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Health Systems and the Millennium Development Goals: the case of maternal health and intergenerational transmission of poverty

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ABSTRACT

This paper critically explores how the concept of context is treated in debates on tackling the health-related aspects of the inter-generational transmission of poverty. Based on a two-stage literature review, the arguments developed here identify intergenerational transmissions of poverty as both a key trajectory by which chronic poverty is entrenched across generations and also a significant challenge for attempts by the Millennium Development Goals to improve human capital and achieve the health-related MDG. Context (understood as socio-spatial as well as temporal and multi-scalar) emerges as highly relevant, both in terms of international policy, inter and intra country comparisons and individual positionality. Specific documents by the UN Millennium Project task Force on Child and Maternal Health and UK DFID are analysed more closely alongside other recent literature on MCH-related health systems. We conclude that context matters, and current policy frameworks need to go further in developing a more complex two-directional treatment of context.

INTRODUCTION

The aim of this paper is to explore critically how the concept of context is treated in debates on tackling the health-related aspects of the inter-generational transmission (IGT) of poverty. A number of inter-related strands of research in health systems and health care delivery are concurrently flagging up the importance of influences thought of in terms of contexts of decision-making and action or the embeddedness of systems at their various scales (see for example, Atkinson, 2002; Dobrow et al., 2004; Sheaff et al., 2004; Ferlie and Shortell, 2001; Atun et al., 2005). In the policy domain, discussions on how to move from the current rhetoric for poverty eradication including improved health status into sustainable realities similarly stress the importance of context in determining sensitive strategies and responses (UN Millennium Project, 2005; DFID, 2005).

Two types of information gap are evident in expanding our understanding regarding the influence of context and what to do about it. First, there is relatively little research that captures any of these concerns in detail or in a comparative framework. A systematic literature review of the influence of the relationships between context, organisational structures, organisational processes and organisational performance by Sheaff et al., (2004) identified 1,568 references for review of which only 19% were comparative and only 17% concerned with organisational environment. Almost none were focussed on the specificities of low or middle-income countries or countries in various forms of transition. Secondly, there is little apparent debate within health systems literature about what is meant by context and therefore how to conceptualise it in research and practice. This paper contributes to the second of these knowledge gaps by examining how context is presented as of importance

and how it is implicitly conceptualised in writings relevant to the health-related aspects of the intergenerational transmission of poverty.

The following section locates the paper's themes within the current drive for poverty eradication, investment in human capital and context sensitive strategies. We then outline briefly our sources for this review. The review material is then presented in three sections. The first reviews the general literature on the importance of inter-generational transmissions in shaping the life-course and the implications therein for a role for context sensitivity. The second reviews the most recent documents on progress and strategy in meeting the Millennium Development Goals (MDG) for maternal and child health by the United Nations (UN) Millennium Task Force on maternal and child health (UN Millennium Project, 2005) and by one bilateral agency, the United Kingdom (UK) Department for International Development (DFID, 2005) in order to examine the place of context in contemporary policy and practice. The third complements this applied work through reviewing the parallel treatment of context in recent health systems literature related to maternal and child health. The last section reviews the ways in which context is treated, explicitly or implicitly, in the various literatures relevant to maternal and child related health care with a critical but complementary approach in order to discuss the implications of how context is conceptualised for tackling the health-related aspects of the inter-generational transmission of poverty.

POVERTY, HEALTH SYSTEMS AND INTER-GENERATIONAL TRANSMISSION

The MDGs are contained in a declaration adopted unanimously in September 2000 by member countries of the UN (Gwatkin 2005). They are framed by a meta-goal to eradicate extreme poverty and hunger by 2015, and represent an acknowledgement by the international community that there is a global responsibility to improve the lives of the poorest and most vulnerable (Task Force on Health Systems Research 2004). As such, the 'Millennium Vision' and attendant goals are important in terms of signifying a compact between the Developing and Developed World (Haines and Cassels 2004; Wirth et al 2004), and serve as an international focus against which behaviour, action and declarations of action can be judged (Haines and Cassels 2004).

Improving human capital is treated as fundamental to improved livelihoods as a path out of poverty and thus three of the eight MDGs are health specific: to reduce by two thirds the mortality rate among children under five (MDG Four); to reduce by three quarters the maternal mortality ratio (MDG Five); to halt and begin to reverse the spread of HIV/AIDS, the incidence of malaria and other major diseases (MDG Six). The emphasis on health as human capital in the MDGs is based on the recognition that the relationship between health and poverty conditions the opportunities of many people living in vulnerable circumstances

so that poor health is central to the experience of being poor (Mackintosh, 2001; Freedman, 2005). Ill-health can be both an outcome and a cause of poverty, potentially creating and maintaining a vicious cycle in which individuals and households become trapped (Grant, 2005). As an outcome, good health is one of the goals of poverty eradication, being an inalienable right that should be accorded to humans by virtue of their human status (UN, 1948). Poverty creates the conditions in which ill-health is created and perpetuated: low productivity and income; inadequate diets; unhygienic and unsafe working and living environments; inability to meet health costs; livelihood strategies of asset depletion; reduction in long-term investment (Grant 2005). But ill-health also operates as a determinant of poverty through reduced income of adults when ill, through increased expenditures on health care and through the long-term irreversible effects on functional capabilities (CPRC, 2005; UN Millennium Project, 2005) including ability to maximise returns on the acquisition of education (Mayer-Foulkes, 2003).

These effects on functional capabilities relate to the impact on physiological, cognitive and social development during childhood, processes which literally incorporate poverty irreversibly into the nature of the person. Such effects, then, constitute one pathway through which poverty may be transmitted from one generation to the next and contribute to the entrenchment of chronic poverty (Harper et al., 2003; Harper, 2004). Such entrenchment of chronic poverty occurs across a variety of trajectories at different scales. First, child poor health and malnutrition in developing countries have been shown to have both medium and long-term effects, perhaps most significantly on income through adult agricultural productivity and the market wage rate, which has proven very sensitive to worker size (Croppenstedt and Muller, 2000), on subsequent adult health and susceptibility to both acute and chronic diseases (WHO and UNICEF 2004) and on educational attainments (Alderman, Hoddinott and Kinsey, 2004; Mayor-Foulkes, 2003). A key factor in child health is the IGT link between maternal health, poverty and child health (Case and Ardington, 2004; Freedman, Waldman and Wirth, 2005; DFID, 2005), demonstrating that “malnourished mothers...perpetuate poverty transmissions” through neo-natal complication, low birth weight and child malnutrition (Harper 2004, 1; Harper, Marcus and Moore 2003) including malnourished mothers who are overweight as well as underweight (Garrett and Ruel, 2003). Maternal death is associated with a series of disadvantages including compromised nutritional status and growth (Beegle, De Weert and Dercon, 2005). A further concern is the processes by which ill-health and poverty, operating independently or together, can stigmatise individuals and households and engender exclusion, marginalisation, voicelessness or humiliation not only in social, economic and political domains but in access to good quality health care, impacting on the experience of health systems (Krieger, 2001; Mackintosh, 2001). Finally, scaled up from the individual or household level, population health status is demonstrably an integral component of human capital for developing countries associated with macroeconomic indicators such as gross inflows of

foreign direct investment (Belli et al., 2005; Aslan et al 2006) which in turn are associated with population health status and investment in health care provision. Since it is exactly this entrenchment of poverty which the Millennium Project seeks to overcome, finding entry points to break the processes of IGT contributing to this poverty cycle becomes critical.

The model adopted by the MDG framework for tackling poor health and its IGT impacts on poverty proposes malfunctioning health systems as a root cause of inequity (WHO (WHR) 2004) calling for increased finances and improved management of health systems (Sachs, 2004) to ensure they function in an accessible and fair manner to gain socially equitable outputs and outcomes (Task Force on HSR, 2004). This model has provoked two main criticisms. First, the logic of investment in health systems to improve human capital as the strategy to increase economic productivity has been questioned (Carrin, 2004). The connection between increased finance and improved health outcomes is complicated and cannot be taken for granted. Savedoff (2004) asserts that insufficient funding is only one of the many reasons for the failure of public health services in developing countries alongside other influences of access, utilisation, motivation of health workers and quality of services. Expansions in health services typically reach better-off groups before disadvantaged ones, and thus increased resources for health systems as they are currently constituted may lead to the exclusion of poor people from the benefits (Gwatkin, 2005). Secondly, the aggregate nature of the MDGs does not explicitly take into account or make provision for local contexts and different rates of progress and as such the poorest and most vulnerable are being left behind (Travis et al 2004; UN 2005). These concerns are particularly resonant for the health MDGs, which have been specifically criticised for their aggregate and disease specific targets (Freedman 2005, Gwatkin 2005). The Millennium Project Task Force for maternal health explicitly engages with this criticism, building into their approach for action to meet the MDG four principles: context matters, values matter, process matters and acknowledging responsibility matters.

METHODS

The following sections are based on a review of existing literature. The sources for this were accessed in two stages.

1. A review of health and nutrition in the inter-generational transmission of poverty was commissioned and published as an annotated bibliography by the DFID Chronic Poverty Research Centre (Smith, 2006). The Web of Knowledge, The International Bibliography for the Social Sciences and Cambridge Scientific Abstracts databases were searched using the following terms both singly and in combination of “sub-Saharan Africa”, “poverty”, “intergeneration*”, “health”, “nutrition”, “education”, “deprivation”, “transmission” . The database Eldis was searched using the terms

“intergenerational poverty”, “ending malnutrition” and “malnutrition”. No limits were put on the dates of the literature sourced in this stage of the literature review. The websites and publication archives of key organisations and research projects were also searched: Birth to Twenty at the University of Witwatersrand; DFID Childhood Poverty Research and Policy Centre; Chronic Poverty Research Centre; ESRC Centre for the Analysis of Social Exclusion at the London School of Economics; Food and Agriculture Organisation of the United Nations; HelpAge International; Inter-American Development Bank; International Association for the Study of Obesity; International Food Policy Research Institute; the United Nations; United Nations Children's Fund; the World Bank; World Health Organisation; Young Lives Project, UK. Finally, a few select journals were specifically trawled for further resources as being particularly relevant to the topic: Future of Children; Journal of Marriage and Family; the Lancet child survival series.

2. This broad review was complemented by a search for recent literature more specifically focused on health system strategies and actions to tackle the inter-generational transmission of poverty by tackling maternal and child health issues. To this end the Medline and Social Science Citation Index databases were searched using the terms “maternal”, “child”, “preventative”, “early”, “family”; “health”, “nutrition”; “services”, “care”, “interventions”, “delivery”; “developing countries”, “world”; “MDG” and intentionally limiting the time of publication to 2000-2006. In addition, two journals of particular relevance, World Development and the Bulletin of WHO, one representing a social science perspective on development and the MDGs and one a more medical perspective, were trawled for articles and commentaries from 2005 to double-check that the most recent relevant material was not missed.

A. CONTEXT IN INTER-GENERATIONAL TRANSMISSION OF POVERTY

In order to break intergenerational transmissions of poverty, policy-makers need to identify factors associated with the persistence of poverty compared with mobility out of poverty across the generations. Most work on this has been in high income countries with few comparable data from those of middle or low income. The high income country studies expose, perhaps unsurprisingly, greater mobility and find with reasonable consistency that factors associated with IGT include most significantly economic disadvantage, aspects of family structure such as single parent households, greater numbers of siblings, involvement of children in extensive domestic labour, having a teenage pregnancy or a teenage mother, less educated parents, being born black, social isolation and wider effects of the neighbourhood and civic cultures (Boggess et al., 1999; Corcoran, 1995, 2001; Keister, 2004; Duncan, 1999; Dodson and Dickert, 2004). A number of authors have explicitly

addressed the potential for beneficial social policy intervention, concluding that the dangers of creating a welfare dependency culture amongst the poor are overstated (Bowles et al., 2005; Corcoran, 1995; Gottshalk et al., 1994; Horrell et al., 2001).

The literature which does exist from middle and low income countries echoes the central significance of economic disadvantage, parental education and particularly that of the mother and fewer siblings (Castaneda et al., 1999; Bhargava et al., 2005; Falkingham and Ibragimova, 2005; Ghuman et al., 2005; Blackman and Litchfield, 2001; Handa et al., 2004). However, concern is expressed about creating an overly deterministic theory of inter-generational transmission of poverty rather than focussing on who and when mobility occurs (Yaqub, 2003) and it is here that the interaction of spatial and temporal dimensions through context emerge as significant.

Initially some important differences are evident at the relatively crude scale of broad income-based country groupings. Indeed, it has even been argued that the very direction of the flows of resources between the generations is reversed from old to young in high income settings to from young to old in low incomes settings (Blackburn and Cipriani, 2005). First, levels of mobility out of poverty are in general lower in developing countries than in developed (Andrade et al., 2003). Secondly, the traditional roles of the extended kin system may act as an 'instrument of stagnation' rather than the beneficial view usually accorded to it (Hoff and Sen, 2005). At the same time, the intergenerational contracts are undergoing rapid change with the elderly emerging as a new vulnerable group as family support for them can no longer be taken for granted (Malhotra and Kabeer, 2002). Thirdly, differences noted in developed countries such as between urban and rural setting or by gender may be more pronounced in low and middle income countries (Castaneda et al., 1999; Ario et al., 2004; Paolisso et al., 2002). Fourthly, children are more likely to be required to work in developing countries creating a specific problem around child labour and especially in its impact on the critical factor of education (Blackman and Litchfield, 2001; Kabeer, 2003; Lloyd and Grant, 2004). Lastly, the high mortality amongst the productive adult population from AIDS in many countries makes visible and of high priority any impacts of orphanhood on IGT of poverty (Beegle et al., 2005).

B. CONTEXT IN MDG STRATEGIES: THE MCH TASK FORCE AND DFID

The recent progress documents from the UN Millennium Project Task Force on Child Health and Maternal Health (2005) and from DFID on their Maternal Health Strategy (2005) provide an insight into the conceptualisation of context by two of the most influential actors. Despite the fact that the two reports are doing somewhat different things, the Task Force taking a much broader overview compared to the DFID activities report, they do, of course, share much conceptually in common given the close involvement of DFID in the

Millennium Project. Both documents accord a central role to health systems in meeting the child and maternal health MDGs, both have an explicit interpretation of the child health and maternal health MDGs as addressing inequity and both manifest a commitment to developing the broad MDG targets into strategies and actions that are relevant to the particular challenges of a given country. This is most explicitly articulated in the more discursive document from the UN Millennium Project,

“scaling up is not just a process of multiplication, of more providers, more drugs, more facilities in more places.[it] also means tackling the social, economic, and political contexts in which people live and in which health institutions are embedded. Both dimension - concrete operational issues and wider, contextual issues - need sustained attention and investment”

(UN Millennium Project, 2005: 5-6)

“Social, economic and political conditions present complex environments that resist formulaic solutions..... But too often recognition of this fact spells paralysis or, even worse, new rounds of technical solutions designed to dodge the issues altogether”

(UN Millennium Project, 2005: 9)

DFID's commitment to the argument that context matters is evident at two levels in the Progress Report of activities reviewed here. First, one of the identified four 'Priority Areas for Action' is to address wider social and economic barriers to access and secondly, different activities, strategies and innovations have been developed in different countries.

Neither report, however, really spells out how context is conceptualised leaving this as an implicit construct. How then do these two influential bodies treat context in discussing meeting the child health and maternal health MDGs ?

We interpret context as treated in the two documents at three scales. The first scale is that of embedding related health issues. The specific targets of child mortality and maternal mortality are inextricably interrelated with other health problems which can be seen as part of the context that needs to be addressed. Thus, from a child health perspective provision of vaccines and integrated management of childhood illnesses can achieve much but other health concerns that can be critical include water and sanitation, nutrition and maternal health,

“A healthy mother is more likely to produce a healthy child... Neonatal and maternal deaths are closely linked” (DFID, 2005: 12).

Maternal health, in turn, has been shown to be strongly influenced by reproductive and sexual health, including availability of family planning, safe abortions where legal or safe

treatment for consequences in all cases and services sensitive to the particular vulnerabilities of adolescents, and with HIV/AIDS in that HIV infected women are four times more likely to die in pregnancy or childbirth than those non-infected. The relative importance of these other health issues will vary by country and local context. For example, where significant improvements have been made against child mortality rates, neonatal mortality takes on increased significance.

The second scale of context is that of the embedding the health system itself, the primary target of interventions. However, the health system is not treated as a technical instrument that responds to new parts or some tuning but as a set of political positions, a value system and a social institution. Thus, issues such as the amount of finance available, the level at which decisions are made, the routes for citizen involvement and the scope of the professions in terms of who may do what health actions are all part of the context in which specific health interventions are enacted. These aspects are in turn located almost seamlessly into the third scale of embedding social, economic and political relations which have a direct effect on the extent of availability of appropriate, good quality health care and the ability and desire to access that care.

C. CONTEXT IN RESEARCH ON MCH-RELATED HEALTH SYSTEMS

Improved maternal and child health are of course closely linked to macroeconomic development, but even optimistic models of sustained growth rates estimate that the health MDGs are unlikely to be met by this route alone and forms of more direct health and nutrition interventions are essential (Haddad et al., 2003) or even more important (Croghan et al., 2006). At the same time, claims are made that the impact of health or other early childhood development services on childhood development may be overstated if other significant aspects such as infrastructure (Fay et al., 2005) or characteristics of the local community (Ghuman et al., 2005) are not considered. Study design then has an important effect on study results and the variation in the packages of variables considered makes assessing the place of health systems in breaking IGT challenging. Moreover, whilst the experience of prioritising mother and child health services has clearly made advances, these are most often measured in terms of mortality, particularly infant and maternal mortality rates. A consideration of IGT necessitates that we also assess health system impacts on morbidity, both of the child and of related adults.

We have drawn a number of observations regarding contemporary themes emerging from recent material found by our literature search on health and nutrition of children and mothers and the activities of health systems. At an international level of policy, different views exist as to whether vastly increased resources are needed if the maternal and child health MDG are to be met (Powell-Jackson et al., 2006) or whether overall expenditure is

less significant than targeted effective spending on improved quality and accessibility of maternal and child health care (McGuire, 2006), including reforms both in health financing of countries' own budgets (Falkingham and Ibragimova, 2005) and in the distribution of donor aid to the poorest countries (Powell-Jackson et al., 2006) in contrast to current US and EU practice (Baulch, 2006).

The importance of context emerges from cross-country studies. A four country comparison of health systems issues illustrates the different background, organisational environment and issues in the delivery of maternal health care in different income countries (Parkhurst et al., 2005). The two low income countries continue to have poor access and low utilisation indicating an increase in the absolute number of health workers and strategies to reach out to remote areas and disempowered population groups as promising policy directions (Ssengooba et al., 2003; Rahman et al., 2003). Middle income countries already had good coverage of attended births but poor health worker practices, practices embedded in the context of both institutional and professional cultures but also the context of wider values (Danishevski et al., 2003; Penn-Kekana and Blaauw, 2002; Penn-Kekana et al., 2004). A systematic review of studies on maternal mortality concluded the importance of cultural and political determinants was underrepresented (Gil-Gonzalez et al., 2006). In a similar vein, a five country study of the impacts of the Integrated Management of Childhood Illness (IMCI) programme stresses the importance of including confounding contextual factors such as existing health status and existing health system activities, what the authors term impact-related and implementation-related effect modifiers (Victora et al., 2005) when reviewing expectations and evaluations of health system impacts on health. Moreover, the overall picture demonstrated how sound strategies are dependent on local capacity for implementation, as Gwatkin observes, “the strategy seemed to be implemented least energetically in the areas where it was most needed” (2006:768).

A number of authors agree that current health care approaches, viewed through the lens of poverty eradication and IGT, give inadequate attention directly to the challenges of malnutrition (Jackson et al., 2006; Edejer et al., 2005; Gwatkin et al., 2005). The current structures and practices in health service provision may offer scope to address this given the observable extent of missed opportunities to deliver nutrition services during other routine prenatal, postnatal and child care consultations (Hampshire et al., 2004). Research has also indicated that educating mothers directly regarding practices of child nutrition can be a significant factor independently of the significant impact of mother's general education level, the effects of which are rather on long-term child outcomes (Webb and Block, 2004; Christiaensen and Alderman, 2004). The benefits of reaching the poorest through community and home-based visits or outreach together with a renewed emphasis on prevention can prove particularly cost-effective (Macinko et al., 2006; de Souza et al., 2006; Adam et al., 2005).

At the same time, emphasis has been given to caring practices as important in the IGT of poor health and nutrition including child care options for mothers, complementary feeding and psychosocial care and which could be a target for greater policy support (Smith et al., 2005; Engle et al., 1999; Ersado, 2005; Paolisso et al., 2002). In some cases, the different options and practices of caring contribute to explaining within country differences in prevalence of malnutrition, as for example between rural and urban settlements (Smith et al., 2005).

Finally, research continues to challenge and reject the unitary model of the household with evidence that a range of health and nutrition interventions impact differentially on different household members and most particularly by gender to the detriment of females. These include free distribution, food-for-work programmes (Quisumbing, 2003), vaccinations, vitamin A supplementation (Benn and Aaby, 2006) as well as wider development projects aiming to impact on the health and nutrition benefits for children by, for example, increasing women's cash income (Haddad and Hodinott, 1994).

These different observations refer to different scales within the health system: the international work that seeks to find generalisable interventions but recognises the need for sensitivity to country specific health and health system challenges; within country where different factors may be relevant in different settings such as the role of caring practices in urban and rural settings; the individual scale where evidence demonstrates that social position, such as gender, is associated with different entitlements to health-related resources.

D. REFLECTIONS ON CONTEXT

This review of emergent issues for health systems in tackling IGTP reaffirms the assertion made by the UN Millennium Project Child Health and Maternal Health Task Force (2005) that context matters in a number of ways: the extent of IGTP in different countries, variation in processes of IGTP by region, settlement type and social category; distinctive features in low income countries such as child labour or the impact of the HIV/AIDS epidemic; influences on the impact and implementation of interventions and more specifically on the structures, procedures and practices of health systems. However, we are struck by how these observations emerging from recent research literature all implicitly conceptualise context as uniform, static and constant.

Context is essentially a socio-spatial variable. In the literature we have reviewed, context is treated (often implicitly) in two main ways. First, context affords a static, backdrop comprising a diverse range of variables which may potentially be drawn on to explore and explain variation in health, health care provision, policy implementation and impact and IGT of poverty. This conceptualisation is clear at all scales of research, whether cross-country, within country, within a local region or even within the household. Secondly,

context may be used to define high priority target locations, such as countries, regions, rural or urban, or spaces for intervention, the home or community versus the hospital or clinic. In this respect, although rarely discussing explicitly what context is, the studies we have identified implicitly reflect the categorical type of framework put forward to explore the salient factors in the extra-organisational context such as Leichter (1979) who provides four categories for describing context: situational (the one-off moments); structural (the constant factors); cultural (values); environmental (external/indirect to the policy arena).

A first criticism of this treatment is that the processes by which extra-organisational context exerts its effects have to be mediated through actors and this aspect is little developed. Others have built more explicitly on exploring social relations at individual and collective (structural) scales, such as Schweizer (1997) who proposes the use of social network analysis and explores both vertical and horizontal dimensions to the relationships involved. Criticisms, that the emphasis here on on-going social relations underplays the situatedness of actors and networks within institutional structures have resulted in inclusions of longer-term elements of structure and culture. Zukin and DiMaggio (1990) with particular focus on the mechanisms through which embeddedness exerts its influences, outline categories of cognitive, cultural, structural and political, although critics have questioned whether structural and political are really distinct (Hess, 2004).

However, a second criticism is that most of these approaches implicitly treat contextual embeddedness as a uni-directional influence - or put another way, that it is context, at whatever scale, that influences institutional performance rather than the opposite. Other researchers disagree; the activities of large, publicly visible organisations are important influences themselves upon the structures, politics, values and so forth of society,

“Institutions shape the context in which actors make policy choices” (Hero and Tolbert, 2004: 110)

We have identified two major illustrations of ways that the IGT of poverty through health and the role of health systems in tackling this shapes aspects typically considered as context rather than the more common framing of this relationship: the impact of the HIV/AIDS epidemic; the impact of the Millennium Project MDGs

The HIV/AIDS epidemic is one of the best illustrations of processes by which ill-health and its IGT itself shapes context rather than being reflective of it. The epidemic particularly affects those of productive and reproductive age which is projected to have major impacts on micro- and macro-economic contexts, the social structure of families and communities, social values of caring and the available resources of health systems. There is surprisingly little research to date on the impact of HIV/AIDS of the social and economic fabric of society (Barnett et al., 2001). Serious macro-economic effects over time are predicted

through modelling of different scenarios and from estimates that agricultural productivity may have halved from the effects of AIDS (Gaffeo, 2003). Death or long-term illness of the household head or main income-earner may not only push households into poverty through the erosion of household assets over time (Barnet et al., 2001) but often results in the disintegration of the household altogether (Urassa et al., 2001). Given the unprecedented numbers of deaths occurring in the productive age group, widespread household disintegration will alter local communities radically. The impacts of this on social structures and social values can be seen through some of the studies of the effects of orphanhood. Where traditionally the extended paternal family would take in orphans, shifts have been recorded to both sides becoming involved and which in turn has effects on inter-generational transmission of poverty as some of the effects on development of orphanhood express themselves differentially depending on whether the child ends up in a female-headed household or not (Case and Ardington, 2004; Nyamukapa and Gregson, 2005). An increased number of sibling-led households indicates even more forcibly the growing inability of extended family structures to cope (Foster et al., 1995). The IGT effects of HIV/AIDS go up the generations as well as down with changing roles for the elderly who become not only carers but also significant contributors to the household income where pensions are available (Schatz and Ogunmefun, 2005; Heslop, 2002). The epidemic also undermines the functioning of those very institutions that serve to support the poor such as micro-finance institutions, education and health systems by various processes including loss of staff and staff support payments and in the case of health systems, absorbing most of the budget (Gaffeo, 2003; Barnet et al., 2001). Thus, the HIV/AIDS epidemic not only provides a dramatic illustration of the relationships between ill-health, poverty and the inter-generational transmission of both, but also of the impact of these processes on economic, social and institutional contexts in a dynamic and highly interdependent manner.

Similarly, the dominance now given in international and national development policy to the MDGs means that the existing social and spatial patternings of inequalities in poverty, health, health care and inter-generational transmission have become framed by a new context. In other words, the target goals of the MDGs are not merely the endpoint but also part of the context. This particular framing of the injustices of poverty involves not just socio-spatial variation but also the dimension of time. The different implications for action of achieving a time located target compared with achieving longer-term sustainable change are well documented in many policy spheres and do not need rehearsing here. Rather we revisit the debates outlined above that emerged regarding the place of health systems in IGT of poverty and argue the emergence of some of these themes results directly from the MDG agenda. The themes represent a mixture of calls for, on the one hand, tightly targeted inputs at different scales, such as targeting aid to the poorest countries (Baulch, 2006), targeting effective spending on maternal and child health (McGuire, 2006; Croghan et al., 2006) or specific health and nutrition education programmes for mothers (Webb and Block, 2004;

Christiaensen and Alderman, 2004) and on the other, an expansion of activities to reach those marginalised and excluded through community and home-based activities (Macinko et al., 2006; de Souza et al. 2006; Adam et al., 2005), exploration of involvement in caring practices (Smith et al., 2005; Engle et al., 1999; Ersado, 2005; Paolisso et al., 2002) and strategies for reaching into the dynamics of the household (Quisumbing, 2003; Benn and Aaby, 2006). A general call for increased policy focus on nutrition and malnutrition (Jackson et al., 2006) reflects a concern with health and poverty dynamics and the IGT of poverty rather than simply a focus on mortality rates that can also be related, at least in part, to the effects of the MDG agenda.

The Millennium Project then can be seen to have reshaped the space in which policy discussion about the priorities in health system actions take place. Whilst on the one hand, calls for more targeted resources and actions run the danger of short-termism, on the other, the MDG focus has prompted new ways of looking at the problems of health and the needs of health systems.

CONTEXT MATTERS

The paper has reviewed the treatment of context in three related bodies of literature - intergenerational transmissions of poverty, strategies to meet the health-related MDGs and recent research relevant to the health-related MDGs. Despite exhortations that context matters and cannot be ignored if we are serious in redressing the great inequities evident in health between and within countries, the conceptualisation of context treats its influence upon health systems as operating in a static and uni-directional manner. This treatment needs to be expanded with a complementary understanding of context as also influenced by the policy climate and activities of the health system. The UN Millennium Project Task Force on Child Health and Maternal Health give some intimation of this relationship when they emphasise the role of health systems as a social institution, but fail to take this important observation to its logical conclusion. Thus health systems not only operate as social institutions by being embedded in, reflecting and reproducing the wider social, political and economic relations of society, but are significant actants themselves in constructing new relations through their practices and, as such, constitute part of a two-way, more complex, conceptualisation of context.

How does this expanded conceptualisation of context affect strategies for breaking inter-generational transmissions of poverty?

First, a conceptualisation that places the MDG agenda as central to the construction of context demands a more reflexive approach in terms of what the target indicators represent in terms of human development. Whilst this is currently evident in the policy documents of the Task Force and DFID, more target-driven strategies are evident in a number of the

policy-relevant research papers. Most particularly, in terms of breaking inter-generational transmissions, the emphasis in the MDGs on mortality as the measurable target indicator, runs the risk of ignoring chronic health concerns, most particularly child malnutrition. Again, this is highlighted in both the Task Force and DFID documents, but perhaps treated more as part of the concept of context and certainly not discussed to the same extent or depth as direct causes of mortality.

Secondly, whilst it is widely recognised that discrimination against different social categories of persons such as gender, race, religion, language, age and so forth create inequities in availability and access to health care, more emphasis needs to be given to how the health system itself contributes to this process. Whilst health workers may reflect and enact discrimination as played out in wider society, they will also create discriminatory practices. Certain categories of ill-health are discriminated more than others; certain behaviours do not comply with health staff's construction of a good patient and so forth. The emphasis on human resources within health systems is primarily and understandably concerned with supply. However, there needs to be some room to discuss the cultures of practice of health staff of whatever cadre in order to actively reconstruct the social inequities of discrimination across the generations.

Finally, some of the poorest countries are those specifically hit by the HIV/AIDS epidemic. The MDGs do specifically recognise HIV/AIDS as one of the target diseases. However, there is surprisingly little on the wider social and economic impacts of the disease. The vast majority of health-related research has been on modes of transmission, albeit with emphasis on the social and economic context in which this occurs. A two-directional approach to context highlights the need for much more research and policy focus on the processes by which HIV/AIDS impacts on the social and economic fabric of society and its social institutions including health systems if strategies to break the IGT of poverty are to be more than a dream in the poorest countries of the World.

Thus, this review of the treatment of context finds much that is welcome, particularly in the Task Force discussion document. Our critique is that this could go further, that the current treatment of context in health-related aspects of the IGT of poverty ignores one side of the relationship. In calling for a more complex, two-directional treatment of context, we see this as complementary to existing activities and strategies, taking further some of the observations already made and furthering discussions on how to address the highly complex networks of relationships through which poor health, social inequities and the inter-generational transmission of these are created and perpetuated.

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