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Katharina Viktoria Stein

Public Health and Gender in Developing Countries – with a Case Study in Uganda

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A-1090 Wien, Berggasse 7, Telefon (+43 1) 317 40 10, Fax: (+43 1) 317 40 15
e-mail: office@oefse.at, internet: www.oefse.at
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TABLE OF CONTENT

TABLE OF FIGURES

ABBREVIATIONS

ADB	African Development Bank
AGDI	African Gender and Development Index
AWPS	African Women's Progress Scoreboard
BWIs	Bretton Woods Institutions (the IMF and the WB)
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CSOs	Civil Society Organisations
CSW	UN Commission on the Status of Women
DALY	Disability-adjusted Life Year
DAWN	Development Alternatives with Women for a New Era
DC	Developing Country
ECA	Economic Commission for Africa of the UN (also abbr. UNECA)
FDI	Foreign Direct Investment
GAD	Gender and Development
GBD	Global Burden of Disease
GDI	Gender-related Development Index
GDP	Gross Domestic Product
GEM	Gender Empowerment Measure
GNP	Gross National Product
GSI	Gender Status Index
GWH	Department of Gender and Women's Health of the WHO
HALE	Healthy Life Expectation
HDR	Human Development Report
HDI	Human Development Index
HIPC	Highly Indebted Poor Country
HPI	Human Poverty Index
IFIs	International Financial Institutions
IMF	International Monetary Fund
INSTRAW	International Research and Training Institute for the Advancement of Women
ILO	International Labour Organisation
LRA	Lord's Resistance Army
MDGs	Millennium Development Goals
NEPAD	New Economic Partnership for African Development

NGO	Non-governmental Organisation
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PEAP	Poverty Eradication Action Plan
PfA	Platform for Action
PH	Public Health
PHC	Primary Health Care
PPP	Purchasing Power Parity
PRSP	Poverty Reduction Strategy Paper
QALY	Quality-adjusted Life Year
SAP	Structural Adjustment Programme
SAPRIN	Structural Adjustment Participatory Review International Network
SDAs	Social Dimensions of Adjustment
SSA	Sub-Saharan Africa
SWAps	Sectorwide Approaches
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UPE	Universal Primary Education
USAID	United States Agency for International Development
WB	World Bank (aka. International Bank for Reconstruction and Development (IBRD))
WHO	World Health Organization
WID	Women in Development
WTO	World Trade Organisation
WWII	World War I

1 INTRODUCTION

"One will not know what women are,
until they are not dictated anymore
what they should be."
Rosa Mayreder 1858-1938, Austrian feminist[1]

In recent years, the gender aspect has become an ever more urging and researched field, not only in development but in all aspects of political and social sciences. Civil society and international organisations became aware of the big difference in impact that decisions on the alocation of national budgets or non-financial resources have on both women and men. Due to their specific gender roles, which prevail in all cultures and countries, women experience cuts in social services more heavily than men. This process was substantially influenced by the changing view that politicians, international organisations and development economists took on the role of women. In a long adjustment period from the humble, selfless mother and housewife to a respected individual on equal terms, many obstacles had to be overcome (and have still not entirely been taken).
But there is more to the subject than that. In an ever changing world, with national economies being increasingly interdependent and newly industrialised countries demanding their rightful voice in international trade, not only the roles of women have evolved. Issues, such as distribution and income inequality or health and poverty have received a new, global dimension. After the global protests against the WTO, globalisation and the dominance of the USA at the turning of the century, international donors and national governments have come to realise that it needs more comprehensive and equitable programmes and theories to deal with the preposterous inequalities in the world.

Health has been identified as one of the major concerns of the international community. In order for developing countries to break out of the vicious cycle of debt services, poverty, dependency on international donors and corporations, they not only need a stable and functioning public administration and government – it's their people they have to invest in. What neo-classical economists call human capital and the UNDP labels human development is the simple concept of enabling people to lead a productive, healthy and

[1] Translation by the author

fulfilled life – according to their own terms and choices. The aim of this thesis hence is to analyse the evolution of the gender issue in development economics and how public health, gender and economics are interlinked in the framework of developing countries, in particular. A focus will be laid on the role of international institutions and donors within this process of development.

The first part of my thesis introduces some major ideas and theories of development, in order to make understand, where the development agencies draw their current programmes and legitimisation from; and where and how gender comes into the picture. Moreover, I will define the most commonly used technical terms in development, gender, health and poverty. Obviously, issues as personal and at the same time as public as the aforementioned incite persisting controversies, in theory as well as in practice. Hence, I will dedicate my attention to giving an overview over these diverging opinions on both levels.

Having laid the theoretical basis, it is time to explore the possibilities and methods of measuring the various dimensions of human life. Since there exists a wide array, I have selected the ones most commonly used in development literature and by international organisations – it still amounts to quite a number of possibilities, again also reflecting the different views on human development and welfare.

International organisations have played an influential role from the very beginning. Consequently, I will continue with a chapter on three oustanding initiatives concerning international health and women's issues: the WHO 'Health for All' programme, which brought the primary health care initiative; the UN Millennium Development Goals (MDGs) on health, which set out global targets for improving health indicators; and the Beijing Platform for Action, which constitutes the framework for engendering economy and the state. This chapter will moreover adress the impact that structural adjustment programmes and health care reforms had on the poor, and women in particular.

To conclude and synthesise the afore-outlined concepts, the last chapter will highlight the impacts development programmes had on Uganda, especially its health care sector. The case study will also be used to illustrate how predominant theoretical concepts were translated into country programmes and what their outcome was. Again, special attention will be payed to the gender aspect and its influences on the progress of the country.

2 THEORETICAL CONSIDERATIONS

"Our vision is for the South to achieve a people-centred development: a form of development that is self-reliant, equitable, participatory and sustainable. We envisage a process of development achieved through the active participation of the people, in their own interests as they see them, relying primarily on their own resources, and carried out under their own control."

South Commission[2]

On reading this definition of development one can hardly disagree. Nevertheless, throughout the history of development (economics), the idea of a participatory and sustainable policy, which profits all groups concerned, is quite a modern one. When one is talking about development, one usually means continuous growth and technological advancement in the sense of the industrialised (Western) world. But who says that this is the only way of development? What qualifies as development and is it really gender neutral? In this chapter we lay the theoretical foundations for our topic and we define the basic concepts that we need to evaluate the interrelations between gender, health and development.

2.1 The Evolution of the Development Issue

" Development must be redefined as an attack on the chief evils of the world today: malnutrition, disease, illiteracy, slums, unemployment and inequality. Measured in terms of aggregate growth rates, development has been a great success. But measured in terms of jobs, justice and elimination of poverty, it has been a failure or only a partial success."

Paul P. Streeten, Former Director, World Development Institute[3]

In the 18th century, *Adam Smith* and *David Ricardo* set the scene for modern economics, the analysis of the market and international trade. Ricardo's *Theory of Comparative Advantages* advised governments to concentrate on the production of those goods, which showed a cost advantage in comparison to the (targeted) foreign market[4]. But already

[2] South Commission (1990), p.12.
[3] Paul Streeten cit. in Todaro/Smith (2003), p.110.
[4] His example of a 2 sector market with England and Portugal producing and trading linen and wine is widely known and cited in the economic literature.

then, a contemporary of Ricardo, the German economist *Friedrich List,* observed that this policy advice was only viable for advanced and strong economies. For less developed countries, comparative advantages turn into disadvantages since their products, being less processed, sell at lower prices. In his so-called *infant industry argument*, List advised less industrialised countries to practice *protectionism* and close their markets to foreign goods enabling the domestic economy and industry to develop, without threat of being overrun before actually starting.[5] It took the discipline of development economics, as we know it, however, until after World War II when US-President Truman for the first time demanded for a global effort in advancing the world economy and providing "development for all"[6].

For the past 50 years, economists have been disputing over the why's of development, the how's of overcoming obstacles of inequalities and the recipe against the ever-growing numbers of *absolutely poor*[7].

Within the framework of general economics, one can identify four stages and their dominant theories addressing these issues[8].

2.1.1 Development through Growth (1950s-60s)

The first period was characterised by an axiomatic belief in the self-regulating market mechanisms and the incontestable power of growth. Based on the classical economists and *Max Weber's bureaucracy approach,* the proponents of economic development believed that the only way of enhancing lagging countries was through the same apparently linear path that European countries had followed on their way to industrialisation and prosperity. These so called *Linear Stages Approaches* defined development as "rapid, aggregate economic growth"[9] and believed that economic advancement would only be brought about endogenously. One of the chief proponents of the time was Rostow with his *5 stages of development model*. He was convinced that on the way through the development path, every country sooner or later would pass through

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[5] Szirmai (2004), p.72, Germany in the 18th century was only beginning to industrialise whereas England is commonly referred to as the "motherland of industrialisation".
[6] Todaro/Smith, p.47-50.
[7] A person is considered *absolutely poor* when having to survive at or underneath the *poverty line* of US$ 1 (PPP) per day, as defined by the World Bank.
[8] Compare Nuscheler (2004), Chapter 3; see also Todaro/Smith (2003), Chapter 4.
[9] Todaro/Smith (2003), p.111.

the same stages, every period having its immanent characteristics: traditional society, preconditions to take-off, take-off, drive to maturity and mass consumption society[10].

2.1.2 Battle Against Poverty (1970s)

In the early 1970s, politicians and economists started to realise that, despite sizeable economic growth rates, poverty was a persisting problem in the developing countries and growing. Robert McNamara, then President of the World Bank, strongly criticised the growth concept proclaiming the prioritisation of the fight against absolute poverty[11]. The *Basic Needs Strategy* was formulated, demanding the "provision of health services, education, housing, sanitation, water supply and adequate nutrition […] The rationale of the approach was that the direct provision of such goods and services was likely to relieve absolute poverty more immediately than alternative strategies that would simply attempt to accelerate growth or would rely on raising the incomes and productivity of the poor."[12] As can be concluded today, this approach has so far lacked success, also because a new dimension for controversy was introduced to economics: what are basic needs? Does anyone have the right to define them for all humankind? And what about cultural and societal aspects of basic needs? They can be seen as the bottom of Maslow's *Basic Needs Pyramid,* as the consumption possibilities at the poverty line or as the possibility to lead a healthy and fulfilled life – where to draw the line?

2.1.3 The Lost Decade (1980s)

The oil crisis of the late 1970s and falling prices for natural resources brought on its tail the debt crisis of the developing countries ruining the feeble economic successes of the previous years. During much of the decade the developing countries had to pay more debt service than they received in official development assisstance (ODA) and foreign direct investments (FDIs).[13]

As a result, a group of theorists of various scientific fields formulated the so-called *Dependency Theory.* What was revolutionary about this set of approaches was that the ideas surfaced in Latin America, not in the Western world. For the first time, development was not only seen as depending on endogenous factors, but rather the exogenous environment and the (uneven) relations between countries were identified as crucial. The

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[10] Szirmai (2004), p.79.
[11] See Nuscheler (2004), p.79.
[12] Thirlwall (2003), p.107.
[13] For a more detailed explanation on the interrelation of lending, petrodollars and debt servicing in the 1980s and the following explosion of debt in developing countries, see Todaro/Smith (2003), pp.605-613.

Centre-Periphery Model and the concept of *Dualism* were at the core of the theory, the former stating that a dynamic and productive centre (i.e. the industrialised states) controlled the resource-supplying periphery and held it dependent. The latter is not only a term in dependency theory but in development economics as such, expressing the co-existence of two antithetic systems (e.g. an industrial sector and an agrarian sector, market economy for natural resources vs. subsistence economy for domestic food production).[14]

At the same time, the economic West responded with what Todaro called the *Neo-Classical Counterrevolution*[15]*.* Key proponents were the *Chicago School* and *Milton Friedman*, monetarists who propagated free market mechanisms, decentralisation and liberalisation relying once again on the force of the *invisible hand*. Based on these pillars, the so-called *Washington Consensus* became the basis for development politics of the *Bretton Woods Institutions (BWIs)*[16] and the donor states. Some of the elements of the Consensus were[17]:

- Reduction of the budget deficits
- Tax reforms to cut back taxes and broaden the tax basis
- Promotion of FDIs and trade liberalisation
- Deregulation, cut back on government influence and bureaucracy
- Dismantling of the social welfare systems and other public services

It was the era of the *Structural Adjustment Programmes,* which demanded rigorous reforms from the recipient states, in line with the Consensus, and which became a euphemism for the increasing debt crisis, the break down of already feeble political structures, the rise of the poor and the dictatorship of the Western liberalised capital over the poor rest of the world.[18]

2.1.4 The New Era (from the 1990s on)

From the early 1990s onwards, (parts of) the international donor community started to realise that the current situation was far from satisfying. The UNDP and its newly published *Human Development Report* spearheaded the movement of expanding the

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[14] See Kolland, in Fischer (2003), pp.64-68.
[15] Todaro/Smith (2003), p.130.
[16] This acronym refers to the World Bank Group and the IMF, founded in Bretton Woods in 1949.
[17] See Nuscheler (2004), p.83.
[18] For an extensive critique see *The SAPRI Report (2004).*

views on economic growth and human development. Dependency theorists propagated independent networks in the Third World and criticism of capitalism became en vogue in Europe, culminating in the turbulent demonstrations against the World Trade Organisations' conferences in Prague and Seattle.[19]

With the fall of the *iron curtain* and the end of communism, rapidly evolving technologies and the dynamics of globalisation, adequate concepts had to be found for more efficient and more equal co-operation between the countries and regions. Newly industrialised areas, such as India and China, challenge the "old world" and the USA and there is already a tendency noticeable, if yet still faint, that it's the Westerners now that have to follow their jobs into the more dynamic and fast evolving regions of the world.

In the wake of the new millennium and pressuring protests against their policies, the World Bank and the IMF adapted their policies, incorporating more cooperative and empowering methods into their projects, relieving some of the restrictions posed on the countries and allowing for more self-determination. The *Millennium Development Goals (MDGs)* of the UN are a further initiative to bring about more equality in distribution of wealth and health in the world.

Joseph Stiglitz, a former World Bank Vice-President and later critic of the institutions' policies, described the evolution of the development issue quite aptly:

> "First inequality was unimportant, then inequality promoted growth, and now we see inequality as having an adverse effect on growth […] there has been a shift from the view that growth inevitably increases inequality, to the view that growth inevitably improves the plight of the poor, to the view that growth normally improves the plight of the poor, but that some growth strategies are more pro-poor than others."[20]

2.1.5 Post-Washington Consensus

Since ODA and FDIs decreased from 0,35% of national income in 1990 to a mere 0,22% in 2000[21], and donor as well as developing countries were growing discontent with the processing and distribution of resources, the *International Conference on Financing for Development*, which took place in Monterrey, Mexico in March 2002, sought to define more binding and efficient rules to international financing of developing countries.

It was recognised that a substantial increase in funding was necessary to achieve the goals set out by the *UN Millenium Development Goals (MDGs)* and earlier declarations.

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[19] For an alternative view on the anti-globalisation movement see Navarro (2002), Chapter 3.
[20] Stiglitz (2000), p.9
[21] Wabl (2002), www.

While developing countries demanded faster and more substantial debt relief, donor countries, especially the 22 OECD countries, tied their grants for development assistance to conditions such as decreasing corruption and improving governance performance. Further issues of the conference were the protectionist measures established by developed markets against certain, mostly agricultural, goods coming from developing countries and the closer international cooperation on taxation issues, since both developed and developing markets forfeit billions of dollars every year to tax havens or due to tax competition among developing countries.[22]

At the end of the conference, the heads of State adopted the so-called *Monterrey Consensus*, committing themselves "to eradicate poverty, achieve sustained economic growth and promote sustainable development as we advance to a fully inclusive and equitable global economic system."[23] Whereas the Washington Consensus had focused on trade liberalisation and economic policy, the Monterrey Consensus represents the more holistic view acquired by theorists, international organisations and donors in the past few years. It encompasses the goals defined in the MDGs and emphasises the economic and human development process. Still, without the necessary funding this declaration will yet be another proof for good intentions not put into action.[24]

There is yet another notable development worthwhile a closer look: the newly defined role of the World Bank. After the heavy protests against the BWIs and their stringent policies in the late 90s, culminating in the violent demonstrations in Seattle (1999), Washington D.C. and Prague (both in 2000), the World Bank undertook a considerable effort to reposition itself amidst the international donor community. Projects financed by the Bank are now radically different from those financed in the 1950s, when there was little concern for policy frameworks, poverty alleviation, environmental protection or the privatisation of inputs and services.

With the introduction of *the Highly Indebted Poor Country (HIPC) Initiative* in 1996 and the alleviation of access to funding, it introduced a reform process still underway today. Together with the IMF, the World Bank revised its programmes and projects to be more transparent and coherent reacting on the often heard criticism of its secrecy, arrogance and inefficiency. Its concerns now also lie with co-operating more closely with local

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[22] Wabl (2002), www. *Tax competition* describes the phenomenon of attracting international corporations to invest in ones' country by offering extremely preferable tax conditions to the companies (e.g. 0% for some years or a flat tax), undercutting other (developing) countries.

[23] Monterrey Consensus (2002), p.1.

[24] For more information on the outcomes and follow ups of the conference and new developments concerning the Monterrey Consensus, visit: http://www.un.org/esa/ffd/.

governments and grass-roots organisations, adapting the programmes more effectively to the respective situation. These measures should also ensure more independence and self-governance of the recipient governments – a double-edged sword considering the problems many developing countries face in their public administration and governance.[25]
As the World Bank has become more participatory and transparent, protests have apparently subsided or at least, activists have shifted their energy from banging public protests to more effective community work[26]. However, with a new president since June 2005 and reform still underway, the World Bank faces a challenging future if it wants to keep its newly-acquired image of 'the good guy'.

And while economists still argue on the effects, globalisation and the integration of social factors has for their theories, another issue is receiving increasing attention: gender and its implications for development.

2.2 Integrating Gender into Development Economics

"Yet for all societies the common denominator of gender is for subordination, although relations of power between men and women may be experienced and expressed in quite different ways in different places and at different times."

Janet Momsen[27]

Having outlined the evolution of the general development issue, we now will turn to the actual point of interest: women and development. As mentioned in the previous section, the development issue didn't arise until after WWII, yet it took another 20 years before serious considerations were given on the impact of development (programmes) on women.
Again, one can distinguish between different periods of predominant policies, which correlate to some extent with the development theories discussed in section 2.1[28].

2.2.1 Welfare Approach (1950s-70s)

Here, the woman was seen as a helpless, dependent creature which had to be protected (from the vicious outside world) and therefore was reduced to the role of housewife and

[25] BBC (2004), www.
[26] BBC (2005), www.
[27] Momsen (2004), p.18.
[28] See Lukas (2000), Working Sheet 6; Klauninger (2003), pp. 29ff.; Momsen (2004), pp.12ff.

mother. Programmes focused on the reproductive health services and catastrophe relief, hence perpetuating the seclusion of women from the public. According to the mainstream economic beliefs of the time, it was thought that economic growth and income increase would *trickle down* to the poor and the women when household incomes increased.

2.2.2 Equity Approach (1975-85)

Triggered by the *International Women's Decade* and the rise of the Western feminist movement, a group of female development experts formed to establish the *Women in Development (WID)* concept. Their aim was to integrate women into the development process and thereby strengthen their position as individuals. Even though this approach asked for the first time whether and how women profited from economic growth, it missed out to see women as an equal part in society. Influenced by the modernisation movement, WID argued for the amelioration of the status and income of women. *Esther Boserup's* study *Women's role in economic development (1970)* is considered as the foundation for this approach[29].

2.2.3 Anti-Poverty and Efficiency Approaches (1980s)

Under the auspices of the *Structural Adjustment Programmes (SAPs)* of the BWIs, the *Anti-Poverty Approach* saw women only as an idle production factor, which had to be tapped in order to foment economy. Since a consequence of the SAPs often was the reduction of social services, the demand for more efficiency in development programmes rose. Women were granted "equality" as far as long working hours and minimal wages were concerned. A change in gender relations or policies was out of the question, though. "The efficiency approach was criticized for focusing on what women could do for development rather than what development could do for women."[30]

2.2.4 Gender and Development (GAD) (1990s)

As a reaction on the WID concept and the SAPs, the *GAD movement* started off as a "…concept of gender […] and gender relations […][analysing] how development reshapes these power relations. Drawing on feminist political activism, gender analysts explicitly see women as agents of change. […] they emphasize the important influence of differences of class, age, marital status, religion and ethnicity or race on development

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[29] See Hanak (2003), p.108. Boserup, Esther (1970): *Women's role in economic development*, St. Martin's Press/New York.
[30] Momsen (2004), p.14.

outcomes."[31] Hence, it was the first approach to put the individual and its needs into the centre of attention. The *Association for Women's Rights in Development (AWID)* strongly adheres to these principles, one of their researchers, *Lynn Freedman*, applying the approach to the analysis of female health and the Millennium Development Goals (MDGs).

2.2.5 Empowerment Approach (since 1990s)

Originally articulated by female activists from developing countries, more precisely from *Development Alternatives with Women for a New Era (DAWN)*[32], it gradually was adopted by Western institutions thereby watering down its primal meaning. The focal point of empowerment is the reinforcement of a person's self-esteem and the initiation of social transformation. It is often associated with community level work and tries to foment political action on four sets of needs[33]:

- physical: control of one's body and life
- economical: control of one's income and working conditions
- organisational-political: possibilities/structures for co-operation, participation, solidarity
- cultural-ideological: penetrate stereotypes of gender and family relations, foster a positive self-perception

In synthesis, one could say, "…empowerment involves the exercise rather than the possession of power."[34]

DAWN is still active today and has committed itself to feminist research and activism focusing on the impact of globalisation and its economic implications for poor women in the South. Two of the founding members and prominent female economists are *Gita Sen* and *Caren Grown*.

2.2.6 Gender Mainstreaming

A group of experts commissioned by the European Council in 1998 defined *Gender Mainstreaming* as "the (re)organisation, improvement, development and evaluation of axiomatic political processes, with the aim of integrating an engendered point of view in all political concepts on all levels and phases through all participants of political decision

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[31] Momsen (2004), p.13.
[32] For further information on the platform, visit www.dawn.org.fj/index.html.
[33] Lukas (2000), Working Sheet 6, translated by the author.
[34] Parpart (2002), p.4.

making processes"[35]. Based on the GAD concept, Gender Mainstreaming asks for an equitable distribution of resources and responsibilities and, for the first time, poses the question of the role of men within the development process.

The concept was formally integrated into the *Beijing Platform for Action (PfA)* ratified by 189 countries at the *4th World Conference on Women* in 1995 and has since been incorporated into the statutes and programmes of many international institutions and national governments. Nevertheless, a lack of awareness for the gender issue and of appropriate funding for the necessary studies and analyses prove many politicians and governments only paying lip service to the concept. "Gender mainstreaming means being deliberate in giving visibility and support to women's contributions and addressing the differential impact of strategies, policies, programmes and projects on women compared with men. It requires a focus on actual results in terms of gender equality in the practice areas at all levels."[36]

Having briefly outlined the major approaches to the role of women, and later, gender in development through the past decades, it rests to select the appropriate one for this work. If one wants to analyse the interlinkage between gender and development in today's developing countries, one needs an open and inclusive approach. Since international institutions, such as the UNDP or UNIFEM, dealing with these issues have all embraced the *Empowerment Approach,* and *Gender Mainstreaming* has become an integral part of the statutes of many national and international organisations, public adminsitrations, as well as declarations on the Rights of Women, I will be lead by these two concepts in my further analysis.

Summarising some of the most important milestones that marked the way to gender equality, the following table gives a chronogical overview to conclude this section.

[35] Lukas (2000), Working Sheet 1, translated by the author.
[36] UNDP (2002), Executive Summary.

Figure 2.1. Selected Milestones for Gender Equality

1792	Mary Wollstonecraft's *A Vindication of the Rights of Woman*
19th c.	Universal suffrage movement starts in UK
1975	1st UN World Conference on Women, Mexico
1976	Foundation of UNIFEM
1975-85	UN Decade of Women
1980	2nd UN World Conference on Women, Copenhagen, midway evaluation of Women's Decade leading to Platform for Action of Copenhagen
1985	3rd UN World Conference on Women, Nairobi integrating Gender Mainstreaming and other policy recommendations concerning women into development
1993	WHR Investing in Health, first addressing of domestic violence as female health issue
1994	International Conference on Population and Development (ICPD), Cairo, also focusing on gender equality and female empowerment
1995	4th UN World Conference on Women, Beijing Platform for Action
2000-01	UN Millennium Development Goals 23rd Special Session of the UN General Assembly, NY, Beijing+5
2005	49th Session of the UN Commission on the Status of Women (CSW) reviewing the Outcomes of Beijing+10 and the 23rd Special Session of the GA, NY

Source: own compilation

2.3 Basic Concepts in Gender and Health

Before we continue on theoretical approaches to health economics, we briefly will define the main technical terms of development, gender analysis and health.

2.3.1 Development vs. Underdevelopment

"We do know that development is possible. The challenge now is to foster it in ways that benefit the poor, strengthen democratic processes, heighten the overall sense of well being, and widen economic and political freedom."[37]

Joseph Stiglitz, Former Vice President of the World Bank

As briefly touched upon in the introduction, the development issue is a highly political one and so is the question of how to define it. In section 2.1 various theories on development have been introduced but so far no conclusion has been given on what the term actually means.

The verb "to develop" implies an action being taken, a progress and change taking place, a transformation from one state to another without valuation of the process. The scene of development politics and economics shows a different picture: the concept was largely of the Western world having to develop "the rest" without regard of cultural, geographical and structural limitations. Todaro identifies three core values of development, which "…relate to the fundamental human needs that find their expression in almost all societies and cultures at all times"[38]:

- Sustenance: The Ability to Meet Basic Needs
- Self-Esteem: To Be a Person
- Freedom from Servitude: To Be Able to Choose

Yet, underdevelopment is not merely the opposite of development but rather a lack of basic freedoms, structural inefficiencies, political instability and, consequently, human deprivation. As follows, in all their diversity, developing countries all over the world encounter some common characteristics[39]:

- Widespread poverty and malnutrition

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[37] Stiglitz (2000), p.23.
[38] Todaro (2003), pp.21-22.
[39] Szirmai (2004), p.12.

- A relatively large share of agriculture in output and employment
- Pronounced dualism in economic structure
- Very rapid growth of population
- Explosive urbanisation
- Large-scale underutilisation of labour
- Political instability, pervasive corruption
- Environmental degradation
- Low levels of technological capabilities

It should therefore be the aim of development economics and politics to counteract these symptoms of underdevelopment and find various paths appropriate and modified for each specific region *in cooperation with the people, communities and local institutions affected*.
"…development is a highly value-laden concept. The meaning of this concept is determined by societies that are considered dominant or advanced at a particular moment in history."[40] This statement holds true for many concepts and decades, but it is too pessimistic for our pruposes. For this paper, we follow the UNDP Human Development definition:

> "*Human development is about much more than the rise or fall of national incomes.* It is about creating an environment in which people can develop their full potential and lead productive, creative lives in accord with their needs and interests. People are the real wealth of nations. Development is thus about expanding the choices people have to lead lives that they value. And it is thus about much more than economic growth, which is only a means — if a very important one — of enlarging people 's choices."[41]

Hence, while economic development is only concerned with facts and figures, focusing on the economic health and structure of a nation, human development incorporates social, political and individual aspects of life into its understanding of advancement.

2.3.2 Gender vs. Sex[42]

Whereas the obvious biological and physical differences between women and men determine our sex, it is our respective culture and social environment that define gender (roles). Whether an activity is seen as male or female often depends on the „typical gender character traits", such as the caring, emotional woman against the strong,

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[40] Szirmai (2004), p.29.
[41] UNDP homepage (2005), www. Italics by the author.
[42] See WHO (1998)

rationalist man, and hence influences work distribution and the options presented to an individual. Gender therefore is socially determined and shapes and constrains the lives of both women and men in fundamental ways. In synthesis, „gender differences are social constructions that can potentially be changed in ways that most biological characteristics cannot"[43].

2.3.3 Gender Analysis, Engendering and Empowerment

As outlined in section 2.2, it became ever more apparent that any actions taken by governments or institutions (e.g. development programmes, national budgets or health care reforms) have distinct implications for both women and men. "There has been a tendency to equate gender analysis with the 'analysis of the situation of women.' The purpose of a gender analysis is, however, to identify, analyse and act upon inequalities that arise from belonging to one sex or the other, or from unequal power relations between the sexes."[44]

It is difficult to draw a clear line between engendering and empowerment because both terms have been occupied by an array of distinct persons and entities. However, engendering can mainly be seen as the introduction of gender analysis into policy initiatives and programmes whereas empowerment is more the enabling of people, female and male, to actively participate in (political) decision-making processes. Perhaps the most extensive view on empowerment is formulated in the UNIFEM Report *On the Progress of the World's Women (2000)*:

"Women's empowerment includes:

- acquiring knowledge and understanding of gender relations and ways in which these relations may be changed;
- developing a sense of self-worth, a belief in one's ability to secure desired changes and the right to control one's life;
- gaining the ability to generate choices and exercise bargaining power;
- developing the ability to organize and influence the direction of social change to create a more just social and economic order, nationally and internationally."[45]

2.3.4 Gender Equity and Gender Equality

Gender equity deals with the "fairness and justice in the distribution of benefits and responsibilities between women and men"[46], while *gender equality* means "equality of

[43] WHO (1998), p.6.
[44] WHO (1998), Introduction.
[45] UNIFEM (2000), p.7.

opportunity and a society in which women and men are able to lead equally fulfilled lives."[47] Both terms recognise that women and men often have different needs and aspirations, which henceforth have to be dealt with accordingly. Gender equality is often mistakenly equated with affirmative action and preferential treatment of women. Yet, these are only two instruments towards the goal, since women are more often than men confronted with disadvantageous settings. The fundamental idea is to empower all people regardless of their gender to aspire to their goals, therefore "[g]ender equality is not merely a desirable by-product of human development; it is a core goal in its own right […] Any form of gender discrimination is a denial of human rights, an obstacle to human development."[48]

Speaking in economic terms, equality can be described with *horizontal equity* meaning that comparable population groups are treated equally concerning a few predefined criteria; whereas equity is *vertical equity* describing the unequal but just treatment of dissimilar persons.[49]

2.3.5 Health and Poverty

"Chronic poverty is a cruel kind of hell, and one cannot understand how cruel that hell is merely by gazing upon poverty as an object."[50]

David Goulet

In the *Preamble to the WHO Constitution* adopted in 1948, health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[51] Ever since its ratification, there have been extensive discussions on whether this definition is valid and functional or whether it is merely a utopian outlook of no practical value. A topic as intimate but at the same time as publicly relevant as health naturally poses problems of definition. A profound analysis on the topic can be found in Sissela Bok's *Rethinking the WHO Definition of Health*[52].

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[46] WHO (1998), Glossary.
[47] Momsen (2004), p.8.
[48] UNDP (2002), Executive Summary.
[49] Rice (2004), p.212.
[50] David Goulet, cit. in Todaro/Smith (2003), p.17.
[51] WHO Constitution, p.2.
[52] Bok (2004).

Synthesising definitions of health found in the literature of the past half century, Tarlov (1996) identifies three core conceptual components which constitute health[53]:

- It is a capacity to perform, relative and continuously variable
- This is used to achieve individual fulfilment
- It provides the potential to effectively negotiate the demands of the social environment

Hence, health is not simply seen as the absence of disease but as a broader social concept of the capability to lead a prosperous and self-determined life (compare Sen's concept explained in detail in section 2.4.4). This term of health refers to *individual health*, however, which enables or disables us to lead productive and fulfilled lives. At the other end of the scale stands *public health,* which is more concerned with the state's ability to provide its individuals with appropriate infrastructure to maintain or obtain individual health. Since this paper analyses the impact of development programmes on public health and the health care system, a more comprehensive look into the matter will be taken in chapter 4.

One crucial determinant for the level of health is poverty. There is broad empiric evidence that poverty has extensive negative effects on individual and public health. A lack of resources prohibits the adequate use of medical services, hampers information flows and heightens social pressure and stress, which in turn worsen the health status. Poor environments often feature insufficient sewerage systems and clean water supplies, if any, which further degrade the living conditions. An impaired health status limits physical and mental capacities diminishing the chances on the job market.[54] "Human poverty is more than income poverty – it is the denial of choices and opportunities for living a tolerable life"[55]. In its 1997 HDR on eradicating poverty, the UNDP pinpoints six aspects that must be considered in the design of poverty alleviation and development programmes, including the empowerment and active participation of women and men and the importance of an effective and functional state administration to provide an enabling environment for pro-poor growth. Additionally, gender equality and pro-poor growth in this list are identified as a prerequisite for eradicating poverty.[56]

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[53] Tarlov (1996), p.72.
[54] On the effects of poverty on the human health status, compare for examle Szirmai (2005), Chapter 6.
[55] UNDP (1997), p.2.
[56] UNDP (1997), p.6-8.

Health and poverty clearly are interrelated – a fact that often is underestimated or not emphasized enough in economic theory. These links and its theoretical explanations will be further elaborated upon in section 2.4.
In practice, with the formulaion of the MDGs, the UN and its partner organisations and governemnts have recognised the fact that health and poverty can only be tackled together and have therefore formulated goals 1, 4, 5 and 6 to counteract specific health and poverty issues[57].

2.3.6 Feminisation of Poverty

"The development capability of women is an indicator for the development capability of a society."[58]

The issue of *feminisation of poverty* was prominently propagated at the 4th World Conference on Women in Beijing in 1995, where it was also agreed upon in the *Platform for Action* (PfA) that a prime goal of development must be the empowerment of women. With this policy initiative it was hoped to counteract the process, since empowerment, as mentioned already in section 2.3.3, included as diverse measures as raising the level of education, the health status and the political participation of women. Since then, it is also estimated and widely agreed upon that 70% (!) of the world's 1,3 billion people living in absolute poverty are women[59]. This statement is challenged by UNIFEM in its 2000 Report on the Progress of the World's Women on grounds of missing reliable indicators and calculations, nontheless underlining the urgency of the topic[60].
Payne (1992) also contested the subject but for totally different reasons, stating that women have always been disadvantaged and more prone to poverty than men. "This representation of women as a growing army of poor underestimates the extent to which women have always suffered poverty and deprivation, and the invisibility of women's experience, both in society and amongst those who hold the measuring stick […] The feminization of poverty thesis … is therefore misplaced. What has happened however is that women's poverty has become more visible."[61]

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[57] See the apppendix for the complete list of MDGs; also, section 4.2.2 deals in more detail with the health-related MDGs.
[58] Nuscheler (2004), p.165, translated by the author.
[59] UNDP (1995), p.4.
[60] UNIFEM (2000), p.12.
[61] Payne (1992), p.46-47.

Whether or not poverty has a woman's face is secondary: the precarious effects it has on women and their children is a major obstacle to development.

The causes for female poverty are manifold. Even though they have a biological advantage over men with more female babies being born and more surviving under equal conditions (that is, not taking into account the fact that female babies receive less food and medical treatment or are killed deliberately for social reasons in some areas of the world), women throughout their lives must cope with multiple detriments in all aspects of life, which aggravate the effects of and accelerate the way into poverty[62]:

- On average, women worldwide still earn only 2/3 of a mans' wage for same qualification and job.
- In many countries, women are still barred from the rights to own property and apply for credit (in sub-Saharan Africa they represent only 1% of private property owners[63]).
- The systematic discrimination of women, whether on cultural, religious or other grounds, impedes them to acquire adequate schooling, health services or jobs.
- A lack of control over the household income and its distribution drives women into further dependency from the male "bread winner" (see also section 2.4.2).
- 70% of care services are provided by women without remuneration (see also section 2.5.1).

The prevalence of female-headed households fuels the poverty trap and persevering violence against women, such as female genital mutilation, forced prostitution or 'simple' battering, continue to derogate the situation.

Possible Solutions to the Problem

Education plays a key role in improving women's plight. Also, the abrogation of discriminative laws and traditional practices as well as the implementation of international targets, already formulated and signed at various occasions and in distinct frameworks, would mark a turning point in female development. A practical and straightforward approach would be to legalise the informal sector herewith submitting it to labour law, social security and tax regiment; or to push governments to implement the already quite

[62] UNIFEM (2000), pp.10ff.
[63] Nuscheler (2004), p.170.

detailed frameworks on engendering budgets, following the successful examples of Australia and South Africa[64]. We will examine some of these aspects in detail in chapter 4.

Terms such as development, empowerment and poverty reduction are used inflationary by the media, politicians and researchers but seldomly is it made clear which concepts stand behind them. This section has clarified the meaning of these terms, outlined links and contrasts and has introduced the main issues for further analysis: health and gender. The following continues with the theoretical foundation for these concepts giving an overview over the evolution of the development issue, some prominent economic theories and their relevance for research on the topic.

2.4 Theories of Health Economics

Health economics is understood primarily as the examination and evaluation of health systems and their efficiency, of hospital management and the most efficient allocation of doctors and practitioners. In other words, it focuses on problems persisting in the ailing health sector of the industrialised countries after their governments, whether socialist or conservative, came to realise that the social welfare and public health systems needed reforms to guarantee the supply with adequate health services[65]. The definition and extent of "adequate health services", of course, depends from country to government but the aim is clear: to provide services as efficiently and inexpensively as possible.

In my humble opinion, a conclusive theory of health economics does not exist. There have been extensive discussions on health equity[66], on costs, informational assymmetries and on issues of distribution, ethics and responsibilities. On this basis, theoretical concepts have been formulated or economic theories adapted for the purposes, but not one deals exclusively with the importance of health as a prerequisite for a productive and fulfilling life.

Therefore, it was not easy to find adequate theories since most of the theoretical input recycled general economic theories, simply adding health as an additional component or variable (e.g. the *New Human Capital theory*), or interpreting the conclusions as applicable to the health sector. A third category is established by the theories on justice, distribution and social welfare (see 2.4.3 on the *Rawlsian Theory of Justice and* 2.4.4 on *Sen's capabilities approach*).

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[64] For more information on the subject of gender budgets, visit UNIFEM Gender Budgets, www.
[65] Compare for example the table of contents of issues of the Journal of Health Economics, www.
[66] e.g. Anand (Ed.)(2004), *Public Health, Ethics and Equity.*

"Health systems, which follow quite distinct social aims, simply can't be compared by their relative economic efficiency"[67] as Reinhardt correctly argues in his preface to Rice (2004). The tendency to confuse political statements with scientific arguments and the disconcerting, though obvious correlation of health and politics has incited Reinhardt to the following warning to his students:

> "When economists or other actors in health politics fall into their normative pattern – when they pretend to use scientific methods to propose what 'has to be done' and what is 'efficient' – an alarm signal should start ringing in your head. The chances are high that you either have to do with somebody who masks his political ambitions behind science or else with somebody who is not sufficiently clear on the confines of economics as a field of science." [68]

Rice (2004) himself repeatedly stresses the supreme precondition one has to adhere to when using economic theories to analyse health: not to forget to scrutinise the applicability of the theory and its underlying assumptions. In omitting to do so, one easily blocks ones' own view on alternative strategies, which might be more appropriate to foster social welfare.

Baring this in mind, we can now continue to the discussion of different models and theories on social welfare and health, encompassing the main schools of thought and the evolution of the debate in the last three decades.

2.4.1 Preston, McKeown, Mosley - Three Early Models on Health[69]

"Mens sana in corpore sano"

2.4.1.1 Preston: Income and Life Expectancy[70]

In 1975, Preston published an intriguing article on the relation between life expectancy and average per capita income. In his study, he had compared the data on life expectancy at birth from various countries in the years 1900, 1930 and 1960. What he found was that, over time, life expectancy increased in all countries regardless of the level of prosperity. There was a strong positive relation between the two variables. From his set of data he concluded that 75%-90% of the increase in life expectancy are due to

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[67] Reinhardt, as cited in Rice (2004), p.17, translated by the author.
[68] Reinhardt, as cited in Rice (2004), p.17, translated by the author.
[69] Based on Szirmai (2005), Section 6.2.
[70] For further reading, see e.g.: Preston, S.H. (1975) and Preston, S.H. (1980).

other factors than income growth. Even a higher education level and a healthier nutrition could not explain the impact.

Preston's explanation was the significant advancement in health technology, which contributed so significantly to the amelioration of life expectancy. Herein, he did not only include evolvements in medical technology, such as new medicines and vaccination, but also the better understanding of negative impacts of the environment on health, such as poor hygiene and lacking access to primary health care.

This emphasis on the importance of *public health (PH)* also showed the way for developing countries to recognize that improvements in standards of living don't exclusively correlate with economic growth. The findings would also give an explanation on why some DCs rank higher on the HDI list than other DCs with comparable per capita GDP (see also section 3.1.3).

> "However, Preston also stresses the fact that – after the upward shift of the curve – the relation between per capita income and life expectancy for the poorest developing countries is even closer than before. This may be because when life expectancy increases, the diseases that remain are those most closely related to standard of living – like diarrhoea and other infectious diseases." [71]

2.4.1.2 McKeown and the Importance of Nutrition[72]

McKeown (1976) took a quite different approach analysing the history of health and health care in Great Britain during the 18th and 19th century. In his opinion, the extraordinary decrease of disease related deaths as a result of the medical breakthroughs of the period, such as the discovery of vaccination and improvements in hygiene, was overrated. He laid the focus on the importance of nutrition, concluding from his studies that a healthier nutrition resulted in an increased immunity against airborne infectious diseases. Contrary to Preston, he attributed the prime responsibility of an increased life expectancy to economic advancement resulting in higher standards of living and a well-balanced diet.

Even though he underestimated the relevance of preventive medical services and drew his conclusions from the study of only a single country, he must be granted the achievement of shifting the scientific attention to the implications of malnutrition and undernourishment – a significant health issue in combination with infectious diseases in DCs.

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[71] Szirmai (2005), p.194.

[72] For further reading, see e.g.: McKeown, T. (1976) and McKeown, T. (1988).

2.4.1.3 Mosley´s Model on the Importance of Education

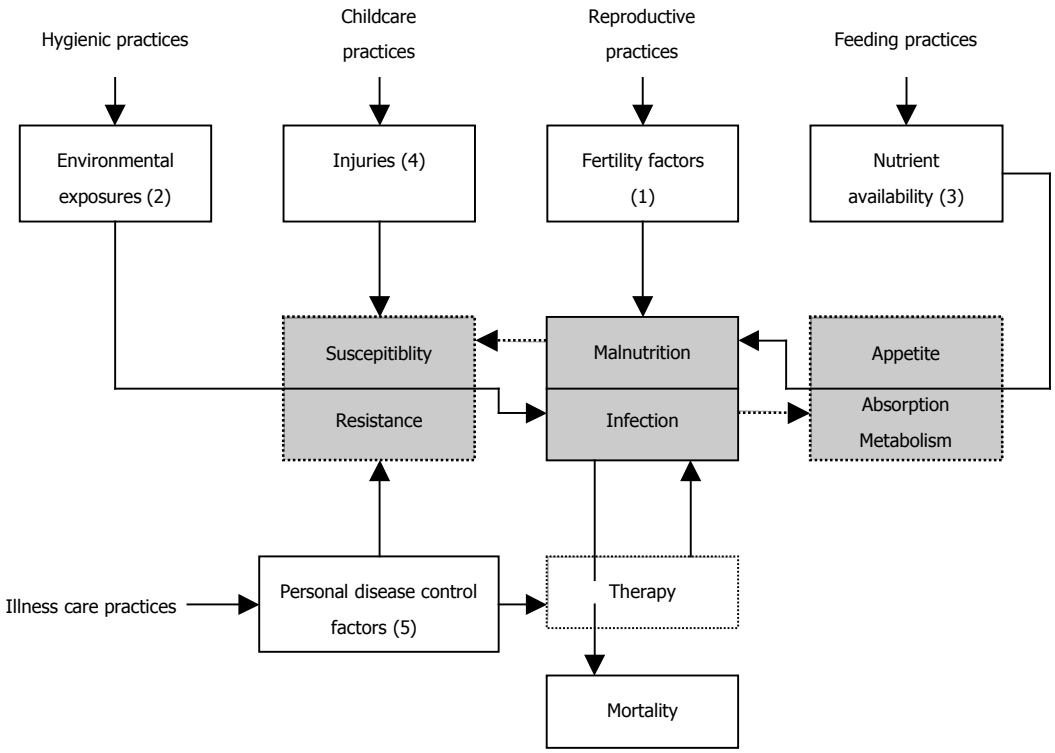
Mosley departed from data on child mortality rather than life expectancy claiming that in an adequate and healthy environment 98% of children under the age of 5 ought to survive, as it is the case in industrialised countries. If this is not the case, the derogative environmental variables had to be identified. Focusing on the environs, he significantly contributed to the discussion on which influence socio-economic as opposed to medical factors had on the health status of individuals. "The essence of the model is the identification of intermediate variables, in order to analyse how primary determinants influence child mortality through the intermediate variables."[73]

Mosley's model consists of the following intermediate variables[74]:

- Maternal fertility factors:
  - Age of childbearing (child may be at risk when the mother is too old or too young)
  - Number of children per woman (large families reduce the health prospect of children)
  - Birth intervals (too short intervals may have adverse effects on health; in general, children from large families are more likely to contract diseases than children from small families)
- Environmental contamination by infectious agents; contamination of:
  - Air
  - Food, water or fingers
  - Skin (caused by soil or mites)
  - Vectors
- Availability of nutrients for foetus and child:
  - Calories
  - Proteins
  - Vitamins
  - Minerals
- Injuries:
  - Accidents
  - Injuries inflicted intentionally
- Personal disease control factors:
  - Personal preventive measures
  - Treatment of illnesses once they are contracted

[73] Szirmai (2005), p.195.
[74] Szirmai (2005), p.196.

Figure 2.2. Intermediate Factors Influencing Child Mortality



Source: Mosley (1983), in Szirmai (2005), p.197.

In the centre of attention stand malnutrition and infection, which are, directly or indirectly, influenced by all other intermediate variables. The quintessence of this model is the fact, that child mortality is not the result of any one single factor. A history of poor hygiene, nutrition and health services lead to a constant physical weakness and therefore higher susceptibility to illness. An otherwise non-lethal malady, such as diarrhoea, can ultimately cause death.[75]

These three early concepts already highlight the devastating impact that poverty, a lack of education and malnutrition can have on the health status of a person. Even though, they suggested that there is only one major cause for child mortality, they clearly stated the importance of a healthy and enabling environment in order to develop into a physically and mentally healthy person.

[75] See Szirmai (2005), p.197.

2.4.2 The Role of the Household

An entity as diverse and complex as a household poses multiple problems when trying to define it. The simplest and basic model in economics is that of the *unitary household*, which typically is regarded as a single person household or else that decisions are taken as if the individuals within had a *single set of preferences*. Further assumptions include the pooling of income and risk in order to efficiently allocate resources for production, consumption and investments. Consequently, gender ought not influence intra-household allocation[76].

Unfortunately for economists, individuals function more complex than that and decisions are not always taken along the lines of theory. In fact, numerous studies have shown that gender does matter, resources are allocated according to competing preferences and bargaining power plays a prominent role on the subject.

> "One implication is that the distribution of resources within a household, not just the level of resources, matters. Policies that alter the distribution of resources among household members shift the balance of power among those members, with implications for gender equality and family welfare."[77]

As aforementioned, a decisive aspect of intra-household allocation is bargaining power. The *WB Report on Engendering Development (2001)* argues that the model would actually give evidence for policymakers to promote gender equality since an increase in incomes and wages typically is associated with a decrease in gender disparities concerning the allocation of resources towards education, health and decision-making power. However, resource allocation decisions are normally inconsistent with the model, as the authors continue.

Some aspects identified as influential for bargaining power are[78]:

- Command over economic resources
- Possibility of 'exiting' the household
- Legal rights concerning ownership of property, marriage laws, etc.
- Access to financial resources such as credits
- Level of education, knowledge and skills
- Traditional social norms and restrictions

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[76] For references on empirical tests of the unitary household model, see WB (2001), Box 4.2, pp.157-8.
[77] WB (2001), p.148.
[78] WB (2001), pp.149 cont.

An array of studies for numerous countries[79] has brought to evidence that a relative reallocation of resources into the hands of women increases family welfare, child nutrition and health, as well as the females' own well-being and status.

2.4.3 Utilitarianism and Rawls' Theory of Justice[80]

2.4.3.1 Basic Concepts

In the *classical utilitarian theory*, the *social welfare function (W)* is constructed as the (additive) sum total of all *individual welfare functions (U).*

$$W=W(U_1, U_2,\ldots,U_n)$$

Realising that this assumption is too simplistic, modern theorists, such as Kenneth Arrow, modified the definition to *ordinal utilitarianism*. Here, W is still an aggregate of U but individuals now choose their preferred bundle of goods, rather than rationally calculating the advantages of each possible bundle of goods and then electing the one with the highest return.

One of the main problems and points of critique of this concept is the total ignorance of social equity and fairness. For market economists in general and utilitarianists in particular, social welfare is the possession of goods which leads to individual utility hence serving society as a whole; society being the aggregate of individual utilities. The concept doesn't ask whether the distribution of welfare is justified since one of the basic principles of economic theory, the *Pareto optimum*, ensures efficient, hence justified, equilibria. The Pareto optimum, named after the Italian Economist Vilfredo Pareto, states that consumer and production markets are in equilibrium. Hence, *it is impossible to increase the personal welfare of one individual without decreasing the welfare of another individual*. In such a system, if redistribution measures, such as an incremental tax system, are implemented, it is not because of concern for social welfare and equity. It is rather the result of a decision making process of society. One can also call it an altruistic decision: by ameliorating the plight of the poor, one integrates their welfare into one's own welfare function U.

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[79] For references see the Appendix 4, WB (2001).

[80] Based on Rice (2004), Chapters 2 & 6, for an in depth introduction see Blackorby, Charles et.al. (2002): *Utilitarianism and the Theory of Justice* in Arrow, Kenneth et.al. (eds.): *Handbook of Social Choice and Welfare*, Vol. 1, Elsevier Science B.V.

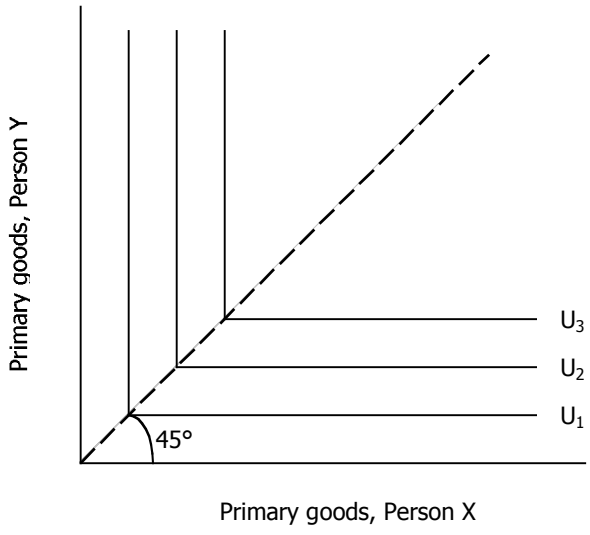
2.4.3.2 Rawls' Theory of Justice

This path breaking theory first published in 1971 gave way to a new dimension in the discussion of social welfare in economics.

Rawls formulates his concept around the idea of a *primitive state* in which people are in complete oblivion of the future (similar to the Cave allegory in philosophy). In this state of mind, the so called *veil of ignorance*, they formulate the pillars of an equitable society, not knowing which political form it will have nor which status or class they will belong to or how properties and capabilities will be distributed. The aforementioned pillars are the *primary goods*: rights & freedoms, power & possibilities, income & welfare and self-esteem (notice that health is not one of them). An inequality in distribution of these goods can occur, if it is advantageous for all. Along these lines, inequalities are unfair only if it is not to the wellbeing of everyone.

The final goal is the *principle of difference*, as Rawls calls it: society will not advance unless it ensures that those who have the least are better off. Only if ameliorations trickle down to the most disadvantaged, will the rest receive resources. This principle is also known as *maximin*: one is willing to maximize the resources of those who only dispose over a minimum.

Figure 2.3. Social Welfare in Rawls' Theory



Source: Rice (2004), p.206.

The 45° line illustrates the perfectly equal distribution of primary goods. A curve on a higher level simply represents a higher degree of social welfare. The only possibility to ascend to a higher curve is by increasing the resources of primary goods of the person

who possesses the least. And why would anybody choose to act upon these principles? Rawls argues that it is the most sensible thing to do since it leads to a situation where everybody receive what one needs and is therefore satisfied.[81]

Various points of criticism have been formulated in the literature which Rice (2004) sums up in three statements.[82]

- People would not opt for a maximin solution.

  Many economists argue that, in order to get to such a solution, one would have to assume risk aversion among the population since it is unrealistic to expect them to prefer a situation where everybody gets a little over a situation where one has the chance of being among the very rich. Even though this critique is quite hypothetical, what one may ask, is whether there is not too much efficiency lost for a spark of justice.
- A greater number of groups should profit.

  A true weak point of the theory is the fact that only the least advantaged should profit. As a point of reference for this group, Rawls draws on a representative person of that society. Still it would be difficult to determine who is the most disadvantaged since in no decision all the aspects of one's personal surroundings can and will be taken into account. Moreover, it is almost certain that some people will make better use of their share of primary goods than others.
- Decisions on redistribution should be based on different criteria.

  In the Theory of Justice, everyone receives the same share regardless of motivation, performance or willingness to work. As has been evidenced in similar social organisation models, such as communism, an egalitarian approach to distribution of resources, and might it only be in theory, hampers the individual to thrive for innovation, excellence, etc. since there is no reward for it. Hence, this mounts in a sizeable loss of efficiency. Also, the aspect of individual capability is forgotten which adds further to deficiency.

Rawls' theory has contributed a whole new framework to development economics, in regarding distribution and allocation of resources from a completely different angle than 'conventional' economists.

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[81] Rice (2004), p.207.
[82] Rice (2004), pp.210 cont.

2.4.4 Sen's Capabilities and Functionings

"[…] it also pointed to the remarkable fact that economic unfreedom, in the form of extreme poverty, can make a person a helpless prey in the violation of other kinds of freedom. […] Economic unfreedom can breed social unfreedom, just as social or political unfreedom can also foster economic unfreedom."[83]

Amartya Sen

1998 Nobel Laureate of Economics, Amartya Sen, is one of the key proponents of development economics and has dedicated a substantial part of his studies to the exploration of the standard of living and an alternative to the *utility approach* of mainstream economics. Unlike the latter, which argues that utility is the end of all commodities, Sen stresses the capability of humans of efficiently putting these commodities to use; or, speaking in his own terms, the capability of individuals to function. "What matters is not the things a person has – or the feelings these provide – but what a person *is*, or can be, and does, or *can* do."[84] The focus of attention hence shifts from the objects (commodities) to the subjects (individuals). In mainstream economics it is often forgotten that individuals are not only a means to an end (production) but that development of the individual is an end in itself. Hence, an economically rich country can also be poor in human development terms, as often said of the oil exporting countries of the Arabic peninsula.

2.4.4.1 Freedom as the Means and the End of Development

According to Sen, the prime prerequisite of development is freedom. Acknowledging that the list is by no means comprehensive or complete, he identifies five *instrumental freedoms*[85]:

- Political freedoms basically are democratic freedoms, such as the right to vote, to express one's opinion freely, a free and diversified press, etc.
- Economic facilities express his belief in the free market, the right to own and manage resources and the importance of distributional considerations. "How the additional incomes generated (i.e. through income growth) are distributed will clearly make a difference."[86]

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[83] Sen (1999), p.8.
[84] Todaro (2003), p.17.
[85] Sen (1999), pp.38-40.
[86] ibid.

- Social opportunities "refer to the arrangements that society makes for education, health care and so on, which influence the individual's substantive freedom to live better."[87]
- Transparency guarantees stand for the disclosure and lucidity required when entering into transactions with other people. In other words, they represent the protection against "corruption, financial irresponsibility and underhand dealings."[88]
- Protective security can be circumscribed as a comprehensive institutionalised social security net to protect from poverty, as well as emergency relief in cases of famine or natural catastrophes. Sen strongly believes in the intervention of the state to secure the individuals' capability to use the freedoms.

2.4.4.2 Functionings and Capabilities

At the core of Sen's concept lies the *capability approach*. It argues that an overflow of commodities is of no use to a country and its people if they are not capable of using them. Sen brings the example of the apparent uselessness of a book to an illiterate person.

> "The concept of "functionings" … reflects the various things a person may value doing or being. The valued functionings may vary from elementary ones, such as being adequately nourished and being free of avoidable disease, to very complex activities or personal states, such as being able to take part in the life of the community and having self-respect. A person's "capability" refers to the alternative combination of functionings that are feasible for her to achieve. Capability is thus a kind of freedom: the substantive freedom to achieve alternative functionings combinations."[89]

Hence, the circle is closed again to arrive at the primordial principle in Sen's work: freedom. In order to make use of one's capabilities and freedoms (or, economically speaking, income), one has to overcome several personal and social obstacles, adversely influencing one's functionings[90]:

- Personal heterogeneities, such as gender, age, health status, etc.
- Environmental diversities consisting of climactic circumstances, regional occurrence of diseases (e.g. malaria), or pollution

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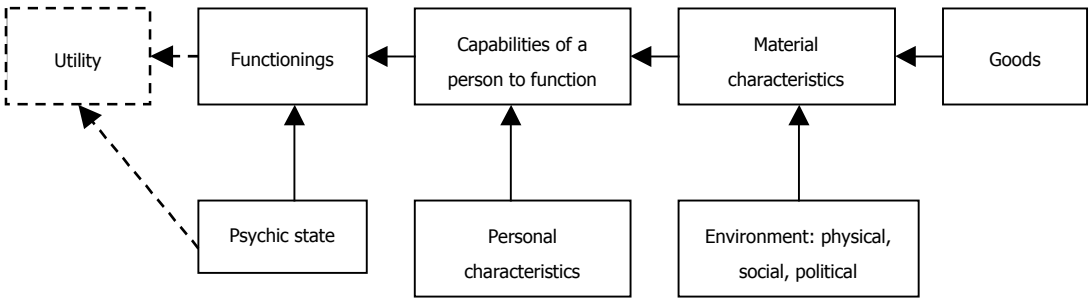
[87] Sen (1999), pp.38-40.
[88] ibid.
[89] Sen (1999), p.75.
[90] See Sen (1999), pp.70-1.

- Variations in social climate refer to the level of criminal offences in the surroundings, as well as institutional settings, such as the existence of public education and health care
- Differences in relational perspectives are concerned with the community surroundings. "…being relatively poor in a rich community can prevent a person from achieving some elementary "functionings" even though her income, in absolute terms, may be much higher than the level of income at which a member of poorer communities can function…"[91]
- Distribution within the family emphasises the relevance of how the pooled income is used for the individual family members, acknowledging the fact that discrimination between family members is one of the most common hindrances for personal development.

In a comment to Sen's book *Standard of Living (1985),* Muellbauer (1985) tried to capture the relations of Sen's concept in the following model. The quintessence is that relations between commodities and individuals are much more complex than the utilitiy approach or the GDP make us believe.

Figure 2.4. Sen's Concept According to Muellbauer



Source: Muellbauer (1985), in Fellner (2004), p.73.

The grafic displays the relationship between the human individuals' variables (and the possible obstacles which lie therein), the economic situation and Sen's functionings and capabilities which all, directly or indirectly, influence utility (of a service, an action, a good, etc.).

[91] Sen (1999), pp.70-1.

2.4.4.3 Some Points of Critique

In commenting on *Development as Freedom*, Vicente Navarro (2002) formulates the major weaknesses he sees in Sen's concept, which are only briefly hinted at as a starting point for further exploration:

- Sen frequently refers to the interrelationship among his established instrumental freedoms but never explains in detail the nature or reasons for this interdependency.
- The absence of a theory relating these freedoms is "within the classical economic tradition, based on Adam Smith, in which the individual is the subject and object of analysis; collective agents and subjects such as social classes do not appear, nor does any analysis of what articulates these collective agents such as exploitation or domination."[92]
- Considering that democracy is such an important point of reference within Sen's work, it is surprising that he never discusses the political context of development and its variations. "Sen constantly refers to liberty and freedom without once making reference to the political context that gives them meaning."[93]
- Further along these lines, Navarro criticises the lack of explaining the sources of power that work in a society and their reproduction, disentitling the freedoms of their framework within which they exist.

Navarro's critique focuses on the lack of presenting an adequate political context for Sen's approach, the latter expressing a dualistic view of political systems, referring to democracy versus dictatorship, without once outlining the fundamental pillars of these concepts.

Overall, one has to pay Sen his due credits, as being one of the first development economists who challenged the dominating viewpoints of the World Bank and the IMF. In moving his interests from economic growth as the ultimate solution to all development problems and bringing the human being and his development back into the picture, he not only laid the basis for the UNDP Human Development Index, lectured upon later, but gave development back its human face.

> "With adequate social opportunities, individually can effectively shape their own destiny and help each other. They need not be seen primarily as passive recipients of the benefits of

[92] Navarro (2002), p.465.
[93] Navarro (2002), p.466.

cunning development programs. There is indeed a strong rationale for the recognizing the positive role of free and sustainable agency – and even of constructive impatience."[94]

2.5 Economic Aspects of Engendering Society

While the previous sections have dealt with theoretical concepts and their proponents, the following sections introduce more practical aspects of engendering economy. Still on the basis of diverse concepts from economic researchers, the question will be discussed of whether it pays to promote gender equality and female empowerment and how this can be assessed.

2.5.1 Valuing Unpaid Female Work[95]

"We have two economies: the economy in which people earn wages in order to produce things to be sold on the market or financed through taxation. This is the economy based on goods, which everyone considers "the economy". On the other hand we have the hidden economy, the invisible one, the one devoted to care."

(Diane Elson, 1995) [96]

As recently as during the past two decades have institutions, governments and economists turned to the subject of evaluating the proportions of work done unpaid, whether voluntarily or as part of the housework chores, sparked by UNDP statistics estimating that an equivalent of 40% of the world's GNP is productive work not accounted for. Since work has generally been viewed as connected to the market with prices, products and services being efficiently allocated, household work and any other unpaid work has been regarded as "economically insignificant". Similar distinctions have been made in defining *labour force* or the *economically active population* as "all persons of either sex who furnish the supply of labour for the production of economic goods and services" (UN Statistical Commission 1966). Whereas this definition let it open how to value agricultural work done by family members, it did not allow for the inclusion of domestic housework.

"The Commission proposes …to redefine work in a broad sense that encompasses both employment and unpaid activities benefiting society as a whole, families as well as individuals, and ensuring an equitable distribution of the wealth generated." [97]

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[94] Sen (1999), p.11.
[95] Based on Benería (2003), Chapter 5.
[96] Elson, Diane cit. in Campillo (2003), p.106.

Namely, there exist four distinct types of unpaid work, all facing different levels of recognition and valuation:

2.5.1.1 The Subsistence Sector

Per definition, this work is included in the labour force, but in practice, there are still severe obstacles to be overcome, especially concerning the recognition of women's predominance in this sector in rural Africa (women produce 90% of the food in Africa[98]). As the subsistence sector is typically associated with agricultural production of goods for family use, it is often viewed as part of the housework and therefore as part of women's obvious tasks which are not to be remunerated. It follows that, even though there have been extensive surveys on the amount of time and work load allocated to this sector, women's work is systematically underestimated and underreported due to cultural perceptions and political ignorance.

2.5.1.2 The Informal Sector

This sector has been a focal point of governments and labour organisations but for different reasons. The informal sector poses the problem of existing on the verge to illegality, primarily producing goods for the garment, shoe and chemical industries. The infamous *sweatshops* on the Mexican-US boarder first brought this sector into the focus of public attention but little has changed since then. Governments are looking to legalise the sector because of the taxes not paid, labour organisations protest against it because of the precarious working conditions with low wages, long working hours and virtually no safety precautions and social benefits. And again, it is predominantly women and children working in this sector because it is often the only chance of earning at least a little money for their families.

For these reasons, efforts of collecting data and information on the topic exist since the 1990s by the UNDP and local governments in order to be able to draw up reliable estimates on the sector and improve conditions for those involved.

2.5.1.3 Domestic Work

The discussion of where to draw the line between domestic work, care work and leisure time is turbulent and ongoing. Clearly, in many societies domestic work such as cooking,

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[97] Report of the Independent Commission on Population and the Duality of Life, *Caring for the Future* (1996), as cited in Benería (2003), p. 152

[98] ECA (2004), p. 1

child care and washing is seen as a natural female task no matter whether looking at a "modern, industrialised country" in Europe or "rural, traditionalist countries" in sub-Saharan Africa. Of course, a considerable amount of this work is performed by (female) non-family members when women access the labour force and household income is high enough to afford it. That is also the main argument of why this type of work should be included in the national accounting system since it is productive work, benefits society and individuals and has market prices associated with it.

2.5.1.4 Care Work

> *"Conservative social thinkers, including many economists, insist that women are naturally more suited to child care, and that this, in turn, gives them a comparative advantage in providing care to others, including the sick and elderly. Specialization, after all, increases efficiency. But specialization also effects the development of human capabilities and the exercise of bargaining power."*[99]

The Neo-classical Approach

Especially care work has received wide attention from economists of all fields. As already hinted at in section 2.4.2, the (neo-)classical approach to care work is based on household models, which all believe in the alleged truths of the market mechanism. An extension to the unitary household model trying to account for some of the problems is Nobel laureate *Gary Becker's model of the division of work (1981)*[100] within the family. In Becker's model, both women and men start out with the same intelligence and education. When a child comes in the household, the woman will increase her biologically prone predisposition to household work, therefore increasing her efficiency by means of specialisation. While she is accumulating household-related human capital, the man increases his productivity in the labour market, also adding to his specialisation. By pooling and trading their inputs and outputs, the household gains as opposed to both acting in isolation. This model, also called *trade model* or *pure transaction model*, rectifies the postulation that women should stay at home where their strengths lie and let the 'breadwinner' earn the money.

On behalf of the feminist neo-classical camp, Wunderink-van Veen (1997) elaborates on *New Home Economics*[101]. Based on the *model of consumer behaviour* and *Becker's*

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[99] Folbre (2001), pp.5-6.
[100] as described in Gustafsson (1997), pp.39-41.
[101] Wunderink-van Ween (1997), pp.17-35.

household production model her concept tries to explain a two-person households' allocation of time in the presence of children. Furthermore, it gives an explanation of how the household decides on each individuals' labour market participation, depending on income, availability of subsidies and day care services. She comes to such surprising conclusions as that an increasing wage rate increases not only the probability of participating in the labour market, but it also intensifies participation; or that cheap and sufficient child care services foster labour market participation of both women and men. All the same, she recognises the threat of an 'unwanted dependency' through 'extreme specialisation'.[102]

The Invisible Heart

A very different approach, and more along the lines of UNDP and UNIFEM, is taken in Folbre's *The Invisible Heart*[103] (2001) in which she skilfully contrasts the invisible hand of the free market and its underlying principles with the enormous workload executed unpaid and unrewarded by women around the world. Whether it is childrearing, care for elderly family members or helping out in every day life, without all these efforts our social and health systems would have crashed a long time ago. Values such as trust and respect, acquired in the family, are important prerequisites for the functioning of the market in order to minimize the risks for an individual and compensate for the (in neo-classical theory non-existent) information gap (How would a contract work without trust and respect).[104]

> "We have more trust in the invisible hand of the market if it is joined by an invisible handshake that conveys not only trust but good will. A long-term personal relationship improves the efficiency of a short-term transaction."[105]

Folbre(2001) not only criticises the invisibility of female house and care work, but she also points to the fact that 'pink collar workers' as she terms them, such as nurses, nannies or social workers, are among the employees earning the least amount of money for some of the most responsible and strenuous jobs in and for society.

Where Wunderink-van Ween comes to the prosaic conclusion that, upon balancing the pros and cons of child rearing, parents might neglect "changes in human capital and long-term earning capacity" in the short-term, but - and here comes the flabbergasting insight

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[102] Wunderink-van Ween (1997), p.35.
[103] Folbre (2001).
[104] Folbre (2001), p.25.
[105] Folbre (2001), p.27.

– "in the long-term analysis it is very common to neglect *the short-term joy of raising one's own children.*"[106], Folbre reverses the argument stating that "Parents who raise happy and successful children create an especially important good"[107]. Where else in the free market would society (aka. the aggregate) receive such a precious contribution for free?

2.5.1.5 Volunteer Work

Typically associated with female, high income input, volunteer work often is limited to community, religious or health care work. Not wanting to underestimate the high value for society of these kinds of activities, we here want to focus on the problem illustrated by Benería with the following example. In the poverty-stricken areas of the Lima slums, women came together to form communal food kitchens, pooling their resources, organising for cheap provision of aliments, negotiating with public administration offices and aid organisations to feed up to 200,000 people as often as five times a week. Given the enormous social benefit but also the impressive managerial skills needed for this sort of event, who can say that that is "economically insignificant" work because it is done voluntarily, or, as Benería formulates it more aptly, when "participation in volunteer work results from choice or lack of it" [108].

2.5.2 Positive Effects on Education, Health and Economy

> *"Foremost among the costs of gender inequality is its toll on human lives and on the quality of those lives. It is not easy to identify and measure those costs, but evidence from countries around the world demonstrates that societies with large, persistent gender inequalities pay the price of more poverty, more malnutrition, more illness and more deprivations of other kinds."*[109]

There is a long list of advantages for an equitable society, as well as for the linkage between education and health. Closing the educational gender gap would first and foremost empower women to gain more independence, respect and self-esteem. Furthermore, even a basic education of a mother improves child nutrition and health, lowers infant mortality and fertility. Naturally, education fosters labour market participation and increases women's productivity, same as does better health. An

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[106] Wunderink-van Ween (1997), p.34, italics added by the author.
[107] Folbre (2001), p.50.
[108] Benería (2003), p.140.
[109] WB (2001), p.73.

improved health status also decreases maternal mortality and supports educational efforts by ameliorating the concentration and receptiveness. All these aspects automatically increase the value and capacities of human resources.

A report from the *Economic Commission for Africa (ECA),* the *African Development Bank (ADB)* and the WB, establishes the fact that Africa has hidden growth reserves residing in potential partnerships between governments and households, particularly the women in the households, concluding that "…greater gender equality could be a potent force for accelerated poverty reduction in Africa."[110] Gender inequalities in education and employment combined are estimated to have reduced sub-Saharan Africa's per capita growth in the 1960-1992 period by 0.8% per year.
In addition, surveys have shown that a higher percentage of women involved in political and business institutions counteracts corruption and is associated with better governance.

In order to add economic value to the unpaid work done, the *International Research and Training Institute for the Advancement of Women (INSTRAW)* and the Statistical Office of the UN Secretariat, since the 1980s, took the lead in promoting the establishment of indicators and models to integrate hitherto unaccounted workload into national accounting systems. Their conceptual approach was via *satellite accounts* whose "purpose … is to measure unpaid production of goods and services by households and to provide indicators of their contribution to welfare."[111] As reference point served the market activities and Margaret Reid's *third-person principle*. It stated that those household activities should be included in national accounts, which are also conducted by non-family members.[112]
Methodologically, two approaches are commonly used:

- The input related method based on the imputation of value to labour time by means of time use surveys
- The output related method based on the imputation of market prices to goods and services produced in the domestic sphere.

Another issue of importance is the changing social environment. Through the globalisation and privatisation trends of the past, public health and care services have been cut

[110] ECA (2004), p.3.
[111] Benería (2004), p.141.
[112] See also Sikoska (2003), *Measurement and Valuation of Unpaid Household Production: A Methodological Contribution,* in Gutiérrez (2003).

significantly in many countries, as already mentioned above. Hence, "[w]ith globalization, men and children also begin to experience a care deficit, if the pressures of the double burden of paid and unpaid work becomes too much for women and men do not take on more of this work."[113] But as Payne (1992) observes not without cynicism: "…even where men participate in this work, women remain largely responsible for ensuring that it gets done, the needs of different members of the household are met, children visit the dentist and there is a new role of toilet paper in the bathroom: it is a system in which men may help, but women do."[114]

To summarize, there are many reasons for the inclusion and valuation of unpaid work into national accounts and public awareness[115]:

- Unpaid (female) work is important in relationship with the total work time.
- Women bear a larger burden of work and therefore valuation of their work performance would also increase their bargaining power.
- Engendering budgets would provide insight into how policy initiatives affect women and men differently, therefore enabling programmes to be designed more effectively.
- The valuation of unpaid work would considerably increase GNP and GDP values in developing countries.

The ultimate question remains how to measure human wellbeing and what is considered of value to our societies.

> "The point repeatedly being made is that current GNP statistics include what is bad for our health – such as the production of food with carcinogenic chemicals – or for the environment – such as the output of polluting factories. Yet, there has been resistance to the measuring of work and production of goods that sustain and enhance life."[116, 117]

2.5.3 Conclusion

This chapter has given an outline of dominant development theories, their impact on development politics and the gradual introduction of the gender issue into economic development theory and thinking. The concepts defined and explained in section 2.3

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[113] UNIFEM (2000), p.8.
[114] Payne (1992), p.81.
[115] UNIFEM (2000), Conclusion.
[116] Benería (2003), p.159.
[117] For more information on the topic of gender budgets, visit UNIFEM Gender Budgets, www.

serve as the basis for the further analysis of public health and gender issues in developing countries, international organsiations and development assisstance programmes. Terms such as empowerment, engendering, health and poverty will guide like a thread through the following chapters.

In an age, where people demonstrate for the rights of animals to be treated in a more "humane" way, it is preposterous to consider that women in all countries of the world are still punished for their being female and denied of basic human rights, such as the control over their own body. From a gender perspective, every country needs further development, even if, of course, there are huge differences in the treatment of women across regions and nations.

> "Nothing, arguably, is as important today in the political economy of development as an adequate recognition of political, economic and social participation and leadership of women. This is indeed a crucial aspect of "development as freedom"."[118]

[118] Sen (1999), p.203.

3 MEASURES OF POVERTY, INEQUALITY AND HEALTH

"…there is no such thing as a purely objective measure. Valuation also enters in the choice of what to include and exclude…"[119]

When making a statement, one usually wants to give proof of its validity and significance. In order to be able to measure the extent of poverty, inequality and health in a population, many statistical methods, tools and indices have been designed over the decades. In recent years, researchers have also tried to capture the complex relations between the three by developing compound measures and added gender and racial variables to give an even preciser picture. This chapter gives and overview over the most commonly used indices and indicators and what they stand for. To conclude the topic, the last section will briefly introduce the difficulties and traps which can arise when working with figures and databases.

3.1 Measuring Welfare and Inequality

The measurement of welfare and inequality is closely connected with the discussions on the definition of quality of life, poverty and development within the prevailing economic concepts. In economics, welfare is most commonly associated with the growth of per capita income following the concept of neo-classical growth theory. Thus, it is only seen as the expansion of individual consumption possibilities, ignoring such eminent factors as health, leisure time and social integration.

One of the predominant questions, however, is on the choice of indicators to measure the desired entity. An indicator is an observable and measurable parameter, which figures as a descriptor for "immeasurable" circumstances (e.g. literacy rate – level of education) whereas an index is the aggregate of several indicators.[120]

3.1.1 GDP and GNP

The *gross domestic product (GDP)* measures the total value for final use of output produced by an economy, by both residents and non-residents. When adding the difference between the income residents earn abroad for labour and capital less payments made to non-residents who contribute to the domestic economy one receives the *gross*

[119] Hanson (2002), p.314.
[120] Feldmann (2000), pp.9-10.

national product (GNP), being the indicator most widely used for the overall level of economic activity.[121]

To compare economic statistics across countries, though, the data must first be converted into a common currency. Since conventional exchange rates bare the risk of volatility and fluctuations, hence distorting the picture, the international financial institutions started to use *purchasing power parities (PPP)* to smooth out the discrepancies. "PPP rates of exchange allow this conversion to take account of price differences between countries. By eliminating differences in national price levels, the method aids comparisons of real values for income, poverty, inequality and expenditure patterns."[122]

Over the decades there have been many points of critique against the consistent use of GNP and GDP per capita[123]:

- The indicators ignore income distribution. Countries with a fairly equitable income distribution rank on the same level as countries where for example 5% of the population earn 60% of income.
- The comparison between countries is difficult, not only because of diverging data but also because differing economic structures influence the GDP and GNP as well.
- Externalities such as exploitation of natural resources and environmental damage are not accounted for.
- The informal sector such as charity work, work in NGOs, and most importantly, household work are not included unless they are processed via the market (the issue of including household work into the national accounting system and economics has already been discussed in section 2.4.1).

To compensate for these and other critiques, economists have designed alternative measures for human welfare and development spearheaded by the UNDP and its *Human Development Reports* (see section 3.1.4).

3.1.2 Lorenz Curve and GINI Coefficient[124]

The *Lorenz curve* images the income distribution, that is, it shows the actual quantitative relationship between the percentage of income recipients and the percentage of total income they received during a given period of time (in cumulated values). By drawing the

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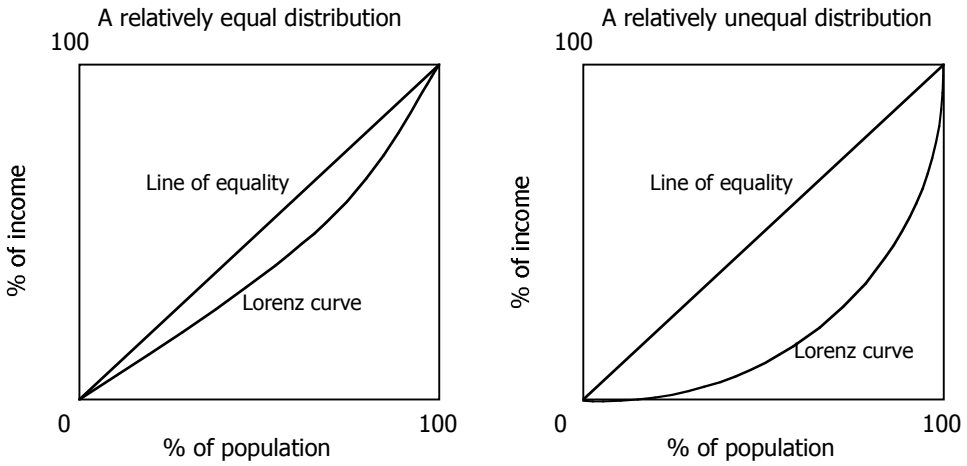
[121] See Todaro/Smith, p.47-50.
[122] HDR (2002), Box 5.
[123] See Diefenbacher (2001), p.121.
[124] See Todaro/Smith (2003), p.199-203.

line of equality and measuring the degree the Lorenz curve bends away from it, the degree of inequality of income distribution can be estimated.

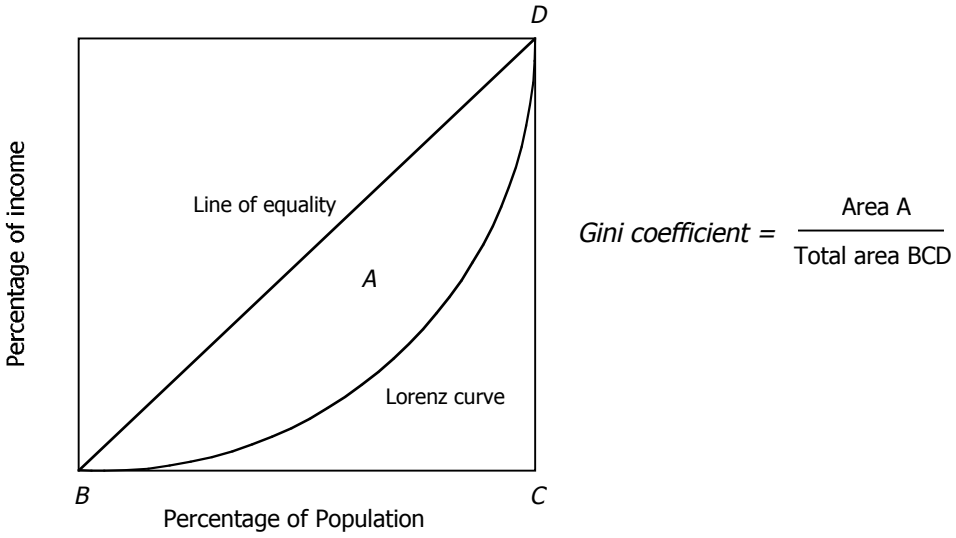
Figure 3.1. Lorenz Curve and Relative Degree of Inequality



Source: Todaro (2003), p.201.

To compare income distribution levels among countries, the *GINI coefficient* is deduced from the Lorenz curve. It is an aggregate measure represented by the area confined between the line of equality and the Lorenz curve. Its value ranges from 0 (perfect equality) to 1 (perfect inequality) lying between 0.50 and 0.70 for highly unequal income distributions and between 0.20 and 0.35 for rather equitable distributions.

Figure 3.2. Estimating the GINI Coefficient



Source: Todaro (2003), p.202.

As already mentioned for the GDP and GNP, there are of course certain problems concerning the Lorenz curve and the GINI coefficient[125]:

- The comparison between countries may be difficult because what is counted as income or how the data is collected may differ, sometimes significantly.
- In countries where richer households put their income to use more efficiently than lower income households, the Lorenz curve underestimates inequality.
- The distribution of income can vary greatly between countries even though they display similar GINI coeffiecients, since Lorenz curves can have different shapes and still yield the same results for the coefficient.
- In order to interpret the GINI coefficient correctly, one needs to know the proportions of the quantiles used, since a higher proportion (e.g. twenty 5% quantiles) results in a higher coefficient.

Therefore, one should always examine more than one indicator in order to get a better picture of the inequality, which exists within a country or between populations.

3.1.3 Poverty, Poverty Line and Poverty Gap

Normally, when speaking of the *poverty line*, one refers to the US$(PPP) 1 a day World Bank definition of *absolute poverty*. Following this defintion, a person is absolutely poor if

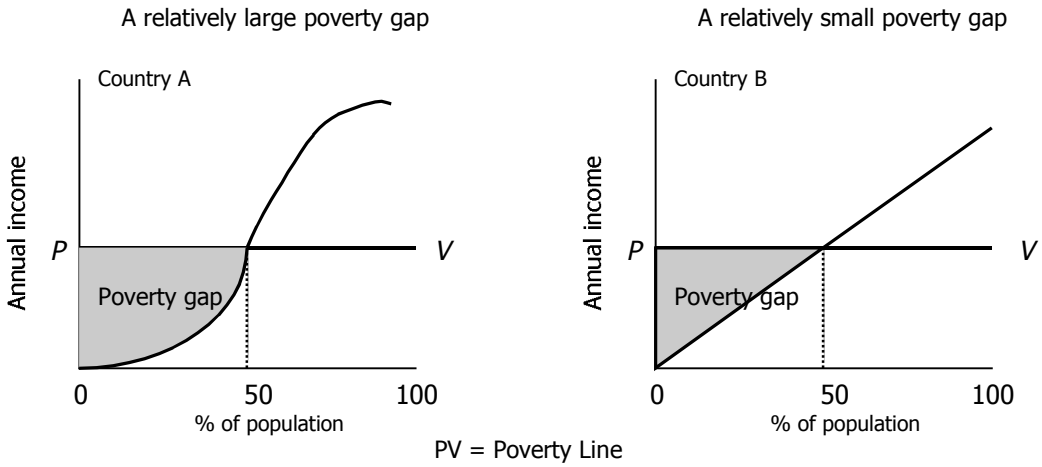
[125] Wikipedia (2005), www.

he/she does not have more than US$(PPP) 1 to spend a day. When this *headcount* is set into relation with the total population, it becomes the *headcount index* and displays *relative poverty*.[126]

Generally speaking, any minimum income levels defined for example by national governments are poverty lines. In the HDR, the WB poverty line is used as part of the *income poverty line* to calculate the HPI-2 (which is explained in the next section)[127], whereas *income poverty* is generally defined as the population having less than 50% of the median adjusted household income to dispose of.[128] The problem with measuring poverty by means of a poverty line is "that the cut-off point is artificial. […] [d]ifferences between those just above or on the poverty line and those at the very bottom of the income scale are not accounted for."[129]

The *poverty gap* is measured as the total amount of income necessary to raise all the people below the poverty line above it.

Figure 3.3. Measuring the Poverty Gap



Source: Todaro (2003), p.207.

3.1.4 HDI and HPI[130]

The *Human Development Index (HDI)* was designed and formulated by the UNDP and introduced in the HDR 1990, based on Sen's capabilities approach. After several adaptations it is now "a composite of three indicators which reflect important dimensions

[126] Absolute poverty is also defined as the number of people not disposing of enough resources to satisfy their basic needs (food, shelter and clothing). See Todaro/Smith (2003), pp.205-6.
[127] HDR (2004), Table 3, p.3, and Table 4, p.1, www.
[128] UNDP Definitions, p.5, www. See also Einkommensarmut, www.
[129] Payne (1992), p.25.
[130] See UNDP (2004), pp.1-3, www.

of human development: *longevity* as measured by life expectancy at birth; *educational attainment* as measured by a combination of adult literacy (two-thirds weight) and combined primary, secondary and tertiary enrolment ratios (one-third weight); and *standard of living* as measured by real GDP per capita (in purchasing power parity dollars)."[131]

Before calculating the actual HDI, the three components are set into relation with a minimum and maximum value (*goalposts*) for each of the dimensions:

$$\textit{Dimension index} = \frac{\textit{actual value} - \textit{minimum value}}{\textit{maximum value} - \textit{minimum value}}$$

Figure 3.4. The Goalposts for the HDI 2004

Indicator value	**Maximum**	**Minimum**
Life expectancy at birth (years)	85	25
Adult literacy rate (%)	100	0
Combined gross enrolment ratio (%)	100	0
GDP per capita (PPP US$)	40,000	100

Source: HDR Technote (2004), p.1, www.

To receive the HDI, these dimension indices are simply averaged out, receiving a result between 0 and 1. Highly developed countries typically score 0,95 (Norway) and 0,80 (Antigua and Barbuda); medium human development countries range between 0, 79 (Bulagria) and 0,50 (Cameroon); and low HD countries rank between 0,49 (Pakistan) and 0,27 (Sierra Leone).

The concept of the HDI shows major improvements in comparison with the mere calculation of GDP per capita, integrating social and health related indicators to mirror a more holistic view of development. Still, it is far from being the end to all discussions on welfare and must itself face serious critique, especially concerning its social indicators:

- Life expectancy at birth does not give evidence on the quality of the life lead.
- Enrolment ratios use numbers of national enrolment at the beginning of a school year and don't take into account the drop out rate.

[131] UNDP (2004), p.2, www. Italics by the author.

Moreover, there has been extensive political protest when governments were not pleased with their country's rank in human development. This lead to the decision by the UN to discard the HDR, in which the HDI List of countries is published every year, as official UN document[132].

Acknowledging these objections, the UNDP asserts that, "The HDI should be seen as evolving and improving rather than something cast in stone. It is also an exercise in which as many as possible of its users should actively participate."[133]

To appreciate the structural and political differences, there exist *two Human Poverty Indices*: for developing countries *(HPI-1)* and for selected OECD countries *(HPI-2)* but only the first shall concern us here.

While the HDI measures average achievement, the HPI-1 measures deprivations in the three basic dimensions of human development captured in the HDI[134]:

- A long and healthy life: vulnerability to death at a relatively early age, as measured by the probability at birth of not surviving to age 40
- Knowledge: exclusion from the world of reading and communications, as measured by the adult illiteracy rate
- A decent standard of living: lack of access to overall economic provisioning, as measured by the unweighted average of two indicators, the percentage of the population without sustainable access to an improved water source and the percentage of children under weight for age.

[132] See Nuscheler (2004), p.191.
[133] UNDP (1993), p.104.
[134] UNDP (2004), p.3, www.

Figure 3.5. Selected Countries and HDI/HPI Indicators

HDI Country Rank	HDI Value (2002)	HPI-1 (for DCs) HPI-2 (for OECD) Rank	HPI-1 (for DCs) HPI-2 (for OECD) Value (%)	Population living below national poverty line (%)
1 Norway	0,956	2	7,1	…
9 Japan	0,938	10	11,1	…
19 Germany	0,925	6	10,3	…
68 Venezuela	0,778	11	8,5	31,3
94 China	0,745	24	13,2	4,6
146 Uganda	0,493	60	36,4	44,0
176 Niger	0,292	94	61,4	63,0

Source: HDR Statistics (2005), www.

Along with the HDI and HPI ranks, the UNDP also publishes statistics on gender inequality and the presence of women in public life: the GDI and the GEM are introduced in section 3.2.2.

3.2 Gender and Health related Indicators[135]

"[…] it is important to keep in mind that this [i.e. income inequality] is only a small part of the broader inequality problem in the developing world. Of parallel or even greater importance are inequalities of power, …, gender, …, conditions of work, degree of participation, freedom of choice, and many other dimensions of the problem […]"[136]

GDP per capita is still the predominant indicator used for evaluating the welfare and health status of developing countries even though a series of studies has demonstrated that not the richest countries are also the healthiest, but those with the most equitable income distribution. It's not wealth determining individual health but the social status.[137]

3.2.1 Maternal and Infant Mortality Rates and Life Expectancy

Maternal and infant mortality rates are the most commonly used indicators to deduce information from concerning the health status of a country. The *maternal mortality ratio* represents the percentage of women per 1,000, 10,000 or 100,000 live births who died as a consequence of pregnancy and childbirth, respectively (within 42 days of delivery).

[135] For the exact definitions see also HDR (2004), *Health Situation Indicators: Definitions,* www.
[136] Todaro/Smith, p.196.
[137] Polak (1999), p.25.

Infant mortality is measured as the percentage of under 1 mortality per 1000 live births; *child mortality* is calculated as the death rate of under-5 year olds (the latter is called *Under 5 mortality rate* by the WHO). *Life expectancy at birth* is an estimate on the life span of a newborn. Another indicator used is the *life expectancy at birth ratio*, measuring the ratio of the life expectancy at birth of females to that of males, expressed as a percentage.[138]

Bearing in mind the difficulty of acquiring accurate data on maternal mortality, the University of Columbia in co-operation with UNICEF developed a set of *process indicators* better suited to monitor maternal health. Process indicators show changes in the circumstances known to contribute to maternal death, such as non-availability of medical treatment. They are therefore useful for planning and monitoring projects to avert maternal deaths, telling policymakers which minimum health facilities are needed in an area, whether they are actually used by the women and whether the quality is adequate.[139]

Analysing these rates, they draw a dire picture of differences in regional chances of survival. Life expectancy at birth has increased constantly in all regions of the world, except for SSA where it has actually dropped from around 55-60 years in the 80s and early 90s to below 40, in some countries. Also, infant and maternal mortality oscillate tremendously depending on literacy and educational level of the mother, availability of primary health care services and social practices, such as female genital mutilation in parts of SSA or girl child killings in India and China. Additionally, the rural or urban environment can also influence survival and of course the HIV/AIDS pandemic demands an ever-growing toll.

Regarded as prime indicators of world health, the decrease of maternal and infant mortality in developing countries constitute two of the eight *UN Millennium Development Goals,* further explored in Chapter 4. Highlighting the urgency of this goal, the following table shall give an impression of the discrepancy between developed and devloping countries concerning these indicators.

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[138] All definitions are taken from UNDP Definitions, www.
[139] See HDR (2003), Box 5, www.

Figure 3.6. Health Indicators for Selected Countries

HDI Country Rank	Life Expectancy at Birth (2002)	Infant Mortality Rate (per 1,000 live births, 2002)	Maternal Mortality Ratio (Reported , per 100,000 live births, 2002)	Maternal Mortality Ratio (Adjusted, per 100,000 live births 2000)
1 Norway	78,9	4	6	16
8 USA	77,0	7	8	17
14 Austria	78,5	5	…	4
69 Romania	70,5	19	34	49
72 Brazil	68,0	30	160	260
146 Uganda	45,7	82	510	880
177 Sierra Leone	34,3	165	1,800	2,000

Source: HDR Statistics (2005), www.

3.2.2 GDI and GEM[140]

The *Gender-related Development Index (GDI)* was first introduced in the HDR 1995 following the model of the HDI. The same three components – longevity, education and standard of living – are used to compile the index but now integrate the gender perspective. First, the disaggregated data for each of the components is brought together via the following formula:

$$\text{Equally distributed index}=\{[\text{female population share}*(\text{female index}^{-1})]+[\text{male population share}*(\text{male index}^{-1})]\}^{-1}$$

Finally, the unweighted mean of the three components is calculated:

$$GDI=1/3\ (\text{life expectancy index})+1/3\ (\text{education index})+1/3\ (\text{income index})$$

Accompanying the GDI, the HDR 1995 also presented the *Gender Empowerment Measure (GEM)*, which sheds light on whether women can actually take advantage of the aspects measured in the GDI. It analyses the active role women have in the economic and political life of a country and to which extent they are integrated in the decision making processes in relation to men. The following indicators are taken into account:

- Political participation and decision-making power, as measured by women's and men's percentage shares of parliamentary seats
- Economic participation and decision-making power, as measured by two indicators— women's and men's percentage shares of positions as legislators,

[140] Based on UNDP (2004), pp.4-6.

senior officials and managers and women's and men's percentage shares of professional and technical positions

- Power over economic resources, as measured by women's and men's estimated earned income (PPP US$)

Figure 3.7. Goalposts for Calculating the GDI

Indicator value	Maximum	Minimum
Female life expectancy at birth (years)	87,5	27,5
Male life expectancy at birth (years)	82,5	22,5
Adult literacy rate (%)	100	0
Combined gross enrolment ratio (%)	100	0
Estimated earned income (PPP US$)	40,000	100

Source: HDR Technote (2004), p.3, www.

For the indicators of female participation in economic and political life the actual percentages are used. After calculating these, the same formula as for the GDI is used to bring the data together, only this time the sum total is called *equally distributed equivalent percentage (EDEP)*. The GEM results as follows:

GEM=1/3 (EDEP for parliamentary representation)+1/3 (EDEP for economic representation)+1/3 (EDEP for income)

Figure 3.8. Selected Countries and GDI/GEM Indicators

HDI Country Rank	GDI Rank (2002)	GDI Value (2002)	GEM Rank	GEM Value	%Activity Rate[141] (2002)
1 Norway	1	0,955	1	0,908	59,9
8 USA	8	0,936	14	0,769	59,3
14 Austria	17	0,924	13	0,770	44,1
92 Tunisia	77	0,734	…	…	37,5
146 Uganda	113	0,487	…	…	79,3

Source: HDR Statistics (2005), www.

[141] Female economic activity rate age 15 and above in % of the total and active population as calculated by the international Labor Organisation (ILO).

3.2.3 Measuring the Global Burden of Disease: DALYs and QALYs

With its *1993 World Development Report (WDR)* entitled *Investing in Health*[142], the WB became a heavyweight proponent of health promotion as a means of accelerating development. Launched with the report was the concept of the *Global Burden of Disease (GBD)*, which tries to draw a picture of the costs of ill health and premature death on the world's economy. It was acknowledged that still too many people died of preventable childhood and communicable diseases, such as measles or whooping cough. The report for example estimated that 12,4 million children in 1990 had died of efficiently curable causes in developing countries. Had all of them been living in a high-income country, 90% would have survived!

3.2.3.1 GBD and the DALY

The WB collaborated with the WHO in conducting a study on the global health status and designing a method to mirror its outcomes. Hence, the GBD set out as a strategic and political tool to give evidence for the *priority setting* of health programmes and initiatives.
The GBD is measured in units of *disability-adjusted life years (DALYs)* and is composed of two indicators[143]:

- The years lost as a cause of premature death (compared to a global standard life expectancy of 82,5 years for women and 80,5 for men)
- The years lived with a disability caused by ill health

The latter is obtained by multiplying the expected duration of the disability with a predefined severity weight according to the category of disease. To obtain the DALY, the last step is to multiply the components with an age weight (a multiplier assigning different impacts to different ages; a disability at the age of 25 would have the gravest implications for the DALY).
"DALYs incorporate four values in their construction:

- Choice of expectation of life at each age that, for purposes of GBD, reflects life expectancy in a low-mortality setting;
- Sex gap in life expectancy (part of the gap that is assumed to be related to biological differences in longevity between sexes);
- Value of a year of life lived at each age (age weights);

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[142] WB (1993).
[143] See WB (1993), Hanson (2002), pp.313 cont. and WHOSIS, www.

- Value of time lived at different time periods (discounting)"[144]

As always, there is a long list of critical points concerning the use of DALYs, some of which have already been anticipated in the WDR 1993. Caused by its global nature, it completely ignores social subgroups such as ethnic minority or poor households, which obviously face quite different health burdens than affluent social segments. Also, it ignores social impediments caused by disfigurement (e.g. from leprosy) or dysfunction (e.g. infertility) and clearly underreports social factors of illness, such as violence against women. Furthermore, since it only counts the fatal or disabling disease respectively, it presumes that only one disease causes death or disability, overlooking the fact that a weak or undernourished body is more susceptible to diseases than a strong and healthy one. "This is particularly problematic for calculations of the cost-effectiveness of interventions, where the assumed health gain may be overestimated. But it may also overstate the true burden of illness due to particular causes."[145]

Hanson (2002) contests further issues in regard to gender bias[146]:

- The same age weighting function is used for females and males taking no account for women's caring role and reproduction function.
- In low-income countries women use less health care services than men, in high-income countries it's the other way round.
- The severity weights for diseases are based on studies ignoring the different implications and consequences of diseases in women and men – a field of study that is still inexistent.
- Sexually transmitted diseases are often underreported, not only because of the stigma that goes with them but also because 50-80% run without clear symptoms in female bodies.

3.2.3.2 An Adaptation: the QALY

A similar but more qualitative approach is taken with the *quality-adjusted life years*. This measure adjusts the standard life expectancy by quality weights for time spent in less than perfect health. Instead of using a catalogue of diseases, it derives its data from personal interviews and surveys therefore delivering a more adequate estimate on the quality loss of life due to ill health. It is exclusively used to measure the cost-effectiveness

[144] Hanson (2002), p.316.
[145] Hanson (2002), p.326.
[146] See Hanson (2002), pp.329 cont.

of health interventions and its simple and express manageability makes it a popular and widespread tool.

Both DALYs and QALYs are widely used and accepted indicators for global health, guiding the allocation of time and resources in health initiatives on the local, national and international level. With all their indisputable strengths and validity, one should always stay cautious and aware of their equally apparent weaknesses:

> "Social states as risk factors are not examined. One reason for excluding an analysis of social states as risk factors in the GBD work is that it would almost certainly require going beyond the narrow confines of the health sector and the interventions it alone can deliver. It would require what the current British government calls "joined-up thinking", involving multisectorial policy initiatives. At a very minimum, this must be based on a broader vision of health policy, rather than the current narrow focus on health services."[147]

A vision that would certainly provide inspiring new pathways and possibilities for governments and institutions and is applicable to many fields apart from the health sector.

3.2.4 Alternative Indicators

3.2.4.1 The African Gender and Development Index (AGDI)

The AGDI was introduced in the *2004 African Women's Report (AWR)*[148] *of the UN Economic Commission for Africa (ECA)*. Designed as an exclusively regional index it is a composite of two African indicators[149]:

- The Gender Status Index (GSI)
- captures quantitatively measurable issues related to gender equality contrived of three blocs: social power capabilities, economic power and political power agency
- The African Women's Progress Scoreboard (AWPS)
- measures government policy performance regarding women's advancement and empowerment in the areas of women's rights, social power capabilities, economic power opportunities and political power agency. As a qualitative indicator, it is designed to fill gap between the GSI and more country or sector-specific indicators.

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[147] Hanson (2002), pp.340-1.
[148] For more information visit www.uneca.org/acgd.
[149] See above.

The AGDI was designed as a strategic tool for stimulating the process of community participation and enhancing political awareness of gender issues, but since it was not launched until October 2004, no evaluation as of whether it can make an impact on decision makers is available yet. Data in the pilot studies can be found in the AWR[150].

3.2.4.2 HALE and DALE

The most recently developed indicator for the HDR is the *disability-adjusted life expectancy (DALE).* "Designed to be directly comparable with life expectancy, DALE weights expected years of ill health by their severity and subtracts these from overall life expectancy to give equivalent years of healthy life […] It is primarily intended as a summary measure." [151]

The *healthy life expectancy (HALE)* used by the WHO, on the other hand, measures the forecasted years of healthy life at birth.

Besides these, there exist an unmanageable number of additional indicators for health, often measuring similar conditions. As often, almost every organisation or institution, whether national or international, developed some indicator or another for their own uses.

3.2.4.3 More Indicators

Over the decades, indicators on wealth, health, education, happiness and virtually any other aspect of life have been designed, but most of them were only short-lived. So for example the *Human Freedom Index*, published in the HDR 1992, which tried to establish the degree of personal and political freedoms enjoyed in a country. Due to extreme problems in measurement, it was abolished the next year. Another index of the HDR, and newly introduced, is the *Technology Achievement Index (TAI),* composed of the four dimensions technology creation, diffusion of recent innovations, diffusion of old innovations and human skills.

An index that has arisen to quite some popularity is the *Human Happiness Index*[152], which illustrates in plain numbers what we have established already earlier on: it is not necessarily the wealth of a nation, which determines quality of life. How else should one explain that Bangladesh, one of the poorest countries in the world, ranks under the top 25 happiest countries, even before Spain and Italy. Even better known is the so-called *Big Mac Index,* compiled by the business magazine *The Economist*, and comparing PPPs via the price of a Big Mac in the respective countries.

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[150] See above.
[151] Hanson (2002), p.316.
[152] Published in the internet, see HHI, www.

3.3 Difficulties in Data Collection

"[…] costs of gender discrimination are hidden […] Even those potentially quantifiable are often not measured – for three main reasons. Extensive personal data are expensive and difficult to obtain. Some topics are considered too sensitive for societies or their governments to raise in surveys. And policymakers often do not recognize the value of gender-disaggregated information."[153]

This quote holds also true for health data.

As with all statistics, the indicators and measures presented in this chapter are only as good as the underlying raw material, the data available. Every organisation publishing international rankings or economic indicators, whether it is the WB, the UNDP or the OECD, notifies the users of insufficiencies in data collection. Especially in countries with weak political and governmental structures or with geographically secluded regions, data collection often is insufficient, with estimates taken at random or data not collected at all. Moreover, even if sufficient material exists, comparisons are still hampered by different methods or standards of data collection applied. Therefore, the interpretation of all sorts of statistics is to be handled with precaution and conclusions drawn from them should be revaluated with care[154].

Since general data is already hard to acquire, an even more challenging issue is the collection of disaggregated data. Whether on gender or minorities, the problem of finding authoritative data on marginalised groups is a quest of its own. A second problem already hinted at in previous sections, is the question of what to measure and which indicators to compile, respectively. Still, adequate data alone will not make the difference.[155]

> "The point is that with appropriately gender-disaggregated data, it should be possible to measure the health burden of these [i.e. female] roles, but the focus on health interventions to minimize this burden will not resolve the fundamental causes of differential exposure to such risks."[156]

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[153] WB (2001), p.74.

[154] A paper dealing with the problems of statistical data provided for in the HDRs is Haishan Fu, *Data Inconsistency, Statistical Credibility and the Human Development Report*, Paper presented at the Conference on Data Quality for International Organizations, 27-28 May 2004, Wiesbaden, Germany.

[155] For more information on the subject and international standards of statistical data processing and evaluation, visit the UN Statistical Division in the internet. See UN Statistics in the internet resources of the References for the adress.

[156] Hanson (2002), p.341.

This chapter, by introducing the most commonly used indicators and methods to quantify inequality and the levels of poverty and health within a given population, has given us the tools to evaluate the current status of a country and the progress (or regress) being made. It has been underlined continuously that attention has to be paid to the quality of data and the methods of compilation and calculation in order to guarantee the highest level of data reliability possible. The following chapter will now deal with public health, its implications and (international) policy intitiatives, which have been implemented in the past and present to improve the afore-mentioned indicators and hence, fight inequality.

4 PUBLIC HEALTH POLICY INITIATIVES

"Of what use is all the money on earth to me;
a sick person cannot enjoy the world."
Johann Wolfgang von Goethe

After having defined the basics of health economics and outlined the problems and alternatives of measurement, this chapter will focus on how these concepts are integrated into practice, which policies international organisations follow and how public health respectively health care reforms can be designed to ensure that their effects turn out positively for both women and men.

4.1 Introducing Public Health

4.1.1 Definition[157]

Public health (PH) is defined as

> "the science and the art of preventing illness and disability, prolonging life, and promoting physical and mental efficiency through organized community efforts for the sanitation of the environment, the control of infectious and non-infectious diseases as well as injuries, the education of the individual in principles of personal hygiene, the organization of services for the diagnosis and treatment of disease and for rehabilitation, and the development of the social machinery that will ensure to every individual in the community a standard of living adequate for the maintenance of health."[158]

Additionally, German-speaking literature puts an emphasis on the pluralistic and cross-sectional aspect of public health, integrating under its roof professionals from fields as diverse as medicine and law, insurance and public administration[159]. PH therefore encompasses not merely community health (care) but every aspect, whether cultural, political or scientific, of the health sector and society concerned. Additionally, people working in the field should keep the following statement in mind: "In public health practice, what you *count* is what you *do* and where your resources go."[160] In other words, the importance of quantitative and qualitative analysis and data collection should not be

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[157] Based on a definition by Winslow (1920), to which all other definitions in literature make a reference. Original definition cited in Baggot (2002), p.1.
[158] TDR (2004), p.30.
[159] See Polak (1999), Preface.
[160] Freedman (2003), p.99.

underestimated, since in public health, when one usually plans and works with the financial resources of institutional sponsors and donors, one is held rigorously accountable for what one does.

4.1.2 A Short History[161]

Apparently, the concern for public health dates back over 4000 years with archaeological evidence found for Ancient India as well as Ancient Egypt and Mesopotamia proving that already these early 'high cultures' were concerned with the importance of hygiene and clean water supply. The Ancient Greeks were the first to implement a more scientific approach to health with *Hippocrates* writing a treatise on the influences the environment, whether clean or polluted, has on the health status as well as recommendations to avoid disease.[162]

Throughout the centuries, people were concerned about health but only slow progress was made on hygienic, dietary or medical grounds. Knowledge and comprehension of the human body and its needs grew with the advancement of science and society. Hygiene improved with the introduction of sewerage systems and public waste control and the discovery of penicillin and vaccination boosted life expectancy. Nevertheless, "…public health has, even then, often had to await the enlightened self-interest of those who are capable of getting things done; so that it has been practised when it seemed to lead not only to 'pastures new', but to pastures pleasant."[163]

It was not until the late 18th century when public health measures, as we understand them, came into practice. With the discovery of vaccination against smallpox by William Jenner in 1792, and the first international conferences on guidelines for quarantine throughout the 19th century, the first steps were taken to unveil the greater picture: for all the knowledge that had been acquired over the centuries, it was now time to be combined to realise that nutrition, hygiene, the environment, culture and society all represented variables for the overall health status of an individual and of a community.

Today, governments in the industrialised countries face the problems of financing an ever more sophisticated health care system while developing countries are still struggling with the comprehensive provision of *primary health care (PHC)* for their citizens. Within the framework of this chapter, we now explore different policy initiatives of major

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[161] An extensive historical outline which founds the basis of most of the literature is: Rosen, G. (1958), *A History of Public health*, The Johns Hopkins University Press, Baltimore/London.
[162] See Baggott (2002), p.15.
[163] Brockington (1967), pp.132-3.

international agents and then analyse the impact that health care reforms had on communities and especially, their women.

4.2 International Health Care Policy Initiatives

4.2.1 WHO's 'Health for All by the Year 2000'

"The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries….The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace."[164]

4.2.1.1 Cornerstones of the PHC Approach

When development economists and international agencies finally came to realise that the trickle down effect had apparently been blocked, the WHO began to develop a new concept entitled *primary health care (PHC)*. Formally presented to the public in the *Declaration of the World Health Conference in Alma Ata*[165], then still USSR, in 1978, it incorporated a more holistic view on health than simple medicine. Abel-Smith (1994) identified five reasons, which the WHO came to recognise and hence lead to the emergence of the PHC approach[166]:

- The importance of inter-sectoral action for health development
- Key infectious diseases could not be combated by isolated vertical programmes
- Preventive and promotive action should not be separated from curative action
- Existing cheap and effective activities did not reach the people in need for them
- It was a reaction against authoritarian attempts of health professions to impose their understanding of health undifferentiated onto the world

The revolutionary elements of PHC were the integration of the community and local culture, including traditional health practices and treatments. Moreover, the programmes were intended to pay more attention to deterring social customs such as female doctors for female patients, etc. The focus was laid not so much on gargantuan global disease eradication programmes (the WHO had just suffered a shameful drawback with its malaria programme), but on basic principles for better health. PHC therefore had its focal

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[164] WHO (1978).
[165] For the original version, see the Appendix.
[166] See Abel-Smith (1994), pp.106-7.

point on commonly accepted necessities such as proper nutrition and supply of safe water, basic sanitary services, maternal and child health including family planning, education on and promotion of preventive measures against endemic and common diseases and the provision of essential drugs.

> "Primary health care is essential health care based on practical, scientifically sound and social acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."[167]

The Declaration stated 12 indicators with which the PHC approach and the participating countries would be evaluated according to the overall effect the measures had on public health.

4.2.1.2 The Key Proponents – Watering Down the Concept

As always, funding was scarce from the beginning. Hence, major development agents, USAID, UNICEF and the WB in particular, adopted what was called in the literature the *selective PHC approach*[168]. According to this logic, it was sensible to start with the priority PHC initiatives in a country and gradually expand the programme to its full extent. In effect, this viewpoint represented a contradiction of the PHC approach in the spirit of the Alma Ata Declaration, since the very basics of PHC were defined as being holistic and comprehensive. The WHO in this situation did not earn itself glory, after not being willing to defend its own policy recommendations. Even though it promoted the *comprehensive PHC approach*, it allocated too little resources towards this end. At the same time, in its own programmes it followed the much criticised vertical eradication programmes, which had led to the establishment of PHC in the first place[169].

One has to acknowledge, though, that not all eradication programmes were a failure, the smallpox programme being one of the impressive mega-projects proving that global vertical initiatives can lead to a groundbreaking success. As Koivusalo (1996) explains, the WHO has put itself under pressure with positive results like these since successful disease eradication and vertical programmes are viewed as efficient and show measurable results already in the short-run.[170]

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[167] WHO (1978).
[168] See Walsh and Warren (1979): *Selctive Primary Health Care. An interim strategy for disease control in developing countries*, New England Journal of Medicine No. 301, pp.967-974.
[169] Koivusalo (1996), p.119.
[170] Koivusalo (1996), p.120.

This cost efficiency rationale guided the WB in its massive promotion of the selective approach. As with the Structural Adjustment Programmes (SAPs)[171] for developing economies, so was the prime variable for support of health initiatives the question of cost, efficiency and effectiveness in line with the industrialised principles of business. Hence, the fervent furtherance for one of the most widely mentioned instruments established by the PHC process: the *community health worker*. S/he was a local layperson who would take up responsibility for basic health support after a short training provided for by the WHO or local health system. The intent was to bring the programme to where the people were, to heighten acceptance and participation through the employment of community members - and to cut costs. "The cost-effectiveness of the training of community health workers has been appreciated by the World Bank, which funded and promoted schemes with community health workers in the 1980s because of their short training requirements and low cost."[172]

4.2.1.3 Points of Criticism

To tie in with the community health workers' concept, according to an evaluation authored by the WHO (1989), it is admitted that disintegrated approaches such as the vertical programmes severly damaged the concept of community health workers. A failure to get the participation of local health workers and support of communities demonstrated the inadequate planning and implementing of the PHC programmes. As Szirmai (2005) notes, the potential of PHC was narrowed to the focus on medical facilities and services – there has been insufficient realisation of community participation and democratising control of health services.[173]

Overall, the critique is formulated around the following subjects[174]:

- A lack of resource allocation, commitment and implementation on all levels
- Unrealistic goals set by the Declaration and nebulous phraseology
- A lack of monitoring and data collection
- Problems with health information systems in DCs
- An ill-guided focus on cost-efficiency and cost-effectiveness

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[171] For more on the subject, see section 4.3.3.
[172] Koivusalo (1996), p.123.
[173] See Szirmai (2005), pp.207-209.
[174] See WHO (1989), cit. in Koivusalo (1996), p.129.

"The practice of health policies based on the most cost-effective interventions also easily leads to a kind of assembly-line logic and approach to health policies where the whole system is built on the cost-effectiveness of separate and specific interventions."[175]

Nevertheless, the PHC approach brought to wide attention the importance of understanding and respecting cultural and social circumstances and of active participation of local community members. With its emphasis on education and promotion, and the recognition that improvements in the health status are not merely improvements in medical technology it gave way to a more comprehensive understanding of health and to the many factors that influence and are influenced by it.[176]

4.2.2 Health related MDGs

"Gender equality is not only a goal in its own right, but an essential ingredient for achieving all the other Millennium Development Goals. Attempting to meet the MDGs without promoting gender equality will both increase the costs and minimize the likelihood of attaining the goals [….] As we strive to attain these goals we must learn from the past and remind ourselves that achieving them requires multi-faceted approach: because the MDGs are mutually reinforcing, progress towards one goal will affect progress towards others."[177]

The *Millennium Development Goals (MDGs)* were issued as the central part of the Millennium Declaration by the UN General Assembly in September 2000. One year later, UN Secretary General Kofi Annan presented the formalised MDGs, assigning to each of the eight goals targets and indicators to monitor and quantify progress[178]. Five of the MDGs are directly concerned with health and the *Department for Gender and Women's Health (GWH)* of the WHO henceforth set out to *'En-gender[ing]' the MDGs on Health*[179]. It is characteristic though, that not even at the beginning of the 21st century, when designing a new strategy to further human development, is the gender aspect automatically integrated into the programme.
Since a dire analysis of the subject would reach too far, I will only briefly enumerate some suggestions made in the GWH report.

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[175] Koivusalo (1996), p.134.
[176] See Szirmai (2005), pp.207-209.
[177] WB (2003), p.21.
[178] See Appendix for full list of MDGs.
[179] Publication by the WHO (2003).

Goal 4: Reduce Child Mortality

Since it is universally recognised that the mother has an overwhelming impact on child's health, this goal can only be reached when including the female aspect. Therefore, it is recommended that the antenatal treatment of diseases should earn a priority rating, along with the financial support of mothers. Furthermore, programmes and health care workers should work towards a shift in attitude since many women have to perform heavy physical labour during much of their pregnancy.

Goal 5: Improve Maternal Health

Obviously, this is the one goal putting a priority on women and female health, as it is. Still there are some aspects, which have not been incorporated yet. To begin with, another well-established fact is that poor nutrition can lead to complications during pregnancy and a lack of access to *emergency obstetric care (EmOC)* is the prime cause for female mortality in developing countries. Every year, 515,000 women die as a cause of pregnancy, 99% of these deaths occur in DCs, namely in sub-Saharan Africa and East Asia. And most of them could be prevented if adequate access to EmOC would be provided for. "The fact that most life-threatening complications cannot be predicted or prevented means that many of the actions and interventions that we commonly associate with women's health care that is effective - for example, antenatal care programmes and nutrition programmes – *will not substantially reduce maternal death*. To make a dramatic change in maternal mortality…all women must have access to EmOC, in case they experience complications."[180]

Goal 6: Combat HIV/AIDS, Malaria and other Diseases

There is a global trend in HIV/AIDS becoming an ever more pressing problem with women. For long, the virus was regarded as primarily male, but in many countries of SSA the female prevalence rate is already higher than the male one. One of the reasons lies in the issue thoroughly elaborated in section 2.5.1.4: the female role of caregiver. Furthermore, the only widely available preventions against HIV/AIDS – the condom and abstinence – are generally available to men independent of their partners' desires, while they can usually only be practised by women with male co-operation.

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[180] Freedman (2003), p.101.

Goal 7: Ensure Environmental Sustainability

It is not at first sight obvious, that this goal has also major implications on health. Two major problems fall under this array: indoor air pollution caused mainly by burning solid fuels or biomass and inadequate clean water supply. "Making available alternative fuel sources…can thus have a particularly positive effect in the health of women, both by reducing their exposure to damaging fumes, and by reducing the burden on them of a particularly taxing and time-consuming form of labour. Time saving may open up opportunities for education and income generation. This may help break a vicious cycle where solid fuel use restricts economic development, while poverty reduces the ability to switch to cleaner fuels."[181] The same can be said concerning clean water supply: the extension of a network of public wells would save girls and women an enormous amount of time and would at the same time help reduce illnesses caused by contaminated water.

As was already stated in the concept of the PHC, "meeting the health goals requires an awareness not only of the biological aspects of disease transmission and treatment, but also of the social and cultural factors that promote or reduce good health."[182]

Whether the MDGs will reach their ambitious targets set for 2015 remains to be seen, the preliminary evaluation for 2005 paints a rather dark picture of their progress[183]:

- Child mortality has risen in 16 countries since the early 1990s, 14 of which are in sub-Saharan Africa – nearly 11 million children under the age of five still die every year.
- The rate of attended deliveries has increased only in South-East Asia and North Africa. The pregnancy-related death toll of sub-Saharan Africa is still 1000 times higher than in highly developed countries.
- There has still not been found an adequate means to counteract the HIV/AIDS pandemic,which has nullified positive developments in life expectancy and economic programmes in many African countries.

The WHO (2005) estimates that in order to achieve the MDGs an annual doubling in spending is needed from now on, increasing aid for all MDG-related programmes to US$ 100 billion. By 2007, an additional US$ 20 billion should be provided to fight HIV/AIDS

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[181] WHO (2003), pp.7-8.
[182] WB (2003), p.17.
[183] See WHO MDGs (2005), www. For more data on the evolution of the specific targets and indicators, visit the UN Statistics Division homepage on the Millennium Indicators, http://unstats.un.org/unsd/mi/mi_worldmillennium_new.asp.

and achieve Goal 6, while increasing the spending on health in general by five. Furthermore, the structural framework for functioning health systems has to be provided and political will demonstrated more openly. If these measures are taken, the WHO (2005) is optimistic of even reaching the MDGs before their deadline.[184]

4.2.3 The Beijing Platform for Action

At the 1995 *4th World Conference on Women in Beijing*, a groundbreaking consensus was reached on the topic of women's empowerment and equality. 189 countries agreed on 12 areas of concern and priorities in the fields of female health, education and participation in the community, in business and in the political arena in which efforts for the improvement of female living conditions should be concentrated.

Figure 4.2. The 12 Areas of Cirtical Concern of the Beijing Platform for Action

- The persistent and increasing burden of poverty on women
- Inequalities and inadequacies in and unequal access to education and training
- Inequalities and inadequacies in and unequal access to health care and related services
- Violence against women
- The effects of armed or other kinds of conflict on women, including those living under foreign occupation
- Inequality in economic structures and policies, in all forms of productive activities and in access to resources
- Inequality between men and women in the sharing of power and decision-making at all levels
- Insufficient mechanisms at all levels to promote the advancement of women
- Lack of respect for and inadequate promotion and protection of the human rights of women
- Stereotyping of women and inequality in women's access to and participation in all communication systems, especially in the media
- Gender inequalities in the management of natural resources and in the safeguarding of the environment
- Persistent discrimination against and violation of the rights of the girl child

Source: UN PfA, www.

The so-called *Beijing Platform for Action (PfA)* set new standards in the acknowledgement of women's influential role in society and development and found its way into many

[184] See WHO MDGs (2005), www. All figures taken from there.

countries' legal bodies and decision-making processes. The *African Union (AU)*[185] for example was founded in 2002 on the basis of a 50:50 gender parity and is committed, by its statutes, to gender equality and gender equity.

The 12 core areas have also been closely examined and considered when designing the MDGs, since "failure to achieve many of the Beijing objectives will stall the achievement not only of the third Millennium Development Goal – which explicitly sets out to promote gender equality and empower women – but the remaining MDGs as well, thereby undermining the quality of life for girls and women and slowing the course of development."[186]

In the constant review process taking place since 1995, the *23rd Special Session of the UN General Assembly* stands out as producing a report on enhancing the PfA. Known to the public as *Beijing+5*, it not only strengthens the 12 prioritised fields but suggests to add new areas of concern to the agenda:

- Globalisation
- The impact of science and technology on development
- The changing patterns of migratory flows
- Demographic trends
- The rapid progression of the HIV/AIDS pandemic

This year, *Beijing+10* is on the agenda drawing a double-edged conclusion. In some areas such as female education there has considerable progress been made: the girls primary enrolment rate in many regions more than doubled in the second half of the 20th century and the educational gender gap in low income countries diminished from 16% in 1975 to 5% in 2000. On the other hand side, as already mentioned in previous sections, the maternal mortality rate has not even feebly changed over the last decades, with 1 in 16 women dying as a consequence of pregnancy in sub-Saharan Africa in comparison to 1 in 5000 in Europe (per 100,000 live births). Also, the global representation of women in parliaments did not exceed 15,6% in 2004 compared to 13,9 in 1990.[187] "In many countries, women still lack independent rights to own land, manage property, or conduct business. And in most countries, women are under-represented in political decision-

[185] The African Union has replaced the Organisation for African Unity (OAU) in its quest for economic, social and political integration of the African countries and is the premier organisation of the continent for stability, peace and integration. For more information, visit: www.african-union.org.
[186] WB (2005), p.17.
[187] All figures derived from WB (2005).

making bodies. Progress in some of the "critical areas of concern" identified at Beijing does not necessarily guarantee progress in others."[188]

4.3 Health Care Reforms and Their Effects

"The general egalitarian principle in health care has been defined as receiving treatment according to need and paying according to ability to pay. […] The current emphasis on health care reform has potential to lead increasingly to the provision of health services and treatment according to willingness to pay, a trend which undermines the principle as far as both paying according to the ability to pay and provision of care according to need are concerned."[189]

4.3.1 Defining the Framework

Health care reforms have an air of being something innovative and purposeful. They are designed to perpetuate the provision of public and private health services by redefining the framework for the market. Koivusalo identifies three possible specifications of reform models: *managed competition* uses market forces to establish competing health plans. The financing and provision sides both are open to competition under restricetd rules, which mainly allocate the prices for the annual premium of comprehensive health care (e.g. USA, UK, the Netherlands). *Managed care* on the other hand side is geared towards the privatly organised sector of health networks. The health programmes herein "may or may not be competitive, and may or may not involve a strong government role."[190] It is associated with extensive administrative costs. Thirdly, *managed markets* refer to the introduction of competitive elements on the provider side, which are financed by single or multiple purchasers acting without comeptition.

In developing countries, health care reforms usually are part of the broader adjustment programmes necessitated by statal inefficiency, budget constraints and overall structural problems. Under these circumstances, health care reforms are even more sensitive because the states often lack an appropriate economic and governmental infrastructure to cope with the transition phase.

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[188] WB (2005), p.12.
[189] Koivusalo (1996), p.167.
[190] Koivusalo (1996), p.146.

There are three major concerns common to all reforms: the introduction of user charges, the issue of health insurance and decentralisation.[191]

- "The *user charges* in government health facilities have been promoted as a way to mobilise revenues, promote efficiency, foster equity, increase decentralization and sustainability, and foster private sector development."[192] In practice, however, they have contributed only marginally to cost-revenue for the public health sector and, on top of it, have evolved into a consumption barrier for the poor, undercutting the role of preventive care and often reversing tendencies in child and maternal mortality.[193]
- "*Health insurance* is seen both as a problem and a solution in health care reforms. […] According to the egalitarian aims in the health care, insurance cost-sharing should be based on the ability to pay, without changes in benefits."[194] However, the population of developing countries, which is eligible to insurance schemes, tends to be rather small because of the limited amount of people with formal employment, and universal health insurance is virtually unknown. Navarro (2002) argues that commercial health insurance has added to the dismantling of public health services und that their interests often override public health interests in the reform process.[195]
- *Decentralisation* can be defined as the transfer of authority in public planning, management and decision-making from the national to the regional and community levels. Different degrees according to the actual transfer of power are distinguished: deconcentration, devolution, delegation and privatisation. Although it is appreciable to move the decicion-making process nearer to where the people concerned are, this concept also poses many problems in execution. The subordinate levels may lack the managerial skills and the financial and human resources to administer the new responsibilities. Furthermore, it adds yet another layer to public administration and hence increases instead of decreases costs.[196]

National health care reforms have stood at the centre of interest of international development organisations, namely the World Bank and OECD. The WB issued four recommendations on policy reforms, coinciding with the concerns mentioned above. It

[191] Koivusalo (1996), p.153.
[192] Koivusalo (1996), p.154.
[193] See Bangser (2003), p.265.
[194] Koivusalo (1996), p.159.
[195] See Navarro (2002), pp.114-5.
[196] See Koivusalo (1996), pp. 162-164.

further suggested to governments to promote the provision of chargeable health services by NGOs and the private sector, thereby freeing public resources for community programmes. "The government responsibility in financing health services is limited to public health measures and ensuring universal access to an essential package of clinical services, which is oriented towards the poor, as they cannot buy such care for themselves."[197] The content of the essential clinical services package is not clearly defined but should in any case contain "prenatal and delivery care; family planning services; management of the sick child; treatment of tuberculosis and case management of STDs"[198] and be delivered in the framework of a competitive model. Since health care reforms are embedded in the SAPs accompanied by loans, the international donor institutions can actively impact the design of the programmes and have commonly done so in the past.[199]

Koivusalo concludes that "[T]he basic problem in the public/private mix approaches and those emphasizing competition and the private sector is not only that of who will eventually subsidize whom (public sector vs. private sector), but also that of accountability, regulation and whether the market mechanisms will end up being virtues or vices in the health sector, given the known possibilities to market failure."[200]

4.3.2 Reforms and Their Impact on Women[201]

Standing (2002) analyses specific reform concepts regarding their impact on women. First, she draws a chronology of reform periods, which she associates with distinctive policy measures and international proponents:

[197] Koivusalo (1996), p.148.
[198] WB (1993), p.112.
[199] See Bangser (2002), pp.258-260.
[200] Koivusalo (1996), p.160.
[201] This section is based on Standing (2002).

Figure 4.3. Chronology of Reforms

Policies on or influencing health sector	Macroeconomic political climate	Institutional points of articulation
SAPs, early 1980s on	❖ Economic crisis ❖ Neo-liberal responses ❖ "State failures"	IMF World Bank
Bamako initiative, 1987	❖ Crisis in health sector spending ❖ Need to protect the most vulnerable	UNICEF WHO African health ministers
Health sector reforms, late 1980s-early 1990s	❖ Public sector reform and governance ❖ Efficiency-effectiveness agenda ❖ Controlling government expenditure	WDR 1993 US and UK health reforms
Sectorwide approaches (SWAps), 1997 on	❖ Development assistance as "partnership" with national governments ❖ Defining priorities within a sound macroeconomic and institutional framework	WHO European bilaterals Sector investments programmes of the World Bank

Source: Table adapted from Standing (2002), p.348.

Structural Adjustment Programmes (SAPs)

They are the infamous development prorammes of IMF and WB. As they more often than not inflicted stringent cost-reduction measures to curtail the expanding budget deficits, invariably followed by financial cut backs on social services. Indirectly, this hit women hardest in their roles as care givers: as inaffordable or intolerable health care services were often substituted for home treatment, women's work load increased, as well as their higher exposition to illnesses.

The Bamako Initiative

It was spearheaded by UNICEF focusing on community participation and community financing schemes. As concept of the UN's children fund, it was tailored towards the improvement of children's health, but at the same time, incomprehensibly, ignoring the dominant role mothers play in this field. "Several components, such as oral rehydration and immunization, are highly dependent on women's time for their realization. Yet the time burden is rarely factored into policy considerations in the area of child health."[202]

[202] Standing (2002), p.354.

Health Sector Reforms

According to Standing (2002), the key elements of health sector reforms are financing, resource allocation and management issues. They focus on the reorganisation of the Ministry of Health and represent an institutionalised process (as described in management handbooks). Decentralisation is again identified as a major plank because "national policies often failed to be implemented locally either because budgets were not allocated at local level, or because implementing agents disapproved of a policy and did not carry it out."[203] For women, these reforms mean even less access to health care services. They often lack access to sufficient financial resources or the time burden of travelling to and fro is too high.

Sector-Wide Approaches (SWAps)

"SWAps are a coordinated approach by donors to health sector funding in which the donors relinquish specific project funding in return for a voice in the development of the national sectoral strategy as a whole."[204] Nevertheless, they represent a major shift in donor attitude towards the receiving developing countries:

- They acknowledge the pivotal role of the government and hence accept the national ownership of the reform process.
- For the first time, it is challenged whether reforms actually improve access of the poor.
- In the design and implementation a wider range of stakeholders is involved.

But:

- The reforms are still focused on the supply side and are not gender mainstreamed.

Standing (2002) summarises her findings with the question of how to conceptualise gender into health care reforms. She acknowledges the fact that there is no single correct answer. Instead, she proposes to adapt two existent concepts: that of *gender mainstreaming* and of *contextual-situational frameworks*. While criticising the former for being too bureaucratic, she expresses her preference for the latter, arguing that its inclusion of the overall social environment, its adaptiveness and its consideration of both female and male positions makes it more viable for science and for practice.

> "It seems vital, given the complex nature of health as a social good, to embed gender more firmly within other sets of social relations, such as class, households, and generation. […]

[203] Standing (2002), p.357.
[204] Standing (2002), p.359.

> One challenge is that gender is part of a complex nexus of actions and behaviors taking place within somekind of household arrangement. And households themselves exist within a wider political and social economy of differentiation. Gender is thus more to the fore in some kinds of decisions than others, but it is also linked intrinsically to time and generational dynamics of households, and to the household level of security."[205]

4.3.3 Examining Structural Adjustment Programmes (SAPs)[206]

4.3.3.1 The Outline of the SAPs

As already mentioned earlier, SAPs were heavily criticsed for their negative impact on public spending and henceforth the poor segments of developing countries. Responding to this criticism, the IFIs designed a second generation of SAPs which are called *Social Dimensions of Adjustment (SDAs)*. Contrary to Standing's chronology, the SAPs are still a technical term in use and most countries still follow some form or other, even though they are now accompanied by complementary programmes, such as the *Heavily Indebted Poor Countries (HIPC) initiative* and the *Poverty Reduction Strategy Papers (PRSPs),* both of which will be explored in more detail by example of Uganda in the next chapter.

The goalposts of the SAPs are[207]:

- A ceiling on budget deficits
- A freeze on, or reduction in, spending levels
- The removal of subsidies
- A rationalization/streamlining of government bureaucracy
- An increase in certain types of taxes and/or introduction of new taxes
- Currency devaluation

> "In some cases, IMF and World Bank conditionalities did not explicitly specify measures to control spending on social services. But in the interest of achieving the bottom-line objectives of curbing deficits and reigning in inflation, reductions in spending on public services were considered inevitable, acceptable and even necessary consequences of

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[205] Standing (2002), p.367.

[206] This section is based on *The SAPRI Report (2004), which was designed as a joint evaluation of SAPRIN and the World Bank of SAPs in 12 developing countries representing all regions of the world and involving extensive research and surveys together with local stakeholders and NGOs. The WB however bailed out when realising that the outcomes were not very favourable for the institution, so alternative sources of funding were found to be able to publish the report.*

[207] SAPRI Report (2004), p.174.

> adjustment. The maintenance of debt-servicing and stabilization were non-negotiable elements of all adjustment programmes studied."[208]

The reforms involved a radical shift in the notion of the state from being a provider and guarantor of universally accessible social services to being a supplier of only essential services for the marginalised segments of society. Along with this transition came the conviction that public subsidies – including social services – were an acherontic device to destabilise the markets. This belief was (and partly still is) held by the World Bank, IMF and national governments. Civil society actors, on the other hand, tend to define subsidies as a governmental financial aid to gap the difference between production and market price. Moreover, they draw a clear distinction between public subsidies and social services, such as health and education. While they also include those public transfers made in support of the corporate and financial sectors, the international financial institutions prefer to overlook those kinds of subsidies even though they are officially banned by the WTO agreement. This rationale led to a total transformation of the social sector in developing countries[209]:

- The drastic reduction of government spending focusing only on essential aspects of social service provision.
- The implementation of cost-recovery and cost-sharing measures.
- The ceding of control and management of social services to the private sector wherever possible.

These measures led to sometimes dramatic cutbacks in health care budgets as the example of Zimbabwe shows where the per capita budget fell from US$22 in 1990 to US$11 in 1996. Uganda features in this group as a special case, experiencing considerable fluctuations. The temporary increase in public health care expenditure, however, is due to debt relief under the HIPC regime and not because of innate budget expansion. 1997 also marks the start of the Universal Primary Education initiative, eplaining the significant increase in education. More on the subject will be presented in the next chapter.

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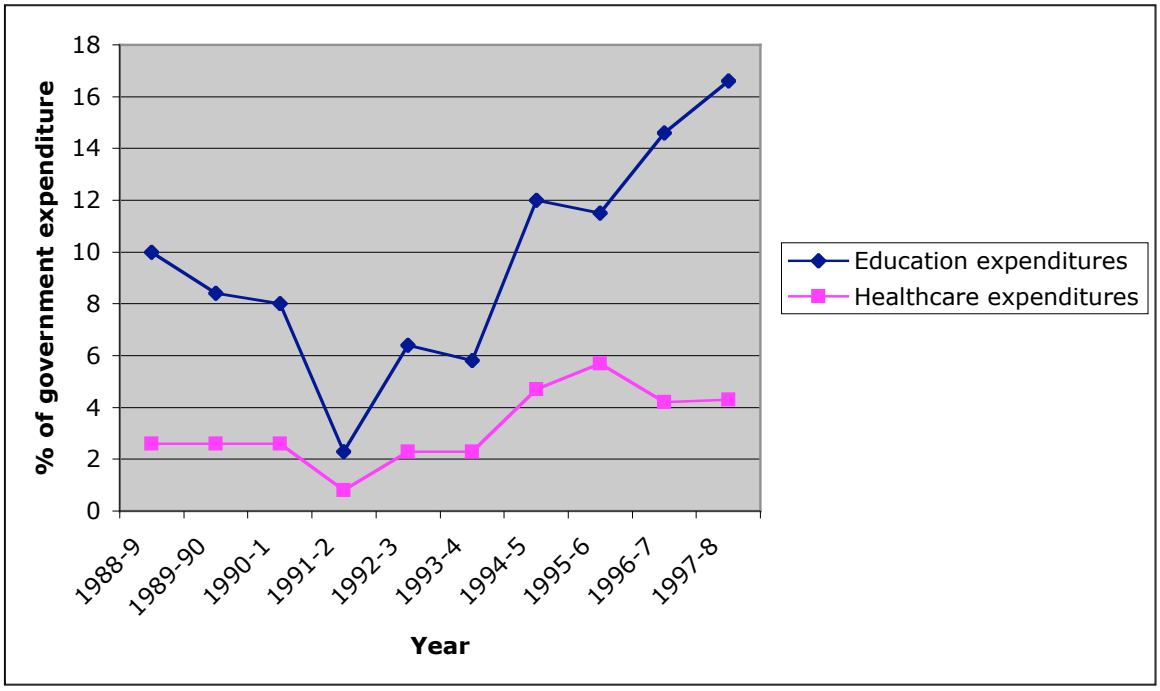
[208] SAPRI Report (2004), p.176.
[209] SAPRI Report (2004), p.177.

Figure 4.4. Share of Total Government Expenditures for Healthcare and Education



Source: SAPRI Report (2004), p.181.

4.3.3.2 Main Points of Criticism

The priority given to debt servicing before all else and the massive devaluation of local currencies are viewed as most critical. These practices further increased social services costs, especially in the health sector, since most of the equipment and drugs must be imported. Through this mechanism, even the Ugandan spending increase was outweighed by the import prices and in Zimbabwe the medicare price index skyrocketed 2106,3% (!) from 1991 to 2000 due to devaluation and inflation. Furthermore, the introduction of user fees in Zimbabwe accelerated the patients' costs to up to 1000%. "More people now seek medical attention only when their illness is already severe, causing an increase in the number of people who die in their homes from curable diseases and often creating public health hazards by spreading disease in their communities."[210]

Another perturbing point of concern is the quality of health care provided – or more precisely, the lack of quality. Reduced maintenance activities, shortage of equipment and even essential drugs, and low salaries disillusion the employees as well as the patients who often prefer to save their time and money and stay at home. The circumstances further contribute to the prevailing low confidence in the public health sytsems in the countries. "Many of the country studies have shown that it is the women at the household level who have had to cope with the need to compensate for the reduction in provision of

[210] SAPRI Report (2004), p.187.

public services and the inability to access through the market what the government no longer provides."[211] On top of it, the already meagre maternal health care services have deteriorated further, leaving a large majority of women without professional attendance during delivery and even less antenatal health services.

4.3.3.3 Conclusions

> "Low income groups have been asked to sacrifice and suffer the consequences of cuts in subsidies and social spending and the imposition of cost-sharing and cost-recovery measures. Yet subsidies continue to be extended to private corporations through credit guarantees, tax incentives and even bail-out packages and loans to rescue ailing banks and corporations."[212]

The authors additionaly draw the following conclusions from their studies:

- SAPs have led either to a sharp deterioration of social services or, at the most, to insufficient improvements in spending levels.
- The imposition of user fees and other cost-recovery measures have created additional constraints in accessibility of services, especially for the poor.
- The quality of education and health care has generally been pejorated by excessive budgetary cuts and disparities between urban and rural areas continue to be significant.
- The elimination of universally provided subsidies for essential goods and services has negatively affected the quality of life of the poorest.

The policy recommendations deduced from these aspects are evident and self-explanatory: eliminate user fees and similar schemes, increase the social services budgets and improve their allocation, as well as the allocation of staff, ameliorate the quality of staff and maintenance of equipment, acquire additional funds through sponsors and cutbacks in other budget positions, such as military expenses or the implementation of taxes on luxury goods, and finally, prioritise the HIV/AIDS pandemic.

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[211] SAPRI Report (2004), p.195.
[212] SAPRI Report (2004), p.199.

5 A CASE STUDY: UGANDA

Figure 5.1. Map and Key Data of Uganda

Republic of Uganda

Capital City: Kampala

Population (2002): 27,269,482

GDP per capita (in US$ PPP 2002): 1,390

GDP Rank (2002): 149 (of 177)

HDI Rank (2002): 146 (of 177)

GDI Rank (2002): 113 (of 144)

HPI-1 rank: 60 (of 95 DCs)

Life expectancy at birth: 45,7

HIV/AIDS prevalence rate: 4,1%

Literacy rate (2002): 68,9%

Source: CIA World Factbook and UNDP Country Fact Sheet Uganda, www.

Uganda is a very interesting country, in many respects. Its autocratic government has brought about significant economic reforms, successfully applied for the HIPC initiative of the World Bank and cut back the HIV/AIDS prevalence rate considerably. Women are well-represented in all levels of government and public administration and the educational gap has also been reduced successfully. Still, these achievements are only punctually considering that there is still an unresolved conflict in the North, the first democratic elections with participation of oppostion parties is due to take place in 2006 and the country's maternal mortality rate ranges among the highest in the world. This case study gives an example of how the theories and concepts introduced in the previous chapters have been applied into practice, which effects development programmes had on Uganda's health care system and how the situation of women has changed over the years.

5.1 Key Data

5.1.1 Political Aspects[213]

Uganda is a landlocked country on the equatorial belt of Western Africa, bordering Sudan, Kenya, Tanzania, Rwanda and the Democratic Republic of the Congo. With its 236,040km^2 it is only slightly smaller than the United Kingdom. Uganda is ruled by a tropical climate with two dry seasons. Almost all of the country lies on a plateau with a rim of mountains on the Eastern and South-western borders and Lake Victoria in the Southeast. The river Nile has its origin here. Uganda is especially rich in copper, cobalt, limestone and salt. Due to the many lakes and rivers, hydropower plays an important role, whereas arable land represents only about 26% of the total area.

The Republic of Uganda, as is the official name, is governed by President Lieutenant General Yoweri Kaguta Museveni, who seized power in 1986. The capital city is Kampala, in the South, on the shores of the Lake Victoria. President Museveni is also head of government and was last re-elected in March 2001 for another 5-year term. The legislative body is a uni-cameral National Assembly voted for directly. Of the 303 members 81 are nominated by legally established special interest groups (e.g. women, army). There is universal suffrage from the age of 18 and the legal system is based on English common law and customary law. The constitution was adopted after restoration of democracy in 1995.

The constitution requires the suspension of political parties while the Movement organization – President Museveni's political party - is in governance; of the political oppistion parties the most important are the Ugandan People's Congress or UPC (Milton Obote, former prime minister) and the Democratic Party or DP (Paul Ssemogerere). As a former British colony, which acquired independence in 1962, Uganda is part of the Commonwealth, as well as a member of various international organisations such as the African Union (AU), the ADB, G-77, the World Bank Group, WTO and the UN.

5.1.2 Short History

Until the mid 18th century, the area of today's Uganda was a secluded region with three kingdoms - Buganda, Bunyoro and Ankole - on its grounds. It was not until 1862 that the

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[213] See CIA – The World Factbook, www.

first European – a British explorer – visited the realms. On his foot followed Catholic and Protestant missionaries and the Britsh East India Company. In 1890, the British signed a treaty with Germany, which extended their control over what was to become Uganda. By 1894, Uganda had become a protectorate only to be turned into an autonomous constitutional monarchy in 1900. Independence was finally granted in 1962, with Milton Obote as first prime minister.

After some years of economic and structural development, the 1970s and 1980s brought 6 military coups, dictatorships and chaos to the country. One who gained questionable international fame during that period was General Idi Amin who seized power from Obote in 1971 starting an eight year tyranny in which over 400,000 people were killed and the bordering regions of Tanzania and Kenya were invaded. His regiment was toppled by resisetnce forces sponsored by Tanzania in 1979, but not until Yogevi Museveni took over the presidency in 1986 did the country finally come to peace.

Uganda today has started to reconcile with its neighbours Sudan and the Democratic Republic of Congo, the latter accusing Uganda of an invasion in 1999. Together with Kenya and Tanzania it has founded the East African Union and is viewed in the eyes of international organisations as a role model in democracy and economic performance for the region. Still, it is one of the poorest countries in the world and has, in its Northern district, a war running for two decades now, with the *Lord's Resistance Army (LRA)* abducting thousands of children, looting villages and refugee camps and fighting for a Uganda based on the Ten Amendments of the Bible – a preposterous claim considering their dispisable methods[214].

5.1.3 Economy

5.1.3.1 The Three Sectors and Real Economy

Uganda has substantial natural resources, including fertile soils, regular rainfall, and sizable mineral deposits of copper and cobalt. Agriculture is the most important sector of the economy, employing over 80% of the work force. However, with a contribution to GDP of only 35,8% it has already lost its first place to services (43,6% and occupying only 13% of the labour force). The industrial sector represents 20,8% of GDP and employs 5%

[214] For more information on the war, visit the BBC homepage and consult the BBC articles, www.

(all figures are estimates for 2004). These figures also highlight the low efficiency arrived at in the agricultural sector.

Coffee accounts for the bulk of export revenues. Other exports commodities are coffee, fish and fish products, tea, gold, cotton, flowers and horticultural products, horticulture being the primary strategy in agriculture to rid the country from ist dependency on coffee.

Uganda's major exports partners are Kenya (14.7%), Switzerland (13.7%), the Netherlands (9.2%), UK (6.4%) and South Africa (5.6%).[215]

5.1.3.2 Financial Situation and International Aid

Since 1986, the Government - with the support of foreign countries and international agencies - has acted to rehabilitate and stabilise the economy by undertaking currency reform, raising producer prices on export crops, increasing prices of petroleum products, and improving civil service wages. The policy changes are especially aimed at dampening inflation and boosting production and export earnings. During 1990-2001, the economy turned in a solid performance based on continued investment in the reconstruction of infrastructure, improved incentives for production and exports, reduced inflation, gradually improved domestic security, and the return of exiled Indian-Ugandan entrepreneurs.[216]

In 2000, Uganda qualified for enhanced Highly Indebted Poor Countries (HIPC) debt relief worth US$1.3 billion and Paris Club debt relief worth US$145 million. These amounts combined with the original HIPC debt relief added up to about US$2 billion. Still, its total public and private external debt in 2004 amounted to an estimated US$3.865 billion[217] of which US$ 1.9 billion are owed to foreign creditors by the government. For this, the total debt service in 2003 amounted to 7%. The annual GDP growth rate was estimated at 5% and inflation rate at 10% in 2003.[218]

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[215] All figures from CIA – The World Factbook, www.
[216] See CIA – The World Factbook, www.
[217] See CIA – The World Factbook, www.
[218] WDI (2003), www.

Figure 5.2. UNDP Indicators

	HDI rank 2002 (177 countries)	GDP per capita rank 2002 (177 countries)	GDP per capita (PPP US$) rank minus HDI rank (higher means better on HDI)	HDI value 2002	GDP per capita value (PPP US$) 2002
Uganda	146	150	4	0.493	1,390
Sub-Saharan Africa Countries	-	-	-	0.465	1,790
Best performer in Sub-Saharan Africa (Seychelles)	35	33	-2	0.853	18,232
Worst performer in Sub-Saharan Africa (Sierra Leone)	177	176	-1	0.273	520

Source: UNDP Country Fact Sheet Uganda (2004), www.

5.1.4 Socioeconomic Indicators

5.1.4.1 General Population Indicators

In 2004, Uganda has a population of 27,269,482 of which 50% are under the age of 15 and only 2% over 65. The overall sex ratio is 1 to 1. The population growth rate is an estimated 3,3%, and total fertility rate at almost 7 children born per woman. The ethnicity of Ugandans is diverse, the Baganda with 17% being the largest group. Christian beliefs are the dominant religions, 33% of the Ugandans being either Roman Catholic or Protestant. Still 18% follow indigenous beliefs and 16% are Muslim. The official language is English, Ganda or Luganda is the preferred indigenous language.[219]

5.1.4.2 Health and Education Indicators

In 2002, the infant mortality is 82 deaths per 1,000 live births, the life expectancy at birth averages at 45 years, whereas the male expectancy is slightly below it and the female one slightly above. The HIV/AIDS adult prevalence rate in 2003 is with 4,1% astonishingly low for the region. In 2000, 79% of the population had sustainable access to sanitation and 52% to an improved water source but a considerable lack of health personnel is represented by the following figures: in 2002, there are only 5 physicians for per 100,000

[219] See CIA – The World Factbook, www.

Ugandans and only 39% of deliveries are attended by trained health personnel. Public health expenditure only reached 3,4% of GDP in 2001.[220]

The literacy rate (percentage of 15 year olds and over that can read and write) amounts to almost 80% for men and 60% for women[221], whereas the combined gross enrolment ratio for primary, secondary and tertiary level schools reached 68% for girls and 73% for boys in the school year 2001/02. Even though public expenditure on education only amounted to 2,5% of GDP in the period from 1999-2002, Uganda's educational situation is considerably better than its health status.[222]

5.1.4.3 Income Distribution and Poverty

Taking a closer look at the population, the statistics reveal a familiar picture: from 1990-2001, 44% are estimated to live below the poverty line. During the same period, the poorest 10% of households consumed only 2,3%, while the richest 10% acquired 34,9% of income or consumption, respectively. This transfers into an inequality ratio of 14,9% and a GINI index of 43, which translates into high income inequality.

The following table gives an overview over three important indicators, while the resepctive indicators of Uganda and their development are discussed in more detail in the following sections.

Figure 5.3. Selected Socioeconomic Indicators

Life expectancy at birth (years) 2002	**Combined primary, secondary and tertiary gross enrolment ratio** (%) 2001/2002	**GDP per capita** (PPP US$) 2002
1. Japan (81.5)	1. Sweden (114)	1. Luxembourg (61,190)
2. Sweden (80.0)	2. Australia (113)	2. Norway (36,600)
3. Hong Kong, China (SAR) (79.9)	3. United Kingdom (113)	3. Ireland (36,360)
154. Niger (46.0)	90. Venezuela (71)	146. Côte d'Ivoire (1,520)
155. Djibouti (45.8)	91. Belize (71)	147. Togo (1,480)
156. Burkina Faso (45.8)	92. Namibia (71)	148. Moldova, Rep. of (1,470)
157. Uganda (45.7)	**93. Uganda (71)**	**149. Uganda (1,390)**
177. Zambia (32.7)	176. Niger (19)	175. Sierra Leone (520)

Source: UNDP Country Fact Sheet Uganda, www.

[220] See HDR Statistics (2004), www.
[221] WB Data and Statistics, http://devdata.worldbank.org/data-query/
[222] See HDR Statistics (2004), www.

5.2 Economic Policy

5.2.1 Before the 1990s

When Uganda acquired political independence, its economy was that of a peasant and pastoral culture dominated by subsistence economy and self-sufficient households. The main agricultural products were cotton and coffee. In order to get right on track from the beginning, the Ugandan government in 1960 asked the World Bank for recommendations on the country's way to prosperity. In its report, one already recognises the pillars of the Bank's policies for the next three decades[223]:

- Increase production
- Hold line on social services except education and health
- Encourage evolution from subsistence to modern monetary economy
- Secure organisation and efficient execution of development efforts
- Encourage private investment and economic use of resources
- Set price for public utility services at cost-recovery level

The prime aim of the strategy was to raise national income and production. It was also suggested to diversify the economy since the dependence on the international prices for coffee and cotton caused considerable insecurities.

"The determination of the optimum distribution between what is commonly called productive and non-productive public expenditures is a problem of the first order… [it] is one of establishing the proper allocation of funds…In determining these priorities, political as well as economic realities must be kept in mind and balanced against each other. But it must be remembered that vigorous promotion of economic growth is at this stage an essential part of successful self-government."[224]

Concerning the organisation of the health setor, the report promoted a decentralisation approach and the reintroduction of user fees. The Ministry of Health was to relinquish its administrative responsibilities and restructure itself into a sole advisory body.

In the health centres, the focus was suggested to be laid on preventive medicine, health education and the combat against poor hygiene and insect-inflicted diseases, since the health status of the population had greatly improved under British rule. Although, this is in any case a sensible approach, the following justification for the reintroduction of user

[223] compare WB (1962)
[224] WB (1962), p. 41

charges puts it into perspective again. "This is possible because there is no longer any need to induce people to learn the value of modern medicine; now, it is more important to economize on the services of doctors and other medical personnel by eliminating patients who are only interested in the dispensary as a social center."[225]

5.2.2 (Pro-poor) Growth in the 1990s[226]

After the chaotic situation of military coups in the 1970s and 1980s had destroyed most of the economic achievements of the earlier decades, President Museveni started on a successful mission to build up and stabilise his country's economy. Even though, Uganda didn't improve its HDI rank (150 out of 173) during the ten year period of 1990 to 2000, it still was considered a model for success of post-conflict recovery in Africa. During this same period, per capita income doubled and poverty was reduced substantially.

Uganda's achievements can be attributed to three pillars:

- The activation and utilisation of existing capacities and repatriation of capital after the period of dictatorship and conflict.
- The stabilisation and liberalisation through reforms, in particular of the coffee market, and the promotion of privatisation and sectorla programmes under President Museveni.
- Foreign aid, which constituted a third of the overall per capita growth rate.

The abolishment of the coffee marketing board enabled coffee farmers to profit from the high-rising coffee prices on the world market, a special poverty eradication programme (the PEAP) was implemented even before PRSPs came into existence and the Universal Primary Education (UPE) initiative raised the literacy rate, and therefore human capital, considerably. But the question arose of who profited from these attainments? Were the gains distributed evenly throughout the country and across social segments or was growth limited to a group of few?[227]

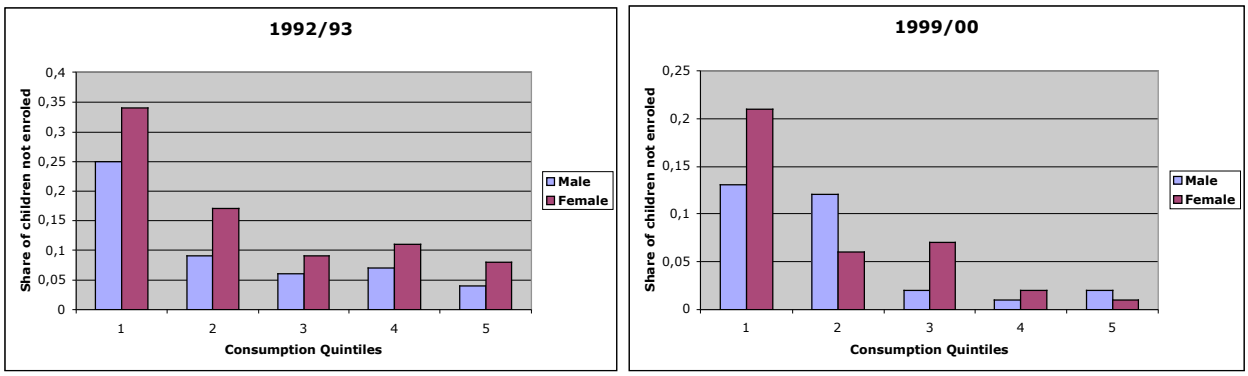
5.2.2.1 Universal Primary Education

The UPE initiative introduced in 1997 and guaranteeing free primary education and free text books for up to four children of a family (of the four at least two should be girls) has additionally contributed to poverty reduction since a lack of education and skills is

[225] WB (1962), p. 116
[226] This section based on Kappel (2004).
[227] See Kappel (2004), pp.197-199.

reported to be the reason for poverty by 58% of the rural and 42% of the urban households. UPE dramatically increased primary school enrolment and virtually eliminated the previously existing gender bias in education. Only in the poorest, predominantly rural, segment, when parents have to choose whom to send to school, it is still the boys that are enroled first. In the following graphs, which illustrate the impact of UPE and the decline of the gender gap, this segment is represented through the consumption quintile 1.[228]

Figure 5.4. Share of Children between 7 and 13 not Enroled in School



Source: own graph with figures from Kappel (2004), p.216.

5.2.2.2 The Health Status

Considering the improvements achieved in education, the picture that the Ugandan health sector presents seems decrepit. In the same period as poverty decreased and the enrolement rates rose, health indicators either stagnated or worsened. Infant mortality rates from 1995 and 2001 saw an increase from 81 to 88 deaths per 1000 live births, while under-5 mortality deteriorated from 147 to 152 in the same period. Maternal health care is still hardly available for rural and poor women and the supply with health centres is scarce.

Only in the HIV/AIDS combat, Uganda has achieved respectable results with an all-time and all-region low, considering a prevalence rate of only 4,1% by 2003 compared to 13% in the 90s[229]. This is due to a concerted effort by politicians, religious leaders and civil society organisations, and the highly acclaimed *ABC (Abstinence, Be faithful, Condoms) approach* spearheaded by President Museveni. Lately, there have appeared some cracks in the picture, though, with an NGO survey claiming that the inofficial prevalence rate still

[228] See Kappel (2004), pp.214-217.
[229] Compare www.unaids.org, Factsheet Africa.

amounts to over 15%, and in some regions as many as 30% of the population are said to be infected with the HI virus. True or not, a notion of religious concerns on the emphasis of the condom has sparked discussions on the importance of abstinence and no sex before mariage – a tendency which could easily counteract the efforts already delivered.[230]

In March 2001, Uganda has abolished the user charges for health centres at the local and sub-regional level to facilitate access for the poor. So far, reports have confirmed that the attendance of this segment has risen since then.

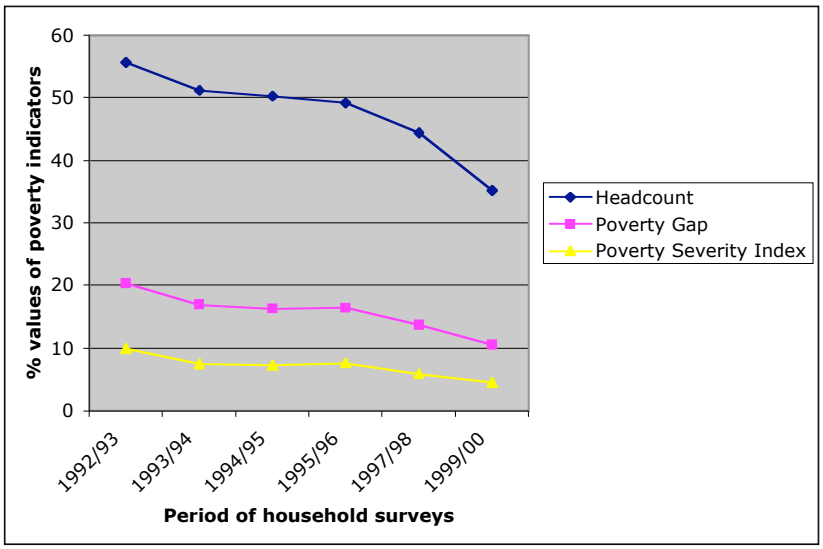
5.2.2.3 Recent Pro-poor Growth

Pro-poor growth is defined as a process in which the poor are enabled to actively participate in economic and social life. The *direct way* immediately increases their income, taking place in the sectors where they are employed. The *indirect way* alludes to the redistribution of the obtained income through progressive taxation or other transfers, financial and non-financial. In any case, it is widely accepted that growth must be labour- and land-intensive otherwise it leads to "growth without work" as has happened in other developing countries, such as Saudi Arabia.[231]

When measured in terms of consumption, poverty decreased considerably throughout the decade, in rural areas as well as urban ones. The rural poverty gap fell from 22% in 1992/93 to 11,8% at the turning of the century, and from 8,3% to 2.2% in urban areas. The following graph depicts the aggregate national percentage points for the poverty indicators *poverty headcount, poverty gap and poverty severity index*.

[230] Compare BBC (2004) and BBC (2005), www.
[231] See Kappel (2004), p.199.

Figure 5.5. National Poverty Indicators



National Inequality measured by the Gini coefficient

1992/93	0,364
1993/94	0,354
1994/95	0,365
1995/96	0,366
1997/97	0,347
1999/00	0,384

Source: own graph with figures from Appleton (2001), cit. in Kappel (2004), p.204.

Taking a closer disaggregated look at the data, growing disparities between the four regions surface, but overall it can be stated that growth has been pro-poor and broad-based, benefiting all percentiles of the population in rural and urban areas. "However, the evolution of asset ownership by socio-economic strata shows that the better off own much more today than they did a decade ago, whereas asset ownership of the middle class and the poor has been virtually stagnant."[232]

In 1998, the government introduced the *Poverty Action Fund (PAF)* to channel freed resources from the HIPC debt relief to profit social services, especially primary education and PHC. It has now become the sole financing source for public services.

5.2.2.4 Some Conclusions[233]

As already mentioned above, Uganda has experienced considerable welfare gains in terms of consumption but these gains have not been equally distributed throughout the country and regions. Moreover, the foundation for this increase is rather feeble, since much of it can be attributed to high coffee prices in the 1990s and debt relief under the HIPC initiatve. With an annual deficit of 8%, 35% of the budget consituted of foreign grants and an agricultural sector which is still highly dependant on coffee and cotton, a long-term perspective for sustained growth can not be realised. Additionally, tax collection is meagre in Uganda and priority programs are also financed by foreign donor aid rather than nationally accrued resources. Given the UPE outcomes, the younger generation

[232] Kappel (2004), p.212.
[233] Compare Kappel (2004), pp. 220-1.

definitely has better prospects for finding adequate employment in the formal sector. However, it is still the poorest and the girls who are most likely to be kept away or drop out of school. Finally, Uganda has to put major efforts into advancing the health sector because holding HIV/AIDS down is by far not the only mission of a functioning health care system.

5.3 PEAP/PRSP Implementation

In 1995, the Ugandan Government started the *Poverty Eradication Action Plan (PEAP)* to counteract the high prevalence rate of porverty in the country. During the entire project, *Civil Society Organisations (CSOs)* were actively involved and their advise and input sought after by the Government. By 1997, the first PEAP was finalised and implemented. The PEAP was designed as an evolving programme, hence the need for revision came up two years later, also because new findings and research were to be intergrated in the PEAP. The decision to revise the initiative coincided with the demand by the World Bank and IMF to elaborate a national *Poverty Reduction Strategy Paper (PRSP)* as a prerequisite to qualify for the HIPC debt relief initiative. It was therefore decided by the donors, the Government and CSOs to incorporate the PRSP into the revised PEAP – and there were only three months to do so.

5.3.1 The PEAP/PRSP Programme

"The donors' interest [in producing a PRSP in time] was a result of the international pressure that HIPC was not working and that only a few countries had benefited. Uganda therefore became a show-piece for donors to stem the increasing tide of criticism."[234] Pressure to deliver the PEAP/PRSP in time worked as a catalyst on all levels. Government set up a technical committee to gather all the information and data necessary, which was assisted by an international consultant. A steering committee was put in charge of the overall co-ordination, reporting and management of the process, consisting of senior government officials, CSO and donor representatives. Upcoming reseach was constantly integrated into the paper to fine-tune the propositions and findings. While Government held workshops for local authorities, CSOs organised them for grassroots organisations and interested individuals.

[234] Gariyo (2002), p.14.

5.3.1.1 The Key Agents: CSOs and the Government

Uganda Debt Network (UDN) took the lead on the CSO side. Founded in 1996 as a lobbying network to achieve universal debt relief, it had already participated in the formulation of the first PEAP and had considerable experience in managing grassroots meetings. The Ugandan Government on the other side had been pro-active towards the inclusion of CSOs from the very beginning and made the first step to invite them into the revision process. "In spite of the strict guidelines that civil society participation in the formulation of a country's PRSP is essential, most governments in Africa are not yet ready to accept CSOs as serious stakeholders in policy planning. The Government of Uganda ensured that CSOs were given enough space in the PEAP/PRSP process by organising independent consultations and incorporating as much of their inputs into the documents as possible."[235] Hence, the co-operation proved very productive and visionary for other countries. Only, when it came to the actual transition phase of incorporating the PRSP into the PEAP, did the CSOs feel left out, since most meetings with the WB and IMF went without them.

5.3.1.2 The Content of the PEAP/PRSP 2000

The final draft for the PEAP identified four pillars on which to concentrate resources[236]:

- Creating an enabling environment for sustainable economic growth and transformation
- Promoting good governance and security
- Raising the incomes of the poor
- Improving the quality of life of the poor

"The PEAP/PRSP in Uganda is largely acknowledged as having put poverty eradication in addition to economic growth, macro-economic stability and private sector development at the centre of policy design, formulation and implementation."[237] In order to meet the goals, the budget process was re-aligned to focus on social services. To ensure that resources were allocated to the previewed programmes and projects, Government introduced regular accountability reports, which were presented to CSOs, donors, local authorities and the media, as well as published in media and on bulletin boards in the respective districts. CSOs and government officials lobbied towards the donors to accept a basket funding rather than the usual project-linked grants. Their argument was to stay

[235] Gariyo (2002), p.32.
[236] Gariyo (2002), pp.21-2.
[237] Gariyo (2002), p.22.

more flexible in the allocation of funds and to ensure there was no over-funding of 'favourite projects' such as UPE. Even though donors consented, they stayed sceptical since the accountability process was not all that transparent and clear as stipulated and rumors arose every once in a while that funds were disappearing in the vast technocrat system of public administration. Despite these and other obstacles, the process proved successful and the final PEAP/PRSP was presented to the donors in May 2000, in due time. Henceforth, Uganda also qualified for the HIPC debt relief allocating the money, as aforementioned, into the PAF.

> "What is clear is, that, for CSOs to effectively influence policies in Uganda and elsewhere in Africa, there must be a conducive policy environment. Thus, to require a participatory PRSP in a short time when such governments do not have respect for their own people's views, is not realistic."[238]

The PEAP/PRSP process also was a success for the co-operation of Government and civil society.

5.3.2 Further Revisions of the PEAP/PRSP since 2000

5.3.2.1 The PEAP 2003 and the MDGs on Health

The PEAP was again revised in 2003 to incorporate experiences made and to evaluate the targets formulated in the PEAP in comparison to those of the MDGs. The four pillars of the previous PEAP remained untouched, but interesting results were obtained relating to the MDGs.

As the MDGs are envisaged as global targets, they are, in most cases, more demanding and ambitious than local PRSPs, such as the PEAP, which in turn is more realistic about reaching the goals. In this specific case, "the PEAP targets relating to poverty, UPE, HIV/AIDS and water are more ambitious than the MDG targets. On the other hand, the MDG targets for gender equality in education, infant mortality and maternal mortality are more ambitious than those set out in the PEAP."[239] Subsequently, Uganda is performing rather poorly concerning its infant mortality and maternal mortality rates. Infant mortality is viewed as a good indicator for the success of the PEAP because it is influenced by many factors prioritised in the programme, such as female education and literacy, safe water supply and access to basic health care. The stagnation since 1970 of this specific indicator is a perfect example that economic growth does not (entirely) heal a country (Uganda

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[238] Gariyo (2002), p.41.
[239] Tashobya (2004), p.36.

experienced economic growth rates of around 6% since the 1990s). Similar with the maternal mortality rate, with which Uganda is ranking among the eight countries with the highest maternal mortality rate in the world.
Hence, a lot remains to be done, especially in the health sector, if Uganda wants to achieve all of its own set targets in the PEAP and the MDGs by 2015.[240]

5.3.2.2 Evaluation by the International Development Agency (IDA)[241]

In preparing for the allowance of a new grant for Uganda, the IDA evaluated the progress the Ugandan Government made in implementing the PEAP/PRSP targets. By 2004, the PEAP was still being revised[242], and now consists of five pillars with key priorities:

- Economic management
- Production, competitiveness, and incomes
- Security, conflict-resolution, and disaster management
- Governance
- Human development

Again, CSOs were heavily involved in formulating this third version of the PEAP, which for the first time features a section on "public expenditure to implement the PEAP". The above-mentioned targets, which were compared to the MDGs, were also implemented with this version to further secure accountability and evaluation of the progress made.

The IDA report attests Uganda a positive development of its macro-economic reforms, with all the required targets met so far. All its non-income welfare indicators have improved since 2000, while a major setback is the increase in the poverty headcount to 38% in 2003, up 3%. The agency also acknowledges the transparent and robust budget process, which is periodically being published and discussed with stakeholders (e.g. CSOs) and the donors. However, the decentralisation process in the public administration is hampered by the inability of local authorities to meet their budget frameworks. Financial resources towards PEAP priority areas, i.e. social services, have increased under the

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[240] See Tashobya (2004) for a more detailed analysis.
[241] See WB (2004).
[242] The author supposes that the PEAP in question is the same as the one talked about in Tashobya (2004), since there only have been three revisions so far. Since the latter paper was published earlier in the year 2004 (in April compared to August), the difference in the number of pillars can be explained because the revision process was still in progress during most of 2004. Tashobya (2004) most likely draws on an earlier draft of the PEAP than the IDA.

Poverty Action Fund (PAF) from 35% to 37,3% in 2004. The revised PEAP also looks into an evaluation of the PAF to ensure that it is still in line with the PEAP key priorities.

One major concern is identified in the increasing budgets for public administration and defense. "Unless corrected, this trend may jeopardize the consistency of the budget with the PEAP and undermine the credibility of the strong budget process in Uganda."[243] Another issue is the lacking gender focus of the macro-economic reform agenda, which the IDA has been trying to correct with prior funds and is proposing to continue with new resources. Its focus was on "(i) the revision and update of the National Gender Policy; (ii) development and implementation of gender and equity budget guidelines for the 2005/06 cycle; and (iii) adressing gender and growth linkages in Uganda."[244] Furthermore, it goes in accordance with previously cited authors that Uganda has to get a grip on its blatantly high infant and maternal mortality rates.

In synthesis, the report strongly supports the outcomes of already mentioned studies and agrees in the causes and solutions to the obstacles for Uganda's development. It seems that the international financial institutions really performed a shift in their attitude towards development.

However,

> "[f]ull implementation fo the PEAP would require an additional 63% of the current government spending, while attaining the MDGs would be far more expensive. Currently the social sectors are heavily under funded. […] There is no true stability without health, and the Ugandan economy can usefully absorb massive increases in foreign grants for health – indeed, and also, much greater amounts than the donors are likely to make available. Growth in health expenditure is essential if Uganda is to meet its poverty eradication goals."[245]

[243] WB (2004), p.5.
[244] WB (2004), p.7.
[245] Tashobya (2004), p.39.

5.4 Engendering Uganda – The CEDAW Report

"Without progress in the situation of women, there can be no true social development. Human rights are not worthy of the name if they exclude the female half of humanity. The struggle for women's equality is part for a better world of all human beings, and all societies."

Boutros Boutros-Ghali, 2003[246]

5.4.1 What is CEDAW?

The *Committee on the Elimination of All Forms of Discrimination against Women (CEDAW)* was founded in 1982 to monitor the implementation of the Convention under the same name. It is part of the UN organisation and convenes once a year to prove and evaluate the reports submitted by the member countries; currently 180 countries have ratified the Convention. The 23 person committee is elected by the countries for a four year term – so far they have all been women with only one exception.

CEDAW has the authority to propose specific measures to the member countries to eliminate female discrimination. A further field of activity is the co-operation with NGOs.

It reports its findings to the Economic and Social Council (ECOSOC) of the UN, which in turn informs the General Assembly and forwards the reports to the Commission on the Status of Women (CSW).[247]

5.4.2 The Findings of the Report[248]

Uganda ratified the Convention in July 1985 and submitted its Initial and Second Country Reports to the Commission in 1994.

The Third Report was submitted in 2000 and follows in its structure the 16 articles of the Convention, which directly deal with the aspects of female discrimination in daily life. For readability considerations, I have summarised the major positive and negative findings and will present them in the following, more comprehensive way.

5.4.2.1 Legal Aspects

With the new Constitution inaugurated in 1995, sex has been added on the list of prohibited reasons for discrimination. Many NGOs as well as governmental institutions are preoccuppied with the legal education of girls and women, organising seminars and

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[246] Boutros Gali (2003), cit. in Klauninger (2003), p.42.
[247] Compare http://www.un.org/womenwatch/daw/cedaw/index.html
[248] Based on CEDAW (2000).

workshops in community centres or distributing brochures in schools and workplaces. The introduction of paralegals has considerably increased the amount of women going to court, after receiving legal advice and support there.

Most of the Law has also been reformulated to conform with the Constitution and the Convention. However, especially in the field of family and property law legislation remains, which still contradicts anti-discrimination. It is especially the putting into practice of the protective laws that is hampered by adverse attitudes (of men). Many lawyers, judges and police still think that domestic violence is a family matter, that prostitutes are themselves responsible for their plight or that women are not to join the formal workforce (but, to be fair, these attitudes are also quite common in some European countries). Pro-active law enforcement hence is still more difficult to achieve for women.

Prostitution is still illegal, leaving the women with no protection at all. Hand in hand goes the problem of abducted women, very common in the Northern Region, where the LRA kidnaps girls and women as sex slaves. There does exist an article, which one could interpret as the prohibition of female abduction, but no prosecutions have been recorded so far. One obstacle is that women would have to bring up another "unbiased" witness to prove their case.

Passports can only be acquired with the consent and signature of the husband or custodian. And family law makes it very difficult for women to receive custody for her children. "It follows therefore that in the laws of marriage, divorce or inheritance, there is no gender equity or fairness, to date. The woman is always the subordinate person. […] Customary marriages are potentially polygamous…"[249] Her situation is further aggravated by the tradition of a bride price that the family of the husband has to pay.

5.4.2.2 Political Representation

In principle, one third of all the representatives at all Council levels should be women. Affirmative action has gradually improved the relation between male and female representatives but the overwhelming part is still male-dominated. At the 1996 elections, only 32 women applied for the 214 direct county seats in parliament, and only 8 made it. The rest to the 18,5% female rate in parliament are there through affirmative action, as representatives of their district – according to the law, every district must elect one woman to represent female issues in parliament.

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[249] CEDAW (2000), p.66.

Figure 5.6. Women and Men in the Top Decision Making Positions in Uganda

Position	1994		1995		1996		1997	
	W	M	W	M	W	M	W	M
Cabinet	6	38	7	45	7	47	7	47
Parliament	51	219	51	226	51	226	51	226
Top Civil Service	32	122	21	112	59	215	60	213
Judiciary	-	-	-	-	13	44	16	51
Local Authorities	14	103	5	73	5	73	12	105
Total	98	482	79	449	135	605	146	642
Percent	16,9	83,1	14,9	85,1	18,2	81,8	18,5	81,5

Source: CEDAW (2000).

In comparison with industrialised countries and other DCs, Uganda fares still quite well on its gender indices:

Figure 5.7. Gender Indices in Comparison

Seats in parliament held by women (% of total)	Estimated female income in US$ PPP	Ratio of female earned income to male earned income
1. Sweden (45.3)	1. Luxembourg (33,517)	1. Kenya (0.90)
2. Rwanda (45.0)	2. Norway (31,356)	2. Sweden (0.83)
3. Denmark (38.0)	3. United States (27,338)	3. Cambodia (0.77)
25. Turkmenistan (26.0)	121. Moldova, Rep. of (1,168)	22. Mozambique (0.66)
26. Trinidad and Tobago (25.4)	122. Bangladesh (1,150)	23. Bulgaria (0.66)
27. Switzerland (24.8)	123. Senegal (1,140)	24. Jamaica (0.66)
28. Uganda (24.7)	**124. Uganda (1,088)**	**25. Uganda (0.66)**
163. United Arab Emirates (0.0)	153. Sierra Leone (337)	153. Saudi Arabia (0.21)

Source: UNDP Country Fact Sheet Uganda, www.

5.4.2.3 Media

For several years now, TV and radio stations have been featuring special programmes to sensitise the public about gender issues. Every medium, whether TV, radio or newspaper, has a weekly magazine devoted to women issues, talking about traditions such as bride prices, the importance of female education, etc. to further heighten awareness. Moreover, NGOs have designed seminars for reporters and journalists in which gender topics and how to treat them in the news are discussed. So far, this has proven very successful.

5.4.2.4 Education

As has been demonstrated earlier, the UPE initiative dramatically enhanced the number of girls attending and completing primary school. However, especially at the secondary and tertiary levels, girls are still a minority, although the government has introduced severall aspects of affirmative action to facilitate girl's access to higher education. The female enrolment rate at the countries' biggest university, Makerere University in Kampala, amounted to 35% in 1997 and has most likely been on the rise since then.

Since literacy rates are still low for women (44,9%) compared to men (63,5%), Government embarked on another programme in 1992 called *Functional Adult Literacy (FAL)*. Over 80% of learners attending the courses so far in all districts have been women.

5.4.2.5 Labour Market and Access to Assets

Even though agriculture is a women's business, as in most of sub-Saharan Africa, female access to land is still extremely low. Legislature takes an egalitarian view on property ownership, but culture and tradition still do not. Hand in hand goes the problem of access to financial assets and credits. In order to assist women in acquiring financial resources, microfinance institutions were built up after Grameen Banks' role model. But reality shows a different picture. Under the scheme of the *Povertey Alleviation Project (PAP),* which was supposed to allocate 60% of its funds to female projects fostering income and employment, not even the highest ranking district (55%) reached the set goal. Nationwide, 52% of the resources were accessed by men.

On the labour market, female participation is primarily hampered because of a lack of child care centres. And if the mother does go to work, she leaves her eldest daughter with the household chores. "Women are responsible for producing 80% of Uganda's food and they provide about 70% of the total agricultural labour force. Women are mainly limited to the unpaid subsistence sector , working with no technological or financial support."[250] A look on the distribution of domestic work reflects the general picture for an African DC.

[250] CEDAW (2000), p.42.

Figure 5.8. Gender Division of Domestic Work in Selected Districts

Village/District	Working hours		Leisure/sleeping hours	
	W	M	W	M
Budondo/Jinja	16	5	8	19
Gogonyo/Pallisa	14,5	4	9,5	20
Mutojo/Bushenyi	18	12,5	6	7,5
Rubaga-Kabusu/Kampala	18	15	6	9

Source: CEDAW (2000), p.42.

The general notion is perfectly mirrored in the following statement: "A man who is in paid employment is highly regarded even if he cannot feed his family, whereas a woman who is merely a subsistence producer is undervalued even if she feeds her family."[251]

5.4.2.6 Female Health Status

In order to guarantee an advancement in the health status of all Ugandans, the Ministry for health has formulated a list of principles upon which to focus[252]:

PHC remains the basic philosophy and strategy for health care

- Equitable and easy accessibly provision of health care throughout the country, regardsless of socio-economic situation
- Good quality and a high level of efficiency, responsiveness and accountability
- Health promotion, disease prevention and the empowerment of the individuals shall be given a greater attention
- Closer co-ordination with independent voluntary providers of health care
- Achievement of a gender sensitive and responsive national health system

It is further acknowledged that health is an integral part of development and should therefore be promoted via inter-sectoral co-operation between ministries, NGOs and development agencies. Moreover, the improvement of the health care system has been announced to be a national priority, since quality and quantity are still insufficient.

Uganda is no exeption from the picture which one finds in all of sub-Saharan Africa with the same problems as already discribed several times in previous sections. And again, it's the women which are hit hardest. Even though life expectancy and mortality rates already show the biological advantage of women in this respect, they are the ones who attend health centres the least and whose health problems are adressed last.

[251] CEDAW (2000), p.43.
[252] CEDAW (2000), p.45.

One of the biggest issues is the extraordinarily high teenage pregnancy rate, with 70% of the under-19 girls having begun childbearing. It is also one of the highest in the region. Teenage pregnancy is associated with higher infant mortality and a higher eventuality of complications during pregnancy and delivery.

Very positive on the other hand is the 91% of women receiving antenatal care services, while only 40% are assissted by trained personnel during delivery. Also, the already low incidence rate of female genital mutilation experienced a 36% decline after extensive community-based awareness training.

Finally, women have been actively involved in upgrading the national water supply and sanitation. "Throughout the country, women form part of the water management committees, and in some cases, women NGOs are contracted to make sanitation platforms. Women are also being trained and contracted as masons."[253]

5.5 Challenges for the Future

Uganda poses an interesting case, since it features very positive and very negative developments at the same time. The Ugandan Government has proven its belief in poverty eradication and sustained development. Initiatives such as the PEAP, UPE and the close co-operation with NGOs and CSOs are a rare example for pro-active and inclusive governing in the region (and elsewhere on the planet). It has achieved a relatively high literacy rate for both sexes and UPE almost eliminated the gender bias in primary education. Another role model is its campaign against HIV/AIDS with a stagnating prevalence rate well below the regions' average. This is also reflected in a higher life expectancy compared to other countries in the region which pay a high toll to the pandemic (Zambia's life expectancy has plumeted to 39 years!). Also, its budget transparency policy and its prudent use of the media could make a good example. Poverty headcount has risen recently but in comparison to the beginning of the 90s, with 56%, it is now stagnating at around 35%. Growth has overall been evaluated as having been pro-poor, with inequality between rural and urban areas and within the quintiles not rising considerably. Also, Government was able to receive debt relief not only under the HIPC initiative but also in bilateral agreements, for example from India and Japan. Its net-present-value of debt to GDP ratio is well within the range of HIPC limits, amounting to 31% in 2003[254].

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[253] CEDAW (2000), p.59.
[254] WB (2004), p.17.

On the other hand side, Uganda was not able to put its high GDP growth rates over the past 15 years to use. Appart from its education programmes not much seems to have changed, with an ailing health system and a technocratic public administration in which the local authorities are especially weak performers. Moreover, it faces an unresolved conflict in its Northern region, which preferably is overlooked by local and international agencies alike.

The country still ranks among the poorest countries, with one of the lowest HDIs and high infant and maternal mortality rates. Notwithstanding its astonishingly good performance in some indicators of the GDI, women in Uganda still are discriminated in all aspects of daily life.

Clearly, the government must intensify its efforts in the health sector, securing basic health services for everybody at no costs and close distance. Further, it must concentrate on the empowerment of women to lower birth, infant and maternal mortality rates, to open up more possibilities for them than just getting married and working in the subsistence sector. Another aspect is to strengthen its democracy and legislature, foster higher quality prosecution and eliminate remaining discrimantive laws. Even though Ugandans have given their consent to the one-party policy of President Museveni, it is not in the interest of an evolving democracy to start off with no (official) opposition. Museveni and his Government have come a long way and should continue in integrating civil society into all stages of the development process to ensure a close contact to the people concerned.

In my opinion, Uganda is a good example of how many different aspects and parameters influence development; and that economic growth and priority programmes for selected aspects of human development, such as education, by far don't make a more prosperous and egalitarian country.

> "Uganda's continuing economic development requires a further intensification of investments in human capital – the health and education of its people. With these investments, Uganda can fulfil its potential as one of the world's great success stories in economic development. Without these investments, however, Uganda will flounder, with slowing economic growth, insufficient foreign direct investment inlfows, and unnecessary human suffering."[255]

[255] Tashobya (2004), pp.38-9.

6 CONCLUSION

Over the past decades, there has been a notable shift towards the issue of women and development. International organisations, national governments and economists alike have begun to appreciate the role women play in society in general and the development process in particular. The introduction of social and gender-specific indicators and the collection of gender-disaggregated data have given empiric proof of the discrimination of women and the influence this has on the economic and social performance of a country.

If women are to be active and equal partners in development, they need to receive the possibilities to make efficient use of their capabilities. Concepts like empowerment and gender mainstreaming have already given a voice, not only to women but to marginalised groups in general. The intergration of the Gender Devleopment Index (GDI) and the Gender Empowerment Measure (GEM) into the canon of Human Development indicators and the establishment of engendered budgets have hereto provided tools in progress for the evaluation of the integration and equalisation achieved. The empowerment process has already come a long way and in most above-mentioned areas of concern, have there improvements been registered. Now, it is also important not to forget that gender is about both women and men. If further improvements want to be achieved and the social status of women changed, then it is essential to include men in the projects and process to heighten their awareness for equal chances, as well.

As the early development concepts of Preston, McKeown and Mosley have already recognised, education and health are prime issues in development. The focus of new projects and programmes on clean water supply, profficient maternal and primary health care and female eductaion is a step in the right direction. But even if the targets for these MDGs is reached, one can not simply stop short there. First and foremost, it needs an enabling and encouraging environment for women to realise their potentials. That includes access to assets and financial resources as well as a stronger voice in society and politics. Of what use is literacy to a woman, if she is confined to the house? It should be the concern of any development project, whether bilateral or multinational, to consider the broader picture, and not, as with the vertical programmes of the WHO, merely concentrate on the elimination of a problem without knowing all the causes. The importance of health has often been emphasised and documented throughout this analysis. It is a precondtion for development. Without good health, an individual is not

able to function efficiently or meet her/his capabilities. Hence, the efforts of the WHO and the MDGs focusing on health can not be valued enough in the prioritisation of the topic.
Similarily, financial resources, budget responsibility and structural reforms are important, but not to forget that the so-called weak and failed states do not have structures to reform – they need assisstance in building up a whole new public administration.
So, of course, one can formulate a long list of criticism concerning the politics and theoretical foundations of the international development agencies, whether World Bank, IMF, WHO, UNDP, or any other, the fact is, that developing countries need their support. Finally, it seems that governments and development experts in the donor countries have also realised that it's not only about lending money and dictating the rules for the international economy. The key word is an equal partnership – a concept that is beginning to earn its supporters, even though it will still take years to reach it.

Uganda has proved an interesting case study to the theory, since it perfectly demonstrates the complexities of economic and social development. Despite continued, largely pro-poor growth, and a government which is supportive of civil society engagement and development programmes, it has not been able to advance neither in the HDI ranks nor in basic social indicators such as clean water supply or access to health care. Despite a successful Universal Primary Education initiative, that brought widespread improvements to all areas of the country and society, a 20% gender gap in literacy remains. Despite a comparatively high female percentage of parliamentary representation, Uganda has not been able to improve its maternal and infant mortality rates – on the contrary – or has adressed the urging issue of violence against women.

"We now recognize that development is possible but far from inevitable."[256] Given the manyfold components of development and looking at Uganda, this statement holds very true. Development theory has still to find a framework to grasp this complex phenomenon, while international donors and development agencies should continue on their path of empowering not only women, but all of society, ensuring basic health care services are accessible to all and guaranteeing edcuation without barriers for women or poor, all within a framework of a stable and functional state.

[256] Stiglitz (2000), p.22.

The evaluation of the MDGs in the HDR 2004 and the World Development Indicators for 2005 have brought to light the many obstacles, which still exist to reach the targets by 2015. Without a concerted effort by the international community and all its members the MDGs, and with it millions of poor, will suffer the same 'success' of their predecessors: to fail mid-way through as a cause of lacking support and financial resources. One may argue that even if the MDGs, similar as the PHC movement, the Beijing Platform and other international initiatives, will not meet their final goals, they still brought considerable impovements. This definitely is true, but what sense does it make to formulate highreaching targets, if one satisfies oneself with only half the success?

Development and equality are issues that effect everyone everywhere. It is time to realise our responsibility and not just let others do.

"If many little people at many little places, start to do many little things, we will go end change the world."[257]

[257] Latin American proverb, source unknown to the author.

7 REFERENCES

Abel-Smith, Brian (1994): *An Introduction to Health: Policy, Planning and Financing*, Harlow/Longman.

Anand, Sudhir/Peter, Fabienne/Sen, Amartya (Eds.) (2004): *Public Health, Ethics and Equity*; Oxford University Press, Oxford/New York.

Baggott, Rob (2002): *Public Health – Policy and Politics*; Palgrave/New York.

Bangser, Maggie (2002): *Policy Environments: Macroeconomics, Programming, and Participation*, in Sen, Gita (Ed.) (2002): *Engendering International Health*, MIT Press/Cambdridge, Mass., pp. 257-280.

Benería, Lourdes (2003): *Gender, Development and Globalization – Economics as if All People Mattered*; Routledge New York/London.

Bok, Sissela (2004): *Rethinking the WHO Definition of Health*; Harvard Center for Population and Development Studies, Working Paper Series Vol. 14, Nr. 7, Oct. 2004; Cambridge/MA.

Brockington, Fraser (1967): *World Health*, 2nd edition, Churchill Ltd./London.

Campillo, Fabiola (2003): *Unpaid Household Labour: A Conceptual Approach* in Gutiérrez, Martha (Ed.) (2003): *Macro-Economics: making Gender matter*, Zed Books London/New York.

Diefenbacher, Hans (2001): *Gerechtigkeit und Nachhaltigkeit – Zum Verhältnis von Ethik und Ökonomik*, Wissenschaftliche Buchgesellschaft Darmstadt, Germany.

ECA (2004): *The Missing Link in Growth and Sustainable Development: Closing the Gender Gap*, An Issues Paper, ADB/ECA Symposium on Gender, Growth and sustainable Development, 24th May 2004, Kampala/Uganda.

Feldmann, Alfred (2000): *Die Wohlfahrtsökonmie von Amartya Sen und ihr Einfluß auf die Messung von Entwicklung*, Band 18, University of Bremen/Germany.

Fellner, Wolfgang ((2004): *Lebensstandard bei Amartya K. Sen und Hugo E. Pipping – "Das Ökonomische im Spannungsfeld von Soziologie and Psychologie",* Master thesis at the University of Economics and Business Administration, Vienna.

Fischer, Karin/Hanak, Irmtraut/Parnreiter, Christof (Eds.) (2003): *Internationale Entwicklung: Eine Einführung in Probleme, Mechanismen und Theorien*; Geschichte, Entwicklung, Globalisierung 4, Brandes & Apsel/Südwind/Vienna.

Folbre, Nancy (2001): *The Invisible Heart – Economics and Family Values*; The New Press/New York.

Freedman, Lynn (2003): *Strategic Advocacy and Maternal Mortality: Moving Targets and the Millennium Development Goals* in *Gender and Development: Women Reinventing Globalisation*, Vol. 11, No. 1, pp. 97-108, published by the Association for Women's Rights in Development (AWID) on www.eldis.org.

Gariyo, Zie (2002): *Participatory Poverty Reduction Strategy Papers (PRSPs) – The PRSP Process in Uganda*, Discussion Paper No. 5, Uganda Debt Network (UDN)/Kampala.

Gustafsson, Siv (1997): *Feminist Neo-Classical Economics: Some Examples* in Dijkstra, A. Geske/Plantenga, Janneke (eds.) (1997): *Gender and Economics – A European Perspective*, Routledge London/New York.

Hanak, Irmgard (2003): *Entwicklung – ein männlicher Mythos?* in Fischer, Karin/Hanak, Irmtraut/Parnreiter, Christof (Eds.) (2003): *Internationale Entwicklung: Eine Einführung in Probleme, Mechanismen und Theorien*; Geschichte, Entwicklung, Globalisierung 4, Brandes & Apsel/Südwind/Vienna, pp.103-115.

Hanson, Kara (2002): *Measuring Up: Gender, Burden of Disease, and Priority Setting*, in Sen, Gita (Ed.) (2002): *Engendering International Health*, MIT Press/Cambdridge, Mass., p. 313-345.

Kappel, Robert/Lay, Jann/Steiner, Susan (2004): *Uganda in the 1990s: A Case of Pro-Poor Growth* in Krakowski, Michael (ed.) (2004): *Attacking Poverty: What Makes Growth pro-poor?*, HWWA Studies 75, Nomos Verlagsgesellschaft/Baden-Baden.

Klauninger, Michaela (2003): *Gender Aspekte in der Entwicklungszusammenarbeit unter besonderer Berücksichtigung der Beziehungen zwischen EU und AKP Staaten*, Thesis at the University of Economics and Business Administration, Vienna.

Koivusalo, Meri/Ollila, Eeva (1996): *International Organisations and Health Policies*, Stakes/Helsinki.

Lukas, Karin (2000): *Gender and Development: Entwicklungspolitik im Interesse der Frauen*, Materialien zu Gesellschaft, Wirtschaft und Umwelt im Unterricht 4/99, Austrian Society for Critical Geography/Vienna.

McKeown, T. (1976): *The Modern Rise of Population,* Basil Blackwell/Oxford.

McKeown, T. (1988): *The Origins of Human Disease*, Basil Blackwell/Oxford.

Momsen, Janet Henshall (2004): *Gender and Development*, Routledge Perspectives on Development Series/London/New York.

Navarro, Vicente (ed.) (2002): *The political economy of social inequality: consequences for health and quality of life*, Baywood Publ. Amityville/NY.

Nuscheler, Franz (2004): *Entwicklungspolitik*, Lern- und Arbeitsbuch, 5th completely revised edition, Verlag Dietz/Bonn.

Parpart, Jane L./ Shirin M. Rai/ Kathleen Staudt (Eds.) (2002): *Rethinking Empowerment: Gender and development in a global/local world*, Routledge/Warwick Studies in Globalisation/London/New York.

Payne, Sarah (1992): *Women, Health and Poverty – an Introduction*; Harvester Wheatsheaf/New York.

Polak, Gerhard (Ed.) (1999): *Das Handbuch Public Health*; SpringerMedizin/Vienna/New York.

Preston, S.H. (1975): *The Changing Relation between Mortality and Level of Economic Development* in Population Studies 29/02, published by the United Nations Dept. of Economic and Social Affairs, Population Unit, New York, pp.231-48.

Preston, S.H. (1980): *Causes and Consequences of Mortality Declines in Less Developed Countries in the 20th Century* in R.A. Easterlin (ed.): *Population and Economic Change in Developing Countries*, University of Chicago Press, pp.289-341.

Rice, Thomas (2004): *Stichwort: Gesundheitsökonmie – Eine kritische Auseinandersetzung*, KomPart Verlagsges.mbh & Co. KG Bonn/Germany, English original: *The Economics of Health Reconsidered*, Health Administration Press Chicago/Illinois 1998.

Sen, Amartya (1999): *Development as Freedom*, Alfred A. Knopf Inc. New York.

South Commission (1990): *The Challenge to the South, An Overview and Summary of the South Commission Report*, UN General Assembly A/45/810, New York.

Standing, Hilary (2002): *Frameworks for Understanding Health Sector Reform* in Sen, Gita (2002)(ed.): *Engendering International Health*, MIT Press/Cambdridge, Mass., pp. 347-371.

Stiglitz, Joseph (2000): *Development Thinking at the Millennium*; without publisher.

SAPRI (2004): Structural Adjustment Participatory Review International Network (SAPRIN) (2004): *Structural adjustment – the SAPRI report*; a report on a Joint Participatory Investigation by Civil Society and the World Bank of the impact of structural adjustment policies, Zed Books/London.

Szirmai, Adam (2005): *The Dynamics of Socio-economic Development*, Cambridge University Press/UK.

Tarlov, Alvin R. (1996): *Social Determinants of Health – The Sociobiological Translation* in Blane, David/ Brunner, Eric/ Wilkinson, Richard (Eds.) (1996): *Health and Social Organization*; Routledge/London.

Tashobya, Christine Kirunga/Ogwal, Peter Ogwang (2004): *The effort to achieve the Millennium Development Goals in Uganda: Reaching for the sky?* in Health Policy and Development, Vol. 2, No. 1, April 2004, UMU Press/Kampala, pp. 33-39, published on www.eldis.org.

Thirlwall, A.P. (2003): *Growth & Development – With a Special Reference to Developing Economies*, 7th edition, Palgrave MacMillan/London/New York.

Todaro, Michael P./ Smith, Stephen C. (2003): *Economic Development*, 8th edition, Pearson Education Limited/UK.

WB (1962): *The Economic Development of Uganda*, a Report of a Mission organized by the IBRD at the Request of the Government of Uganda, Johns Hopkins Press/Baltimore.

WB (1993): *World Development Report 1993 – Investing in Health*, Oxford University Press/New York.

WB (2001): *Engendering Development – Through Gender Equality in Rights, Resources, and Voice*; a World Bank Policy Research Report, Oxford University Press/New York.

WB (2003): *Gender Equality & the millennium development goals*, Gender and Development Group, World Bank/Washington DC 4th April 2003.

WB (2005): *Improving Women's Lives, World Bank Actions since Beijing*, Gender and Development Group, World Bank/Washington DC.

WHO (2003): *'Engendering' the Millennium Development Goals (MDGs) on Health*, Department of Gender and Women's Health, World Health Organisation, Geneva.

Wunderink-van Ween, Sophia (1997): *New Home Economics: Children and the Labour Market Participation of Women* in Dijkstra, A. Geske/Plantenga, Janneke (eds.) (1997): *Gender and Economics – A European Perspective*, Routledge London/New York.

Internet resources:

BBC (2004): Madslien, Jorn: *IMF and World Bank: Is reform underway?,* published on BBC Online 22/04/2004, http://news.bbc.co.uk/go/pr/fr/-/1/hi/business/3914961.stm, downloaded 06/08/2005.

BBC (2005): Davis, Matthew: *Where did all the protesters go?,* published on BBC News 17/04/2005, http://news.bbc.co.uk/go/pr/fr/-/1/hi/world/americas/4453135.stm, downloaded 06/08/2005.

CEDAW (2000): *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women, Third periodic reports of States parties, Uganda*, CEDAW/C/UGA/3, source: http://daccess-ods.un.org/TMP/2653015.html, downloaded 03/04/2005.

CIA World Factbook: http://www.odci.gov/cia/publications/factbook/geos/ug.html, as of June 2005.

Einkommensarmut: Das Jugendrotkreuz macht sich stark für arme Kinder in Deutschland, *Hinrtergrund: Wie wird das durchschnittliche Einkommen statistisch gemessen?,* http://www.schaunichtweg.de/wissenswertes/Einkommensarmut.htm, downloaded 07/08/2005.

HDR (2004): *Table 3*, hdr.undp.org/statistics/data/pdf/hdr04_table_3.pdf, and *Table 4*, hdr.undp.org/statistics/data/pdf/hdr04_table_4.pdf, downloaded 06/08/2005.

HDR Statistics (2005): All figures published on the HDR homepage of the UNDP on http://cfapp2.undp.org/hdr/statistics/data/rc_select.cfm, as of August 2005.

HDR Technote (2004): *Technical Note 1: Calculating the Human Development Indices*, http://hdr.undp.org/statistics/indices/, as of June 2005.

HHI: *Human Happiness Index* published on http://www.nationmaster.com/graph-T/lif_hap_net, as of June 2005.

Journal of Health Economics, various issues, published online by elsevier on http://www.sciencedirect.com/science?_ob=JournalURL&_cdi=5873&_auth=y&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=4709f34d8f24f0763cbdf8e92ad9e6dd., as of June 2005.

Monterrey Consensus (2002): Final Version of the Monterrey Consensus as agreed upon at the International Conference on Financing for Development, http://www.un.org/esa/ffd/, downloaded 06/08/2005.

TDR (2004): UNICEF/UNDP/ World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) (2004): *Definitions and Terms in Implementation Research and Health Systems Research*, published 20/12/2004 on http://www.paho.org/common/Display.asp?Lang=E&RecID=8124, downloaded 09/05/2005.

UNDP Country Fact Sheet Uganda: http://hdr.undp.org/statistics/data/country_fact_sheets/cty_fs_UGA.html, downloaded June 2005.

UNDP Definitions: *Definitions of statistical terms*, hdr.undp.org/docs/statistics/understanding/definitions.pdf, downloaded 06/08/2005.

UNDP *Human Development Report*, various years, Oxford University Press/New York/London.

UNDP (2002): *Gender Equality*; Practice Note, www.undp.org.

UNDP (2005): *What is HD?,* http://hdr.undp.org/hd/, homepage of the UNDP as of 05/2005.

UNIFEM (2000): *On the Progress of the World's Women 2000*, UNIFEM Biennial Report, http://www.unifem.org/resources/item_detail.php?ProductID=9.

UNIFEM Gender Budgets: http://www.unifem.org/gender_issues/women_poverty_economics/gender_budgets.php, as of 05/2005.

UN PfA: Homepage of the UN Department for the Advancement of Women (DAW), http://www.un.org/womenwatch/daw/beijing/platform/plat1.htm, as of May 2005.

UN Statistics: Homepage of the *UN Statistical Division*, http://unstats.un.org/unsd/default.htm, as of May 2005.

Wabl, Mattias Georg (2002): *A 'Monterrey Consensus' Might Replace the Washington Consensus*, an article published in the United Nations Chronicle Online Edition, http://www.un.org/Pubs/chronicle/2002/issue1/0102p17.html, downloaded 06/08/2005.

WB (2004): *Programm Document for a Proposed Grant in the Amount of SDR 102.6 Million to the Republic of Uganda for a Fourth Poverty Reduction Support Operation*, International Development Agency, Report No. 29287-UG, published August 5th, 2004 on www.eldis.org, downloaded 09/05/2005.

WDI (2003): *World Development Indicators* data base of the World Bank, http://devdata.worldbank.org/data-query/, as of June 2005.

WHO Constitution: *The Constitution of the World Health Organisation*, Geneva 1948, http://whqlibdoc.who.int/hist/official_records/constitution.pdf, downloaded 09/05/2005.

WHO (1978): *Declaration of Alma Ata*, .http://www.euro.who.int/AboutWHO/Policy/20010827_1, downloaded 09/05/2005.

WHO (1998): *Gender and Health*, Technical Paper WHO/FRH/WHD/98.16, http://whqlibdoc.who.int/hq/1998/WHO_FRH_WHS_98.16.pdf, downoaded 10/05/2005.

WHO MDGs (2005): The score at half-time, published on the WHO homepage, http://www.who.int/mdg/score/en/, as of 10/08/2005.

WHOSIS: WHO Statistical Information System, *About the Global Burden of Disease Project*, published on http://www3.who.int/whosis/menu.cfm?path=whosis,burden,burden_about&language=english, downloaded 10/08/2005.

Wikipedia (2005): *Gini coefficient*, http://en.wikipedia.org/wiki/Gini_coefficient#Disadvantages_of_the_Gini_coefficient_as_a_measure_of_inequality, downloaded 06/08/2005.

8 APPENDIX

8.1 The MDGs

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	**Indicators for monitoring progress**
Goal 1: Eradicate extreme poverty and hunger	
Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	**1.** Proportion of population below $1 (PPP) per day[a] **2.** Poverty gap ratio [incidence x depth of poverty] **3.** Share of poorest quintile in national consumption
Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	**4.** Prevalence of underweight children under-five years of age **5.** Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	**6.** Net enrolment ratio in primary education **7.** Proportion of pupils starting grade 1 who reach grade 5 **8.** Literacy rate of 15-24 year-olds
Goal 3: Promote gender equality and empower women	
Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015	**9.** Ratios of girls to boys in primary, secondary and tertiary education **10.** Ratio of literate females to males of 15-24 year-olds **11.** Share of women in wage employment in the non-agricultural sector **12.** Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	**13.** Under-five mortality rate **14.** Infant mortality rate **15.** Proportion of 1 year-old children immunised against measles
Goal 5: Improve maternal health	
Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	**16.** Maternal mortality ratio **17.** Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	**18.** HIV prevalence among 15-24 year old pregnant women **19.** Condom use rate of the contraceptive prevalence rate[b] **20.** Number of children orphaned by HIV/AIDS[c]
Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	**21.** Prevalence and death rates associated with malaria **22.** Proportion of population in malaria risk areas using effective malaria prevention and treatment measures[d] **23.** Prevalence and death rates associated with tuberculosis **24.** Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)
Goal 7: Ensure environmental sustainability	
Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	**25.** Proportion of land area covered by forest **26.** Ratio of area protected to maintain biological diversity to surface area **27.** Energy use (kg oil equivalent) per $1 GDP (PPP) **28.** Carbon dioxide emissions (per capita) and consumption of ozone-depleting CFCs (ODP tons) **29.** Proportion of population using solid fuels
Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water	**30.** Proportion of population with sustainable access to an improved water source, urban and rural
Target 11 By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	**31.** Proportion of urban population with access to improved sanitation **32.** Proportion of households with access to secure tenure (owned or rented)

Goal 8: Develop a global partnership for development	
Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development, and poverty reduction – both nationally and internationally **Target 13:** Address the special needs of the least developed countries Includes: tariff and quota free access for least developed countries' exports; enhanced programme of debt relief for HIPC and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction **Target 14:** Address the special needs of landlocked countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly) **Target 15:** Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	*Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked countries and small island developing States.* *Official development assistance* **33.** Net ODA, total and to LDCs, as percentage of OECD/DAC donors' gross national income **34.** Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) **35.** Proportion of bilateral ODA of OECD/DAC donors that is untied **36.** ODA received in landlocked countries as proportion of their GNIs **37.** ODA received in small island developing States as proportion of their GNIs *Market access* **38.** Proportion of total developed country imports (by value and excluding arms) from developing countries and LDCs, admitted free of duties **39.** Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries **40.** Agricultural support estimate for OECD countries as percentage of their GDP **41.** Proportion of ODA provided to help build trade capacity[e] *Debt sustainability* **42.** Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) **43.** Debt relief committed under HIPC initiative, US$ **44.** Debt service as a percentage of exports of goods and services
Target 16: In co-operation with developing countries, develop and implement strategies for decent and productive work for youth	**45.** Unemployment rate of 15-24 year-olds, each sex and total[f]
Target 17: In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries	**46.** Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18: In co-operation with the private sector, make available the benefits of new technologies, especially information and communications	**47.** Telephone lines and cellular subscribers per 100 population **48.** Personal computers in use per 100 population and Internet users per 100 population

The Millennium Development Goals and targets come from the Millennium Declaration signed by 189 countries, including 147 Heads of State, in September 2000 (www.un.org/documents/ga/res/55/a55r002.pdf - A/RES/55/2). The goals and targets are inter-related and should be seen as a whole. They represent a partnership between the developed countries and the developing countries determined, as the Declaration states, "to create an environment – at the national and global levels alike – which is conducive to development and the elimination of poverty."

[a] For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.

[b] Amongst contraceptive methods, only condoms are effective in preventing HIV transmission. The contraceptive prevalence rate is also useful in tracking progress in other health, gender and poverty goals. Because the condom use rate is only measured amongst women in union, it will be supplemented by an indicator on condom use in high risk situations. These indicators will be augmented with an indicator of knowledge and misconceptions regarding HIV/AIDS by 15-24 year-olds (UNICEF – WHO).

[c] To be measured by the ratio of proportion of orphans to non-orphans aged 10-14 who are attending school.

[d] Prevention to be measured by the % of under 5s sleeping under insecticide treated bednets; treatment to be measured by % of under 5s who are appropriately treated.

[e] OECD and WTO are collecting data that will be available from 2001 onwards.

[f] An improved measure of the target is under development by ILO for future years

8.2 Declaration of Alma Ata

Declaration of Alma-Ata

International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following

Declaration:

I
The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II
The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III
Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV
The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V
Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI
Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and