Campaigns to decrease the health burden of measles and control wild polio had initial success. Later years, however, would see failures of measles vaccination and the emergence of wild polio albeit at a significantly lower rate than that experienced prior to the WHO campaign.

### 2.2.2 *Malaria and Smallpox Campaigns*

In 1955, the WHO undertook the eradication of malaria, one of the great plagues of humankind. **Malaria** was an enemy of colonial expansion, an enemy of states made free following the war, an enemy of those living in tropical and temperate climates. It is a parasitic disease spread to humans via mosquito bites. Although the disease had been the target of regional eradication efforts for considerable time, technological innovations of the mid-century combined with international organization suggested that this old enemy could be destroyed once and for all (Gilles and Warrell 1993; Najera-Morrondo 1991). The campaign entailed widespread use of chemicals, in particular, dichlorodiphenyltrichloroethane (DDT), to kill vectors. Prophylactics would eliminate the human reservoir. The vision of health with the anti-malaria campaign presented health as an outcome included agent, host and a broader ecology. During the post war years, malaria was eradicated in the United States, parts of Europe, and the Middle East, and declined in parts of Latin America and some parts of Asia (Gilles and Warrell 1993; Newman 1965). No such success was experience in Africa and other parts of Asia. By the 1970s, temporary gains began to erode and the disease resurged in Latin America and Asia. Today, an estimated 250 million people are infected each year, and almost one million people, mostly children, die (WHO 2009c). Social and economic costs are manifold.

In the 1960s, the WHO continued to target specific diseases, and undertook the most successful disease eradication program to date: the elimination of smallpox. At the time WHO launched its smallpox eradication campaign, 60% of the world's population was at risk of this disease (WHO 2009d). The disease killed nearly one quarter of those whom it infected. Survivors often bore pox mark scars or were blinded as a testament to their dangerous encounter. The WHO's launched its campaign in 1967. The last naturally-occurring case was found in Somalia in 1977. In 1980, the World Health Assembly certified that smallpox was no more.

### 2.2.3 *WHO: Health as a Human Right*

By the early 1970s, the number of member states in the UN had more than doubled from its initial membership as a result of decolonization and formation of newly independent nations in the global South. This ushered in the era of the New International Economic Order (NIEO) which was a concerted effort by UN members representing the global South to create a more just distribution of global economic power and resources between the global North and the global South. It was also a period in which the inequities—in economic status and population health—between the 'haves' and the 'have nots' of the world became a focus for international political rhetoric. These concerns also came at a time when public dialogue reengaged with ideas of social determinant of health. A revolution in thought about how to improve

health inequalities between the developed and developing world was called for, one which included social determinants as well as an understanding of historical context and power structures. Such concerns were reflected in the 1970s with a refocusing of health as a right and as a component of economic and social development. On September 12, 1978, attendees at the International Conference on Primary Health Care signed the Declaration of Alma Ata. This reaffirmed the commitment of the global health community to the ideal of health being a human right, and declared, "... that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector." (WHO 1978) Social justice and the health divide between nations spoke to concerns of the NIEO. The declaration said that state governments had the duty to provide basic health care and coordinate health services, and acknowledged that local actors are essential in creating healthy communities (WHO 1978).

The Declaration marked the beginning of the era of primary care. The WHO directed programs and policies towards achievement of the goal of universal access to primary care in an atmosphere where there was a growing realization of the importance of intersectoral coordination for health outcomes. In describing eight essential areas of primary health care, the Declaration addressed social and biomedical aspects of health. The eight elements of primary care were health education, nutrition, access to water and sanitation, maternal and child health care, immunization, prevention and control of locally endemic disease, treatment of common diseases and injury, and provision of essential drugs (WHO 1978). Despite the Declaration's affirmation of the economic sector's contribution to community well-being, no explicit economic goals or inputs were described. Efforts to place health at the fore of economic and social policy remained hobbled by the comparative lack of power and resources of the WHO and many state ministries of health. A global scaling up of primary care would not be achieved easily. Perhaps the greatest consistent success came in expanding vaccination coverage vis-à-vis the Expanded Program on Immunization (EPI) launched in 1974 which will be discussed later in this chapter (Jamison et al. 2006). The era from 1978 to the late 1980s saw WHO focus on health as an outcome associated with broad socio-cultural milieu, in that success would be gauged by changes in the overall health profile of populations and communities, rather than changes in any the health burden of any one disease.

### 2.2.3.1 Primary Health Care

Primary health care includes an array of strategies to prevent disease, to target endemic diseases of particular public health import, provide basic needs such as clean water and sanitation, and provide access to health care for common conditions that require low levels of technology and technical expertise. Maternal and child health is a prime focus of primary care based on the impact improved child survival and maternal health have on social, epidemiological and demographic change. Primary care services are often among the most cost effective interventions in that the inputs

are low cost and result in direct cost saving through prevention or mitigation of more severe health sequelae, and result in indirect savings in terms of opportunities costs. When we consider global change in primary care since the 1970s, global immunization coverage and improved access to safe water and sanitation are clear achievements. But the full promise of primary care is yet to be realized and gains that have been made are threatened. Economic contraction and declining GDPs mean that financing for primary care is in jeopardy; national revenue is more tightly constrained and competition for resources is greater, and foreign aid is neither sufficient nor sustainable (WHO 2008a, b). A shortage of qualified health care workers impacts the developed and developing world (WHO 2008d).

Since the Alma Ata conference, the WHO is and has been a major proponent of primary health care including maternal and child health (MCH). Preeminent among MCH programs are childhood vaccines and programs targeting maternal health. These two programs are emblematic of the successes and failures of primary health. Progress increasing global immunization coverage is one of the great success stories of public health, but it is not without a down side as evidenced by backsliding in immunization rates and continued loss of life to vaccine-preventable disease. Maternal health is one of the more sensitive indicators of human development in that it reflects access to skilled health services, pre- and postnatal care, nutrition, education, female empowerment, social and economic development. Maternal health is considered important for its intrinsic value and for the multiplier effect it has on child and household health and attendant societal impacts. Despite being on the global agenda for nearly four decades, gains in maternal health are inconsistent and well below what is feasible and equitable.

Maternal health refers to the health of a woman during her pregnancy, at childbirth and in the post-partum period, a period generally considered to be 42 days (WHO 2005c). Complications which result in maternal death or disability can occur before giving birth, during delivery, or when recovering from child birth. Of the causes of maternal death, hemorrhaging is the most common and accounts for 25% of the deaths, followed by infection (15%), complications related to unsafe abortion (13%), pre-eclampsia and eclampsia (12%), and obstructed labor (8%) (WHO 2010). When maternal health complications do not kill, they can damage a woman physically, emotionally and socially. Birth complications can damage a woman's reproductive organs. If the damage is severe enough, the woman may not be able to have children, and may therefore lose social status and economic protection. Obstetric fistulas are another complication which, if not surgically mended, cause loss of bladder or bowel control among other sequelae. This can also lead to social and economic isolation, loss of personal dignity, and mental illness (Wall 1998).

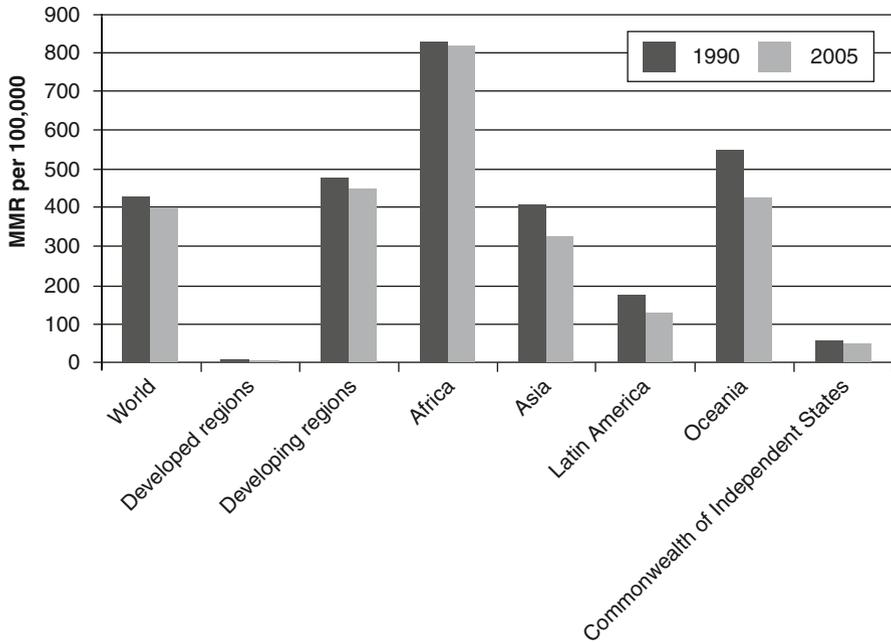
Direct obstetric complications are only one part of the maternal health equation. Complications which occur during pregnancy rather than during childbirth are difficult to measure but are believed to account for one out of every four maternal deaths (WHO et al. 2007). A study in Zambia found that 40% of the referrals made to a teaching hospital were related to pregnancy complications, not childbirth (WHO et al. 2007). Such complications may be a result of a condition developing because of the pregnancy. For example, a woman may develop high blood pressure

related to the pregnancy. Disease and pre-existing conditions also cause complications during the course of pregnancy. Malaria, anemia and maternal malnutrition can be exacerbated by pregnancy and result in maternal mortality, still birth, and infant mortality. An estimated 10,000 women die each year during pregnancy as a result of malaria (WHO et al. 2007). HIV is another complicating factor in maternal and infant mortality.

Between 1990 and 2005, global maternal mortality decreased at less than 1% per year (WHO et al. 2007). These data reflect the dismay of the international community which found little to cheer about in terms of progress in maternal health. Some regions demonstrated improvement in maternal health. South-east Asia, for example, improved access to antenatal care, that is care received during pregnancy, by 34% (WHO 2005c). But during the same period, African nations improved access by only 4% (WHO 2005c). Only a third of births in Niger are attended by skilled health personnel (Save the Children 2008). Between 1990 and 2005, maternal mortality ratios declined by a total of 5.4% worldwide. The largest decline was in East Asia (47.1%), the smallest in Sub-Saharan Africa (1.8%) (WHO 2005c). Around the world more than half a million women will die because of poor maternal health care and ten million will suffer pregnancy-related injuries. Ninety-nine percent of these deaths will occur to women living in developing countries (WHO et al. 2007). One million children will be left motherless (WHO 2010). **Maternal Mortality Ratios (MMR)**, the number of maternal deaths per 100,000 live births (or 1,000 depending upon conversion), are as high as 2,100 per 100,000 live births in Sierra Leone, 1,800 in Afghanistan and Niger, and greater than 1,000 in several African nations (WHO et al. 2007). Progress has been slow and uneven. Figure 2.1 shows the unequal progress in reducing maternal mortality by region. The global community agreed it could do better. It committed to improving maternal care with the Millennium Development Goal (MDG) 5 to reduce 1990 MMRs by  $\frac{3}{4}$  by 2015.

Maternal health can be enhanced by improving access to adequate health care and by improving the position women have in society. Neither task is easy. Adequate health care entails having access to clean and sanitary facilities, proper equipment, and trained personnel. Maintaining financial commitment to facilities and care, and adequate levels of trained staff has proven difficult. The WHO, World Bank and other IGOs have long advocated health districts and local clinics to provide essential services such as maternal care. Health systems failed due to stagnant funding, inadequate flow of aid and loss of health care workers to the private sector or over international borders (WHO 2005c). Capacity and quality of services are not equal across nations or even within nations as can be inferred based on the outcomes described in Fig. 2.1. Access to care relates to obstetric care and antenatal care.

When one considers that maternal mortality is a function not only of the risk associated with the specific pregnancy, but also with the number of pregnancies a woman experiences during her reproductive years, it becomes clear that family planning and access to safe abortion are also important elements of maternal care (WHO et al. 2007). Family planning includes access to knowledge about reproduction as well as access to birth control methods. Although access to contraception has risen from 10% of the population in the 1960s to 59% of the population, there re-



**Fig. 2.1** Changes in maternal mortality between 1990 and 2005. (Data source: WHO, UNICEF, UNFPA and The World Bank (2007). *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and The World Bank*. Geneva: World Health Organization. Derived from data on p. 17.)

mains a large gap between need and availability. An estimated 87 million unwanted pregnancies occur each year; there are 46 million abortions of which some 40% are unsafe (WHO 2005c). Addressing family planning includes education and access, but it also includes looking at the position women have in any given society. Family planning and abortion services continue to be controversial around the world. Such programs suffer funding cutbacks and political backlash based on cultural acceptability and social mores—at times driven by donor rather than local community morals (Thornton 2008).

Institutional capacity, and failures of the same, are one part of the equation in maternal health, a part which lends itself to technocratic and economic solutions. The social aspect is more difficult to address. Maternal health care needs to involve societal knowledge of pregnancy and birth, societal norms about health seeking behavior, and critically, the empowerment of women. Where women do not have the same legal rights as men, or are not valued socially as much as men, they may be excluded from care (WHO 2005c). Social norms may dictate what is appropriate care for a woman, and may dictate whether or not she may show pain let alone be allowed to seek care. Where women do not have equal decision-making powers or are excluded from economic and social circles and hierarchies because of gender, their health may be jeopardized. They may also be subjected to violence and abuse.

Such disempowerment is magnified if the women are poor (WHO 2005c). Societal and cultural change is difficult to realize as it entails changing norms and behaviors at individual, community, national and global scales. Further, there is no one 'true' approach to health care and behavioral change. The challenge of maternal health care is to address such care as a scaling up of a basic entitlement or human right rather than to caste such programs as health initiatives which target a specific sub-population particularly one which is not empowered politically (WHO 2005c). Only through such high level and large scale buy-in of the program can sufficient support be garnered and directed to provide care for women.

In contrast to the limited gains made in maternal health, immunization is one of the true successes of primary care in the late twentieth century. Between 1967 and 1977 smallpox was eradicated thanks to a global effort which included widespread vaccination programs. This victory proved that global coordination of health care could take on and overcome a centuries-old killer. It was both a symbolic and real victory which provided momentum to the EPI established in 1974 under the aegis of WHO and UNICEF. The EPI principles entailed establishing routine childhood immunization for six of the most relevant vaccine-preventable diseases: measles, polio, diphtheria, pertussis, tuberculosis and tetanus. The logic of the program was manifold. First, immunization would increase the likelihood of childhood survival and was thus an investment in the future. Second, decreases in infant mortality are associated with declining total fertility and movement along the demographic transition. This in turn relates to lower dependency ratios and improved standard of living and improved human development within the broader population (WHO 2001, 2009a). Third, vaccinations are an efficient public health intervention in that there is a targeted group, minimal contact with the health system is necessary, and no major lifestyle changes are required (WHO 2009a). Fourth, vaccination programs benefit the individual who receives the vaccine as well as the broader community through herd immunity. Thus, immunizations were a public good. Fifth, immunization is cost effective. In the mid-1990s, the cost for the six basic EPI vaccines was US\$ 1 per child (WHO 2005a).

The initial obstacles to the EPI campaign were logistical, fiscal and related to technical capacity. The primary obstacle was that the necessary vaccines were manufactured in the developed world but would be used in the developing world (Lee et al. 1997). Technological transfer for vaccination campaigns entailed the costs of the vaccines as well as the logistical support to transport and administer vaccines while maintaining cold chain and ensuring trained personnel managed the programs (Lee et al. 1997). To meet these challenges, the WHO, UNICEF and their partner agencies created innovative processes and partnerships. Initial financial obstacles were overcome through bilateral and multilateral aid and donations. The actors developed public-private partnerships to provide low cost equipment to transport and store vaccines while maintaining the cold chain (Lee et al. 1997). Procedures for vaccine administration and personnel training were established. Monitoring and surveillance followed. The administrative mechanisms were in place to evaluate program successes and failures, and modify approaches as programs became established and data gathered. For example, during national immunization days all chil-

dren under age 5 received polio vaccines regardless of previous vaccination status (Keegan and Bilous 2004). This innovation created a larger population catchment and circumvented the difficulties associated with vaccination eligibility tied to paper records. In-country vaccination networks provided an established health system which can be utilized to deliver other health care (Lee et al. 1997).

As technology and knowledge advanced, immunization campaigns changed. The resurgence of yellow fever in the 1980s resulted in WHO adding yellow fever to the list of recommended vaccines (Keegan and Bilous 2004; Lee et al. 1997). The development of a hepatitis B vaccine also resulted in a change to the EPI vaccines. There are new foci for international campaigns such as the Global Polio Eradication Initiative, formed in 1988, and the Global Immunization Vision and Strategy put forward in 2005 by WHO and UNICEF (WHO 2009a). The Vaccine Independence Initiative helps countries assume financial responsibility for vaccination programs (Lee et al. 1997).

The immunization program has made some remarkable achievements. When EPI was established, only 5% of the world's children were vaccinated against these diseases. Today, 79% are (Lee et al. 1997). Since the launch of the Global Polio Eradication Initiative, polio cases dropped by 99%—five million people were spared paralysis associated with the disease (WHO 2005a). Seventy-seven percent of WHO member states now provide hepatitis B vaccines. Global mortality from measles decreased by 74% between 2000 and 2007 (WHO 2009a).

But not all news is good news. Vaccination programs are showing strain and, in some cases, losing ground as financing dries up and personnel are no longer trained. Vaccination coverage dropped by 5% or more in 41 countries since 1990 (Lee et al. 1997). DTP3 coverage which began to fall in the 1990s has stabilized (Keegan and Bilous 2004). Coverage in the African region averages only 56% (Keegan and Bilous 2004). In 2002, 1.4 million children died from vaccine-preventable diseases (Keegan and Bilous 2004). The reasons for the stagnation and failure include social change, war and humanitarian crises, poverty and unsustainable external support for immunization (Keegan and Bilous 2004; Lee et al. 1997; WHO 2009a).

Even with one of the most successful health campaigns, we cannot escape economics. The success of the vaccination programs was partially dependent upon foreign aid and multilateral funding, funds which are unsustainable. Further, as nations experienced economic contraction or fought wars, prioritization changed and funding for primary health care eroded. The economics of vaccination campaigns have also changed. Vaccination costs for the initial six targeted diseases were low and there was an economy of scale. Newer vaccines are more expensive. The cost of a hepatitis B vaccine, including administering the vaccine, is between US\$ 20 and 40 per child, an expense beyond the ability of some nations to pay (WHO 2005a). Global alliances have formed to try to overcome some of the obstacles to obtaining and maintaining high levels of vaccination coverage. For example, the Global Alliance for Vaccines and Immunization (GAVI) provides funds to poor countries with low vaccination coverage. It also brought together public and private actors to address development and sustainability of vaccines in both the developing and developed world.

But the strain on primary care remains. It is interesting to see the different achievements in terms of MCH. Vaccination programs targeting children are widespread with visible impact on morbidity and mortality. Maternal health is less clearly defined and associated with no single intervention. Vaccination entails a one (to three) time encounter with the medical system; maternal health entails a bare minimum of one but frequently more contacts. There is also a difference in terms of the political value placed upon children as opposed to women which differs from nation to nation. Obstacles to maternal health include a dearth of basic medical materials and training. None the less, poor countries such as Mozambique are investing in low cost medical training for nursing assistants and mid-wives to decrease maternal mortality (Falck 2008). The logistical and technical obstacles are certainly no greater than those initially faced by EPI. Perhaps the ultimate barrier is political will to value women as much as children, and rearrange power structures and norms to ensure women equal chances of living health-filled lives.

### ***2.2.4 Social Determinants of Health and the WHO in the Twenty-first Century***

The WHO maintains the position that health is a human right but throughout its history, the agency has had little power to enforce this view and has achieved only a modicum of success in harnessing collective action to promote health based on any intrinsic value. The WHO has been more successful in operationalizing health as an outcome related to the control of specific diseases and ascribing value to states and a planet free from certain diseases both in terms of alleviating suffering, thus ensuring health as a right, and protecting various social and economic interests. The end of the twentieth century saw a renewed interest in the linkage between socioeconomic, political and physical environment and health outcomes captured in studies of social epidemiology and the language of social determinants of health, as well as health as an input into the same. The work of medical anthropologists such as Nancy Scheper-Hughes, Arthur Kleinman and Paul Farmer became greatly influential in reconsidering the micro- and macro-level factors which alter health outcomes of entire groups of people and contribute to what Kim et al. (2000a) refers to as the deserted places: areas in which health declines even while health indicators for the broader community improve. **Epidemiology**, the field of medicine which specifically examines the occurrence and distribution of disease within a population, began looking beyond the more traditional environmental determinants to the broader social order and its influence in creating risk exposures in susceptible populations. The sub-field of social epidemiology, which examines "... how social conditions give rise to patterns of health and disease in individuals ...", became firmly established (Berkman and Kawachi 2000, p. 10). Health was once again understood to be the product of numerous factors but increasingly these factors were seen to occur outside the geographic and institutional boundaries of any one nation-state.

Of growing concern was the role macro-economic policy had in creating vulnerabilities and limiting the ability of nation-states, local communities and individuals to respond to health risks.

This concern is infusing new interest in and research on the links between health and development.

## 2.3 The World Bank

Macroeconomic stability and financial relationships are another important aspect of global peace, security and development. The existing Bretton-Woods institutions were created in 1944 to better manage the global economy through rebuilding the shattered economies of both the defeated and the victorious in the war, and by creating international resources and policies to further economic growth from which, in theory, prosperity and peace would follow. The Bretton-Woods institutions are the International Bank for Reconstruction and Development (IBRD or the World Bank) and the International Monetary Fund (IMF) which are distinct yet complementary organizations. The World Bank's mission was to rebuild the shattered infrastructure of Europe and Asia and provide technical and financial assistance to create the conditions of economic and political stability, growth in trade, and improvement in living standards. The IMF's role was to manage and promote international monetary cooperation and trade. Its initial focus was to provide short-term loans to nation-states for investment in capital expenses and structures deemed necessary for economic growth, and also provide countries with assistance in overcoming balance of trade problems. Such issues were initially viewed as being short-term necessities of economic growth. The role of the IMF evolved partially due to the Debt Crisis of the 1980s, the financial crises of the 1990s, and the global recession. Its role is no longer limited to monetary policy and short-term balance of payments issues. Rather, the IMF is engaged in macro-economic management of monetary and fiscal policy, longer term debt negotiation and restructuring, and global financial stability. It serves developed as well as developing countries as witnessed by the US\$ 2.1 billion loan to Iceland initiated in 2008 (Anderson 2008).

Of the two Bretton-Woods institutions, the World Bank was created specifically to address global development. As the full title indicates, its initial *raison d'être* was post-war reconstruction. Only after a modicum of stability was achieved in rebuilding could the World Bank focus on the project of development. Today, the World Bank is the largest public development institution in the world with annual lending totaling US\$ 24 billion. It consists of five institutions, including the original IBRD, the International Development Association (IDA), the International Finance Corporation (IFC), the Multilateral Investment Guarantee Agency (MIGA), and the International Centre for the Settlement of Investment Disputes (ICSID). The IFC was added to the World Bank Group in 1956 to assist with and coordinate private sector investment. The IDA was created in 1960 to provide interest-free loans and technical assistance to only the poorest nations. In 1966, the ICSID was created as a

forum to settle disputes arising between investors and national governments. MIGA is the most recent addition to the World Bank Group. It formed in 1988 to better encourage foreign direct investment (FDI) through the provision of risk insurance to protect investors against political risks in developing nations (Bretton Woods Project 2006).

The broad mission of rebuilding and redevelopment allows a great deal of leeway in terms of programmatic operation. The World Bank policies and priorities continue to change to address the evolving geopolitical and economic landscape. At its inception, the programmatic focus was to rebuild the physical and economic structure of Europe and Asia. Allied bombing left a devastated landscape which necessitated construction of infrastructure for transport, communications, commerce, and governance. The bank emphasized the creation of infrastructure throughout the 1950s. It reasoned that in order for nation-states to function in the global network, they needed not only roads and buildings but capital equipment and materials for industrial production. Modernization theory, which held that societies move from rural/agricultural base to urban/industrial base, was dominant. Through investment in industrialization, it was believed that the ultimate goal of increasing national income would be achieved as states would have the tools to produce for and compete in an international economy. It followed that once the tools and structures were in place, the human resources necessary for production would need to be addressed. Thus, the bank turned its attention to investment in education, agriculture and the basic needs of the populace in the 1960s.

But the project of development is not easy nor is any outcome assured. Despite increased levels of urbanization and industrialization, many poor countries remained poor and wealth distribution within countries bypassed many. By the early 1970s, the World Bank became increasingly focused on programs to reduce the number of people living in poverty and providing for the necessities of a minimal standard of living, or **basic needs**, which included caloric intake, housing, and income generation.

### ***2.3.1 The World Bank: Evolution of Development***

During the last 30 years, the primacy of economic growth and market liberalization underpinned the World Bank's agenda, policies and actions. The neoliberal model infused the work of the World Bank and continues to guide the agency's program. However, despite the philosophical underpinning, the World Bank did not operate with a single unaltered vision. It modified how it operationalized its policies in response to critiques and evidence of program achievements and failures. As a result, the World Bank development platform transformed from one with a narrow focus on macro-economic growth and fiscal responsibility to the detriment of the social sector, to a program of growth with provision of social safety nets and targeting of interventions to the most vulnerable segments of society. In other words, the institution proved flexible and adapted to earlier program failures. Three programmatic

eras related to health and development policy are evident. The first era is marked by the Structural Adjustment Programs (SAPs) and their attendant impact on macro-economic stability, government spending and currency valuation. This is followed by the World Bank as a health systems authority. Finally, there is an era of using Poverty Reduction Strategy (PRS) for development.

### 2.3.1.1 Structural Adjustment Programs

With the onset of the Debt Crisis in the 1980s, World Bank directives re-iterated the primacy of economic growth and economic management as a central tenant of development. The SAPs were the primary tool in the bank's toolkit for dealing with shrinking or debt-ridden economies. The success of the SAPs is widely debated. While they benefited some countries' macro-economic performance over the course of five to ten years, they also heightened inequality within and between nations, limited the sovereign decision-making ability of some nations, and caused a decrease in social conditions and human development outcomes in a number of states (Kakwani et al. 1990). The bank's response was to retool the macro-economic focus of the SAPs, by allowing governments more flexibility in fiscal management, and allow for maintenance of social safety nets. Today, growth of national income, poverty alleviation and reduction of income inequality remain strong foci but with rhetoric, and various degrees of supporting action, around developing pro-poor policies and building human capacity.

In 1982, Mexico's Finance Minister declared that Mexico could no longer make payments on its national debt. The reason was the debt service on commercial loans exceeded the country's earning power. The low interest loans entered into in the 1970s, when commercial banks were flush with petrol dollars, had transmogrified into massive debt with increasing interest rates. This occurred against a backdrop of rising oil prices. Mexico was not alone in its pending default. A number of developing nations could not service their debt. This constituted the **Debt Crisis**. The threat was a grand scale of default which could have ruined large commercial lenders based in the developed world, and destabilized the global economy. The solution to what was feared to be a global economic collapse was intervention by the World Bank and IMF. The institutions offered to renegotiate debt schedules and loan money to governments to cover balance of trade deficits so long as the debtor nation agreed to abide by a set of fiscal and monetary policies. These were the SAPs.

With the Debt Crisis, an opportunity arose for international finance institutions to implement neoliberal principles on a broad scale. The underlying tenant was simple. "Economic growth was viewed as the best form of social policy, and social spending itself was considered an obstacle to growth." (Ewig and Kay 2008, p. 250) The guiding principles of the SAPs were also known as the **Washington Consensus**, so named because the Washington-based international financial institutions recommended this package in response to the Debt Crisis. The SAPs used monetary and fiscal measures, and employed market liberalization with the intent of achiev-

ing fiscal balance, decreasing inflation, and spurring outward-oriented economic development. Although these policies did not directly address human development, the actions necessitated by the SAPs caused a dramatic restructuring of government social services, contraction of social safety nets, and reduced the agency of poor populations. **Conditionalities** for receipt of loan adjustment and financial assistance were the order of the day, with an eye towards fiscal balance and monetary stability and market liberalization. Such stability would come through a focus on economic growth rather than investment in human capabilities.

As part of the structural adjustment, debtor nations were required to reduce public spending. This action would serve three purposes. First, it would reduce the imbalance in government revenues versus expenditures—an imbalance which was viewed as especially problematic in states such as Chile with entrenched welfare programs (Ewig and Kay 2008). Second, such reductions would lower government consumption and thereby bring down inflation (Gershman and Irwin 2000). With a reduction of government spending particularly in the social sector, subsidies for imported goods such as food would be decreased or removed. This would cause a reduction in demand for the imported goods and potentially impact the **balance of payments**—that is the amount of money spent on imports compared to that earned on exports. This third aspect of fiscal restraint addressed the balance of payment deficit—one of the main triggers of the debt crisis.

Economists attribute part of the trade imbalance to over-valued exchange rates. Rather than maintaining an artificial value in the international market with fixed exchange rates, the currencies of developing countries were floated in the international market. Devaluation resulted. Residents of nations undergoing restructuring lost buying power in the local and international markets (Gershman and Irwin 2000; Kim et al. 2000a; World Bank 2004). This, coupled with a reduction in public subsidies for goods such as food, fuel and medical imports, meant that the poorer members of society could no longer afford the essential inputs to health and well-being.

Market liberalization was yet another tenant of the SAPs. Trade barriers were removed and public facilities were privatized. Industrial protections and occupational safety regulations were weakened or removed (Armada et al. 2001). Public services were privatized, including social services. This, coupled with the reduced public spending, resulted in increasing unemployment as public sector employees were laid off (Kim et al. 2000b; Oppong 2001).

The outcomes of the SAPs are heavily debated. The achievements of the SAPs may best be measured by looking at long-term economic trends. Over the course of ten to twenty years, some countries which implemented these programs achieved economic growth and modest improvement in GDP/capita (see Table 2.1). Living standards increased in conjunction with rising national income (Kunitz 2007). However, the question as to whether or not such growth was worth the price paid, especially by the poor, remains subject to debate. The SAPs have been widely criticized for causing social strife and failing to achieve their stated goals. The SAPs did not reduce the debt burden of the nations the programs were intended to help. In fact, by 1997, in numerous cases debt had grown (Gershman and Irwin 2000). The programs removed the public safety nets for the poor and created ‘health

**Table 2.1** Changes in macro-economic features, measured by GDP growth, change in GDP/capita, and Balance of Payment (BoP), in select countries that undertook structural adjustment programs. (Data source: World Bank (2009b))

	1980	1990	2000	2005
Argentina				
GDP growth (annual %)	4.2	-2.4	-0.8	9.2
GDP per capita (constant 2000 US\$)	7,535	5,607	7,694	8,097
Current account balance (BoP, current US\$)	-4,774,000,000	4,552,000,000	-8,980,617,893	5,274,866,972
Bangladesh				
GDP growth (annual %)	0.8	5.9	5.9	6.0
GDP per capita (constant 2000 US\$)	226	255	335	401
Current account balance (BoP, current US\$)	-702,138,191	-397,909,577	-305,831,651	-176,224,669
Egypt, Arab Rep				
GDP growth (annual %)	10.0	5.7	5.4	4.5
GDP per capita (constant 2000 US\$)	867	1,135	1,423	1,539
Current account balance (BoP, current US\$)	-436,428,572	2,327,000,000	-971,000,000	2,102,800,000
Ghana				
GDP growth (annual %)	0.5	3.3	3.7	5.9
GDP per capita (constant 2000 US\$)	239	218	255	290
Current account balance (BoP, current US\$)	30,200,000	-223,200,000	-386,500,000	-1,104,610,000
Peru				
GDP growth (annual %)	3.1	-5.1	3.0	6.8
GDP per capita (constant 2000 US\$)	2,256	1,657	2,049	2,351
Current account balance (BoP, current US\$)	-101,100,000	-1,419,000,000	-1,545,828,520	1,147,610,229
Tanzania				
GDP growth (annual %)	-	7.0	5.1	7.4
GDP per capita (constant 2000 US\$)	-	275	274	330
Current account balance (BoP, current US\$)	-521,165,462	-558,926,906	-498,600,924	-864,330,117

shocks' in which health indicators actually got worse, albeit for a brief period of time (Armada et al. 2001; Kim et al. 2000b; Oppong 2001; World Bank 2004). The programs undermined investment in growth and in some cases, by undermining human development and removing the human benefits of a welfare state, set countries back in terms of development (Farmer and Bertrand 2000; Gershman and Irwin 2000). The programs also resulted in unequal growth, rising inequality and exacerbated poverty (Armada et al. 2001; Farmer and Bertrand 2000; Oppong 2001; World Bank 2004). Further, it is argued that the programs violated the international principle of sovereignty in that the national governments had little leeway in negotiating the SAP conditions. Critics argue that such conditions were set to further hegemonic interests of the United States and other large economic powers which control IMF and World Bank policy through an unequal voting structure (Armada et al. 2001).

The World Bank responded to the criticism as evidenced by the shift to targeted interventions for the poor which occurred in the 1990s. The bank continues to work with issues of macro-economic stability but its strategies evolved to incorporate lessons learned from the failures of the SAPs, and to provide supports for vulnerable populations. The more recent PRS places a premium on protecting social supports for the vulnerable, targeting programs to benefit the poor, and includes a participatory process in which national and community stake-holders are represented in policy debate and roll-out. PRS have been praised for allowing nation-states greater flexibility in agenda setting, allowing greater ownership of development policy, in safeguarding public safety nets, in protecting health outcomes (generally maternal and child health), and in providing for greater participation across political and geographic scales. At the same time, evidence suggests that participation in the PRS process is varied and dependent upon existence of a strong civil society; although input may be sought from different sectors of society, decision-making is not jointly undertaken; the parameters of PRS are not flexible enough to manage external shocks such as the global economic contraction of the current debt crisis; PRS continue to be heavily biased by donor preferences; and do not allow enough for context specific factors to alter policy prescriptions (Booth et al. 2006; Braathen 2006; Gottschalk 2005). The long term impact of this strategy remains to be seen. Whether or not the poverty reduction strategies currently employed represent a true shift in World Bank action as opposed to mere rhetorical change remains subject to debate.

Although the structural adjustment policies of the 1980s focused on overall economic performance, many of the conditionalities attached to loans and debt relief touched upon social services including health. Cost-cutting programs, privatizing of social services, and cost recovery ideas were introduced in the 1980s, and continued through the 1990s. It was during this latter period when the World Bank presented a cohesive health platform and rose to the fore of global health actors. This occurred when the bank revisited its previous work which, rather than furthering the mission of poverty alleviation was found to foster inequality and breed poverty (World Bank 2004). The new era of the World Bank thus saw economic efficiency continue as a concern, but such concern was married to an ideal of addressing inequity.

### 2.3.1.2 World Bank as a Health Authority: World Development Report 1993

The World Development Report in 1993 saw the World Bank embrace the notion of health as an outcome of economic growth thereby recognizing health as a credible focus for development policy. It also placed import on health as a constituent of economic growth. In this, the World Bank perspective differs from the WHO-espoused notion that health is a human right which therefore, based solely on its inherent and natural value, should be at the apex of policy concerns.

Economic growth has traditionally been of central concern to the World Bank, and it was the dominant focus of this particular World Development Report. The opening paragraph of the 1993 Report marks gains in life expectancy, decreases in childhood mortality and the elimination of smallpox as successes in trickle down effects from national economic prosperity and embraces the standard of living thesis. The report states that such health gains are important due to both their intrinsic and economic values. “Not only do these improvements translate into direct and significant gains in well-being, but they also reduce the economic burden imposed by unhealthy workers and sick or absent schoolchildren.” The report proffers policy options that encourage economic growth: “Economic policies conducive to sustained growth are thus among the most important measures governments can take to improve their citizens’ health.” (World Bank 1993, p. 7)

Health improvement will trickle down from growth in the national economy because such growth translates into increased money for public goods, such as education and health care, and increased incomes which impact health through higher standards of living. Health is an outcome of value because it translates into money, but to obtain it, one must have money to invest. This position revitalized the debate as to how economic development and health impact each other. This interpretation also positioned the World Bank as a global health authority.

Part of this new authority was undoubtedly tied to the World Bank’s finances. Unlike the WHO, the World Bank had resources to act upon its convictions. The World Bank lends approximately US\$ 24 billion every year (World Bank 2009a). Its lending for health and social services amounted to US\$ 2.7 billion in 2007—a little more than the amount the WHO hoped to raise in donations to meet its total operating budget (World Bank 2009a). Loans, grants and debt-restructuring would be available to those nation-states which adopted the practices put forward in the development report. The WHO could offer technical guidance but the World Bank could pay to make things happen. The practices recommended in the 1993 report included investing in human capital, encouraging government provision of primary health care and public health interventions such as vaccination, decentralization of health services, improvements in efficacy through (re)structuring of fees to incentivize appropriate care uptake and ensure cost recovery mechanisms, and promotion of competition for health care vis-à-vis opening insurance markets where appropriate (World Bank 1993). The most important elements of the health reforms espoused by the World Bank were provision of primary care, decentralization and privatization. The focus of these latter two programs was health system reform rather than improvements in population health, and hastened in an era of health commodification (Armada et al. 2001; Gomez-Dantes 2001).

Parts of the report repackaged principle elements of the SAPs, including privatization, but there were some important departures. Decentralization was viewed as a more efficient way to deliver necessary health care and was put forward as a central tenant of health care restructuring. The sustainability of health care could be achieved by using cost effective methods and cost recovery mechanisms such as user fees, an idea that was in keeping with free market principles. Importantly, the report departed from the neoliberal ideology which guided the SAPs in that it discouraged conditionalities for receipt of funds, argued for investment in human capital, argued in favor of equitable distribution of health care goods through programs targeting the poorest 20% of the population, and acknowledged the different capabilities of poor versus very poor nations.

As the World Bank focused on health, it entered into a series of contradictory policies intended to make public provision of health care more cost effective and make service delivery more efficient through privatization and competition. On one hand, World Bank programs encouraged public provision of primary health care and essential health services which would especially benefit the poor. The bank's directives encouraged public financing and provision of primary education especially for girls. At the same time, however, the World Bank emphasized the mixed public and private financing for health care vis-à-vis insurance, and the introduction of private provision of health care, competition, and cost recovery mechanisms including user fees which created financial burdens upon the poor.

A major criticism of the Bank's entrée into health care was that the policies put forward commodified health and, as such, was counter to the ideal of health being both a basic human right and provision of the same being an obligation of government (Armada et al. 2001; Gomez-Dantes 2001). Further, the argument that the Bank's policies were swayed largely by donor nations, to the disadvantage of the recipient nations, continued (Armada et al. 2001).

Efforts to decentralize health care services and to better target the poor proved to vary widely in terms of impact. In many nations, public health services favored tertiary care facilities such as hospitals which were located in urban areas thereby excluding rural, typically poorer areas services. The ideal of decentralization was to empower regional and local governing bodies to decide upon which services and health interventions were most necessary and suitable within the local context and to remedy the bias towards tertiary care. Decentralization would shift power away from the administrative center, typically in the urban capital, and disrupt problems which cronyism and patronage wrecked in terms of hiring, concentration of personnel, and flow of financial resources. These actions would allow health care to be better targeted towards the poor. At the same time, social service would be pared down to exclude subsidizing the non-poor and wealthy classes.

Although policies failed to account for differential abilities and costs associated with decentralized provision of health serviced, they provided impetus to continued reforms targeting inequitable resource allocation. The differences in technical capabilities at regional and local administrative levels were not accounted for. As a result, decentralization efforts failed because highly skilled medical practitioners

maintained an urban bias; municipal amenities and salaries were simply not enough to attract skilled practitioners (Oppong 2001; World Bank 2004). Further, the administrative capacity of municipal authorities was seldom up to par and training/capacity building were not addressed. In some cases, poor management persisted and, even with additional revenues from decentralization, the local authorities still could not pay for the services needed by the local populace (World Bank 2004). In other cases, decentralization actually increased cost of service delivery (World Bank 2004). In El Salvador, for instance, despite overall increases in public funding of health care, the funds which were allocated to the rural sectors decreased in part because the government, following a model of increased competition, contracted with NGOs to provide health care (Smith-Nonini 2000). In African, Latin American and Asian nations, decreases in public spending and resultant low levels of salaries for health care professionals created a 'brain drain' with medical staff either concentrating in urban areas or relocating to other countries which offered higher wages (Oppong 2001; World Bank 2004). In addition, some nations continued to suffer from trade imbalances which caused the import of essential drugs to slow or stop (Oppong 2001). The decentralized health authorities were often left without necessary drugs or medical supplies.

Cost sharing and recovery mechanisms were implemented as a method to contain escalating costs of health care provision and to provide revenues to invest in public health and deteriorating health infrastructure. These mechanisms included the introduction of user fees on a sliding scale and self-funding for insurance (World Bank 1993). Evidence shows that the cost sharing mechanism essentially excluded the poor from accessing health care (Farmer and Bertrand 2000; Oppong 2001; Shaw and Ainsworth 1995; World Bank 2004). Increased user fees were shown to decrease health care utilization by the poor, to delay health seeking behavior such that treatment costs escalated and health impacts worsened because the disease progressed to a more severe state; people turned to traditional healers, informal consultants, non-Western medicine and/or self treated because of lower costs (Farmer and Bertrand 2000; Oppong 2001; Shaw and Ainsworth 1995; World Bank 2004). Privately-funded insurance programs proved unviable for the extremely poor, those with irregular salaries, and are of limited success in rural areas. Even in markets where payment did not present an obstacle, lack of information and coordination between public and private insurance can confuse the consumers, lead to underutilization of insurance, and result in cost and performance inefficiencies in the insurance market (Gershman and Irwin 2000; Raczynski 2001). Further, both decentralization and introduction of competition in financing and provision of health services necessitate having a strong, local civil society which can be social advocates. Where civil society is weak, many of the benefits continue to be captured by the elite (Ewig and Kay 2008; Gershman and Irwin 2000; Raczynski 2001). Insurance programs have met with moderate success in middle income areas; evidence from low income and highly indebted poor countries (HIPC) shows insurance programs tend to be weak because of insufficient numbers who can afford to pay into the system, inadequate risk pooling due, in part, to fragmentation across plans, and poor incentives for competitive

insurance markets (Medici et al. 1997; Oppong 2001; Shaw and Ainsworth 1995; World Bank 2004).

Privatization occurred in both the financing of health care delivery, through public and private insurance programs, and in the delivery of services. The balance between public and private responsibilities is highly contentious in the developed and the developing world. The health reforms to the UK's National Health Service which occurred under Margaret Thatcher and Tony Blair speak to the constant struggle to find affordable, equitable mixtures of public-private finance and provision. During the writing of this book, the United States was in the process of major health care initiative to provide equitable access to health care through public and private means. Economists consider health care incentives to be among the most perverse in terms of using price points to signal certain behaviors. Given the struggles of high income countries to balance equity in care with consumer choice, satisfaction and free market principles, it is little wonder that low- and middle-income countries struggle with privatization.

The failures of privatization in low- and middle-income countries were numerous. The combination of shrinking budget allocations for social services and the entry of private actors into health care resulted in a contraction of service provision (Armada et al. 2001; Oppong 2001). While ideally private competition would create more effective, competitively priced service delivery, such a theory was based upon a notion that all markets are equally attractive. This simply did not prove to be the case. For example, in some rural areas sparse population and low income levels meant that economies of scale for health care delivery could never be realized, and that people would not be able to pay for medical care (World Bank 2004). These two factors alone would be enough to dissuade private health care providers from operating in the area. It would be difficult to get a single private enterprise to provide services, let alone allow for competition.<sup>2</sup> With the lack of private entrants in the high cost, high risk areas, provision falls to the public sector. However, with constrained fiscal and human resources, and in some cases the loss of more profitable markets to the private sector, the public sector proved not capable of providing adequate levels or types of health services (Oppong 2001; Smith-Nonini 2000; World Bank 2004). The response to the noted failures of the first phase of health care reform was to address logistical problems with program implementation, and further evaluate context-specific barriers.

The emphasis on delivery of primary services put forward by the World Bank clearly resonated with the WHO's primary care platform. Likewise, the policy proposals for decentralization re-enforced the import placed on local authorities in understanding improving population health in a way no bureaucrat living in an urban center far away from the area in question could understand. Less resonant were the cost-recovery mechanism, privatization and health system reform. The WHO espoused the program of health system reform during the 1990s. Some see this as a failure of the WHO to maintain an interest in broad social determinants of health

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<sup>2</sup> This phenomenon is not limited to the developing world. For example, lack of quality and service options are problems experience in the rural United States.

(Armada et al. 2001; Gomez-Dantes 2001). However, the action speaks to a degree of *real politick* which cannot be ignored. Developing nations and the WHO faced very real financial and operational constraints. To the extent that health care provision favored urban and tertiary sectors over rural and primary sectors, progress towards the goal of universal provision of primary care could be gained through reallocating resources to local level administrations.

Throughout the 1980s and 1990s, the failure of macro-economic policies and dominant development theory that health impacts will trickle down through economic growth fueled continued debate and research on the relative importance of health and development with an intent of creating better policy. Critics of the SAPs argued that the focus on macro-economic policy constrained a nation's ability to address real concerns and vulnerabilities of its population, exacerbated societal inequalities, and hurt the poor. Further, critics argued that the financial IGOs adopted a cookie cutter approach to macro adjustment policy which failed to account for different cultural and geographic milieus, and institutional capacity which contribute to a nation's prospects for economic growth. Although the extent of SAPs impact on health and human development was not fully understood at the time of its writing, the 1993 World Development Report did address this latter concern by making a case for addressing each nation's unique capacities.

### 2.3.1.3 Towards Change

The continued dissection of the failures of SAPs and development programs, growing alarm about the negative impacts of globalization, and increased acceptance of a broader definition of development to include increasing capabilities created an opening for multiple disciplines to contribute to the dialogue about improving development and human well-being. Researchers turned to anthropology and the role of culture to explain successes and failures in the arenas of development and political science. Social scientists outside of the economic discipline worked to dispose of the racist (but sadly prolific) idea that when economic policies failed it was because some cultures were innately inferior. Rather, critics questioned the economic policies and institutional structures of IGOs and the global market in setting goals based on a single, western model of development, ignoring cases which went against dominant theory, and setting certain countries up for failure based on unrealistic goals and inappropriate conditions. These debates changed both health and development policy.

The impacts of the World Bank development program and health reforms are varied across region of implementation and across timeframe. In the long term, there is evidence of improvement in aggregate indicators of both health and development (Kim et al. 2000a; World Bank 2004). Health sector reforms have demonstrated some cost savings and efficiency gains in middle income countries (Medici et al. 1997). The impacts are more varied in low income nations or HIPCs. To the extent that program failures caused a re-evaluation of World Bank operations which now include explicit provisions to protect the vulnerable, and provisions for a par-

ticipatory process, one can argue this, too, is a long-term success. The long term sustainability of the programs remains in question. However, the short term costs of the reforms are great. The contraction of social services under the SAPs created a health shock which had the greatest negative impact on the poorest members of society, those least able to mitigate risks of economic and health service contraction. As a result, short term health indicators for some groups worsened. For example, infant mortality rates in Peru decreased during the early 1990s period of economic restructuring. The occurrence of sickness increased more than 20% while medical purchases dropped by 50% in some sectors of society (Kim et al. 2000b). The contraction of the health care structure equated to a collapse of the monitoring, surveillance, prevention and treatment—the keystones of public health. This collapse was associated with disease outbreaks, strengthening of the HIV epidemic, and increases in incidence and prevalence of endemic diseases (Kim et al. 2000b; Oppong 2001; World Bank 2004). The opportunity costs associated with the disease retrenchment are immeasurable. Further, the short-term impacts include increased inequity in both health and income (Armada et al. 2001; Medici et al. 1997; World Bank 2004). The human and fiscal costs associated with redressing this are incalculable. What remains unknown is whether the individual health and development situation of the countries which participated in the World Bank programs would be better or worse had there been no intervention at all.

## 2.4 The Beginning of Convergence: State and Human Security

At the end of the twentieth century, a shift in geopolitical forces altered the priorities for the global community to address. The end of the Cold War momentarily dispersed fears of a nuclear apocalypse. There was a sense that all societies would benefit from the dismantling of the global stand-off between the U.S., the U.S.S.R., their satellite nations and their proxy conflicts. The monies once spent maintaining the war machine could be redirected to social goods... the so-called **peace dividend**. The integrity of the nation-state in the ideological stand-off was no longer of sole import because of increasing integration across economic, political, social and cultural spheres with heightened globalization and increasing fluidity of the principle of sovereignty in defining and addressing global issues. At the same time, there was a shift in development thought and a new paradigm of **sustainable human development** was replacing the economically-oriented model of development that had prevailed for decades. Sustainable human development incorporated the capabilities approach developed by Amartya Sen with the idea of sustainability that seeks to ensure future generations have the same opportunities for development as does the current generation. This re-examination of development, peace-building and the role of multilateral institutions looked back to the original goals of the survivors the global warfare and rediscovered a *raison d'être* which focused on people rather than states. That reason was human security.

The concept of security has for too long been interpreted narrowly: as security of territory from external aggression, or as protection of national interests in foreign policy or as global security from the threat of a nuclear holocaust. It has been related more to nation-states than to people. ... Forgotten were the legitimate concerns of ordinary people who sought security in their daily lives. For many of them, security symbolized protection from the threat of disease, hunger, unemployment, crime, social conflict, political repression and environmental hazards. (UNDP 1994, p. 22)

For decades, the international community remained narrowly focused on state security to the exclusion of a more anthropocentric approach. **State security** is concerned with external threats to the borders, institutions, and governance of nation-states. It emphasized maintaining military defense, state territories and protecting national interests. But at its inception, the UN Charter promised freedom from fear and freedom from want; state security would provide freedom from fear but human security would speak to freedom from want. **Human security** spoke to security of individuals in their home, in their work, in living their lives. It spoke to the UN Charter's promise to harness economic and social progress as means to foster human well-being and dignity from which peace would follow. The collapse of the Soviet Union illustrated one of the short-comings of the state security paradigm in that it had come to focus almost exclusively on external threats to the nation-state. But the Soviet Union did not fall in battle against a foreign military. It collapsed because of economic and social disorder. This reminded the international community that a broader interpretation of state security, one that included internal threats to national integrity, was a real concern. The 1994 Human Development Report reminded the global community of the promise initially laid forth by the UN and positioned human security as a valid, complimentary paradigm to that of state security. Governments were responsible for protecting its people as well as its territory from the threats of conflict, repression, disease, hunger, and want. The main threats to human security include lack of economic opportunities of households as well as states, security of food, health, environment, personal security from external forces and domestic forms of oppression, protection of community, political participation and preservation of democratic institutions.

With the growing acceptance of the sustainable human development and human security models, health emerged as a critical input not only to economic success but to the very preservation of state and regional security upon which international governance was built. Throughout the 1990s, the import of health grew, transcending mere rhetoric of IGOs and nation-states and actually becoming a central component in the international agenda and policy-making forums.

This is not to say health never factored into international security concerns. In fact, the threat infectious disease—whether introduced deliberately or accidentally—posed to military, to the civilian population, and to socioeconomic structures were well understood for hundreds of years. With the epidemiological transition, chronic diseases entered the radar of policy-planners. Towards the close of the twentieth century, the developed world was especially concerned about the implications of an aging population on health and financial security of the household and government institutions. The growing discussion of health in state and human security

brought the global community back to the early ideal of health being necessary for global peace and stability as seen in the UN Charter and in the *Office International d'Hygiène Publique* and the League of Nations Health Organization before that.

International protocol for addressing disease threats to state security were codified by the WHO in 1951 under the International Sanitary Regulations. The International Health Regulations (IHR) replaced the International Sanitary Regulations in 1969. The IHR listed specific diseases which were to be monitored and reported vis-à-vis a global monitoring network, and set forth reporting and control protocol. Resurgent and newly emerging infections proved a challenge to the international community. Malaria re-emerged as both a regional and global threat. In fact, this single disease was found to limit economic growth in endemic countries by as much as 1.3% of GDP per year as compared to malaria-free nations (Gallup and Sachs 1998). The HIV/AIDS pandemic touched nearly every country in the world. Cholera and plague resurged; and the world acknowledged that 'tropical diseases' like malaria presented a persistent threat. In 2002–2003, the emergence and rapid spread of Severe Acute Respiratory Syndrome (SARS) showed that diseases spread quickly in the globalized landscape, and cost money and lives. The infection spread to 30 countries and caused 623 deaths worldwide (WHO 2003). Global economic costs are estimated to be as high as US\$ 30 billion in Asia alone (Saywell et al. 2003). Among the nations which experienced greatest morbidity, mortality and/or economic losses were Singapore and Hong Kong, and Canada (Saywell et al. 2003; WHO 2003).

The IHR really lacked teeth and coordination until the twenty-first century when international interest in state and human security converged, the symbiotic relationship between economic growth and health was understood and accepted in global power centers, the costs to global economics and security for ignoring health problems became clear, and international action began to back-up rhetoric. The world health community began the slow process of revising international instruments to better address disease threats in 1995. There result was a major revision of the IHR which was adopted in 2005. Under the current code, the number of internationally notifiable diseases expanded to include wild polio, novel strains of human influenza, and SARS. In addition, member states must notify WHO of any Public Health Emergency of International Concern (PHEIC) that includes biological, chemical, infectious, and radioactive threats (WHO 2005b). The health threat is to be reported regardless of the source of origin, a provision which allows for reporting zoonotic infections, or animal-based disease, which may pose a threat to the human population by leaping species. The IHR 2005 also created an extensive international network for disease surveillance and mechanisms for coordinated response to public health risks to minimize impact on international trade and traffic (WHO 2005b). The revised code attempts to foster a scaling-up of national public health capacity.

The strength of the IHR is that it created a disease intelligence network with surveillance and monitoring serving as the backbone of the global public health system. Although the regulations are legally binding to the signatories' compliance with the IHR is voluntary as the WHO has no enforcement capacity. Positive and negative incentives are used to encourage compliance. The positive incentives include access to technical expertise, assistance in mobilizing funding to comply with

the enhanced monitoring and reporting protocol, and logistical support for outbreak verification and response. The threat of international disdain should a state fail to comply with the IHR creates a negative incentive to moderate behavior. The SARS outbreak serves as one such example. China reported the outbreak of a novel disease in February, 2003 stating that it had detected 305 cases of this new disease (WHO 2003). Subsequent investigation proved that China has obscured the facts (WHO 2003). The outbreak had actually been detected in November and the number of cases was more than double the initial figure (WHO 2003). The international community chastised China for failing to report a public health threat which did indeed create a global crisis (WHO 2003). Critics said that had China reported the initial outbreak, actions could have been taken to limit the geographic spread, health impact and economic damage. However, the economic and political costs of disease stigma, and being labeled as a source or impacted country, are high and create perverse incentives which can cause states to hide disease outbreaks. National short-term interests may supersede a longer-term global perspective.

The revision to the IHR represented a change in health policy which occurred over nearly two decades. In the 1990s the WHO and UNDP tried to redefine health as an input into development whereas the World Bank emphasized economic growth's pre-eminence in triggering human development and expanding economic opportunities. The perspective shift associated with the human development and human security models created research and debate but encouraged little in terms of reorienting international health policy until the scares associated with the anthrax attacks in the United States in 2001 and the SARS epidemic showed that economic and military strength were no protection from global threats from disease. These cases also solidified the rise of human health as a concern for state security and showed that state and human security were inextricably linked.

Health had been gaining in-roads into the state security discussion since the collapse of the Soviet Union and the growing realization that HIV/AIDS was a ubiquitous and growing problem. A 1998 USAID report stated that HIV/AIDS was impacting military preparedness around the world, with an especially tenacious foothold in Africa, and therefore represented a clear and present threat to international security and peace (Peterson 2002). In January 2002, the UN Security Council convened to address the threat HIV/AIDS posed to regional and world security. This marked the first time in UN history that a disease was addressed as a security issue (Peterson 2002). Health intersected with state security in that an alteration in population health could create social effects which could destabilize or alter domestic political structures. As domestic institutions falter, regional instability could result.

HIV/AIDS was already proving it could erase decades of development progress by killing the most able-bodied age cohorts. The average life expectancy in Southern Africa decreased from 60 in 1985–1990 to 53 in 2000–2005, a decrease many attribute to HIV/AIDS (World Bank 2009b). In some countries, the loss was much greater. HIV/AIDS struck at the most economically productive age cohort. It was also the cohort of parents and primary care-givers to young children. Malawi alone has around two million AIDS orphans (Mutume 2001). Without parents, who will take care of the children? In some cases, child care falls to aging grandparents,

creating societal strains which are exacerbated by the needs of the elderly. In other cases, the state provides care. In still other cases, the children are left to fend for themselves. Homeless and unguided, the hope of the future generations fall. The children leave school. With their exodus goes the hope not only for their own social and economic development, but for the country's future development prospects which are predicated upon having a healthy, productive, and educated population.

Health is linked to state security in a variety of ways. Health risks, chronic and communicable, endanger the lives of citizens at home and abroad (Peterson 2002). The military is not immune to these risks. As military men and women become sick or die, the military weakens and may not be adequately able to respond to other security challenges. Social and political stability may be at risk if a society is confronted with excess morbidity or mortality (Peterson 2002). A single event or disease could hamper development prospects for years, and reverberate across a broader population which may not have initially been exposed to the first disease. In 2001, the United Nations Food and Agriculture Organizations (FAO) found that a food security crisis was being exacerbated by HIV which was expected to kill an estimated 26% of the agricultural workforce in ten African nations (Peterson 2002). Those dependent upon the agricultural production would suffer too. If a single disease could take away 1.3% of economic growth potential in a year, as was the case with malaria, the implication for economic distress from several health hazards across multiple years was staggering. The ultimate concern was that disruption in population health could not be isolated as it could cause a shift in the political, social, economic or military balance of power (Peterson 2002). International thought about health was changing. A critical mass of research and rhetoric had been reached. The international community could not longer address health as an isolated sector, nor as a domestic social issue. It was global, and it was important for peace, security and prosperity.

## **2.5 True Convergence and the Way Forward in the Twenty-first Century**

The twenty-first century began with two seminal events which firmly united health and economic development as being in a symbiotic relationship in which neither could be divorced from the other. These two events were the formation of the Commission on Macroeconomics and Health (CMH) and the Millennium Development Summit resulted in the Millennium Development Goals (MDGs).

The CMH was founded in 2000, under the aegis of the WHO, as an attempt to bridge diverse views about the primacy of health or economic growth. The commission turned prior emphasis on health trickling down from economic development, or simply being good in and of itself, to health being a foundation to economic development. The CMH's 2001 report declared:

Health is a priority goal in its own right, as well as a central input into economic development and poverty reduction. The importance of investing in health has been greatly underestimated, not only by analysts but also by developing-country governments and the

international donor community. Increased investments in health as outlined in this Report would translate into hundred of billions of dollars per year of increased income in the low-income countries. There are large social benefits to ensuring high levels of health coverage of the poor, including spillovers to wealthier members of the society. (WHO 2001, p. 16)

The CMH has become a leading researcher on links between socioeconomics and health, as well as an advocate for addressing macroeconomic policies and structures that have the power to impact population health through intended and unintended consequences. The CMH also represents a confluence of health conceptualization in that it places health as both an outcome of various factors and processes as well as an input into the same.

The same year, the United Nations hosted the Millennium Summit, which brought together world leaders to strategize ways in which to meet human development targets. This meeting focused on multiple pathways to achieving sustainable human development. It addressed the ideals of building human capacity and human capital as well as global sustainability. The group adopted the United Nations Millennium Development Declaration which established eight goals UN members will strive to achieve by 2015. Three of the eight goals explicitly address population health. The goals acknowledge the need for public and private spheres to operate together as they will both benefit from improvements in human development. Although progress towards the goals is inconsistent, and many argue the goals are not achievable, the Summit and MDGs are a hallmark in development and health in that they represent a convergence of the needs and wants of the North and the South, explicitly address the cyclical relationship between health and economic development, and invite public-private partnerships. The conceptualization of health as an input to and an outcome of other desirable goods is complete.

Many IGOs now use the MDGs as benchmarks for programmatic success. What remains to be seen is how successful the new agenda will be in actually informing program actions and realizing improvements in the human condition. The MDGs present the notion that development and health are not separate and that the two should be addressed in a unified manner in order to truly realize the potential synergies and accelerated improvements possible with joint actions. The MDGs inform programs and goals for the WHO and the World Bank.

## 2.6 Conclusion

We have seen how the WHO and the World Bank have separate but important roles in global governance and as drivers of health and development. We saw, too, that the institutions, their foci, and strategies change from internal and external pressures. The World Bank moved from a narrow definition of development to engaging in a more holistic approach to development with concern for social safety nets. Like the WHO, it also uses the MDGs to guide its operations. In the twenty-first century, the WHO was strengthened in its ideal of health as a human right by the MDGs and the work of the CMH, by international financial institutions and by a

**Table 2.2** Millennium development goals. (Data source: United Nations (2010). <http://www.un.org/millenniumgoals/>. Accessed 9 Oct 2009)

<p><b>Goal 1: Eradicate extreme poverty and hunger</b>            Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than \$ 1 a day            Target 2: Achieve full and productive employment and decent work for all, including women and young people            Target 3: Halve, between 1990 and 2015, the proportion of people who suffer from hunger</p> <p><b>Goal 2: Achieve universal primary education</b>            Target 1: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling</p> <p><b>Goal 3: Promote gender equality and empower women</b>            Target 1: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015</p> <p><b>Goal 4: Reduce child mortality</b>            Target 1: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate</p> <p><b>Goal 5: Improve maternal health</b>            Target 1: Reduce by three quarters the maternal mortality ratio            Target 2: Achieve universal access to reproductive health</p> <p><b>Goal 6: Combat HIV/AIDS, malaria and other diseases</b>            Target 1: Have halted by 2015 and begun to reverse the spread of HIV/AIDS            Target 2: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it            Target 3: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases</p> <p><b>Goal 7: Ensure environmental sustainability</b>            Target 1: Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources            Target 2: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss            Target 3: Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation            Target 4: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers</p> <p><b>Goal 8: Develop a global partnership for development</b>            Target 1: Address the special needs of least developed countries, landlocked countries and small island developing states            Target 2: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system            Target 3: Deal comprehensively with developing countries' debt            Target 4: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries            Target 5: In cooperation with the private sector, make available benefits of new technologies, especially information and communications</p>
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new focus on human security. Of the eight MDG goals, three explicitly focus on health. Goal 4, reduce child mortality, and Goal 5, improve maternal health, are both pillars of primary care. Goal 6, combat HIV/AIDS, malaria, and other diseases, speaks to both public health and human security. The MDGs call for creating

global partnerships between public and private actors. The World Bank and the WHO are engaged in a number of such partnerships. For example, they provide technical guidance to the Global Fund to Fight AIDS, Tuberculosis and Malaria, a partnership we will learn more about in Chap. 6. The call for increased public-private partnerships recognizes the asymmetric economic powers and resources of the private versus public sector and underscores the message that public and private actors have common interests.

## 2.7 Discussion Questions

1. What are three ways in which health is conceptualized by international actors? Which view is closest to your own?
2. What aspects of social medicine differentiate it from biomedicine? How does the difference between the two impact the debate about health and development?
3. The charter of the WHO was heavily debated between countries that favored social insurance and those that did not. The role of the agency in regulating biomedicine was also a point of contention. Why do you think these aspects of health care were so contentious?
4. What are the health outcomes associated with maternal health? Describe technocratic and social routes that may be effective in decreasing maternal deaths.
5. Compare the obstacles associated with global vaccination to the obstacles associated with global improvements in maternal health. What important differences do you see? How might you address these?
6. What were the roles of the World Bank and the IMF when created in 1944? What are their roles today?
7. What are the structural adjustment programs? What politics do they entail?
8. What was the purpose of decentralizing health care? What were some of the (unforeseen) negative consequences?
9. Do you believe the WHO approach to development through health vis-à-vis primary care, or the World Bank approach to health through development via structural adjustment and health sector reform will yield better results in terms of development and human well-being? Why?
10. What global geopolitical factors contributed to the growing importance placed on human security at the end of the twentieth century?

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