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TOWARDS A HEALTH AND SOCIAL POLICY RESEARCH AGENDA

A Background Paper
Commissioned as Part of the
Overseas Development Administration
Social Policy Work Programme

Morag Reid
Alastair Ager
Fiona O'May
Doreen MacWhannell

Institute for Health Sector Development
0171 253 5064

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Towards a Health and Social Policy Research Agenda

Executive Summary

This background paper is one of three commissioned by ODA to identify a framework for a research strategy for comparative social policy. This paper focuses on social policy issues impacting health and healthcare delivery within developing societies.

Key social challenges to health within developing societies are examined. Social policy initiatives addressing such challenges are placed within historical, economic and political context. The complex relationship between social conditions and health status is illustrated with respect to specific health risks of salience within ODA health and population priority countries. Social sector initiatives which are frequently supported as means of achieving health gain are identified. Specification of the conditions under which such initiatives have proven impact on health status forms the core of the recommended research agenda.

Towards a Health and Social Policy Agenda
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1. The Social Challenges to Health

The health status of developing societies is inextricably linked with prevailing social conditions. In many such societies powerful social forces currently militate against advances in health care provision. This paper begins by an examination of some of these core social challenges to health.

1.1. Urbanization

Whilst necessary for the growth of a developing society, the speed and volume of industrialization has commonly led to the development of poor living conditions in urban areas, compromising the lives, health and social values of millions of people. Currently, approximately 50% of urban populations live at levels of extreme poverty, rising to over 70% in some cities, such as Addis Ababa and Casablanca (Harpham, Lusty & Vaughan, 1987). Overall, health indices suggest that urban residents fare better than rural populations (Santon 1994), but poorest urban communities may endure more nutritionally debilitating conditions than rural counterparts and experience extreme disparities in the distribution of resources and services (Harpham, Lusty & Vaughan, 1987).

Historically, colonization of Africa brought about large scale economically motivated migration of people from rural to urban areas. The current economic crisis and structural adjustment policies introduced by many African governments, have aggravated urban drift and the consequent landlessness and urban poverty. (See section 2.2 for more detail on the macro economic context)

Urban sprawl through rapid the expansion of urban areas complicates efforts to deal with environmental and health problems arising from the location of industries. New migrants and low wage labourers are forced to settle dangerously close to industrial or chemical plants, as was most dramatically evidenced at Bhopal, India.

Urbanization in Africa has drained resources from the rural areas, including girls and women who have come into towns and cities in search of employment (Sanders and Sambo, 1991). Rural women who might have been left to cater for young, elderly or infirm relatives are at risk from their partners who may have formed sexual relationships in the urban area. The possibility of the spread of sexually transmitted diseases including HIV and AIDS to rural areas is thus increased (Santow 1995).

Services are frequently compromised by logistical constraints and the inefficiencies in government infrastructure. Urban health services are frequently established (if at all) long after the population has settled in a location. People move to escape congestion and poverty into areas with poor (or no) health and social service provision. The sprawling slums in many major cities, such as Bombay, Calcutta, and Nairobi, are evidence of the manner in which planning lags behind human need. Shortages of housing, water, schools and environmental sanitation, all contribute to the marginalisation of the urban poor. Tackling the physical symptoms of urban poverty in developing countries without

understanding structural inequalities within urban societies is not a solution; rather, policy makers should address the more difficult questions of structural inequality underpinning differential access to an adequate urban environment (Stephens, 1995).

1.2. Industrialization

Many developing countries either have little experience of industrial regulation or experience pressure to relax environmental laws in order to create favourable conditions for investment by multinational corporations. Specialization of industry, such as heavy metal, or chemical production, generally leads to an increase in water and air pollution, and in solid wastes, which increases the risks of a wide range of health and environmental problems (Weil et al, 1990, p63).

The concentration of wealth and political power, as well as infrastructures in urban areas generally militates against the siting of industries in rural areas, despite the economic benefits of choosing areas where there is an abundance of low-cost labour (Tower, 1986, cited in Weil et al, 1990, p68). Modernization of agriculture has led to new health hazards from the poorly controlled use of pesticides, fertilizers and fungicides. The agricultural models and technologies which are developed, tested in agricultural development projects, and then promoted for adoption may also have a negative impact on the health and nutritional status of rural populations.

1.3. Demographic Change/Dependency Ratios

High population growth rates create a strain on the overall provision of health services and lead to predominantly young population. This places a heavy demand on maternal and child services. Also inherent are high dependency rates, as illustrated by figures for Malawi, showing an increase in the dependency ratio from 0.97 in 1977 to 1.01 in 1987 (Reid, 1993).

Health programmes are inevitably driven by the demographic dynamics of a population, but can also play a major role in shaping the demographic future. Thus, health and family planning programmes alleviate human suffering and promote family welfare, and also ultimately reduce population growth rates. This can have the effect of dramatically shifting the age structure of the population and disease burden to the elderly. Such demographic and epidemiological transitions are occurring rapidly in many developing countries, although at different rates and to different degrees. Sub-Saharan Africa is extreme in having high fertility and high mortality resulting in 46% of the population being under the age of 15, with 60% of all deaths found in this age group, mainly under 5 (Mosley, 1994). The majority of African countries have a declining, or static fertility rate, when compared over the past 20 years, with the exception of Ethiopia, Mali, and the Central African Republic (World Bank, 1994).

The population pyramid in most African countries is symmetrical with a broad base. However, urbanization has produced a prominent bulge on the female side

within many rural settings as a result of migration of young males into the cities, searching for employment (Decosas & Pedneault, 1992).

With the emergence of HIV/AIDS, which has affected primarily the younger, economically viable members of both rural and urban communities, many children are left orphaned, with grandparents or older persons responsible for their welfare, when they themselves may require support. A study in Rakai District, Uganda found that the proportion of children orphaned because of AIDS ranged from 10%-17% of all children, with 31% of orphaned children under the care of their grandparents (Hunter, 1990).

It is projected that AIDS will kill a total of between 1.5-2.9 million women of reproductive age in Africa by the year 2000 (Piot & Carael, 1988). The projected net demographic effect of the AIDS epidemic in Africa is a marked and very selective decrease in population among the young and sexually active age groups. It will also reduce some of the health gains made. For example infant mortality rate in Malawi are expected to rise to 180 per thousand by 2005 because of the impact of AIDS (United Nations 1992).

1.4. Inequality/Poverty

The gap between the health of the world's rich and poor continues to widen. Extreme poverty remains the world's biggest killer and diseases linked to poverty are increasing (WHO Report, 1995). An estimated 1500 million people have no basic health care, and only 44% of the rural population has access to basic medical care (Yunes et al, 1994).

Economic Structural Adjustment Programmes (ESAPS) have been introduced in more than 40 African countries. They have been associated with increasing food insecurity and undernutrition, rising ill-health and decreasing access to health care in the two-thirds or more of the African population that already lives below recognised poverty levels. ESAPs have also affected health policy, with the general loss of a proactive health policy framework and an apparently widening gap between the affected communities and policy makers. The principle of equity in and social responsibility for health care, is increasingly displaced by policies in which health is a marketed commodity and access to health care more an individual responsibility (Loewenson, 1993).

1.5. Gender

Globally expanding female education and the empowering of women is recognized as a critical underpinning of a health development strategy. Improving women's access to formal education, especially in rural areas has multiple benefits. It helps equalize the age of partnership formation; it increases women's competitiveness in the urban economy, helping to eliminate the unequal gender mix among young people in cities; and it is an important factor in contributing to a decrease in fertility, particularly when complemented with better access to birth control methods (Decosas & Pedneault, 1992). In comparison to men, women still have severely restricted access to primary and secondary

education in Africa. In the 24 low-income African countries which reported male to female education ratios in 1991, on average, only 75 girls for every 100 boys attend primary school, and only 60 girls for every 100 boys in secondary school. Similarly, for Pakistan, Bangladesh and India, the primary ratio is 68:100 for primary education, and 48:100 for secondary (World Bank, 1994). In rural areas, the ratio of girls to boys receiving education is even poorer.

With regard to HIV, the multiple, social, economic and cultural burdens carried by the African woman of child-bearing age may pose the major risk of her acquiring HIV (Sanders & Sambo, 1991). Women in Africa generally have limited control over their own lives. Attempts to control HIV spread must recognize the crucial importance of increasing women's economic options through income-generating projects and political initiatives that will strengthen their position and status in society.

With regard to women's health and work, research in Tanzania found that those performing heavy agricultural tasks were at a higher risk of having low-birth weight babies than women engaged in less strenuous work (Kamuzora, 1986, cited in Weil et al, 1990).

Industrial development in developing countries has resulted in serious, but often unreported, health hazards in factories and small sub-contracting shops employing primarily women. In addition to supplementing (or in some cases solely providing) family income, women in most countries are solely responsible for tasks of family care and household maintenance. This 'double burden' increases women's susceptibility to disease, accidents and stress in the workplace (Singh & Kelles-Viitanen, 1987, cited in Weil et al. 1990).

Family planning, i.e. contraception and the spacing of births can radically improve a women's chances of better health, and yet in many developing countries and societies, it remains the male who has effective control over such decisions (Heise & Elias, 1995; Santow, 1995). However, there is a great need for integrated health services, not just those targeted at family planning.

1.6. Environment

There are a number of ways in which the environment is being degraded at an unprecedented rate. These can have a direct impact on the health status of populations. The processes of industrialisation and urbanisation which accompany economic development and the need to feed growing populations cause a variety of environmental problems. For example an estimated 26 billion tons of topsoil is lost every year; more than 6 million hectares of land are turned into desert every year; 20 million hectares of tropical forest are cleared each year - mainly for subsistence and commercial farming; ground water tables are falling in parts of Africa, China and India; deforestation is producing shortages of fuelwood for the rural populations and increasing fuel costs for urban populations. It is estimated that 70% of India's surface water supplies are polluted and that by 2100 65% of rainfed crop land in developing countries will be destroyed by erosion (Save the Children Fund 1990).

These environmental problems have implications across all sectors. The supply of safe water becomes more difficult and expensive as water tables drop and there are fears that reserves are being mined, with insufficient rain to replenish stocks. Deforestation - whether incremental or sudden (such as that which occurred in Zaire around Goma refugee camp in 1994 or Malawi around Lisungwi refugee camp in 1992/3) - creates problems associated with diminishing fuel supplies and makes the land more vulnerable to soil erosion. Land previously considered marginal is now being cultivated which also exacerbates soil erosion. The combination of these can result in poorer nutritional status, increased morbidity and mortality as a result of poor water and sanitation facilities and increased pollution levels.

The impact of environmental degradation on women is significant since they have often to spend more time collecting water and firewood as supplies of both become scarce. This might prevent them from obtaining education which has long term consequences (see section 1.7 below). Thus the cycle of poverty is perpetuated by - and perpetuates - the degradation of the environment.

1.7. Education

It is not the intention here to examine the education sector in depth since this is the subject of a separate paper. However it is important to stress the role played by education in the health and social well-being of populations. The education of women is particularly important (see also section 4.4) for the direct benefits it can have as a result of women's pivotal role as guardians of the family's health. The indirect benefits are also significant. As women become educated and empowered, they are able to become more involved in economic and community activities. Although many of the traditional attitudes to women persist, attitudes and behaviour are changing (Santon 1995).

1.8 Conflict

The end of the 'cold war' - and the resulting curtailment of 'proxy' conflicts between the superpowers - has not eliminated warfare as a major factor influencing the health of nations across the developing world. Within Africa and South-East Asia, especially, the legacy of such conflicts continues. In Cambodia for instance, the widespread laying of mines has resulted in the highest frequency globally of physical disability. The widespread availability of armaments in southern Africa (particularly AK47s) is seen as a major contributing factor to lawlessness and threats to civil society (including health care provision).

Continuing conflicts in Rwanda, the Sudan, and Cambodia constitute major challenges to the health status of these nations, This is not only through the direct impact of warfare on morbidity and mortality. Modern low-intensity warfare is increasingly targeted on civilian populations, their economic livelihood and social infrastructure (Zwi & Ugalde 1991). Thus health status is impacted through the influence of warfare on household production and food supply, and through the loss of - and disruption to - health facilities. Summerfield (1995) notes - from

observations in Central America, South-East Asia and southern Africa - how clinics and other health facilities have increasingly become the direct focus of military action.

2. The Policy Context

This section examines the overall context of health and social policy. Its global perspective, although fraught with the dangers of generalisations, is essential given the shrinking world system in which economic and social developments at the global, national and local level are inextricably linked.

2.1. The Historical Context

Much has been written about the relevance of a nation's historical background to its current social policy (see MacPherson and Midgley (1987) for a summary). Although it is not possible to explore this debate here, a number of points are pertinent. The first is that whilst the heterogeneity of developing countries is evident, there are commonalties which are relevant to this discussion. The colonial era had the effect not only of obscuring and in some cases destroying the traditional welfare systems but also of establishing conditions which today still have a profound influence on the social sector. These include the orientation towards export production, the existence of a centralised and bureaucratic administration system and the presence of economic and social inequalities with patterns of social segregation and elite privilege (MacPherson and Midgley 1987). The welfare services were influenced by external values and approaches with their location and nature to a large extent being determined by the primacy of economic development and the consequent orientation to urban areas. Generally the health and education services were the most developed services with comparatively poor social services and housing provision.

Following independence governments expanded the welfare institutions and services, for example by encouraging primary education and primary health care and considerable improvements were made (Collins et al 1994). Despite this expansion the historical legacy of an externally influenced orientation of social services continues, having been strengthened during the period of the expansion and retaining its primacy during recession (Zaidi 1994).

2.2. The Economic Context

The dependence on primary production which was established in the colonial era has continued in many developing countries since independence, leaving their economic development vulnerable to the global economic climate. The impetus behind the expansion in the economic and social sectors in the 1950s and 1960s came partly from the newly independent nations' desire to improve the welfare of their citizens and partly from the donor nations in an attempt to 'treat' the 'disease' of underdevelopment (Zaidi 1994). The period of growth ended with the recession of the 1970s which saw significant increases in the levels of poverty.

This in turn prompted the donors to concentrate less on the assumption of there being a trickle down effect of economic development and more on 'redistribution with growth' and 'the basic needs approach' (Macpherson & Midgley 1987). At the same time developing countries, faced with increasing costs and a decreasing export values began to borrow funds, a trend which soon precipitated the global economy into the debt crisis. The value of external debt rose from $87 billion in 1970 to $592 billion in 1984, with the servicing of these debts accounting for about 20% of exports by 1983. By 1992 the total external debt for low income countries alone amounted to over $450 billion, with the servicing of this accounting for over 25% of exports for 11 of these countries (World Bank 1994).

Thus by the 1980s the influence of donor governments and agencies had become such that they were able to effect national policy through the ESAPs. These programmes aimed to improve the internal structural problems of developing countries which were identified as one of the causes of the debt crisis. This was to be done by increasing export earnings, controlling imports and trimming government expenditure. The policies were therefore characterised by cuts in the civil service, rising prices for imported goods and a continued concentration on export - often primary - products. The negative impact on household income balances has been such that poverty, it has been argued, has become the biggest killer in the world today (WHO 1995). Today the net flow of funds amounts to $60 billion per year - from the South to the North (Loewenson 1993).

Whilst widespread criticism of these policies supported by information emerging about their impact (particularly on the poorest in society) has led to a softening of the approach and an emphasis on supporting the health and social sectors (World Bank 1993a), the underlying principles continue to be advocated (Zaidi 1994, Loewenson 1993). It remains to be seen whether this policy of structural adjustment will in due course provide the conditions for real and sustained growth and an improvement in the welfare of all citizens. Meanwhile it is important that the situation regarding the positive and negative impact on the health and social sectors is monitored and that methods to alleviate any problems which result are explored.

2.3. The Political context

The political context of developing countries are as much a product of global trends as their economies are. It has been argued that the economic and political agenda of developing countries have always been dictated - to a greater or lesser extent - by external factors (Zaidi 1994). "The fundamental purpose of development policy is to determine the progress (or lack of it in some rare cases) of citizens or other intended beneficiaries. As such, policy is not an exclusive prerogative of governments." (Mburu 1994 p 1375). Thus it is relevant to examine the roles of the various actors involved in the policy arena - governments, donors, NGOs, the private sector and communities and will acknowledge how difficult it is to disentangle each one.

The economic crises of the 1970s and 1980s revealed that the previous stability of governments had masked a high degree of rigidity and bureaucratisation

(Belmartino 1994) which may initially have been the legacy of the colonial era. Loewenson (1993) argued that in post independent Africa the role of the state was as an instrument for social transformation through public sector driven reform, but that it had monopolised this role to such an extent that no sense of civil society had developed to complement it. Reform of this central inertia was thus one of the targets of ESAPs and policies were adopted which aimed to reduce governmental responsibility in the public sector. The World Bank (1991) recommended that the financing of services and their provision should move from the government sector using four mechanisms: user charges, insurance, the de-restriction of the private sector and decentralisation. The 1993 World Development Report suggested that the challenge for governments would be to "withdraw from areas of health care provision best left to the private sector while concentrating resources and attention on things which only government can do: responding to market failures ... and investing in health and education for the poor" (World Bank 1993). It is important to note that even though its role might diminish, the state still plays and will continue to play a central role in policy making, regulation, monitoring and, to various degrees, service provision (Walt 1994).

As the role of the state has changed so has the role of the donors. In 1990 assistance to the health sector in developing countries from donor countries amounted to $4.8 billion - $3.9 billion of which came from public sources (Michaud and Murray 1994). Of this $1.9 billion came from bilateral agencies, $1.6 billion from the UN, $0.8 billion from NGOs and $0.4 billion from banks. The donors' influence in the policy arena has increased along with their funding levels - whether through loans or grants. The World Bank provides a useful example. Its involvement in the health and social sector grew out of its concern about the population increase which it saw as undermining economic advancement. (The debate about whether poverty causes high fertility rates or vice versa will not be included here - see Lane 1994.) Its support moved from health systems development towards projects and gradually it asserted its leadership in the policy arena with two reports: Financing health services in developing countries: an agenda for reform (World Bank 1987) and the World Development Report 1993: investing in health (World Bank 1993). The volume of its disbursements - about $1 billion goes to the population health and nutrition sector every year - puts it ahead of the 'traditional' health sector agencies, WHO and UNICEF (Buse 1994). It could be argued that this level of support gives it considerable leverage in the social and health sectors, though World Bank executives are keen to emphasise the importance of collaborating with other donor agencies and with host governments (Choo 1995).

The extent to which donors' agendas are decided at their headquarters, thus suggesting a 'one size fits all' policy, is a cause for concern. For example one criticism of the 1993 World Development Report was that it was simplistic and unrealistic given the situation in the poorest countries which do not have the institutional or material capacity to implement the policies outlined (Save the Children Fund 1993).

It seems that there is a gap between governments' and donors' policies and priorities. The fact that 55% of World Bank conditions in structural adjustment

programmes are not fully implemented by the last tranche might indicate a mismatch of policies (Walt & Gilson 1994). There are also problems relating to the funding priorities. Michaud and Murray (1994) analysed donor funds for particular diseases. They conclude that important causes of morbidity and mortality - such as acute respiratory infection and malaria - received a fraction of that received by programmes dealing with leprosy, sexually transmitted diseases or blinding conditions as measured by funds per disability adjusted life year (DALY). They also noted that it appeared that smaller and poorer countries received more funds and that the decision did not appear to relate to health need. They quoted Drager et al (1992) who stated that health assistance is unrelated to need and is therefore entirely political.

Donors' priority for reform "as distinct from gradual or incremental change" (Foster et at 1994 p175) implies an underestimate of the timescale required and the obstacles to implementing radical policy changes within poorly resourced environments (Save the Children Fund 1993).

One priority must therefore be to investigate practical ways in which donors, governments and other relevant parties can work in a co-operative manner in order to address the real issues in the health and social sector. This process has begun in Malawi where the government, donors and NGOs are working on specific areas of the health sector which need to be developed. Save the Children Fund (1993) recommended that

> the way forward lies through long-term partnerships for health systems development, through which ideas tailored to local circumstances can be tried out, monitored, and modified in the light of experience, backed by greatly expanded, consistent and co-ordinated external support for recurrent funding of public health services (p2).

Two other groups which would be involved in this process are the private sector (which are considered in section 2.4.2) and NGOs. Gilson et al (1994) outlined the four functions of NGOs in the health sector as: service provision; social welfare activities; support activities such as training; and research and advocacy. NGOs' potential strengths lie in their flexibility, closeness to the community, high quality inputs and efficiency. These strengths have ensured that they are increasingly viewed by donors as appropriate partner and implementation agencies, often in preference to government departments (Charlton et al 1994). Whilst this has prompted an expansion in the number of NGOs, their activities and the funds channeled through them, the issues of financial and political independence, co-ordination and their relationship to government and government policy are being raised (Edwards & Holme 1992). This issue is examined further in section 4.5.

The intended beneficiaries of health and social sector services - individuals and their communities - form a final part of the political context. As with the private sector and NGOs, the heterogeneity of this group makes it impossible to apply generalisations. Specific issues relating to communities and to women within them will be explored further in sections 4.3 and 4.4.

2.4. Current Policy Issues

2.4.1. Centralisation / decentralisation

One of the legacies of the colonial era was a large centralised administration which has continued to be a feature of many developing countries. It has been regarded by many observers (for example MacPherson and Murray 1987) as an obstacle to the development of the country and the promotion of greater equality within it. Zaidi (1994) traced the emergence and subsequent consolidation of an elite whose interests are best served by a continuation of the centralised system and who support the biomedical model of health care. There are therefore strong historical and political reasons for the continuation of a centralised government.

Recent trends in donor policy include the shift towards greater decentralisation of decision making and services, the move away from the centralised and bureaucratic administration of health and social services being seen as a way not only of improving efficiency but also of improving the services' responsiveness to local needs.

> Decentralisation of government health services is potentially the most important force for improving efficiency and responding to local health conditions and demands. It will be successful only when local government agencies and hospitals have a sound financial base, solid administrative capacity and incentives for improving efficiency - and when they are accountable to patients and local citizens (World Development Report 1993 p 163).

This philosophy applies equally to social services.

There is no doubt that in general the concentration of decision making and services in urban areas is technically and allocatively inefficient. Mburu (1994) for example shows how the large tertiary hospitals in Southern Africa predominantly serve the local population predominantly. With the increasing scarcity or resources and the increasing demand for better access and services, this system is clearly ineffective, inefficient and serves to exacerbate the inequalities existing in health and social services.

There are three specific developments which are required for the development of decentralised decision making and services. The first is to strengthen the management capacity at the regional or district level so that they are able to provide relevant and good quality services to their population. The second, which is related to the first, is the empowerment of local communities so that they are genuinely involved in the decision making and service provision. (Community participation will be examined in section 4.3.) The last is, paradoxically perhaps, the strengthening of the management capacity at the central level so that the roles of policy

making, planning and monitoring outlined by Walt (1994) can be relevant and of high quality. Morley (1994) advocated the development of scientific, analytical and technical capacities within the Ministry of Health so that it could serve the needs of the districts more effectively. It is thus not simply a matter of concentrating solely on the lower administrative strata, but of simultaneously strengthening the overall system to ensure that each level fulfills the functions most appropriately located there.

2.4.2. Increasing the scope of the private sector

The increasing scope of the private sector is a second key policy issue currently and is sometimes confused with decentralisation (Collins and Green 1994) . They defined the former as the transfer of authority, functions and / or resources from the public to the private sector and the latter as being the transfer of the same from the centre to the periphery within a specific sector. It is the former that is now examined.

The advocacy of market principles became pronounced in the 1980s within donor countries with debate focusing on the comparative advantages of the private versus the public sector. One question concerned whether, given the increasing demands placed upon it, the state should or could provide the current level of services in the health and social sectors. The debate initially had a strong ideological slant but with the greater understanding of the complexity of the issues it has since focused more on operational issues (Belmartino 1994).

Supporters of the market put forward their three interlinked tenets (Collins et al 1994). The first was the division of the financing functions from the provision of services. Thus ministries would become purchasers of services and able to dictate quality standards. The second was the competition provided by a market setting which would encourage providers to improve efficiency, quality and choice in order to compete successfully with other providers. The third was the shift from social and collective to individual responsibility which would ensure that services were made more relevant and appropriate to the consumer and would shift the resourcing of services from taxation towards user charges.

The opponents of the application of market principles to the health sector argued that these principles would at best be limited because of the specific conditions found in the health sector such as externalities, the agency relationship and the lack of perfect information. Further they highlighted concerns that "although economic theory would suggest that private providers are more efficient technically, tendency to over provide services, combined with higher prices, may mean that fewer people are adequately treated" (WHO 1992 p47).

Despite this inconclusive debate, the donors, through structural adjustment programmes and their health and social sector policies, promoted various market oriented policies. For example the contracting out of support and

clinical services is being implemented in countries such as Zimbabwe, Pakistan and Mexico (McPake & Banda 1994). The World Development Report (1993b) recommended an expanded private sector to such an extent that the role of the state in service provision should be diminished to being the filler of any gaps left (Save the Children Fund 1993). This despite a statement from the World Bank that "a private sector can cooperate only if it works within the environment of a well functioning market system, which provides price signals that accurately reflect the social and financial costs of production" (cited in Belmartino 1994 p1316).

Creese (1993) summed the situation up:

> I wish to show that *both* markets and governments lack the competence to define and implement efficient and equitable health systems. This is because of the intrinsic complexity of the health care market, and consequently the sophisticated nature of information and skills necessary to manage it (p1)

The impact of increasing the role of the private sector will be examined in section 4.2.

2.4.3 Financing health care

"Health reforms are usually brought on by a lack of finances and most involve a search for new or supplementary mechanisms of funding. Besides generating additional revenue for health the reformers often seek to stabilise the source of funding or to diversify away from single sources, particularly general taxation, and turn to user fees, earmarked taxes, or social insurance" (Foster, Normand & Sheaff 1994, p 176). The increasing burden being placed on health services coupled with falling tax revenues due to the economic recession faced by many countries has prompted governments and donors to seek alternative forms of financing. This has in many cases meant that the policy of free health care and education has had to be abandoned.

The main alternatives to taxation based funding are social insurance, user charges and the expansion of the private sector. The last two are examined in greater depth in sections 4.1 and 4.2 respectively. Social insurance systems have been fore runners to national health systems with their premiums based on income rather than health status which is the case with private insurance schemes. As such they are more equitable and can constitute a progressive taxation. They also have the advantages of economies of scale. Their disadvantages include the problem of 'paper rights' whereby a person might be covered by social insurance but there are no health facilities available. In addition there is the problem that there are no incentives for providers to be efficient (Green 1992).

3. The Relationship Between Social Conditions and Health Status

Desjarlais et al. (1995), in conclusion to their global review of factor influencing world mental health, note:

> Policies that encourage gainful employment, reduce poverty, protect the environment, improve the quality of leisure, and provide universal basic education, primary health care, decent housing, and adequate nutrition are all prima facie beneficial. They are not merely a concession to an abstract vision of social justice; they have real effects on the health of individuals and communities. (p.270)

Hertz et al. (1994) identify a similar listing of social conditions favourable to health status following regression analysis of a number of country profiles:

> ....better health and nutrition is produced by the synergistic action of improved sanitation, higher levels of education, controlled overpopulation and more equitable distribution of economic resources, better housing, increased investment, higher wages and generally more extensive welfare services. (p. 113)

Such enumeration of the social conditions conducive to health is informative, but of constrained value for social policy makers for two distinct reasons. First is the familiar issue of finite resources. Such listings provide little guidance with regard to priorities for action with respect to prevailing social conditions when resource limitations severely constrain latitude for social policy initiatives.

Second, and rather more subtly, such listings only identify the generalised potency of social conditions on health outcomes. They indicate little or nothing of the complex interrelationship between social conditions and health status in specific settings, where circumstances can significantly mediate generally established relationships. The social policy research agenda needs increasingly to focus away from gross generalisation and much more on the effectiveness of policy in specific circumstances. The focus of such work is identification of those circumstances where policies are of proven effectiveness and those where anticipated effects are constrained.

Whilst the broad principle of linkage between social conditions and health status is now generally accepted, the intricacy of the relationship between the two is seldom fully acknowledged in the course of development planning. Greater understanding of such relationships will assist in identifying the areas where inter-sectoral collaboration is most crucial. The potential roles of Ministries of Education, Ministries of Community Services, Ministries of Forestry and Natural Resources and Ministries of Trade and Industry - in addition to Ministries of Health - in fostering health gain need to be defined with respect to identified linkage between conditions influenced by the work of such ministries and health status.

Social conditions may be seen to influence health and healthcare provision with respect to a very broad range of conditions. However, their influence with respect to such health challenges as provision for the elderly, mental illness, HIV/AIDS, disability and substance abuse is particularly significant. These not only represent some of the major challenges to health and social care systems of many of ODA's health and population priority countries, they also demand the broadest analysis in terms of the influence of policy and programmes across ministerial sectors. The latter three are considered here in some detail as a means to illustrate the range of factors which mediate the relationship between social development and health status, and which therefore need to be considered when formulating social policy initiatives targeting health gain.

3.1. HIV / AIDS

The transmission of the HIV virus is a health-impacting event with a well-documented association with changing social conditions. Caldwell et al (1989) provide a persuasive case regarding the pre-existing vulnerability of sub-Saharan African societies to heterosexual transmission of HIV. However, their own work documents the manner in which the increasing potential for educational advancement of women, within the context of economic constraints on their completion of schooling, puts young girls at considerable risk of coercive sexual relationships with a high risk of HIV transmission. Many of the girls interviewed by Caldwell et al (1989) saw the maintenance of a sexual relationship with an older man as an adaptive strategy to ensure completion of their schooling. The social trends encouraging greater educational and career ambition in women, without the provision of public funding to facilitate more prolonged educational attendance directly, may be seen to have put a sector of the population at significantly increased health risk.

The policies of labour pool expansion and industrialisation pursued by the Ceausescu regime in Romania provide perhaps the starkest illustration of the manner in which changes in social conditions have facilitated the spread of HIV. The institutionalisation of some 2% of the nation's children as a direct result of such policies (Ager 1995) provided a child population at considerably risk for cross-infection by HIV. Industrialisation within sub-Saharan Africa and South Asia has produced, albeit by differing means, similar exacerbation of health risk (Barrett & Blaikie 1992). Increased mobility and the growth of transit worker populations have been indicated as significant predictors of increased HIV transmission rates. Economic development, more generally, can be argued to have a general impact on the loosening of social conventions, creating shifts in risk profile for sexually transmitted diseases such as AIDS.

Recent discussion has suggested that the failure of many social sector initiatives regarding containment of HIV transmission may be attributed to a limited analysis of the key environmental determinants of health-related behaviours (Good 1995). Good's analysis suggests that health educational approaches are tangential to the key social and economic factors determining shifts in sexual behaviour, and that more radical linkage of social circumstances to health status (e.g. financial

payments for remaining HIV negative) are required. Such an approach, whilst raising a number of ethical and practical implementation issues, serves to illustrate the manner in which forms of social engineering might be explored for the purpose of achieving health gain.

3.2. Disability

The functional handicap associated with any given disability is determined by the social context in which it is exhibited (Helander et al. 1984). Advances in the literacy base of any society inevitably leads to increases in the functional demands made on citizens, and thus an increase in the number of members of the society for whom disability constitutes a functional social handicap. In raising expectations and demands regarding social competence, social development can thus serve to increase social care needs (Baine 1990).

Social conditions not only determine the functional impact of disability, they determine appropriate responses to its amelioration. Community-based rehabilitation, for example, is founded on the premise that it mobilises 'untapped' resources within communities for the support, care and training of disabled citizens (Helander et al. 1984, Ager 1990a). The genuine resource viability of many communities within the developing world to sustain such programmes has, however, been questioned (Miles 1985). Planning can too easily be predicated upon unreasonable assumptions regarding both the time availability of community participants and shared understandings of appropriate therapeutic goals. This is not to argue that community-based programmes have no role, simply to acknowledge that there is a finite limit to the 'elasticity' within communities to support initiatives of this nature.

More generally, the pre-conditions for the sustainability of services are poorly understood (Ager 1990b). The global reorientation of services from an institutional- to a community-focus is to be welcomed to the extent that it supports the social integration of individuals with disability within mainstream society. But for such a policy to be effective requires a considerably more sophisticated analysis of the pre-conditions for effective and valued service-delivery than is currently generally undertaken. The construction of ecological inventories (Baine 1990) and specification of prevailing cultural assets and values (Ager 1990b) is a move in this direction.

3.3. Substance Abuse

Substance abuse is a growing global problem, with recent estimates that alcohol-related diseases alone may affect up to 10% of the world's population each year (World Bank 1993 b). Whilst an increasing proportion of the 'market' for illicit drugs is now in Asia, Africa and Latin America (Desjarlais et al. 1995), the complex connection between changes in social conditions and health risk in this area is perhaps best illustrated with regard to the consumption of alcohol.

A high level of alcohol consumption is a common feature within a wide range of traditional societies, where it often plays a significant role within cultural and

ceremonial functions. Such conventional use has obvious implications for the base-rate of alcohol-related disorders. However, whilst there is a paucity of precise data on the severity and consequences of alcohol problems in non-western cultures, there are a number of indications that there has been a steady growth in consumption in such settings (Babor 1993). One recent estimate suggests that between 15 to 20% of adults in Latin America are alcoholics or excessive drinkers (Coombs and Globetti 1986).

Desjarlais et al. (1995) explicitly link such trends to such factors as "speed of social change, rapid urbanization and growing disparity between social groups" (p.87). Desjarlais et al.'s analysis identifies the role of alcohol as a means of absorbing social tensions, quoting from Wolcott's work in Bulawayo (Wolcott 1974) where beer-drinking was encouraged to the extent that it "facilitated rapport and prompted social solidarity; it dissipated some pent-up hostility and frustration....and it contributed to accepting things as they were". To the extent that alcohol serves this form of social function, many governments may feel unsure of the consequences of policies seeking health gain through the restriction of alcohol consumption.

Alcohol abuse illustrates well the circumstance where social conditions and health risk interact in a complex and potentially paradoxical manner, with health gain potentially being seen to put at risk social cohesion. The developing formal and informal beer industry within sub-Saharan Africa also brings local and central economic benefits which may militate against social policy programmes targeted at achieving maximal health gain (Babor 1993). A similar analysis holds for the tobacco industry, and - at a local level at least - to trade in illicit drugs.

3.4. The Social Ecology of Health

Each of these examples illustrates the importance of developing an understanding of the social ecology of health, that is, the manner in which health and disease behaviour is embedded in a complex manner within social conditions. Social policy initiatives based on a 'uni-dimensional' analysis of health and disease (e.g. reducing alcohol availability by legal prohibition) are often likely to prove ineffective and/or to bring unanticipated disbenefits. Rather, social policy initiatives need to be based upon a clear analysis of those factors which are pre-conditions for their effectiveness, and those which are likely to serve to constrain them. The following section develops this theme by noting certain social sector initiatives which have a presumed impact on health outcome. For each of these a deeper understanding of the facilitating and inhibiting effect of social conditions (e.g. *in what circumstances* is community participation *effective* in mobilising health resources?) is vital to guide future health policy. Such analysis is particularly significant to the extent that it informs the potential role of non-healthcare sectors in effecting health gain.

4. Social Sector Initiatives Which Have A Presumed Impact On Health

Having reviewed the main issues confronting the health and social sectors and their historical, economic and political context, this section examines five initiatives which have been embraced as ways of improving health status through social and economic engineering. By briefly reviewing these developments and their degree of success, the emerging research agenda will be identified in section 5.

4.1. User charges

As economic conditions in developing countries deteriorated, so the ideal of free health care at the point of delivery enshrined in so many newly independent states was compromised. Donors were instrumental in the trend towards the adoption of user charges for services.

4.1.1. Rationale for the introduction of user charges

There are a number of reasons for introducing user charges. Firstly there is the objective of raising revenue which may be partly or wholly reinvested in the service. Income from user charges is only ever likely to realize 5 to 10% of the costs of running services and are thus means of cost sharing and not cost recovery. Income from the drug revolving funds - whereby patients are charged for drugs with the revenue used to ensure their continuing supply - is an example of the reinvestment of revenue from charges. This sort of scheme has been successfully implemented in some instances, for example in Khartoum where it forms part of an urban primary health care programme run by the Ministry of Health and Save the Children Fund (personal communication).

Another principle behind user charges is that introducing a systems with charges and exemptions might foster vertical equity, with only those able to pay doing so. One example where this philosophy is being pursued is found in Malawi where an NGO offering family planning services, Banja La Mstogolo, plans to open clinics in rural trading centres where the charges would be lower than, and thus subsidized by, the urban clinics which currently offer services to the better off urban population (Reid 1993).

In some countries, such as Malawi, there are discrepancies between government health facilities which do not charge patients and mission facilities which do. User charges may help to address the consequent distortion of referral patterns and health facility usage which has exacerbated the inefficiency of the health system might be resolved (Reid 1993).

One final stimulus to the introduction of user fees is the impact it might have on raising the quality of services not only by ensuring that supplies and facilities are maintained but also since by paying fees the status of the patient is raised to that of consumer (Foster et al 1994). For example in Uganda it was argued that mission hospitals were able to provide better

quality of care because of the extra revenue they obtained through charges (Okuonzi & Macrae 1995).

4.1.2. The potential negative impact of levying user charges

Although there are sound reasons for the introduction of user charges and examples where this has been done successfully, there are a number of concerns regarding this policy.

The first is the impact user charges are likely to have on the very poor (Werner 1993). Given the deteriorating economic conditions an increasing number of people are experiencing, it is highly questionable whether user charges are affordable for a significant proportion of people in developing countries. Thus the poorest suffer the double burden of a disproportionate level of morbidity and the inability to pay for services they need. Although there are systems of exemptions for the poor these are difficult to implement and become less relevant as the levels of absolute poverty rise. The principle of equity is therefore likely to be compromised by the introduction of user charges (Foster et al 1994) with existing inequalities likely to worsen (Okuonzi & Macrae 1995).

There is mounting evidence that the usage of health facilities has decreased because of user charges which is seen as one cause of poorer health status indicators. For example in Zimbabwe fewer women registered for ante-natal care since the introduction of user fees and maternal and infant mortality rates are rising again (Oxfam 1995). Haddad & Fournier (1995) found that the utilization of Zaire's health services had dropped by 40% between 1987 and 1991, with between 18 and 32% of this decrease due to the cost to patients. Whilst a decrease in the use of services might not in itself be undesirable, since such a trend might indicate more effective services (Vlassoff 1994), given the needs of the poorest populations it is likely to have a negative impact on their health status.

Linked to this is the fact that if the poor cannot afford the charges not only will they suffer from being unable to use the services, but also the health system will not be able to realize the financial benefits of the policy. (Okuonzi & Macrae 1995). Thus the policy might result in poorer health and poorer health services and facilities.

"There seems to be a worrying trend (at least in terms of a move away from any policy of equity) to promote the idea that people do not appreciate what they do not pay for" (Macdonald 1992 p 135). Vlassoff (1994) suggested that it was unlikely that people in developing countries sought services because they were free. The introduction of user charges would thus have no impact on these unproven beliefs.

Paying for services - whether in cash or kind - is not new in developing countries, for example 'traditional' healers or birth attendants are paid for

their services. The question is whether the services being offered are of sufficient quality and relevance that people will find the resources to pay for them. Timyan et al (1993) showed considerable evidence of willingness to pay if services were of high quality.

It is therefore important that any introduction of user charges is preceded by a careful analysis of ability to pay and the ability of the system to deliver high quality services. Gilson (1995) concluded that whilst fees may improve the availability and may improve quality, the organization and management problems must be addressed to ensure that charges do not constitute regressive taxation with the negative impact that would have on health status.

4.2. Increasing The Scope of the Private Sector

As was noted in section *2.4.4* the scope of the private sector in the health and social sectors was expanded with the support of the donors in an attempt to improve the efficiency and quality of services. Three aspects of this expansion and the likely impact it will have are discussed below.

The first is the expansion in the private sector in delivering health care services. The potential benefits of the private provision of services are that it increases choice, quality and efficiency (World Bank 1993b) because it is open to competition from other providers and because it treats patients as consumers. However these benefits are not necessarily realized - "it is not apparent that the private sector will always offer services more efficiently than the public sector" (Belmartino 1994 p1318). WHO commented "although economic theory would suggest that private providers are more efficient technically, tendency to over-provide services, combined with higher prices, may mean that fewer people are adequately treated" (WHO 1992 p47).The cost inflation and relatively poor health status indicators of USA demonstrates this (World Bank 1993b).

Yesudian (1994) examined the behaviour of the private sector in Bombay and found evidence of poor quality with inadequate material and human resources and medical malpractice. He concluded that regulatory mechanisms were not effective and minimum standards were required. This would coincide with the World Bank's view (1993b) that regulation is one of the key roles for the state sector.

Apart from criticisms of specific private systems, there are the general concerns that a private sector has the effect of exacerbating the concentration of health services in urban areas (Okuonzi & Macrae 1995) and that there are tensions surrounding the accountability of the private sector (Collins et al 1994). Also given the absolute lack of resources available to a large section of developing countries' populations, it is unlikely that the private sector could provide a real choice and instead fosters allocative inefficiency.

The second aspect of privatization is the contracting out of services. McPake and Banda (1994) reviewed the current situation in developing countries and

questioned where there could be real competition to make it viable and whether there are the necessary skills available at all levels of the system. They concluded that it is unlikely that the conditions for extensive contracting out of clinical services currently exist in most developing countries but that the information and human resources needs might begin to be developed in the urban areas.

The third aspect of the move towards privatization is the separation of the financing and resource allocation functions from the service provision. Thus in Kenya the government will cease to be a provider of care and will instead function as a purchaser, regulator and policy maker. This is a recent development in the UK's national health service and has been accompanied by the internal market whereby providers within the public sector compete with each other and with the private sector to win contracts from purchasing authorities. The impact of this in terms of efficiency and quality has not yet been established and Collins et al (1994) warn that the considerable advances made in developing countries should not be sacrificed for fashionable unproven dogma. It might be a question of the degree to which developing countries might follow this path once the benefits have been established.

4.3. Community Participation

The trend towards encouraging community participation might be seen as part of the policy of downgrading the role of the state and shifting responsibility from the central to the peripheral levels. Macdonald (1992) suggested that the notion of participation or self reliance had been used in colonial times "as a means of masking central government's abdication of responsibility for some of the needs of the rural population" (p95).

In the 1960s and 1970s 'people centred development' and 'people participation' were increasingly promoted as means of addressing the problems of marginalisation and ensuring that services were relevant to people's needs.

Cohen and Uphoff's research in the late 1970s produced a taxonomy of participation with the most important being participation in implementation, in benefits, in decision making and in evaluation (Cohen and Uphoff cited in Macdonald 1992). Of these the last two, which are closely related, were identified as the most significant but least common. Participation is thus more that just getting communities to assist in providing facilities or allowing them to be beneficiaries of services.

Participatory development

> includes equitable sharing of the control, division, and use of the resources and of the ultimate benefits of development in a community. It also involves taking responsibility and being accountable to the community at all levels. This will be just wishful thinking if the decision making structure remains alien, bureaucratic and elitist. Rather the structures must be made more comprehensible and acceptable to the people. The best way

> of doing this is to look at existing cultural systems and integrate the decision-making structures into them (Anacleti 1993 p46).

There are many examples of community participation having been developed, but the extent of their success however hinges on a number of issues. First is the fact that communities are not homogenous entities and thus any attempt at facilitating community participation must be relevant to the socio-economic, political and cultural context. Second is the tendency noted by Eyben and Ladbury (1995) that the degree of participation is partly related to the extent to which the project benefits the whole community. Thus agricultural, forestry and water projects are supported more than health or education projects. Thirdly there is evidence (for example in Malawi - Government of Malawi 1993) that development programmes and services have bypassed the vulnerable groups since institutional structures have been inadequate to involve the poor and vulnerable groups and that there is a tendency for benefits to be hijacked by those already with power and influence (Macdonald 1992).

Community participation has been viewed as a method of control which satisfies the politico-ideological goals of agencies (Zaidi 1994). Stone (1992) concludes that community participation serves more to reinforce the ideological perceptions of its promoters - those of democracy, equality and self reliance - than to provide benefits to those it aims to assist.

Most importantly true participation is about the redistribution of power and this "involves some form of conflict, not necessarily violent, but nevertheless some readiness to take on board adjustments called for in redistribution of power (Macdonald 1993 p97). Since active participation is by its very nature 'subversive'

> because it encourages people to confront the causes of poverty, motivates dissent and offers hope of positive change. For these reasons it will be opposed by those who have benefited from existing social relations in the countryside including, paradoxically the national elite and international agencies that promote the competition in the first place (Morgan 1990 p218).

The desirability of empowering people through community participation is reinforced by the notion of good governance and democratization which donor countries have attached as a condition for development aid. One example was the withdrawal of non humanitarian aid to Malawi by donors in 1992 at a time when the ruling party failed to introduce democracy. Aid was restored once a free election was called following a referendum on multi party democracy in 1993.

Community financing schemes - methods of raising funds at the community level, such as Unicef's Bamako initiative - might be linked to service use (for example revolving drug funds) or might be genuinely community based (Green 1992). Whilst it has been argued that this not only provides a means of participation but also ensures income, supplies and high quality services, Haddad and Fournier (1995) showed that in Zaire utilization of services decreased because of the costs

of drugs. The key question is whether the community is able to support such schemes - whether they be in a form of pre-paid community taxes or, in the case of revolving drug funds, in the form of individually based user charges (Green 1992). The level of resources available to a community is therefore of paramount importance when considering the likely success of a community financing scheme.

Community participation thus cannot be a 'magic bullet' but instead should be seen as an integral part of broad based development requiring resources and commitment over a long period of time. Macdonald (1992) points to the need of 'participatory epidemiology' which would ascertain communities' perceptions and needs. It also requires a channel whereby views and ideas can be exchanged and plans made.

The integration of such indigenous understandings within health and social care planning is particularly crucial where planned behaviour change is a key element within a strategy. The proliferation of KAP (Knowledge-Attitudes-Practice) surveys in such areas as AIDS prevention and prevention of tropical disease (e.g. Ager 1992, Forster and Furley 1989, Irwin et al. 1991, Mehryer et al. 1991, Nicholl et al. 1993, Wilkins et al. 1989) may be seen as an attempt to ensure that communites' understandings of health and behaviour play a determining role in planned intervention. However, the theoretical analysis used to relate elicited beliefs to robust and potent actions targeting health gain is often somewhat naive.

There is considerable evidence that expressed values and attitudes bear little direct control over a broad range of health behaviours (Prochaska, DiClemente & Norcross 1992). This clearly questions the appropriateness of health education (in its traditional forms) as the primary focus of many preventive programmes. Rather, a broader conceptualisation of the 'social marketing mix' (Ager & Collins 1992, Marks & Downs 1991) is called for, which addresses health beliefs alongside prevailing social norms, authority structures within communities (which may serve to encourage or discourage change), local capacity to implement and sustain changed behaviour (e.g. through access to condoms re: AIDS or bednets re: malaria) etc..

Such analysis encourages community participation to be seen as rather more than canvassing the opinions of the community - more, indeed, than facilitating undertanding of the beliefs, values, practices and aspirations of its people. The goal of community participation must be a broader understanding of the many forces which encourage and constrain action by individuals within that community. Participative planning potentially maximises the likelihood that such forces will be acknowledged and addressed in the planning process, although effective and reliable means to achieve this require further examination.

4.4. Gender and Development

The burdens faced by women because of their reproductive, economic and social status are likely to increase as economic restructuring exacerbates the problem of

the exploitation of cheaper female labour and reduces the social safety nets available (Jahan 1995). The women in development (WID) and gender and development (GAD) approaches are an attempt to address these issues. The latter, which is concerned with the socially constructed roles of both men and women, is being put forward as more appropriate to address the underlying causes of female in equalities than the former which focuses on women's roles. However despite the promotion of these concepts and despite the gains achieved in terms of awareness, mandates and the strengthening of the voice of women, real progress in terms of transforming gender relationships and creating equality remains elusive.

An underlying reason for this is the same as for community participation - the issue of power. As long as women have a lower status economically, politically and educationally than men, improvements cannot be made to their poorer health status. Thus although services may begin to address women's priorities, whilst men remain the gatekeepers to these services, the impact on women's health will be limited (Vlassoff 1994). Similarly the reproductive role women have in many cultures as guardians of the family's health becomes a burden rather than an opportunity (Santow 1995).

"The poverty context ... suggests that the most pressing economic needs are experienced by poor rural and urban women" (Government of Malawi 1993). The promotion of women's productive role has been pursued to address this situation, for example women are frequently the targets of programmes which aim to expand income generating activities or the uptake of credit schemes. Some of these have however had the unfortunate consequence of adding to the burden of women by increasing their overall workload and involving them in low return, high health risk activities (Macgowan & Leslie cited by Dunian 1994). A study of rural women in Zambia showed that women spent more time than men not only on household activities (5 hours per day compared with 1.1 hours per day) but also on farming activities (8.5 hours compared with 7.4 hours) (Landell-Mills 1994).

The role of female education in determining the health outcome of the woman and the family is acknowledged (Stanton 1994). Halstead et al (1985) observed that in those countries which had good health status despite poor economic indicators there was a strong education base which emphasized equal primary and secondary schooling opportunities for women. Educating women is also important as a means of improving the quality and value of women's productive work (Dunian 1994). Despite this however, inequalities in education persist.

The need for and obstacles to mainstreaming women in development are, understandably, similar to those relating to community participation. Women are not a homogenous group so there can be no single solution to meet the problems created by their unequal status. Making changes requires a redistribution of power with women being fully involved in the decision making and evaluation processes. Gender issues need to be seen as an integral part of and fully operational within any programme and not just as a separate add on. Some observers argue that even this would be insufficient and what is really needed is to

transform the development agenda with a gender perspective (Jahan 1995). Specific research which might facilitate these changes are suggested in section 5.

4.5. The Role of NGOs

Section 2.3 above identified the potential strengths of NGOs as being their flexibility, closeness to communities., high quality inputs and efficiency. These advantages have prompted a rapid expansion in their numbers, resources and role. Charlton et al (1994) estimated that there are 3000 NGOs in the North and probably over 50,000 in the South. NGO funding increased by 700% between 1970 and 1990 and now accounts for about 13% equivalent of net disbursements of official aid (UNDP 1993). The NGO community is a disparate and heterogeneous group so generalisations about their role and value can only be tentative.

One broad categorization of NGOs might be between those which are involved in the provision of services and those which are involved in advocacy and policy making. Korten (1990) described three and later four 'generations' of NGO strategies: relief and welfare, community development, sustainable systems and people's movement - with the last two receiving an increasing emphasis recently. This coincides with the impact structural adjustment policies have had: the reduction of the role of the state and subsequent problems of ensuring that services are provided to those sections of the population for whom private provision of health and education is impossible (Dennis 1994). NGOs are increasingly viewed by donors as being the intermediary between the government and the people and playing a key role in defining relationships between state and civil societies (Charlton et al 1994). NGOs are under increasing pressure to replace rather than supplement the state which has serious implications for their orientation and practice (Fowler 1992) and for the state which, as was noted in section 2.3, needs to retain its central role of policy making and evaluation. This role of the state is significant for the success of NGOs' work as Uphoff (1993) observed "countries which had the best linkage between central government and rural communities through a network of local institutions had the best performance in agricultural and social indicators" (p613).

With these changes in the role of the state and NGOs, the latter have in some cases been keen to 'scale up' their operations from being involved in the implementation of micro level projects to being involved in the macro level policy making process. Charlton et al (1994) observed that "the centrality of projects to policies and plans - from Botswana to Papua New Guinea, one of the most enduring of the many colonial legacies is exhibited in the extent to which projects are bundled into programmes, programmes into policies, and policies into plans - does not easily or automatically win NGOs any particular in wider, macro-level planning processes, or result in their incorporation into national policy circles" (pp18-19). The assumption that micro-level experiences are in some way generalisable is therefore questionable. It has been further argued that this focus on projects by NGOs and the increasing trend towards donors being involved in macro-policy reform has left little space for NGOs to influence the macro policy (Charlton et al 1994). This tension is likely to be a key issue in the future.

The accountability of NGOs is another issue which remains unresolved. Charlton et al (1994) comment that whilst NGOs were seen as a tool to promote the greater accountability of governments, they often performed their functions with the same lack of accountability. Although NGOs are improving this, the obstacle of having different (and at times incompatible) constituencies - their funders and the communities with which they work - persists in making this accountability far from straight forward (Dennis 1994).

NGOs have considerable potential which could be utilized in conjunction with the initiatives aimed at empowering communities and especially the women within them. This requires co-ordination, regulation, supervision and promotion (Gilson et al 1994) and research into how proven successes might be transferred or expanded. This will be explored in section 5.

4.6. Conclusion

In each of the areas examined above, social policy initiatives which have been heralded as improving health and healthcare have been shown to be subject to question and qualification. The answering of these questions, and the specification of qualifications regarding their effectiveness and appropriateness forms the core of the required social policy research agenda.

5. Priorities within the Developing Health and Social Policy Research Agenda

The following priorities are identified with respect to the previously identified areas of social sector initiatives which are seen as particularly crucial in improving health. With respect to these priorities, particular gaps in our current knowledge are highlighted by citing concrete and focused examples of potential research projects pertinent to the social policy and health sector research programme.

5.1. General Issues

5.1.1. For the purpose of facilitating the dissemination of findings, what are the major information sources influencing the formation of social policy agendas at a) national and b) international levels? How might specific research initiatives, such as that concerned with user charges at the Institute of Child Health, be incorporated into policy making?

An audit of sources for the process of formulating a five-year health plan within an aid-recipient country.

5.1.2. The significance of effective management in raising the quality of and consumer satisfaction with services has been highlighted (Gilson 1995, Banerji 1994, Foster et al 1994, Haddad & Fournier 1995). What evidence is there of the impact management and institutional programmes have on performance indicators at national, regional and local levels? How could good practice in this area be disseminated?

A controlled evaluation of the impact of an institutional strengthening programme within a specified ministry.

5.1.3. Concern has been expressed over the poor management of resources at national and sub-national levels and the effect this has on the efficient delivery of services (for example the World Development Report, World Bank 1993 b). This issue is perhaps of even greater significance at the international level because of the magnitude of resources involved (Okuonzi & Macrae 1995). What evidence is there of poor practice at the international level and how might this be mitigated?

A comprehensive audit of international resource allocations and flows, investigating the existence of any relationship between demonstrated structures and efficiency.

5.1.4. It could be argued that since the nature and scale of many of the problems facing the health and social sectors of developing countries are known (World Bank 1993 b, Save the Children Fund 1993) the focus should now turn to how the issue of quality might be addressed when adopting strategies to address them.

An analysis of the information needed to identify indicators of the quality of provision which could complement information about the cost and affordability of alternative strategies.

5.1.5. The economic prospects of many developing countries, especially those in sub-Saharan Africa, are unlikely to improve in the foreseeable future for many reasons - for example disadvantageous terms of trade and rising populations (see section 2.2, Loewenson 1993, Mburu 1994, Zaidi 1994). It is therefore likely that the level of demand for donor support to projects and to recurrent budgets will remain high and that additional sources of funding will be required.

An audit of mechanisms to assure the co-ordination of governments, donors and NGOs.

An analysis of the impact social marketing of condoms has on the use of condoms and on household income.

An evaluation of the appropriateness and feasibility of different models of sustainability.

5.1.6. The preceding analysis highlights the manner in which health status is determined by a far broader range of policies than those solely the responsibility of Ministries of Health. Examples of broader social sector initiatives with demonstrable impact on health need to be articulated to foster intersectoral collaboration.

Documented case studies of innovative local multisectoral collaboration impacting health gain - eg the impact of reforestation programmes on infant mortality rates, the outcome of business enterprise schemes on food security within female-headed households.

5.2. Financing

5.2.1. What evidence is there for user charging increasing the efficiency, quality and consumer appreciation of services?

5.2.2. One of the major concerns about user charges is the negative impact on equality (see section 4.1 and Foster et al 1994, Okuonzi & Macrae 1995, Gilson 1995).

An assessment of the impact of different models of user charging on the problems of inequality and strategies which have been adopted to strike a balance between the potential advantages of improved resource efficiency and the disadvantages of a deleterious impact on the health status of very poor people.

5.2.3 Other means of local financing are being explored for example local insurance schemes. Not much is known about their success or failure.

A description of successful insurance schemes in poor countries

5.3. Role of the Private Sector

5.3.1. Given the limitations of applying market ideology to health care (see section 2.4.2 and 4.2), are there examples where privatization has improved quality, choice and efficiency?

An analysis of impacts on quality, choice and efficiency of health provision of district level privatization of acute services.

5.3.2. If such good practice can be demonstrated, what were the existing social and cultural preconditions which enabled this?

5.3.3. Where such formal economic preconditions are not met what is the impact of provision on the quality and equity of provided services?

5.3.4. Sections 2.4.2 and 4.2 considered the various applications of the notion of privatization to the health and social services. One key question is the extent to which these various applications could or should be adopted in developing countries given their specific economic, political and cultural context (Belmartino 1994, McPake and Banda 1994). How might decisions concerning the appropriate form and level of privatization be informed and implemented?

5.3.5. The World Development Report (World Bank 1993 b) was seen as prescriptive by some observers (Save the Children Fund 1993). What evidence is there of its recommendations being adopted in developing countries and what impact has this had?

5.4. Community Participation

5.4.1. What examples are there of community participation effecting substantive health gain at a local level?

Evaluation of local health cooperatives as a means of fostering community participation and substantive health gain.

5.4.2. From such examples, can the preconditions of functionally effective community participation be specified?

5.4.3. How may participative planning facilitate an understanding of the local forces encouraging and discouraging changes in behaviour targeted within prevention programmes? Are there generalised principles which may assist in the design of clinically effective, culturally-sensitive and sustainable behaviour change programmes?

A review of AIDS prevention programmes identifying those factors amongst personal beliefs, social structures and environmental conditions most predictive of attaining targeted behaviour change.

5.4.4. What evidence is there that the type of community participation affects the viability and sustainability of community based finance schemes?

5.5. Gender and Development

5.5.1. Are the programmes which explicitly target women demonstrably more effective than generalised programmes in affecting social indices which themselves have an impact upon health outcomes?

A comparative analysis of local health gain following small business/entrepreneurship training programmes of general access and those targeted on women.

5.5.2. If programmes which target women are more effective, what are the preconditions for such gender targeted programmes to exhibit differential effectiveness?

An analysis of the mechanisms which have contributed to the success of the Grameen Bank in Bangladesh in assisting women's involvement in development and in the high level of recovery of its loans and an assessment of the transferability of these mechanisms.

5.5.3. What is the evidence that structural adjustment programmes differentially impact upon women? If this is the case, what social policy options have demonstrable effectiveness in ameliorating this pattern?

5.5.4. What strategies taking cognizance of gender might be more effective in achieving their objectives?

5.6. The Role of NGOs

5.6.1. What evidence is there for the presumed greater flexibility of NGOs in delivering services?

5.6.2. Which national policy frameworks are more effective in shaping NGO responsivity to national circumstance?

A comparative study of government/NGO sector framework agreements, relating such policy and structure to (a) evidence of participatory planning (b) achievement of sustainable programmes and (c) degree of local flexibility in NGO-led projects.

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