

## BOOK REVIEWS

### **Millions saved: Proven successes in global health**

By Ruth Levine and the What Works Working Group with Molly Kinder (Washington, D.C.: Center for Global Development, 2004), 167 pp., \$26.95 (pbk), ISBN 0-88132372-1.

Is investing in health a good buy in poor countries? The Center for Global Development's (CGD) Global Health Policy Network presents a compilation of 17 large scale successful health intervention stories to make the case that some programs have worked – producing major health and welfare benefits that significantly outweigh the costs.

To make a strong argument for this conclusion the case studies were carefully selected in consultation with 15 experts in international health and development, giving consideration to five criteria for “success” – scale (national, regional or global), importance (in terms of disease burden), impact (producing measurable changes in morbidity/mortality), duration (at least 5 years) and cost-effectiveness (about \$100 per disability adjusted life-year [DALY] saved). Further, the cases span the globe, encompassing 11 different country and 5 regional interventions in Africa, Asia and Latin America. And the diversity of interventions is remarkable, ranging from immunization and targeted treatment programs to environmental interventions and food fortification, to health system strengthening and a social safety net, to behavioural change programme.

The case studies are well written and quite informative for the average policymaker or student wanting to get a grasp of the wide scope of public health, extending far beyond the traditional functions of hospitals, health centers and extension services. Each case presentation follows a common format, explaining the health problem in non-technical terms and then giving an enlightening narrative account of the development and evolution of the intervention program, often highlighting the international political processes and public-private partnerships as well as national commitments that made these programs work. Evidence of the impact and the costs are given to assess cost-effectiveness and, finally, there is a note about future prospects relating to long-term sustainability of the programme and/or expansion to other countries.

These cases lead the authors to six “wows” that challenge critics of international development assistance: 1) success is possible, even in the poorest countries; 2) governments in poor countries can do the job – and in some cases are the chief funders; 3) technology, yes – but behaviour change too; 4) international coalitions have worked; 5) attribution is possible; 6) success comes in all shapes.

For the more serious health planner or professional, this book has some significant limitations. These relate to the question, "What are the lessons that we can take away to replicate these successes in other settings?" A few of these limitations will be highlighted here.

First, the authors admit that this book only presents selected "successful" cases. They recognize that such a one-sided presentation (without a comparable group of "failures") makes it impossible to make any valid inferences about what elements are key for success in other settings. They do make some "educated guesses" however, providing a list of "ingredients" that seem to constitute a recipe for success. These are: political leadership and champions; technological innovation; expert consensus around the approach; management that effectively uses the information; and, sufficient financial resources. There is no way however, of determining if these are necessary or sufficient for success, or how they should be introduced in any particular national context.

Second, the brevity of these case studies sometimes oversimplifies the complexities of international health and development efforts. For example, the Bangladesh family planning case study only begins in 1975, ignoring the tumultuous program experience over the preceding decade. The serious nature of the population problem was actually recognized by the government of Pakistan in the early 1960s, when Bangladesh was still the province of East Pakistan. With massive donor support, Pakistan embarked on a heavy handed, top-down national family planning programme that led to a popular backlash and ultimately the collapse of the government in 1968. This set the FP program back for almost a decade until the new country of Bangladesh emerged after the war of independence in 1971 and experienced a major famine following floods in 1974. The case study makes no reference to this disastrous setback. Yet it was this experience that tempered the leaders in the new country to be more critical as they began to re-institutionalize the national family planning program.

Third, major elements of a story have been left out. The Sri Lanka case study rightly recognizes that the targeted maternity care interventions initiated after the 1950s were built on the foundation of a well developed health system in a South Asian society almost unique for its level of social development and gender equity. These medical and community based interventions are described in great detail and then credited with contributing to the subsequent major maternal mortality decline over the next four decades. But strikingly, nowhere is there any mention of the correspondingly major decline in fertility over this same period, from almost six births per woman in the 1950s to two births per woman by 2000 (a greater decline than in the Bangladesh fertility case study). Yet, it is well known that fertility control itself has a direct impact on maternal mortality rates and ratios by, first, reducing the overall number of women at risk to maternal death and, second, by reducing the proportion of high risk pregnancies (too early, too late, too closely spaced and too many). In addition 60% fewer births per woman with lesser risks per birth will greatly reduce the demand for maternal and child health services,

making it possible to invest in the quality of care, even in the presence of budget reductions.

Fourth, the focus on costs per lives saved overlooks major differences in the effectiveness and efficiencies of some technical interventions. There are two stories of the introduction of life saving medical interventions in the population—“Controlling Tuberculosis in China” and “Preventing Diarrheal Deaths in Egypt”—that have very different strategies and outcomes. The direct observed treatment short course (DOTS), in China was implemented essentially by extending the doctor-driven medical system right down to the village level. This achieved extraordinarily high cure rates per case, but disappointingly low case detection rates. The latter was attributed to “inadequate referral of suspected cases” by the medical system and a major recommendation was for “more trained staff.” There is no mention of any need, or effort, to broadly engage the community in the program in order to increase coverage (and support compliance as well). By contrast, in the Egyptian national oral rehydration therapy (ORT) program that also required strengthening the medical care system, the case study makes it clear that “The most pivotal component of the program was the social marketing and mass media campaign” (p. 69). An important strategic lesson was missed by the authors by not recognizing and drawing this contrast in developing the “recipe” for success.

Fifth, interventions with only transitory gains are effectively given equal value with interventions leading to long term continuing system improvements. For example, the “success” stories of “Eliminating Polio in Latin America and the Caribbean” and “Eliminating Measles in Southern Africa” both document the lives saved and disabilities prevented with relatively modest investments. But these two stories have very different endings: in the first case, polio elimination is being sustained by strong national health systems; in the second, measles immunization levels have been slipping down and more and more outbreaks reported. The authors do note that when mass campaigns are imposed on weak health systems the situation can revert back to lower levels of performance, and, more adversely at times, can even deprive resources from other essential routine health services. Yet, the summary of both of these articles is essentially the same, focusing primarily on directly measured impacts and costs during the study periods, and not considering the very different long term implications.

These last two points raise a key concern in my mind – while the authors use success stories to make a case that modest investments in health in less developed countries can save millions of lives, there is no serious attempt to guide the investor towards those investments where the returns will grow and multiply over the long term *versus* those that are only buying some DALYs for a few years and then will be lost. In effect, no clear distinction is made between *transitory* success, and *sustainable* success, though both kinds of case studies are well represented in this volume. If this distinction were made, many important lessons would be learned. For example, some “ingredients” I would venture to add for a recipe for *sustainable* success are local community and national government *ownership*

of the problem and of the technical, managerial and financial aspects of the solution. If the donor community made the investments in building the essential technical and institutional capacities under their intervention programs, then much of the cynicism about the effectiveness of international aid could be dissipated.

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## **Reproductive health: Women and men's shared responsibility**

Edited by Barbara A. Anderson (Jones and Bartlett Publishers, Inc., Sudbury, MA, 2005) xviii+236 pp., US\$46.95 (pback), ISBN 0-7637-2288-X.

This thin but substantial textbook brings perspectives and research from anthropology, sociology, public health, and women's studies to the broadening field of reproductive health. While divided into four different units, addressing (broadly) human rights, sexuality, reproduction, and reproductive health risks, all of the articles in the book proceed directly from a rights-based framework for reproductive health. Indeed, the editor, Barbara Anderson, states early that "[r]eproductive health and reproductive rights are mirror images of each other" (p. 15), and this reflection forms the backbone that links reproductive health responsibility at different levels – individual, partner, community, and global.

In a brief introductory chapter, Anderson examines how the rights-based agenda has expanded the horizon of reproductive health beyond population control and family planning. However, Anderson notes, that same agenda has somewhat narrowly focused on individual women's rights to determine their fertility, with limited engagement with broader sociocultural norms that may conflict with a rights-based approach and to the exclusion of groups like men, gays and lesbians, youth and the elderly, and the infertile. She links ethical principles like beneficence, respect, relativism and social justice to reproductive rights, noting that these principles may vary in their accord with a rights-based approach.

The second chapter summarizes the evolution of a global reproductive rights agenda in the second half of the twentieth century, focusing on developments leading up to and following the watershed 1994 International Conference on Population and Development (ICPD) in Cairo. The initial international emphasis on population control is traced, as well as the addition of maternal and child health and debates leading up to the adoption of a fully articulated reproductive