Reducing Health-Related Inequities:

Lessons from Program Interventions in Asia and the Pacific

TECHNICAL RESEARCHER REPORT

Prepared by Yana Rodgers, Rutgers University

Commissioned by UNDP Asia-Pacific Regional Centre
Preliminary draft towards Chapter 3,
Regional MDG Report for Asia and the Pacific on Health Inequities

August 2011

Acknowledgment: The consultant gratefully acknowledges Dipa Bagai, Jyotsna Chikersal, Biplove Choudhary, Christopher James, Nobuko Kajiura, Taimur Khilji, Mark Landry, Saramma Mathai, Qimti Paienjton, Anuradha Rajivan, Aparnaa Somanathan, Ferdinand Strobel, Kazuyuki Uji, Bob Verbruggen, and Yumiko Yamamoto for their guidance and helpful suggestions. The chapter draws heavily on text drafted by Biplove Choudhary.

Table of Contents

I. Introduction

Chapters one and two have highlighted the extent of disparities in achieving the health-related MDGs within and across countries in the region. Data analysis has brought out key drivers leading to the persistence of these disparities. It is clear that countries in the region are faced with the multi-tiered challenge of reducing disparities while simultaneously raising attainment levels and accelerating progress on the health-related MDGs.

This chapter presents an integrated and comprehensive approach that holistically addresses the specific determinants of disparities in health outcomes. This approach is expected to directly influence national policies and programs, thus accelerating progress on the health MDGs. Drawing upon success stories around specific public health programs and interventions, the chapter further strives to formulate a coherent action agenda. In order to complete the picture, the chapter also draws upon the larger body of public health research on health determinants.

The discrepancies examined in the previous chapters confirm the importance of eight key policy messages: (1) Addressing health-related inequities requires a renewed emphasis on primary health care; (2) Progress toward health-related MDGs hinges on social determinants, not just economic growth; (3) Closing coverage gaps in health interventions entails sustainable financing of health systems; (4) Health needs of the urban poor have become a more urgent policy priority; (5) Integrating child and maternal health into a continuum of care will help reduce inequities in mortality; (6) Accelerated progress depends on gender equality; (7) Corruption in national health systems can undermine progress toward health security; and (8) Improving a country's health security entails regional and global solutions.[1]

These key messages are discussed more fully in the next section, with reference to health sector reforms and to inter-sectoral approaches that address the complex nature of diseases and

the various risk factors that lie beyond the health sector. Placing a premium on public health policy and finance has helped to lift a number of institutional, supply-side, and demand-side constraints that prevent the achievement of health security for all. In light of such achievements, this chapter identifies successful policies that promote health equity in its various dimensions. Success is defined in terms of innovation, scale, enduring sustainability, transformative change, and geographical spread over the region, especially in countries where disparities are more marked.[2] The chapter also delineates the appropriate roles for the government, private sector, and other stakeholders in helping to achieve broadly-shared development.

The main drivers of poor health outcomes, as indicated by the data analysis, include the cluster of issues surrounding gender inequality, ethnicity, language, caste, religion, poverty, and the disempowerment of marginalized sub-populations.[3] Beside these dimensions of vulnerability and social exclusion, barriers to access also include rural versus urban residence, knowledge and information gaps, and the lack of responsiveness of providers and of the health system itself. Achieving improved health outcomes for vulnerable sub-populations requires a deliberate inter-sectoral, coordinated approach, with strong partnerships among all stakeholders and one that gives marginalized groups a stronger voice in local and national governance. There are also a number of indicator-specific drivers. For instance, the occurrence of breastfeeding is the most important determinant of ensuring child survival across countries.

There is no single, generic approach which can be recommended to unlock progress on the lagging MDGs, and much depends on country specifics. With the right mix of innovation and policy experimentation, countries can successfully overcome implementation bottlenecks. Indeed, a number of countries are now actively engaged in adapting inspiring success stories and

innovative solutions toward their own needs in order to scale up progress on achieving health security for all.

II. Towards Effective Interventions for Improved Health Outcomes in Asia Pacific

This section presents eight key policy messages in relation to achieving health-related targets in the Millennium Development Goals.

1. Addressing Health-Related Inequities Requires a Renewed Emphasis on Primary Health Care. Improving access to and the quality of primary health care serves as a key strategy to strengthen countries' abilities to address issues related to health and equity. Renewed emphasis on ensuring access to primary health as the bedrock of health systems is required to address the persistence of health-related inequities and to accelerate progress toward achieving the MDGs. This point is consistent with the renewed global and regional focus on health systems based on the core values of primary health care. As noted in WPRO (2009), in the past many countries invested heavily in curative services, with relatively lower expenditures on preventive, promotive, and primary health care services. However, there is substantial evidence that an integrated primary health care system enhances the ability of developing countries to address the majority of health problems and inequities (for the case of China, see Box 1). The landmark Alma-Ata Declaration of 1978 on the theme of Health for All provided a strong push for instituting primary health care as a main vehicle for ensuring health security with equity.[4] However, implementation of the primary health care approach has remained uneven.[5]

Insert Box 1 Here

The World Health Organization's 2008 *World Health Report* called for a renewal of primary health care and pointed to problematic movements of health systems in directions that did not pursue equity and social justice goals and also failed to achieve optimal health spending

(WHO 2008a). The report raised concerns about narrow delivery focused on specialized curative care, fragmented service delivery, and a hands-off approach that has allowed uncontrolled commercialization of health to flourish. A review of global health care delivery yielded three common shortcomings. First, health facilities located in areas where poor and marginalized sub-populations are concentrated tend to be fragmented and under-resourced. Second, numerous countries exhibit issues of inverse care in which richer segments of the population – who are often in lesser need – wind up consuming the most services, while the poor – who are often in greater need – wind up being unable to access care. Third, people lacking social protection or other forms of health insurance often slide back into poverty due to disproportionately high out-of-pocket expenses during health episodes.

According to WHO (2010), about 150 million people annually face severe financial hardships due to health care costs from direct payments such as user fees, and over 100 million people annually fall into poverty because they have to pay for health care.[6] For example, while AIDS treatment is officially offered free of charge in most countries, related costs ─ such as for transport and tests ─ constitute barriers to equitable access to antiretroviral therapy (ART). To try to achieve universal access to ART, UNAIDS and WHO have developed the Treatment 2.0 initiative, which is built on core objectives that include reducing costs at all levels, simplifying service delivery, and strengthening community involvement.

The poor stand at a particularly high risk of falling through the safety net when it comes to primary health care coverage. Households living in poverty are more likely to be exposed to health risks, and greater prevalence of undernutrition lowers resistance to disease. This vulnerability is heightened in the face of inadequate health care services. Such disadvantages serve as a major impetus for Asia-Pacific countries to prioritize poor households as an equity

target in public health policies, with policy interventions specifically addressing infrastructure for safe drinking water, improved access to sanitation services, and improved health care services. As shown by the analysis in Chapter 2, these infrastructure investments, which help limit childhood infections, will reduce the risk of children becoming underweight and will contribute to lower rates of under-five mortality. Such investments are all the more crucial given Chapter 2's findings of substantial impediments in access to safe water and sanitation services, including poverty and lower proportions of women in the household.

For some countries, operationalizing the concept of primary health care has entailed applying a strategy known as the Essential Service Package (ESP).[7] The package idea evolved from the primary health care objectives of the Alma Ata Conference and its focus on social justice, empowerment, and improving the health status of the most vulnerable. Under the influence of aid agencies, countries such as Bangladesh and Indonesia have adopted ESPs with primary health care objectives and a focus on efficiency and low costs. However, the strategy has some limitations, such as the introduction of unofficial fees, long waits, supply constraints, and un-served areas.[8] For example, in Bangladesh the ESP was not made available in urban areas, pointing to the importance of the functional convergence of different responsible agencies.[9] Despite these limitations, previous research suggests that the ESP strategy can be an effective way to expand primary health care and channel resources accordingly.[10]

Another strategy for operationalizing primary health care is the ambitious Healthy Islands approach. This approach was instigated by the World Health Organization in 1995 and shortly thereafter was broadly adopted in the Pacific as a conceptual framework for guiding policy. Implementation includes consideration of several objectives, including safe water and sanitation facilities, food security, waste management, human resource development, communicable and

non-communicable disease prevention and control, reproductive health, primary health care, lifestyle and quality of life issues, and social and emotional well-being. Projects inspired by the Healthy Islands framework range from malaria control in the Solomon Islands and Vanuatu; environmental health and health promotion initiatives in Fiji; water supply and sanitation through community development in Tonga; participatory health needs assessments and planning in Nauru; and community-based health promotion in Kiribati, Samoa, Niue, the Cook Islands, and Tuvalu. Despite these efforts, an early evaluation in Galea *et al.* (2000) indicated that the implementation processes were not yet widely in practice, nor had they emerged as a large-scale management model for coordinating health policy at the country and regional levels. More recently, the Health Islands initiative has come back into the spotlight, with calls to renew the emphasis on primary health care, to reposition the initiative into a broader development context, and to address the broad determinants of health ─ such as food security and climate change ─ through multisectoral action.[11]

2. Progress Toward Health-related MDGs Hinges on Social Determinants, Not Just Economic Growth. Although macroeconomic policy reforms in recent decades have helped to remove constraints on economic growth across Asia and the Pacific, many countries have demonstrated less success in assuring health for all. There are deficits in improving the availability, affordability, and access to health care services and products. Moreover, investing in infrastructure for basic needs also lags behind. As shown in the previous chapters, a high level of heterogeneity remains in MDG progress, even for countries that have similar socio-economic characteristics. A mid-term assessment of the MDGs carried out earlier by the Commission on Growth and Development has also pointed to a near-zero correlation between growth in per capita income and improvements in non-income MDGs.[12]

This finding is consistent with the previous chapter's conclusion that economic growth does not appear to play as critical a role in improving health outcomes as it does in reducing income poverty. Economic growth does lead to increased household incomes, thus improving the ability of households to afford health services. However, economic growth is inadequate if households do not have access to health services and skilled health personnel. As argued in WHO (2008b), a key driver to this lack of access are inequities related to class, ethnicity, caste, language, and religion that permeate daily life. These systematic inequities are produced by engrained social structures, norms, and processes that accept and can even encourage unfair distributions of wealth and social resources. For example, high levels of stigma and discrimination against people with certain diseases, particularly HIV, prevent them from accessing testing and treatment in Asia and the Pacific. Similarly, criminalization of certain behaviors such as sex between men, sex work, and drug use also hinders access to health information and services. These persistent barriers constitute a rationale for framing a comprehensive set policies and programs that influence the social determinants of health and will improve health equity.

The acknowledgment that economic growth is not an end in itself suggests that sectoral coordination, social well-being, and health equity goals need to be emphasized as much as growth and availability of adequate financial resources. Governments need to recognize that a healthy workforce is an economic asset, while inequities in health can act as a drag on economic growth and productivity. This point is further supported by the historical experiences of certain states of India that had modest per capita income (such as Kerala and Tamil Nadu) but fared remarkably well on health advancements. Writing on the so-called "Kerala Model" or "Kerala Paradox," Amartya Sen has argued that Kerala is proof of the thesis that greater state

involvement can lead to better social indictors, even if it does not lead to higher incomes.[13] Kerala's high literacy rate, high levels of female education and empowerment, and low infant mortality stand in sharp contrast to the state's relatively low income per capita. Similarly, government actions in Tamil Nadu have also focused on promoting literacy and social gains.

China and Sri Lanka also made substantial strides in their early stages of development in improving health outcomes with a modest per capita income by prioritizing health and social well-being. In China's case, progress on a number of health indicators between 1949 and 1980 outpaced that of many other countries with faster economic growth and more sophisticated health infrastructures.[14] China's success in addressing the major public health challenges was attributed to a number of factors, including improved sanitation, immunization, a hospital delivery policy for giving birth, and health insurance improvements. Moreover, Sri Lanka's health system emphasized universal access and equity as a social right (World Bank 2008). This emphasis ensured that people in the poorest segments could take advantage of physical access to health care in close proximity.[15] Despite these attainments in India, China, and Sri Lanka, there are still major health-related challenges. For instance, in Sri Lanka, policymakers and practitioners are facing changes in the epidemiological pattern of diseases as well as a shift towards non-communicable diseases.[16] However, the point remains that progress on the MDGs needs to be approached in a broader framework than on income metrics alone.

3. Closing Coverage Gaps in Health Interventions Entails Sustainable Financing of Health Systems. Governments face critical questions and tough choices on the financing of universal and equitable coverage. The financial cost of achieving the MDGs in Asia and the Pacific is high. UNESCAP (2010) estimated the total cost of meeting the MDG targets ─ including the resources required to sustain current coverage levels, as well as the additional cost

of closing the gap between the projected value and the target for off-track countries ─ for Asia-Pacific countries. Results indicate a considerable range in the costs of meeting the MDG targets. For example, ensuring access to a skilled professional at birth (MDG 5) will cost $7 billion in order to reach the projected value, and an additional $17 billion for off-track countries to close the gap. The gap in the provision of clean water and basic sanitation in rural areas can be closed by investing $3 billion and $8 billion, respectively. In contrast, ensuring universal primary school enrolment is a relatively costlier investment, with $43 billion to reach the projected value and another $65 billion for off-track countries to close the gap. Overall, the cost of reaching the targets in rural areas is much less than in urban areas – between one tenth and one fourth – and around twice as many people would benefit (UNESCAP 2010).

That said, the benefits are enormous. Simply closing the coverage gap and ensuring skilled care at birth in 49 low-income countries would in itself save the lives of 700,000 women between now and 2015. Similarly, closing the coverage gap in a range of services for children ages five and below – especially immunization, breastfeeding promotion, and pneumonia case management – is estimated to save the lives of more than 16 million children.[17]

In the Asia-Pacific region, out-of-pocket expenses on health are very high (see Box 2). WPRO (2009) recommends that countries limit out-of-pocket expenses to no more than 30 to 40 percent of total health expenditures in order to achieve universal coverage. Higher out-of-pocket expenses as a share of total health spending are associated with increased catastrophic payments, which in turn reflect insufficient health spending by governments (James *et al.* 2010). The need to help people avoid health-related shocks through exceedingly high out-of-pocket expenses, and to provide universal access to health services in a holistic manner, have drawn increasing attention to the imperative of sustainable financing of health systems.

Insert Box 2 Here

The WHO's *World Health Report* of 2010 on health systems financing and the WPRO's (2009) health financing strategy for the region have developed a comprehensive menu of policy options on this score. At the outset, anywhere between 20 and 40 percent of all health spending is wasted through inefficiency. Key areas where improved policies can dramatically improve the impact of expenditures include better procurement practices, increased usage of generic products, better incentives for providers, and streamlined administrative and financial procedures. Moreover, an important barrier to universal access is the requirement to make direct payments at the time of care, often in the form of co-payments. Countries need to develop adequate social protection floors which can help people smooth income flows and help manage risks during times of illness. In addition to sustainable financing, the implementation of equity-focused health policies also requires alleviating constraints with respect to other health systems building blocks, especially the health workforce.

The WHO's 2010 report notes that while countries do need stable and adequate financing for health services, high national income is not a requirement for attaining universal coverage. Hence countries with similar levels of health investments can achieve dramatically different health outcomes, with policy decisions helping to explain the differences. However, no single set of policies can be universally applied, and health financing solutions need to be responsive to individual country needs. Countries such as China, Thailand, and Cambodia have each sought to address the issues of health financing in promising ways with solutions ranging from universal health care coverage to an innovative health equity fund.

What choices do governments have when typically beset with resource shortfalls, especially in low-income countries? Increasing government revenues is one option, especially through tax reforms such as in Indonesia where government revenues have significantly increased and contributed to enhanced health spending. Reprioritization of government budgets is another option, especially along the lines of the Abuja declaration of 2001 in Africa, which exhorts governments to increase budgetary allocations on health spending to 15 percent. As shown in Box 3, countries in the Pacific region, especially Niue, Marshall Islands, the Federated States of Micronesia, and Kiribati, stand out for their relatively high total health expenditures as a share of GDP. These shares far exceed the recommended target of 4 to 5 percent for improving the feasibility of attaining universal coverage (WPRO 2009).[18]

Insert Box 3 Here

Another promising option for governments to consider is Innovative Financing for resource mobilization with a wide array of strategies. Innovative Financing includes mechanisms designed to raise funds in addition to conventional Official Development Assistance, and mechanisms that improve the use of these funds. The main role envisaged is to bridge the funding gap, estimated to be in the range of $36-45 billion globally, in order to reach the MDGs. The International Finance Facility for Immunization, created in 2006 to support the Global Alliance for Vaccines and Immunization, is one such example ensuring predictability of funds for a specified duration. Another successful example is the Debt2Health initiative, where donors forgo a portion of loan repayments against the debtor's commitment to invest half of the debt forgiven in programs approved by the Global Fund. The Global Fund also receives income from the ProductRED initiative, in which companies commit a share of their profits on goods branded with the ProductRED trademark to support the Global Fund.[19]

Also related to financing and scarce resources, donor-driven vertically-integrated programs can place an additional delivery burden on the understaffed and overburdened primary health care systems. To address this issue, stand-alone programs should be integrated into a well-functioning primary health care system, and a part of the resources should be devoted to the tasks of integration and capacity strengthening. The amount of development assistance has increased from $10.5 billion to $27 billion between 2000 and 2010, which has increased the likelihood of redrawing health priorities and moving them away from the core primary health care systems.[20] Even as it is difficult to forecast the evolving contours of the scale or nature of ODA or bilateral assistance, donor countries and emerging economies should continue to mobilize around bridging the resource gaps of low-income countries.

4. Health Needs of the Urban Poor Have Become a More Urgent Policy Priority. With rapid urbanization and growth of the urban poor in the region, the issues of inequities afflicting the urban poor require greater attention, with particular reference to health. Concern has increased over the coverage and quality of health services, with many slum areas remaining un-served or under-served. This coverage gap often includes complete and timely immunization, institutional delivery facilities, and reproductive health care. Environmental health and links with frequent episodes of city flooding – which further worsens health outcomes for the poor – underline the need to work in a cross-sectoral, inter-agency manner with functional convergence. If these issues remain unaddressed with sustained policy attention, they could slow down the achievement of MDGs across a number of Asian-Pacific countries, especially those with higher ratios of urban poor than rural poor.

Bridging the gap between the urban rich and poor constitutes a key pathway toward achieving improved health status for all. In Asia-Pacific countries on average, 36 percent of the

urban population lives in slums, a rate higher than Latin America (25 percent) but lower than Africa (63 percent).[21] India alone has one of the world's largest urban populations with incomes that fall below the poverty line, and the world's largest population of slum dwellers. In 2004-2005, about 81 million urban residents in India had incomes below the poverty line (Agarwal 2011). People living in urban slums experience highly degraded living conditions characterized by pollution, poor water and sanitation facilities, lack of toilets, and poor drainage. These squalid conditions contribute to high susceptibility to disease among the urban poor, and ultimately to high rates of morbidity and mortality.

Demographic trends in Asia-Pacific developing countries suggest that even as urban growth may stabilize on average, slums will keep growing at a faster rate. In the Indian case, average growth of urban areas is expected to stabilize at about three percent, with slums growing at five percent. In some countries ─ such as the atoll states of Kiribati, Tuvalu and the Marshall Islands ─ this growth has resulted in exceptionally high population densities comparable with those in the most highly populated Asian cities, contributing to significant environmental and health problems. Inadequate finance for urban development has meant that Pacific urban centers are increasingly unhealthy and dangerous places to live. Although progress has been made on health facilities, Pacific towns, particularly Port Moresby, Majuro, Ebeye, Kolonia (Pohnpei, FSM) and South Tarawa, face periodic threats of cholera and other water-borne diseases.[22]

Commonly reported averages of the health status of the urban population mask the worrying health conditions of the urban poor. Often in cities, health indicators for the urban poor are as bad if not worse than the rural poor (Agarwal *et al.* 2007). In the Indian metropolis of Delhi for example, the infant mortality rate of 94 for the poor is more than double that of urban Delhi, and because many slums are unregistered, slum inhabitants remain unreached by the slum

improvement programs. Problems in Delhi's slum areas are representative of other cities in India. Numerous policies have been articulated for India's urban poor aimed at improving housing and basic services, environmental conditions, employment opportunities, community empowerment, and food security. However, few of these policies have yielded much evidence to support their effectiveness.[23] Part of the problem is that there are a myriad of agencies that remain weakly coordinated amongst themselves. Well-defined geographic areas that are served by a clear institutional framework are particularly important for programs such as health education or services such as mobile health clinics, thus pointing to the need to build synergies in a cross-sectoral, inter-agency manner.

5. Integrating Child and Maternal Health into a Continuum of Care will Help Reduce Inequities in Mortality. An ambitious and just as necessary policy priority is to reduce inequities in under-five mortality and maternal mortality by better integrating child and maternal health into a continuum of care. Maternal, infant, and child mortality remain a major concern in the region's low-income countries where the lack of skilled health professionals during deliveries makes it difficult to treat obstetric complications such as hemorrhage, hypertension, infection, and obstructed labor.[24] Insufficient access to medical care around the time of delivery in low-income Asia-Pacific countries is a crucial reason why pregnancy and childbirth still result in high rates of maternal and newborn mortality. As demonstrated in chapter 2, the factor with the highest correlation with maternal mortality is the availability of skilled attendants at birth. In emergency situations at birth, the critical priority is to ensure timely support from skilled attendants, and if necessary from doctors. The inadequate health care access in some countries is driven largely by insufficient spending on maternal and infant health, which is considerably lower compared in most countries compared to other health sector interventions (WHO 2009,

2010). Moreover, in the Pacific islands, challenges in meeting MDG 4 and MDG 5 are also related to geographical remoteness, brain drain of qualified health personnel and the low status of women in some islands.

The statistics on mother and child health indicators are hard to accept, especially with the great strides in technical progress (immunization in particular), and with the knowledge and resources at our command. Still, a very high number of women and children die of causes which are preventable in nature. The important issue to note is that nearly all maternal, infant, and child deaths occur in low- and middle-income countries globally. Moreover, national burdens of disease, under-nutrition, poor health, and illiteracy are concentrated in the most impoverished child populations. Yet cost-effective ways of saving these precious lives are usually not available to the needy. The Bellagio Study Group on Child Survival set up by *The Lancet* in 2003 to judge current evidence on reduction of the estimated 10 million child deaths in low income countries found that 90 percent coverage of 23 simple measures could reduce child deaths by 63 percent, thereby saving 6 million lives a year (Jones *et al.* 2003). Three of the most important interventions include oral rehydration therapy, breastfeeding and insecticide treated bed-nets.

Providing children with essential services through an equity-focused approach to child survival and development has great potential to accelerate progress toward the MDGs and other international commitments to children. An equity-focused approach could bring vastly improved returns on investment by averting far more child and maternal deaths and episodes of under-nutrition, and by markedly expanding effective coverage of key primary health and nutrition interventions. Hence governments need to consider adopting a broader strategy aimed at having an integrated package of services offering a continuum of services around women, newborns, and young children, managed in a unified manner. Promoting infant, child, and maternal health

through an entire spectrum of health policies ─ from encouraging the adoption of basic health practices at home, preventing and controlling vector-borne diseases, strengthening the quality and scaling-up of gender responsive education on reproductive and sexual health, and expanding immunization programs, to improving supportive services such as family planning and reproductive health care services ─ will go a long way toward reducing inequities in morbidity and mortality. Good examples of successful programs to have focused on these objectives include India's Comprehensive Emergency Obstetric Newborn Care (CEMONC) in the state of Tamil Nadu, and Indonesia's Integrating Malaria Treatment and Prevention into Maternal and Child Health Services.[25]

Of particular relevance for the health of newborns is breastfeeding. Public health initiatives around the world have renewed efforts to raise breastfeeding incidence and duration. The World Health Organization (WHO) recommends six months of exclusive breastfeeding, with continued breastfeeding alongside appropriate complementary foods up to the age or two or beyond.[26] This recommendation is based on reports of multiple benefits for children from breastfeeding, including, but not limited to, reductions in the incidence of diabetes, asthma, and infectious diseases.[27] These benefits are reflected in the previous chapter's finding that in all the sample countries, disparities in under-five mortality would be reduced substantially if all mothers breastfed their children, with the greatest benefits likely to occur in South Asia.

Moreover, immunizing infants and young children serves as an important preventive health-seeking behavior, as does using malaria prophylaxis. Attending medical facilities for check-ups and other preventive health care services also has a direct bearing on child health. Providing children with appropriate medications and vitamin and mineral supplements can serve both preventive and curative purposes. As shown in Box 4, a number of countries in the region

have fairly low spending on prevention and public health services, which implies an area for policy action.

Insert Box 4 Here

Given the focus of two of the MDGs on under-five and maternal mortality, it makes sense to focus intensively on the critical inputs across the continuum of mothers' health, age of marriage, contraception, antenatal and post-natal care, birth spacing, institutional delivery, and the full spectrum of child immunization and health delivery services. It is also important to address social determinants of health, in addition to these medically-oriented factors. Examples include laws, policies, social norms, customs and practices that impoverish and disempower women, including violence against women. Empirical studies point to an association between violence against women and poor maternal health, while women who are empowered with property rights face less domestic violence.[28] These social determinants of maternal and child health provide a strong rationale for a rights-based approach to health issues.

6. Accelerated Progress Depends on Gender Equality. Cross country research has pointed to relatively less access to health care and resources for women and girls compared to men and boys. These inequities lie at the root of relatively high female mortality rates in a number of countries. In particular, Amartya Sen has drawn attention to discrimination against females as evidenced by the shortfall of women relative to men in the population of some countries, including high-income countries or those experiencing rapid growth (Sen 1989). Further, Klasen and Wink (2003) argue that rising per capita income is associated with mixed evidence for improvements in women's relative status, with an increase in the absolute number of "missing women" and a growing incidence of sex-selective abortions in Asian economies offsetting some of the gains women experienced in education and labour-market outcomes.

Male child preference remains a concern in some South Asian countries and sub-regions with continued imbalances in sex ratios and evidence of disproportionate allocation of food and health care resources within the household. For example, recent evidence for India indicates that on average, daughters were weaned earlier than sons, largely due to the contraceptive properties of breastfeeding and the desire of mothers with fewer than the desired number of sons to conceive again. Given the argument that breastfeeding can protect children from water-borne and food-borne disease, this gender gap in breastfeeding explains 14 percent of the excess mortality of girls over boys in India.[29] The lower status of girls and women, overall, is also a significant contributor to overall health security in Asia-Pacific countries and further influences health outcomes across generations. These imbalances point to the importance of reproductive health services, health education focused on breastfeeding practices, and pressures against sex-selective abortions. Moreover, a holistic systems and community approach to the issue of skewed sex ratios can go a long way to raise awareness, empower girl children, and correct severe imbalances in the sex ratio (See Box 5).

Insert Box 5

Similarly, gender gaps social indicators targeted by the MDGs, such as education, can affect health outcomes negatively sometimes even inter-generationally. In particular, a large group of studies have found that mother's education in particular is positively associated with a number of measures of infant and child health and nutritional status.[30] This large body of empirical work has fueled a global push to educate girls in developing countries. Beyond improving socioeconomic status, education and training can build the capacity of mothers to process health-related information and provide appropriate care for their children by adopting

new health beliefs, gaining general knowledge, and applying specific knowledge about good health and nutritional practices that promote child well-being.[31]

7. Corruption in National Health Systems Can Undermine Progress Toward Health Security. Corruption can occur at all levels within the health sector, from large-scale graft in drug procurement and in the construction of new health facilities, to petty corruption (such as payments to health providers to ensure delivery of routine services), to staffing and absenteeism types of issues.[32] Up to 10 percent of the health budget can disappear en route from the Ministry of Finance to the Ministry of Health, with subsequent leaks through various side channels as the funds flow to provinces, local hospitals, and clinics. Much of the corruption is linked with procurement as companies pay bribes for public contracts for major construction projects or drug procurement, since the largest health expenditure in the region after personnel costs goes toward drugs. Moreover, absenteeism rates can reach 35 to 40 percent and tend to be higher for doctors and nurses than for other health workers. Even basic preventive measures such as vaccination programs can be undermined with added costs of ensuring treatment and care, especially if such added costs become institutionalized over time.

This corruption results in a further dissipation of what are already modest allocations for health spending, and these costs constitute a substantial share of household income of the poor. Poorer households find it difficult to pay for safe drinking water often at high cost relative to their income flows. Often reliable supplies of water are quite difficult to be had without payment of bribes or extra money. These issues are particularly difficult for women-headed households. Related to the impact of corruption on the poor, a growing public health concern is fake, counterfeit, and substandard medicines, especially in Southeast Asia and especially in the case of anti-malarial drugs. This problem has developed into an equity issue in which the rich can afford

quality medicines (whether brands or generics) in the formal market while the poor access the counterfeit drugs in the informal market.

Corruption is widespread not only in social services, but also in such public utilities as water and sanitation. Corruption can skew the distribution of water supplies and undermine the performance and effectiveness of both public and private sectors. In some countries, powerful mafias control the operators of water tankers. These mafias have taken advantage of ineffective water distribution systems, and they have in effect privatized the supply of water by bribing corrupt officials to look the other way and then selling the water to area businesses. These actions have further contributed to health inequities by reducing water supplies to the poor, especially in urban areas and in outer peripheries.

These concerns imply that policy reforms need to focus on action from above and below: governments will need to ensure more transparent and better managed services, while users will need to work together to resist demands for bribes. Several countries have set precedents for good practices, such as Cambodia in the reduction of informal payments, India in improved activism through radio reporting in Gujarat, and the Mekong countries in the reduction of counterfeit drugs. As a particular example, the city of Hyderabad in India established a single window system to process applications for new water and sewer connections, thus eliminating a multitude of applications and red tape that had become a major source of corruption in the past. More broadly, when the public health sector does not perform, the private sector does not perform either.[33] This point highlights the necessity of the public sector setting the rules of the game under a tightly assured regulatory environment which guarantees quality of care alongside due accountability to sensitive pricing of health services.

8. Improving a Country's Health Security Entails Regional and Global Solutions. It is also useful to consider regional and global action on ensuring affordable access to essential medicines. A powerful means toward achieving this objective includes enforcing the hard fought public-health flexibilities of the Trade Related Intellectual Property Rights (TRIPS) Agreement of the World Trade Organization. Furthermore, improving the overall capacity of a country's health care system is closely linked to issues of multi-sectoral partnerships and coordination across countries. Increased research and development efforts can be channeled toward the reduction and prevention of infectious diseases that plague low-income countries.

As a particular example in support of these arguments, Asia-Pacific is at a critical time in its AIDS response—progress has been made but far short of what is needed to reach universal access to key HIV prevention and treatment services. For universal access to become a reality in Asia-Pacific, greater leadership, and increased resources (both domestic and international) are vitally important conditions. Multi-sectoral partnerships – including civil society, people living with HIV, and key affected populations – are crucial for a successful, cost-effective response. Countries need to lead their own HIV prevention revolution. Spending and programs must be focused on key populations at higher risk (in particular people who buy and sell sex, men who have sex with men, and people who inject drugs) and those communities in turn need to be involved in the program design and implementation. As the saying "Nothing about us without us" goes, no policy action should be undertaken by the government without the complete and direct participation of the populations affected by that policy. That said, the flexibilities of the TRIPS agreement also need to be seen in a context beyond antiretroviral therapy drugs, especially with the growing prevalence of non-communicable diseases.

Access to medicines at an affordable price is a basic human right to health care. However, following the establishment of the TRIPS Agreement in 1995, the patenting of medicines and their consequent production at a price not aligned with the fundamentals of drug development and related costs served as a major hindrance to ensuring progress on the MDGs. The cost of HIV/AIDS treatment with patented drugs, for instance, was estimated to be in the range of $10,000-$15,000, in sharp contrast to the non-patented generic versions priced at around $300 at the time. The generics price has since dropped to around $100-$150, thereby widening the gap to astounding levels.

There are provisions though in the TRIPS Agreement which allow for the granting of compulsory licenses for developing countries to overcome the problem of affordability through manufacture or import of medicine to protect public health. Malaysia was the first country in Asia to take advantage of the TRIPS flexibilities when it issued a government license in 2003 to import antiretroviral drugs from the Indian company Cipla for use in government hospitals and clinics, with cost reductions achieved of nearly 83 percent. Indonesia and Thailand followed suit in 2004 and 2006. In a similar vein, the Philippines passed the Universally Accessible Cheaper and Quality Medicines Act of 2008 to enhance access to quality generic drugs at lower prices, and to ensure affordable access to essential medicines.[34] Other countries faced with similar choices can benefit from these experiences to accelerate progress.

III. A 10-Point Health Policy Agenda for Accelerating Progress on the MDGs

These key policy messages lend themselves to a coherent action agenda for policy makers, with the rationale provided by the data analysis in the preceding chapters.

1. Policy makers ought to renew the emphasis on primary health care, in a holistic manner based on multisectoral actions.

2. Progress on the MDGs needs to be approached in a broader human-rights framework than on income metrics alone.

3. Governments must develop a sustainable financing strategy from a comprehensive menu of policy options to close coverage gaps in health interventions.

4. Bridging the gap in health security between the urban rich and poor must become a more urgent policy priority.

5. Health policy planning needs to better integrate child and maternal health into a continuum of care.

6. The soundness of health policy strategies ought to be based on the extent to which they integrate gender equality into their objectives.

7. Policy makers need to ensure more transparent and better managed health services under a tightly assured regulatory environment.

8. Governments need to take greater advantage of the public-health flexibilities of the WTO's Trade Related Intellectual Property Rights Agreement.

9. Countries need to actively engage in adapting successful practices and innovative solutions toward their own needs in order to scale up progress in achieving health security with equity.

10. Moving into the future, health systems must include cost-effective interventions that target non-communicable diseases among longstanding primary-care interventions.

References Cited

Agarwal, Siddharth. 2011. "The State of Urban Health in India: Comparing the Poorest Quartile to the Rest of the Urban Population in Selected States and Cities," *Environment & Urbanization* 23(1): 13–28.

Agarwal Siddharth, Anuj Srivastava, Biplove Choudhary, and S. Kaushik. 2007. *State of Urban Health in Delhi*. New Delhi, India: Urban Health Resource Center.

American Academy of Pediatrics. 2005. "Breastfeeding and the Use of Human Milk," *Pediatrics* 115 (2 Part 1): 496–506.

Bonu, Sekhar, Indu Bhushan, and David Peters. 2007. "Incidence, Intensity, and Correlates of Catastrophic Out-of-Pocket Health Payments in India," Asian Development Bank, Economics and Research Department, Working Paper No. 102. Available at http://www.adb.org/Documents/ERD/Working_Papers/WP102.pdf.

Capacity.org. 2011. *Capacity.org: A Gateway for Capacity Development*. Issue 42 (June). Available at http://www.capacity.org/capacity/export/sites/capacity/documents/journal-pdfs/CAP42_ENG_DEF_LR.pdf.

Chinese Embassy in the U.S. 2002. "China Targets Better Rural Primary Health Care." Available at http://www.china-embassy.org/eng/zt/zgrq/t36653.htm.

Culyer, A. J., and Adam Wagstaff. 1993. "Equity and Equality in Health and Health Care," *Journal of Health Economics* 12 (4): 431-57.

Ensor, Tim, Priti Dave-Sen, Liaquat Ali, Atia Hossain, Shamim Ara Begum, and Hamid Moral. 2002. "Do Essential Service Packages Benefit the Poor? Preliminary Evidence from Bangladesh," *Health Policy and Planning* 17 (3): 247-256.

Galea, Gauden, Brent Powis, and Stephen A. Tamplin. 2000. “Healthy Islands in the Western Pacific—International Settings Development,” *Health Promotion International* 15 (2): 169-178.

Glewwe, Paul. 1999. “Why Does Mother’s Schooling Raise Child Health in Developing Countries? Evidence from Morocco,” *Journal of Human Resources* 34 (1): 124–59.

Hou, Thomas. 2009. The Chinese Primary Care System: Its Evolution, Challenges and Legal Aspects of Reform, *College Undergraduate Research Electronic Journal* 2009: 1-18. Available at http://repository.upenn.edu/cgi/viewcontent.cgi?article=1120&context=curej.

James, Chris, Dorjsuren Bayarsaikhan, and Henk Bekedam. 2010. “Health-Financing Strategy for WHO's Asia-Pacific Region,” *The Lancet* 375 (9724): 1417-1419.

Jayachandran, Seema and Kuziemko, Ilyana. 2009. “Why Do Mothers Breastfeed Girls Less than Boys? Evidence and Implications for Child Health in India,” NBER Working Paper No. W15041.

Jones, Gareth, Richard Steketee, Robert Black, Zulfiqar Bhutta, and Saul Morris. 2003. “How Many Child Deaths Can We Prevent this Year?” *The Lancet* 362 (9377): 65-71.

Kanbur, Ravi, and Michael Spence (eds.). 2010. *Equity and Growth in a Globalizing World*. Washington, DC: World Bank and Commission on Growth and Development.

Klasen, Stephan and Claudia Wink. 2003. “‘Missing Women’: Revisiting the Debate.” *Feminist Economics* 9 (2–3): 263–300.

Kramer, Michael, and Ritsuko Kakuma. 2004. “The Optimal Duration of Exclusive Breastfeeding: A Systematic Review,” *Advances in Experimental Medicine and Biology* 554: 63-77.

Krupp, Karl and Purnima Madhivanan. 2009. “Leveraging Human Capital to Reduce Maternal Mortality in India: Enhanced Public Health System or Public-Private Partnership?” *Human Resources for Health* 7: 1-8.

Kurien, John. 1995. “The Kerala Model: Its Central Tendency and the Outlier,” *Social Scientist* 23 (1/3): 70-90.

Le Gargasson, Jean-Bernard, and Bernard Salomé. 2010. “The Role of Innovative Financing Mechanisms for Health,” *World Health Report* 2010 Background Paper No. 12. Available at http://www.who.int/healthsystems/topics/financing/healthreport/InnovativeBP12FINAL.pdf.

McDonagh, Marilyn, and Elizabeth Goodburn. 2001. “Maternal Health and Health Sector Reform: Opportunities and Challenges,” *Studies in Health Services Organisation & Policy* 17: 375-382.

Panda, Pradeep, and Bina Agarwal. 2005. “Marital Violence, Human Development and Women’s Property Status in India,” *World Development* 33 (5): 823–850.

Rannan-Eliya, Ravi, and Lankani Sikurajapathy. 2009. *Sri Lanka: “Good Practice” in Expanding Health Care Coverage*. Washington, DC: World Bank. Available at: http://www.ihp.lk/publications/docs/RSS0903.pdf

Rodgers, Yana. 2011. *Maternal Employment and Child Health: Global Issues and Policy Solutions.* Northampton, MA, and London: Edward Elgar Publishing.

Sen, Amartya. 1989. “Women’s Survival as a Development Problem.” *Bulletin of American Academy of Arts and Sciences* 18 (2): 14–29.

Smith, Richard, Carlos Correa, and Cecilia Oh. 2009. "Trade, TRIPS, and Pharmaceuticals," *The Lancet* 373 (9664): 684-691.

Soors, Werner, Narayanan Devadasan, Varatharajan Durairaj and Bart Criel. 2010. Community Health Insurance and Universal Coverage: Multiple paths, many rivers to cross. World Health Report (2010) Background Paper No. 48. Available at http://www.who.int/healthsystems/topics/financing/healthreport/48_CHI.pdf.

Thatte, Urmila, Samsinah Hussain, Madeleine de Rosas-Valera, and Muhammad Ashar Malik. 2009. "Evidence-Based Decision on Medical Technologies in Asia Pacific: Experiences from India, Malaysia, Philippines, and Pakistan," *Value in Health* 12 (S3): S18-S25.

United Nations Development Group (UNDG). 2011. *MDG Good Practices* Database. Available at http://mdgnet.undg.org.

United Nations Development Programme (UNDP). 2008. *Tackling Corruption, Transforming Lives: Accelerating Human Development in Asia and the Pacific*. Available at http://hdr.undp.org/en/reports/regional/asiathepacific/RHDR_Full%20Report_Tackling_Corruption_Transforming_Lives.pdf.

United Nations Development Programme (UNDP) and Secretariat of the Pacific Community (SPC). 2010. *Migration, Mobility and HIV: A Rapid Assessment of Risks and Vulnerabilities in the Pacific.* Available at http://www.undppc.org.fj/_resources/article/files/Migration,MobilityandHIV_web.pdf.

United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP). 2010. *Financing an Inclusive and Green Future: A Supportive Financial System and Green Growth for Achieving the Millennium Development Goals in Asia and the Pacific*. Available at:

http://www.unescap.org/pdd/publications/themestudy2010/themestudy2010_fulltext.pdf

United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), Asian Development Bank (ADB), and United Nations Development Programme (UNDP). 2010. *Paths to 2015 MDG Priorities in Asia and the Pacific: Asia-Pacific MDG Report 2010/11*. Available at http://www.mdgasiapacific.org/files/MDG_RegionalReport20102011.pdf.

Wagstaff, Adam, Magnus Lindelow, Shiyong Wang, and Shuo Zhang. 2009. *Reforming China's Rural Health System*. Washington, DC: World Bank. Available at http://siteresources.worldbank.org/CHINAEXTN/Resources/318949-1248160372290/rural_health_full_report_en.pdf

World Bank. 2008. *Good Practices in Health Financing: Lessons from Reforms in Low- and Middle-Income Countries.* Washington, DC: World Bank. Available at http://siteresources.worldbank.org/INTHSD/Resources/376278-1202320704235/GoodPracticesHealthFinancing.pdf.

World Health Organization (2011a). *National Health Accounts Database*. Available at http://apps.who.int/nha/database/ChoiceDataExplorerRegime.aspx

World Health Organization (WHO). 2011b. *Technical Guidance Tools. Module 7. Analysing Patterns of Health Care Provision: Essential Health Service Packages*. Available at http://www.who.int/hac/techguidance/tools/disrupted_sectors/module_07/en/index4.html

World Health Organization (WHO). 2010. *The World Health Report 2010: Health Systems Financing: The Path to Universal Coverage.* Available at http://www.who.int/whr/2010/en/index.html.

World Health Organization (WHO). 2009. *Women and Health: Today's Evidence Tomorrow's Agenda.* Available at http://www.who.int/gender/documents/9789241563857/en/index.html.

World Health Organization (WHO). 2008a. *The World Health Report 2008: Primary Health Care (Now More Than Ever).* Available at http://www.who.int/whr/2008/en/index.html.

World Health Organization (WHO). 2008b. *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*. Available at http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.

World Health Organization (WHO). 2007. *Planning Guide for National Implementation of the Global Strategy for Infant and Young Child Feeding*. Available at http://www.who.int/child_adolescent_health/documents/9789241595193/en/index.html.

World Health Organization Sri Lanka. 2010. "Sri Lanka National Health Promotion Policy," Mimeo. Available at http://whosrilanka.healthrepository.org/bitstream/123456789/290/1/Sri%20Lanka%20National%20Health%20Promotion%20Policy-%20final%20draft-.pdf.

World Health Organization Western Pacific Region (WPRO). 2011. Framework of Action for Revitalisation of Healthy Islands in the Pacific. Available at http://www.wpro.who.int/internet/resources.ashx/PIC/2011/PIC9+6+Healthy+islands_ML+updated+17+June.pdf.

World Health Organization Western Pacific Region (WPRO). 2010. *Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care*. Available at http://www.wpro.who.int/NR/rdonlyres/89BE3251-DD0F-4E61-992B-7C54AD83C048/0/RS_Health_Systems_web.pdf

World Health Organization Western Pacific Region (WPRO). 2009. *Health Financing Strategy for the Asia Pacific Region (2010-2015).* Available at http://www.wpro.who.int/internet/resources.ashx/HCF/HCF+strategy+2010-2015.pdf

Zhaoyang, Zhang. 2011. A Review of Primary Health Care in the People's Republic of China. Report for the World Health Organization. Available at http://www.wpro.who.int/NR/rdonlyres/BC0D99F4-994D-4B4F-9711-560AA0A54377/0/chn.pdf.

Box 1: Renewed Emphasis on Primary Health Care: The Case of China

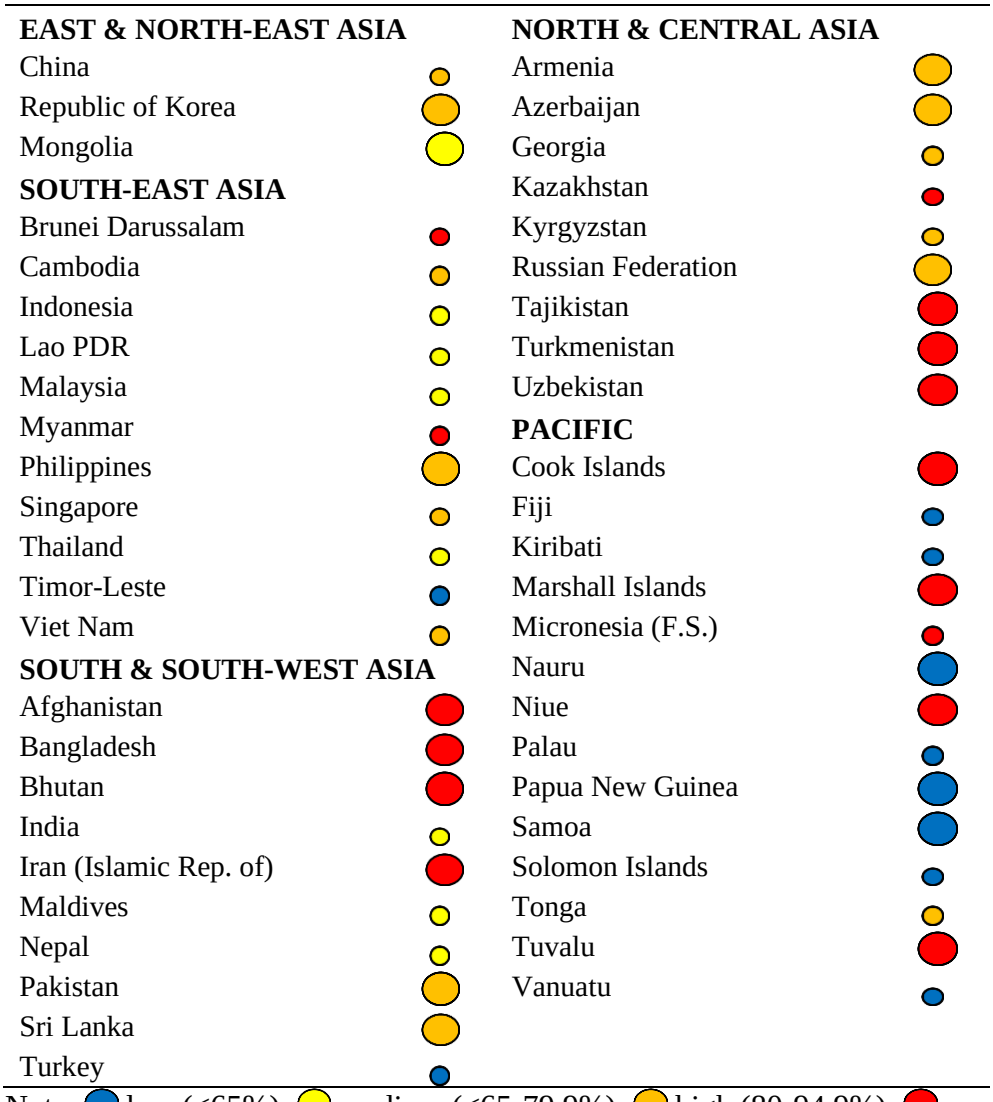
Countries like China appear increasingly to be moving in the direction of a renewed emphasis on primary health care, both in rural and urban areas, in order to address disparities in health achievements. The well-established Cooperative Medical Schemes set up in the early 1950's weakened considerably in the 1980's when the newly-established market mechanism led to reductions in public health investments and the withdrawal of support for the rural health cooperatives. These cuts led to a steep rise in health-related distress in rural areas and to an overall increase in the costs of health care that could not be financed through insurance.[35]

In 2003, the Chinese government announced ambitious national plans to improve primary health care in rural areas, with the aim of providing universal access to primary health services in the rural sector, which encompassed 80 percent of China's population.[36] This plan was expected to contribute to substantial reductions in child mortality and maternal mortality and to bridge the rural-urban divide. Indeed, even for China's hospital-centric urban health care system, the Chinese government had shifted the focus on Community Health Centres (CHC) and Community Health Stations (CHS). This shift started in 1997 due to rising costs of unaffordable and inaccessible health care in urban areas, and intensified after 2003 due in large part to the outbreak of the Severe Acute Respiratory Syndrome. This outbreak was a stark reminder of the importance of organizing a community-based public health system focused on primary medical care.

Chinese health policies have emphasized health equity, universal accessibility, and provision of essential health care at the first level of contact. The Primary Health Care system has led to substantial improvements in health indicators, including 100% immunization coverage, increased access to skilled care at birth, and sharp reductions in the prevalence of several diseases, including polio and TB.[37]

Box 2: Out of Pocket Expenses as a Share of Private Health Expenditures

The figure below shows out of pocket health expenses as a share of private health expenditures in 2009, where ● is a low share (<65%); ● is a medium share (<65-79.9%); ● is a high share (80-94.9%); and ● is a very high share (95-100%). A small circle indicates a falling share since 1999, and a large circle indicates a stable or larger share over time. Overall, out of the ten countries with very low out of pocket expenses as a share of private health expenditures, eight are found in the Pacific. Timor-Leste and Turkey are the only two countries outside of the Pacific with very low out of pocket expenses. At the other extreme, countries with very high out of pocket expenses are relatively concentrated in South & South-West Asia, as well as North & Central Asia. The majority of countries with very high out of pocket expenses have seen an increase or very little change since 1999, implying an extended period of financial burden for households in these countries.



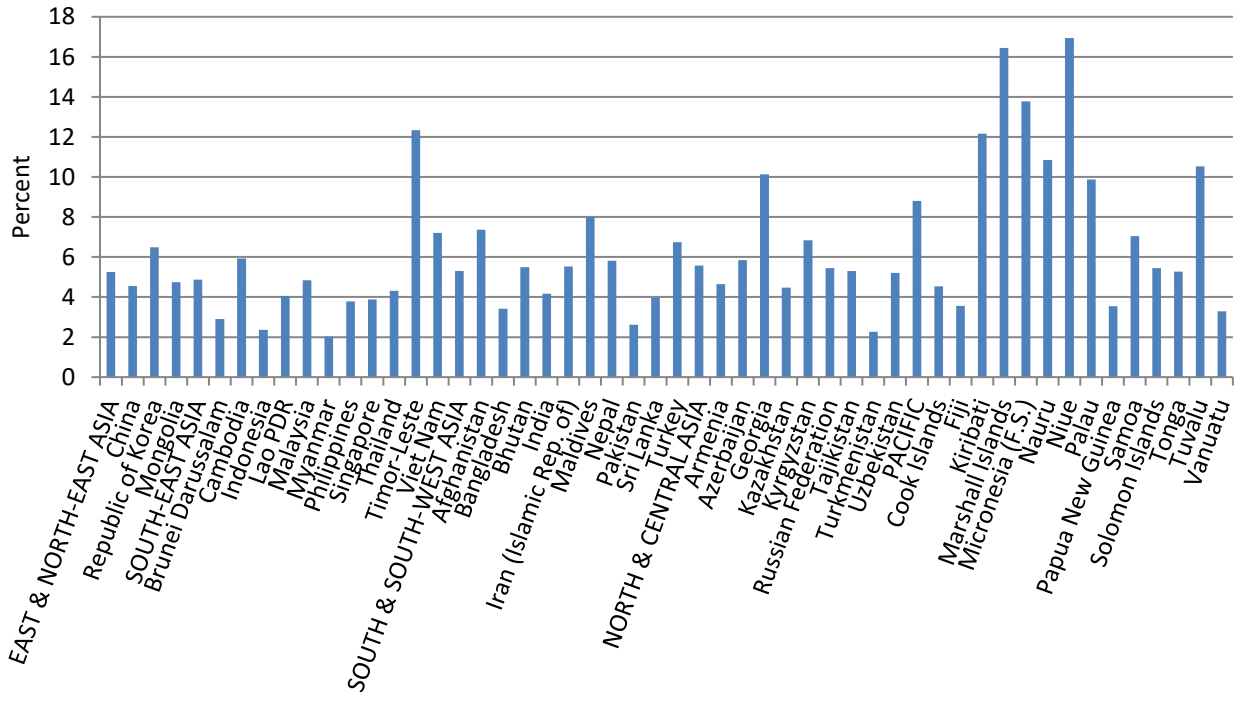
Note: ● low (<65%); ● medium (<65-79.9%); ● high (80-94.9%); ● very high (95-100%). Small circle: negative change (1999-2009); large circle: zero or positive change (1999-2009).
Source: Data for 1999-2009 from National Health Accounts, World Health Organization (2011a)

Box 3: Total Health Expenditures as a Share of Gross Domestic Product (2009)

Among Asia-Pacific regions, the Pacific stands out for having the highest percentage of total health expenditures in GDP as of 2009, the most recent year of data availability.[38] On average, countries in the Pacific had total health expenditures that amounted to 9 percent of GDP, with other regions spending closer to 5 percent of GDP. Driving this high average for the Pacific were Niue, Marshall Islands, the Federated States of Micronesia, and Kiribati, with Nauru and Tuvalu not far behind. One explanation for these high shares compared to other regions is that the Pacific islands tend to have a greater proportion of health expenditures financed by external resources, whereas other regions have higher shares of health expenditures financed by government and private resources.

In Asia-Pacific's other regions, Timor-Leste stands out for having relatively high total health expenditures as a percent of GDP, which is also consistent with external resources playing a larger role in financing health expenditures. In contrast, while Georgia also has fairly high total health expenditures, most of this spending is financed by private resources.

In terms of countries with very low allocations toward health expenditures, many are found in South and South-East Asia. Myanmar has the lowest allocation, with Indonesia, Pakistan, and Brunei Darussalam reporting health expenditure allocations that are not much higher. Turkmenistan also has a very low emphasis on total health expenditures.

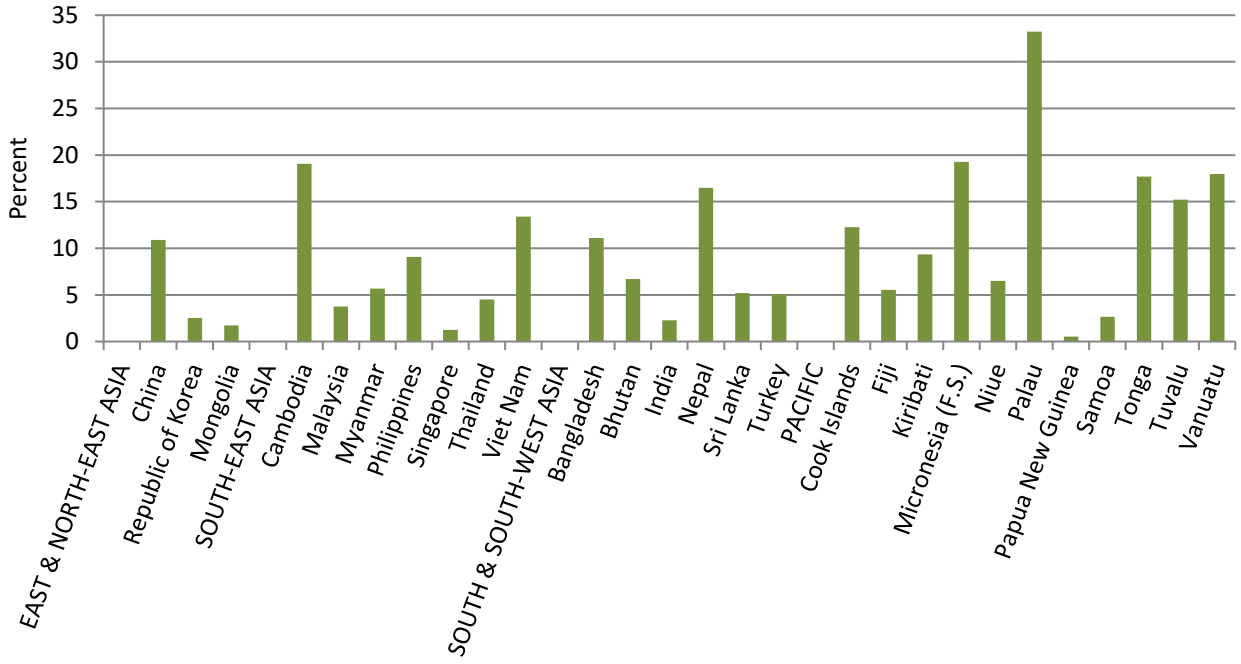


Source: Data for 2009 from National Health Accounts, World Health Organization (2011a).

Box 4: Prevention and Public Health Services / Total Health Expenditures

Although many countries (and especially those in North and Central Asia) did not report health expenditures on prevention and public health services, those countries that did showed considerable variation in allocations. Palau had by far the highest spending on prevention and public health services, at one-third of total health expenditures. A number of other Pacific island countries, including the Federated States of Micronesia, Tonga, and Vanuatu, also had high shares.

Outside of the Pacific, Cambodia, Vietnam, and Nepal all stood out for allocating a relatively high amount of total health expenditures toward prevention and public health services. In contrast, allocations in Singapore, the Republic of Korea, Mongolia, and India were low compared to other Asian economies.



Source: Data for the most recent year with data available in the 2000-2009 period from National Health Accounts, World Health Organization (2011a).

Box 5: A Ray of Hope: The Ganganagar Turnaround [39]

Numerous sources have documented a growing imbalance in India's sex ratio (ratio of females to males) over time. For example, in Rajasthan, India's largest state, the sex ratio among children ages 0-6 years fell steadily from 916 in 1991, to 909 in 2001, and to 883 in 2011. Sex-selective abortions and various forms of neglect of girl children serve as the primary determinants of skewed sex ratios, reflecting a strong parental preference for sons in which sons are seen as assets while daughters are considered liabilities.

A prominent exception to the trend of worsening sex ratios is the case of Sri Ganganagar, the most economically prosperous district in Rajasthan. While Sri Ganganagar had the worst child sex ratio in the state in 2001 (850), it was the only district out of 33 districts to report an increase in the sex ratio by 2011 (854). A number of forces have contributed to this improvement, including NGO interventions, civil society initiatives, support from the government, and efforts by the local media to raise awareness.

In particular, starting in 2006 under the Dignity of Girl Child (DGC) Program, a number of NGOs gained financial support from the International Foundation for Election Systems and the United States Agency for International Development (USAID). The main objective was to boost grassroots and local governance responses against sex selection through community awareness and mobilization regarding issues associated with sex-selective abortions. Additional efforts focused on raising the perceived value of girl children and implementing legislation prohibiting the sex detection of fetuses except under specific medical conditions.

Community mobilization efforts targeted not only households, but also community gatekeepers such as elected local governance functionaries (Panchayati Raj), doctors, lawyers, teachers, and media representatives. Beginning in 2009, the Sri Ganganagar project grew in scope to include ending violence against women and child marriage, along with new measures to address reproductive health. Further interventions included the development of Community Based Response Groups, which exerted pressure against sex selection by increasing awareness, promoting increased value of girl children, and advocating for legal provisions against sex selection. These groups have proven instrumental in bringing sex-selective abortions and other and gender-based discriminatory practices into the public discourse, thus contributing to a new environment of using proactive, inclusive mechanisms to emphasize the dignity of girl children at the local level.

Endnotes

[1] Note that this chapter differentiates between the terms equity and equality in a way that is consistent with Culyer and Wagstaff (1993), which explores four definitions of equity in the context of health care provision: equality of utilization, distribution according to need, equality of access, and equality of health.

[2] These criteria, especially the scale and sustainability of program outcomes and impacts, are consistent with the set of principles of partnership between aid donors and recipients developed under the Paris Declaration on Aid Effectiveness.

[3] Other variously vulnerable groups include the elderly, individuals with disabilities, informal sector workers, migrants and refugees, orphans and vulnerable children (OVC), and prisoners. HIV-specific vulnerable groups include: people living with HIV (PLHIV), male and female sex workers (M&FSW), people who use drugs (PWUD), and men who have sex with men (MSM).

[4] Along with equity, other core values for primary health care include social justice, universality, people-centeredness, community protection, participation, scientific soundness, personal responsibility, self-determination, and self-reliance.

[5] See especially WPRO (2010) for more discussion.

[6] For example, in India in 2004-05, out of pocket expenditures accounted for 4.6 percent of total household spending, and these out of pocket payments caused the poverty headcount to rise from 27.5 to 31.0 percent (Bonu *et al.* 2007).

[7] See WHO (2011b) for more discussion of Essential Health Service Packages.

[8] In addition, while ESPs are part of the sector-wide approaches in several countries, financing for ESPs is often adequate, resulting in the continuation of out of pocket expenditures.

[9] See Ensor *et al.* (2002) for an evaluation of the ESP approach in Bangladesh.

[10] See WHO (2011b), Ensor *et al.* (2002), and McDonagh and Goodburn (2001).

[11] See WPRO (2011) for more discussion of plans to revitalize the Healthy Islands initiative.

[12] See Kanbur and Spence (2010).

[13] For more on the Kerala Paradox, see Kurien (1995).

[14] For a comprehensive study of China's health reforms, see Wagstaff *et al*. (2009).

[15] This discussion of Sri Lanka's achievements in expanding health care coverage draws on Rannan-Eliya and Sikurajapathy (2009).

[16] For further discussion see WHO Sri Lanka (2010).

[17] These figures are from WHO (2010).

[18] However, even a 4 percent target may not be sufficient in itself for countries with very low per capita GDP (WHO 2010).

[19] These initiatives are discussed in Le Gargasson and Salomé (2010). Another option is community-based health insurance, as discussed in Soors *et al.* (2010).

[20] See, for example, the collection of articles in Capacity.org (2011).

[21] These percentages for the urban slum population are from UNESCAP/ADB/UNDP (2010).

[22] See UNDP/SPC (2010).

[23] The arguments in this paragraph draw on Agarwal *et al.* (2007).

[24] It may be difficult in the short term to adequately train and field health personnel in rural and remote locations, thus leaving the next best option of providing additional training for traditional birth attendants for some minimal assistance at birth. Such a strategy is clearly short term and second best, since high rates of maternal mortality are attributed mostly to complications at birth and traditional birth attendants are not sufficiently skilled to handle such complications.

[25] For more information, see Krupp and Madhivanan (2009) and UNDG (2011).

[26] See World Health Organization (2007) for more on this recommendation along with guidance on implementation of its infant and young child feeding recommendations.

[27] Numerous studies support the health benefits of breastfeeding, including American Academy of Pediatrics (2005) and Kramer and Kakuma (2004).

[28] See, for example, Panda and Agarwal (2005).

[29] See Jayachandran and Kuziemko (2009).

[30] Numerous developing country studies have reported a positive association between maternal education and child health. For a review of this literature see Rodgers (2011).

[31] See the discussion in Glewwe (1999) on the channels through which maternal schooling improves child health in developing countries.

[32] The discussion in this sub-section draws on UNDP (2008).

[33] See WHO (2010) for more discussion and evidence on the financing of public health.

[34] See Smith *et al.* (2009) and Thatte *et al.* (2009).

[35] See Hou (2009) for further discussion.

[36] See Chinese Embassy (2002).

[37] See the report by Zhaoyang (2011).

[38] These data on health expenditures were compiled by the WHO using methods to make the data comparable across countries, with further methodological updates scheduled for late 2011.

[39] The material in this box is based on input written by Dr Meeta Singh MD, State Head, Dignity of Girl Child Program, India.