Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood from circumstances beyond his control.

UDHR, Article 25

Introduction

This paper discusses the broad theme of vertical versus integrated health delivery systems within the context of relational poverty knowledge[1] and a feminist ethic of care.[2] The distinction between vertical and horizontal health delivery systems will be the focus of this paper. However, I feel that it is important to note that I will specifically be looking at the evolution of vertical programs as an aspect of the neoliberal policies of welfare retrenchment and subsequent privatization of care work at the global level. Moreover, rather than debate the merits of only vertical or horizontal health delivery programs, this paper will advocate for the use of an integrated health delivery program which combines aspects of both the horizontal and the vertical. The use of an integrated health delivery system allows for the targeting of specific illnesses or at-risk populations while also bolstering the existing health care structures. In this way, the introduction and utilization of an integrated system is both caring and sustainable. I will examine the work of the NGO (non-governmental organization) PATH (Program for Appropriate Technology in Health) through a framework of care ethics with a focus on pervasive global systems of inequality. The focus of my work will be on PATH's Immunization Initiative in Andhra Pradesh, India, where PATH partnered with the Government of Andhra Pradesh to implement an integrated vaccination campaign.

My paper will begin with a careful study of relevant literature discussing topics tied to the

[1] Relational poverty knowledge comes from the idea that it is important to note the "…complex interplay of power, knowledge and agency in poverty" (Brock, Cornwall & Gaveta 2001, 7). See also the work of Joan Tronto (1993) and Paul Farmer (2005 & 2010).

[2] The concept of care will be taken from the work of Joan Tronto and defined as follows: "…caring [can] be viewed as a *species activity that includes everything we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible" (*Tronto 1993, 103). In addition, "…care refers to activities and social relationships that educate, nourish, keep healthy, and sustain emotionally and socially" (Tronto 1993, 112). These complimentary working definitions of care will be used throughout my paper.

development of a discourse on a feminist ethic of care. With this scholarship I will contextualize the work done by PATH in Andhra Pradesh. This literature review will be divided into five sections, each interrelated and integral to understanding the theoretical and contextual framework of a feminist ethic of care and models of health delivery systems. From my literature review, I will move into a brief account of the conception, development, and implementation of health delivery systems in the context of international aid work. Next, I will introduce and give a brief history of the NGO PATH and narrow my focus to PATH's Children's Vaccine Program. Through an examination of the Andhra Pradesh Immunization Project at PATH, the use of integrated global health programs will be discussed and analyzed utilizing the care ethics framework[3] first touched upon in the literature review. In addition, I will examine the positive and negative aspects of PATH's health delivery program through a relational analysis of inequality[4] and the continuation of unequal power relationships[5] born from market supremacy.

Through this analysis, I will shed light on the importance of integrating vertical and horizontal global health efforts. Integrated health delivery systems bolster existing health care structures in middle and low-income countries, while targeting specific illnesses which affect vulnerable populations. Throughout this paper, the importance of social structures[6], cultural practices[7] and structural violence[8]

[3] The care ethics framework used in this paper will be drawn heavily from the works of Tronto, England, Lawson, and England. Tronto illuminated four key components of care ethics, a rubric of sorts, with which an act or organization can be analyzed. From this rubric, I will turn to the work of Johan Galtung and Paul Farmer in order to form connections between the work of care ethics and the theory of care as the work of social justice.

[4] A relational analysis of inequality incorporates the notion of poverty as a process shaped by social and political structures with a historical context. The work of Doreen Massey will greatly influence the way in which relational poverty knowledge is utilized in this paper to discuss the larger idea of the relational construction of the identity of a place.

[5] Power will be defined by the work of Michel Foucault. In this paper, I will examine power as a *relation* that does political work on the most micro to macro scales of society. In addition, I believe that Foucault's assertion that power, when wielded, can be strategic and war-like is exemplified through the discussion of the culture of humanitarian aid.

[6] The notion of the social within a global context has received a lot of attention in recent scholarship.

[7] Foucault defines culture as "…a hierarchical organization of values, accessible to everybody, but at the same time the mechanism of selection and exclusion" (Foucault 2001, 173).

will be emphasized within the larger relational theoretical framework of care ethics, particularly, within the context of development and the implementation of global health programs.

Literature Review

My literature review will serve as a vehicle for the theoretical context needed to competently analyze the work of the PATH in Andhra Pradesh. I will utilize a relational analysis of inequality and a feminist ethic of care to shed light on the social production of global development and aid. In addition, a narrative of academic commentary on health delivery programs, international global health work, and the geographies of care will be formed to provide a contextual structure for my analysis of PATH's Andhra Pradesh Immunization Initiative. My literature review will be divided into five sub-sections: the rise of neoliberalism; a feminist ethic of care; the geography of development; care as an act of social justice; and health delivery strategies. I believe that these five key components will create an academic framework with which we can contextualize and examine the work of PATH in Andhra Pradesh.

The Tide of Neoliberalism

The structures of oppression and the social origins of illness...have emerged as even greater problems as the corporate penetration of healthcare has increased.

Howard Waitzkin, *The Second Sickness*

In order to fully understand the discourses of development, the rich account of neoliberalism, welfare retrenchment, and the notion of the primacy of the market must be kept in mind. The rise of neoliberal ideologies[9] and the policies of welfare retrenchment enacted by Reagan and Thatcher in the

[8] My definition for the term structural violence will be drawn from the work of Paul Farmer and his references to Johan Galtung and Latin American Liberation Theologians. Farmer writes that, "…the latter used the term broadly to describe 'sinful' social structures characterized by poverty and steep grades of social inequality" (Farmer 2010, 354). In addition, Farmer defines structural violence as "…violence exerted systematically—that is, indirectly—by everyone who belongs to a certain social order: hence the discomfort these ideas provoke in a moral economy still geared to pinning praise or blame on individual actors" (Farmer 2004, 307).

[9] Mark Lilla defines neoliberalism as, "The forces of globalized nation that have given us a 'neoliberalism' that people everywhere associated with unregulated markets, labor exploitation, environmental degradation, and

1980s allowed the market to define arenas that were once public sectors of care.[10] As a result, a decline in funding for public care work has become the norm and the work of care, both on the local and global scales, has increasingly been privatized.[11] Growing geographies of inequality stem from these exclusionary policies based on capital accumulation and market supremacy. The shift from Keynesianism[12] to neoliberalism led to the creation of exclusionary capitalist policies on the global scale under the premise of 'international development.' However, it is important to remember that "…neoliberalism, like social liberalism before it, is socially produced and contextual" (England 2010, 136). Indeed, the role of the state under neoliberalism has shifted from providing a social safety net for citizens to creating the optimal conditions for capital accumulation. In this way, current political and economic policies perpetuate structures of oppression and the processes of systemic inequality and impoverishment. As Harvey writes, "...neoliberalization was from the very beginning a project to achieve the restoration of class power...reconstruction of the power of economic elites" (Harvey 2005, 16-19). Thus, the dominant discourse born from the supremacy of neoliberal policies seeks to categorize the impoverished as the deserving and undeserving poor. Indeed, as Farmer states, "…this ideology is indebted to and helps to replicate inequities of power" (Farmer 2010: 364). The justification of the supremacy of the market acts as a vehicle for the maintenance of systems of inequality around the world.

---

official corruption" (Lilla 2010, 15). Though we will use Lilla's definition as the working definition for this paper, it is important to note that the term neoliberalism has a very ambiguous definition. The fluid nature of the definition of neoliberalism in the age of globalization and the cult of the free market is further talked about in the scholarship of Wendy Larner.

[10] However, I would like to give voice to a critique of the 'ideas-driven' account of neoliberalism in the pages that follow. Matthew Sparke writes, "…by overemphasizing the force of neoliberal ideas there is a clear danger of ignoring the more complex forces unleashed by economic developments themselves: both those relating to the over accumulation…that created the context in which neoliberal ideas blossomed; and those relating to the ways in which the ensuing neoliberal orthodoxies… [shaped] further economic developments around the world" (Sparke 2006, 5).

[11] Drawn from the work of David Harvey and Thomas Pogge cited in my bibliography.

[12] My definition of Keynesianism is drawn from the work of David Harvey and his discussion of the collapse of embedded liberalism in the 1960s. Issues of stagflation and economic instability led to the abandonment of embedded liberalism advocated for by Keynes in favor of a new 'neoliberal' ideology. (Harvey 2005, 12).

The intrusion of market based principles and policies into the arena of global health should not come as a particular surprise. The reach of neoliberal ideologies is vast and the power of international aid organizations with a vested interest in the perseverance of certain economic and discursive objectives is strong. As Harvey writes, "…the IMF and the World Bank...became centres for the propagation and enforcement of 'free market fundamentalism' and neoliberal orthodoxy...thus was 'structural adjustment' invented" (Harvey 2005, 29). The rise of neoliberalism that led to systemic welfare retrenchment also had wide reaching implications in the global south. In addition, Wendy Larner writes that, "Neoliberalism [is] understood to refer to the process of opening up national economies to global actors such as multinational corporations and to global institutions such as the IMF and World Bank" (Larner 2003: 509). The policies of 'structural adjustment' implemented by the International Monetary Fund (IMF) and the World Bank (WB) in some countries, often low or middle income nations in the global south, resulted in the increasing ascension of market supremacy abroad. However, policies of structural adjustment often lent themselves to the production and maintenance of systems of inequality by the economic elite for their benefit. In addition, as structural adjustment policies (SAPs) advocate for deregulation and privatization, these SAPs perpetuate neoliberal trends of welfare retrenchment, resulting in a systemic lack of funding for and the eventual disintegration of, among other social service programs, basic health care services. Policies of deregulation, privatization, and the destruction of trade barriers impede a nation-state's ability to redistribute wealth equitably to its citizens as a means of providing quality care. Rather, SAPs exacerbate existing structures of impoverishment through the maintenance of systems of inequality which advocate for the reduction of public services, such as health care.[13] These policies, in turn, gave rise to the NGO development model of international assistance lauded by many nations in the global north.

[13] As seen in the first episode of the PBS television program *Unnatural Causes* titled "In Sickness and Wealth," which chronicles health disparities between the elite and the impoverished in North America. In a similar vein to the work of Paul Farmer and other advocates for health as a human right, "In Sickness and In Wealth" illustrates how disease and disease treatment is often classed to the advantage of the elite and the detriment of the poor.

The Feminist Ethic of Care

The invisible hand of markets depends upon the invisible heart of care.

Nancy Folbre, "Demanding Quality"

In order to explicate a feminist ethic of care, I feel that it is necessary to first explain the use of a relational frame of poverty. The discourse on poverty is informed by two lenses of poverty: residual and relational. The residual definition of poverty looks at impoverishment and subsequent care as a question of worthiness. Specifically, the worthiness of an individual or a state to receive welfare, aid or care is addressed. This frame seeks to categorize and construct the impoverished as a distinct, separate class of people judged without a firm understanding of the power asymmetries which produced the paradigm in which they live their lives. These judgments function as fuel for "...the 'culture of poverty' argument...designed to 'improve' poor people" (Goode & Maskovsky 2001, 8). In addition, residual poverty frames do not view poverty as a manifestation of larger unequal power relations which, in turn, inform systems of inequality. Indeed, "conservatives have developed a strong rhetorical attack on the public sector as a site of inefficiency and redistribution to the undeserving poor" (Folbre 2006, 24). The rhetoric of residual poverty has contributed heavily to the gendering and marginalization of the work of care in today's society. By framing the discussion of care as a private matter based, largely, on merit and familial, the idea that care is a privilege and not a right becomes more ingrained in the fabric of everyday life.

Conversely, the relational frame of poverty examines how deprivation persists in relation to wider social, political, economic and cultural institutions, structures and processes. The cyclical and historical nature of relational poverty illustrates how the upward redistribution of resources and the systemic rollback of welfare systems results in continued impoverishment. In short, this paper will "...treat poverty as a political, economic, and ideological effect of capitalist processes and...as a function of power" (Goode & Maskovsky 2001, 3). By treating poverty as a process, I acknowledge that inequity is

shaped by the histories of a place and without a keen understanding of these histories there cannot be successful attempts to combat the entrenched power asymmetries. Building off of this definition, I will next discuss recent scholarship on relational poverty knowledge to frame the concept of a feminist ethic of care.

The discourse of care ethics is one that emerges organically from the framing of relational poverty knowledge. The evolution of a care ethics critique begins by using relational poverty knowledge to bring attention to the dynamics of power relationships and the unequal distribution of social, political and economic capital. Lawson writes that "...care ethics focuses our attention on the social and how it is constructed through unequal power relationships" (Lawson 2007, 1). Lawson moves from the notion of critique alone into utilizing the rubric of care ethics given by Tronto to recalibrate existing relationships into vehicles for care. Tronto's moral philosophy brings to bear the question of the marginalization of care. Tronto writes that "…to call attention to care is to raise questions about the adequacy of care in our society. Such an inquiry [would] lead to a profound rethinking of moral and political life" (Tronto 1993, 111). Within this 'rethinking' would be the public acknowledgement of the power of relationships, especially relationships of caregiving and care-receiving, within the fabric of our society. As a method, the ethics of care emphasizes the *interdependence* of individuals and the embeddedness of their thinking and acting in social relations, rather than autonomous, rational action" (Williams 2010, 13). This illustrates the ontological approach of an ethics of care.

When we place ourselves within the larger social matrix of our moral and political environment, systems of power asymmetry become glaringly apparent. So too does the systemic devaluation of care within the current neoliberal system. Tronto writes that "we cannot understand an ethic of care until we place such an ethic in its full moral and political context" (Tronto 1993, 125). Tronto lays out the four phases of caring in her work, *Moral Boundaries*, and she writes that "…as an ongoing process, care consists of four analytically separate, but interconnected, phases. They are: caring about, taking care of,

care giving, and care receiving" (Tronto 1993, 106). Each of these aspects of care ethics informs the other and requires discourse, an understanding of the context of a place and historical context, and open, honest dialogue between the caregiver and the care-receiver. The placement of an ethic of care such as this requires systemic revaluation of care within the current structure of society. The work of Tronto, Goode and Maskovsky, Folbre and Lawson supplies the framework of a feminist theory of care. Using this frame, I will critically examine the work of PATH in Andhra Pradesh with added scholarship on the geography of development and care as the work of social justice.

The Geography of Development

Without knowledge about world geography there can be no care. Ignorance is literally care-less.
Victoria Lawson, "Geographies of Care and Responsibility"

Recent scholarship on geographies of development emphasizes an understanding of researchers' positionality within the geographies they seek to study. Indeed, such an analysis must be geographically broad yet nuanced from within. In this vein, Doreen Massey asserts that "…there is also a second geography implied by the relational construction of identity…a global sense of place means that any nation, region, city, as well as being internally multiple, is also a product of relations which spread out way beyond it" (Massey 2004, 6). The notion of national identity as ontological in nature creates a compelling case for a systematic analysis of the rhetoric of humanitarian assistance and development[14]. In addition, Gibson-Graham contends that there exists a "…power differential embedded in the binaries of global and local, space and place" (Gibson-Graham 2002, 29). As such, this power differential illustrates how the identities ascribed to a nation-state through the rhetoric of international development subject low and middle income nations to a narrative of need. Goode and Maskovsky

[14] I hesitate to use the word *developing* or *development* to describe low and middle income nations. The term developing was born in the West and is often used as a rhetorical device to construct some nation-states as lesser or the 'Other.' In the same way that residual poverty knowledge categorizes and constructs ontological boundaries between the impoverished and those who are not, the term developing utilizes unequal power relationships to construct some nations as inferior and in need of assistance from the West.

address the limitations and invisibility of the impoverished in the discourse surrounding power differentials. They contend that "...the problem lies not in poor people's invisibility but in the terms on which they are permitted to be visible in the public discourse… the rubric of visibility and invisibility functions to screen out alternate understandings of impoverishment" (Goode & Maskovsky 2001, 2-3). In short, the production and maintenance of the dominant *residual* poverty knowledge in global discourse stems from the marginalization of the impoverished and systemic limitations on their political capital.[15] The maintenance of these systemic relations of power suggest that the current ways in which development and aid are discussed stem from the production of these systems of power.

Through additional scholarship on development, Ananya Roy continues the conversation begun by Massey on the geographies of development and how "…the study of poverty is marked by the ethics of distance…" (Roy 2010, xi). In this work, Roy raises the question of caring across distance. Caring across distance requires, first, recognition of our own complicity in the structures of power which shape our lives in relation to those of individuals living in poverty. As Brown[16] writes, "'...unless we agree that the world should not be the way it is...there is no point of contact, because the world that is satisfying to us is utterly devastating to them." (Brown 1993, 44). By placing ourselves within the unequal geographies which bound our world, we begin to recognize the structures which bound the work of care and our relation to these structures. Only through this recognition and the continuation of a dialogue will we begin to understand the context of places in need and be able to begin a dialogue through which to better understand this need. Pablo Richard writes that, "…we are aware that another gigantic wall is being built in the Third World, to hide the reality of the poor majorities. A wall between the rich and the poor is being built, so that poverty does not annoy the powerful and the poor are obliged to die in the

[15] The definition of political capital I use in the paper is drawn from the work of Pierre Bourdieu and the interpretation of his work by Farmer. As Farmer writes, I too "…acknowledge the influence of Bourdieu, who has contributed enormously to the debate on structure and agency" (Farmer 2010, 345n6) and the development of political capital.

[16] Robert McAfee Brown paraphrases the work of the Uruguayan Jesuit Juan Luis Segundo in the quote used above.

silence of history."[17] Without an acknowledgement of our position within the current system, the words of Chilean theologian Pablo Richard may well become the only truth in the studies of geographies of development.

The narrative used by agencies of international aid and development for the delivery of health services has been named the *emerging diseases worldview* by Nicholas King. He states that the emerging diseases world view creates a "…consistent, self-contained ontology of epidemic disease…it comes equipped with a moral economy and a historical narrative" (King 2002, 767). King illustrates the importance of understanding how unequal global power dynamics shape the ways in which moral histories are crafted and ascribed. In addition, King shed light on the interplay between neoliberal policies of welfare retrenchment and the global commodity exchange of health services provisions. King states that "…connections between commodity exchange and international health are by no means historically novel" (King 2002, 779) yet, the integration of the emerging diseases world view into the larger narrative of neoliberalism, market relations, and unequal power relationships on the global scale illuminates the ways in which private organizations mobilize their provision of care. Since the emerging diseases world view has "…established a template for linking humanitarian concern with enlightened self-interest" (King 2002, 770), it is important to note that the work of international aid often contains a moral history informed by the mechanisms of social forces. The use of vertical health delivery systems[18] remains heavily determinant upon the construction and maintenance of the emerging diseases world view and the neo-colonial policies of many international aid organizations.[19] Rather than mandating the

[17] Pablo Richard is cited in Nelson-Pallmeyer, *Brave New World Order*, page 14.

[18] The construction of vertical health efforts as crisis management perpetuates vertical health delivery programs due to the inherent 'immediacy' of the constructed need. In this way, the *epistemological power of emotions* discussed by Lawson is effectively harnessed to direct aid and research. The work of Sarah Brun on PAR also speaks to the ways in which disaster situations fuel the trajectories of academic research.

[19] The majority of the academic work that is critical of international aid organizations often discusses neocolonial policies of development by framing aid as an issue of security or as a means of maintaining a 'modicum of kindness' in order to preserve the ability of the indigenous population to work as laborers. In addition, the work of Matt Sparke helped flesh out my understanding of the emerging diseases world view and neoliberal tendencies within the international aid community.

highest conceivable level of health for all, vertical programs provide a quick fix solution for an often extremely visible malady.[20]

Care as Social Justice

There is a significant precedent for both the ideological connections between humanitarian concerns, national security, and economic gain, and the sedimentation of these connections into the institutions of state public health and international health.
Nicholas King, "Security, Disease, and Commerce: Ideologies of Postcolonial Global Health"

Thomas Pogge writes that "…few citizens of affluent countries have such contacts which might interfere with their embrace of two going moral prejudices: that the persistence of poverty abroad does not require our moral attention, and that there is nothing seriously wrong with our conduct, policies, and the global economic institutions we forge in regard to world poverty" (Pogge 2002, 4). Pogge's moral argument contends with the international economic development model of humanitarian aid. The dynamics of unequal power relations are explicitly noted in Pogge's work and he places a harsh moral judgment upon them. The notion of international development as an act of social justice requires the frame of care ethics and an acknowledgement that actions of care must occur outside of the primacy of the market. The work of John Rawls also contributes to the moral argument posited by Pogge. Gerwertz and Amado write that, "Rawls holds that a person's right to health is a basic liberty and therefore of greater moral import than an individual's right to…property. Infringement upon basic liberties cannot be justified by enhanced economic compensation" (Gerwertz & Amado 2004, 296). The notion of a basic liberty speaks to the quote with which I began this paper, drawn from the Universal Declaration of Human Rights, and carries through to the theme of care as the work of social justice. However, a declaration is powerless without the active participation and care of the global population in its defense. Farmer and others write and practice care as a social justice. This work actively attempts to combat

[20] The television program *Rx for Survival* serves as a beautiful illustration of the above point. The episode titled "Disease Warriors" discusses, in detail, the means with which smallpox was combatted in India and Sub-Saharan Africa – often at the expense of primary, preventative health-care for the larger national population.

policies of structural violence which pervade the Western hegemonic system.

The work of Paul Farmer speaks to the concept of structural violence coined by the liberation theologian Johan Galtung.[21] Farmer also addresses the notion of social justice through action in his work and states that "…people who work for social justice…seem to see the world as deeply flawed. They see the conditions of the poor not only as unacceptable but as the result of structural violence that is human-made" (Farmer 2005, 157). The recognition of the structures of power which result in policies of structural violence place illustrates the failure of the neoliberal system to place care in a public context. Indeed, Farmer writes that "rights violations are...symptoms of deeper pathologies of power and are linked intimately to the social conditions that so often determine who will suffer abuse..."(Farmer 2005, 7). Without a revaluation of the human need for care, the work of care will continue to be marginalized and policies of structural violence (such as welfare retrenchment) will continue. The work of care cannot be separated from the question of social justice and a moral obligation to defend fundamental human rights. As stated earlier, without an acknowledgement of one's own position within the hegemonic processes, there can be no honest work to combat processes of inequality – whether they be on the local, national or international scale.

In terms of scale, Pogge speaks specifically about the inherent policies of structural violence within the Uruguay Round WTO treaty: "…these agreements exacerbate poverty and bring about additional deaths from poverty-related causes...our material gains cannot justify the harm" (Pogge 2002, 17-19). Pogge speaks to the structures of oppression inherent in the neoliberal policies of development and humanitarian aid. As Farmer writes, "The charity and development models, though perhaps useful at times, are found wanting in rigorous and soul-searching examination. That leaves the social justice model" (Farmer 2005, 157). The political work of these policies on the global, national and local scales

[21] Johan Galtung pioneered the term *structural violence* and worked extensively within the academic realm of liberation theology. The conception of the term structural violence is often attributed to Paul Farmer and, while his use of the term has propelled the concept into the mainstream lexicon, I feel it is important to place credit where credit is due.

often results in the construction of a narrative of need in the global south. Farmer paraphrases Pogge when he writes, "If we want to discuss our obligations to the' distant needy,' we need first an honest discussion about how our world got to be the way it is and where it is going" (Farmer 2010, 531). Only once that conversation has been had can the work of care move forward in a care ethical manner without settling into the narratives of need constructed by the dominant powers of the hegemonic system.

Health Delivery Strategies

Driven by donor demands, NGOs often focus on narrowly vertical programs that serve limited populations in confined geographical settings for single health problems. As a result, NGOs frequently create showcase projects with questionable sustainability and perfunctory linkages to local health services."

(Pfieffer et al. 2008, 2135)

In the wake of neoliberalism, policies of welfare retrenchment, deregulation, and privatization created an atmosphere in the global marketplace conducive to the creation of vertical health delivery programs.[22] As Kim England writes, "…increasingly social policies echo lessons learnt from neoliberal rhetoric – privatization, decentralization and economic efficiency" (England 2010, 136). Thus, "Many observers link this shift to NGOs, to structural adjustment programs promoted by the World Bank and International Monetary Fund in developing countries to limit public sector spending and privatize services to address the mounting foreign debt crises experienced by many poor countries since the early 1980s" (Pfeiffer et al. 2008, 2135). Often privately funded and specifically targeted, vertical health programs were established to fill the void of severely retrenched local health systems in middle to low income nations through a 'low cost, high yield' temporary program. As King writes, "Connections

[22] Vertical health delivery programs began with the lauded success of the smallpox eradication campaign of the late 1970s. However, following this campaign, very few vertical health programs were effective. A classic example would be the Gates Foundation's work to eradicate polio and the (belated) discovery that, without a strong health care infrastructure to deliver primary care to populations, vertical programs often fail to meet the needs of populations. Health delivery programs are not one size fits all – context, history and place matter in the conception, creation and implementation of global health programs.

between commodity exchange and international health are by no means historically novel..." (King 2002, 779) and vertical health programs utilized global commodity chains to briefly provide necessary treatment to a select few while existing health care structures crumbled. However, "…donor aid to developing countries continues to be disproportionately channeled to international non-governmental organizations (NGOS) rather than to ministries of health" (Pfieffer et al. 2008, 2134). The mechanisms of unequal power relationships continue to structure the agenda and policies of international aid work. Indeed, Ananya Roy writes that "…from setting an agenda around poverty (as does the Gates Foundation) to strategically influencing the development agenda of advanced, industrial countries, these figureheads have become decisive actors in the new global order of millennial development." (Roy 2010, 10).

The power relationships that construct geographies of care again come into play in the creation of health delivery systems. Indeed, the current research available analyzing vertical versus horizontal delivery of global health services is undeniably limited. The WHO[23] policy brief "When do vertical (stand-alone) programmes have a place in health systems?" illustrates the main arguments in the debate over vertical versus horizontal health delivery. In addition, this brief discusses the rhetoric surrounding the trend of integrated health programs. The assertion that "...the arguments against vertical programs tend to assert that they are value driven, often have limited chance of sustainability and have negative spillover effects on health systems and non-targeted populations" (Atun et al. 2008, ii) illuminates many of the negative associations with the implementation of vertical delivery programs. In continuation, Loewenson and McCoy address additional concerns with this system of implementation:

> Vertical programs established to achieve rapid delivery against unrealistic targets can divert scarce resources from strained public health services and bring undesirable opportunity costs and inefficiencies through the creation of parallel management and administrative systems (Loewensen & McCoy 2004, 242).

[23] It is important to note that the majority of effectiveness studies are undertaken by the very organizations which advocate for vertical health delivery programs. Thus, a degree of bias may be incorporated into the research and review. For additional scholarship on this topic, see Ooms et al.

Additionally, the use of vertical health delivery programs also promotes the continuation of the *pharmaceuticalization*[24] of global health work and how the market continues to inform power relationships which, in turn, directly affect the flow of aid.[25]

The power of the current constructions of the emerging diseases worldview, pharmaceuticalization of health, and the continuing primacy of the market inform the ways in which health care work is delivered on a global scale. Many NGOs continue to implement vertical health delivery programs, often to the detriment of those populations they seek to aid. In this way, the use of exclusively vertical health delivery programs is actively uncaring because these programs do not competently address the needs of the target population (through a lack of universal services or adequate primary care) nor do they engage in relationships of reciprocity with those populations they intend to help. Without contextual understanding and active dialogue, care can never be competently provided or received.[26]

Contextualizing PATH: A Catalyst for Global Health

"We envision a world where health is within reach for everyone."

PATH: Mission Statement

PATH is a non-governmental organization (NGO) whose mission is to "improve the health of people around the world by: advancing technologies; strengthening systems; and encouraging healthy behaviors" (PATH 2010, Online). The mission of this organization is commendable and demonstrate PATH's efforts to competently address the health care needs of millions of people around the world

[24] The concept of the pharmaceuticalization of the field of global health aid comes from the work of Biehl. His concept is further illuminated further through this snippet which discussed of the pharmaceuticalization of global health leads to an analysis of aid where "…at both the macro and micro levels, we see a state of triage and a politics of survival crystallizing" (Biehl 2007, 1123).

[25] Ooms et al. discuss the ways in which the market affects the flow of aid and the Western constructions of need in the article "The diagonal approach to Global Fund financing" published in 2008.

[26] Again, I turn to Tronto and her four components of care ethics. While this is the most difficult component to achieve, most vertical health programs so blatantly ignore the need for dialogue that it is important to point out such deficiencies.

through clinical care, technological innovation, and program management. Founded and headquartered in Seattle, PATH has employees on the ground in over 70 countries. In addition, the organization has offices in 30 cities in 21 nations. This international presence is made possible by a unique public-private approach to global health care. PATH's focus on innovation and international health policy advocacy[27] coupled with competent clinical care and immunization development make PATH a global power in the field of international health.

The work of PATH occurs on multiple scales with unique partnerships between the public and private sector facilitating program development, delivery and implementation. In the 2009 Annual Report, PATH engaged in an active discussion of their work across scales to facilitate chains of supply between producers and health workers.[28] The fact that PATH has its fingers in many pies up and down the supply chain allows them to incorporate vertical solutions for at-risk populations into larger global health 'interventions'[29] to improve existing health care infrastructure. In addition, it is important to note PATH's extensive work in the strengthening of health systems. PATH works to "...pursue deliberate and measurable outcomes related to service management, policy financing, supply systems, human resources, and information and monitoring systems" (Kaipilyawar & PATH 2006, 1). The above six interrelated processes are seen as the necessary components of a health system and, as such, are promoted through chains of development and aid (WHO 2007, 6). Thus, PATH's work in global health takes a careful approach to melding vertical and horizontal health programs into individually crafted integrated programs for specific places. As stated above, the importance of context in the creation of a

[27] As stated by Roy in her work *Poverty Capital,* it is the large NGOs, the private foundations, and celebrity activists who galvanize many in both the public and private sectors to become involved in the work of 'development.' On the flip side, it is these foundations and personalities who set the agenda, tone, and rhetoric of the work of international aid and development.

[28] PATH's 2009 Annual Report states that: "PATH reports that, "...we work to find new ways to deliver comprehensive health solutions. Just as important, we bring them into national or regional use, often in collaboration with governments and the private sector" (PATH 2009, 2).

[29] I take issue with the use of the term 'interventions' because the term, similarly to the word development, comes loaded with connotations and insinuations about the populations of nations in the global south who receive these 'interventions.' The use of language such as this illustrates the pervasive use of residual poverty knowledge in the rhetoric of self-described relationally minded organizations.

health delivery system cannot be undiminished. Without a thorough understanding of the social, political, economic and historical processes at work in a place, there can be no successful, sustainable global health initiatives that effectively strengthen systems. While this paper focuses tightly on the aspect of *supply systems* within the context of *health care delivery*, the importance and prominence of the other five components drawn from the work of the WHO remain undiminished in the context of competent global health care.

Following the recognition of the importance contextualizing health delivery programs, PATH began to work within communities to "...identify needs and determine how to extend the reach of health solutions. [PATH] then strive[s] to ensure that health systems can deliver the solutions and that policies reinforce their use" (PATH 2004, 2). This shift illustrates how elements of PATH's approach to global health work fit the four elements of care ethics proposed by Tronto. Indeed, the fact that PATH professes to work with local governments to 'identify needs' works within the bounds of *care receiving* through the construction and maintenance of a dialog across distance. However, further research of PATH's information does not yield an exact account of the procedures through which PATH 'identifies needs.' However, PATH excels at *competently giving care* through their control of the chain of supply and their high trained staff from vaccine development to on-site health workers. Building sustainable connections between existing, disparate health care programs illustrates PATH's commitment to integrated health delivery systems from development to delivery.

Though PATH functions within the emerging diseases paradigm, their work does challenge existing power relationships in several key ways. My focus will be on the ways in which PATH's methods of procurement for the chain of supply challenge not only the current emerging diseases paradigm but the *pharmaceuticalization*[30] of global health work. The work PATH does in the fields of procurement and

[30] The term pharmaceuticalization references the continued position of power pharmaceutical corporations possess within the international development community. Though Roy advocates for the 'democratization of development', this has largely not occurred. However, PATH does work hard to circumvent the structures of

global health supply chains exists within the current paradigm of political economy and market based interventions but it does so in a uniquely caring way.[31] Procurement exemplifies the work of an integrated health delivery system which prioritizes care for certain diseases or populations without sacrificing preventative care for the larger population. In this way, PATH's commitment to equitable measures of procurement and the development of sustainable global health chains of supply illustrates the care of PATH's programs. The work of global health procurement and chain of supply will be further illuminated using the example of PATH's immunization initiative in Andhra Pradesh.

In the state of Andhra Pradesh, India[32], many of the over 80 million residents of the state do not have the geographic or financial access to the available health services. Thus, the population of Andhra Pradesh, especially the children of the state, is extremely vulnerable to common infectious diseases that could be prevented with access to primary care and immunization. Through PATH's Children's Vaccine Program (CVP)[33], the Immunization Initiative in Andhra Pradesh introduced a sustainable system for vaccination that incorporated hepatitis B vaccinations into the normal childhood vaccine regiment. In addition, the Andhra Pradesh program created sustainable chains of supply and effective structures for health system management through partnership with the Government of Andhra Pradesh and local health workers. The five program objectives for the Andhra Pradesh Immunization Initiative are outlined

---

pharmaceuticalization currently in place. Partners in Health (PIH) serves as another example of an organization attempting to not only circumvent the pharmaceuticalization of development but destroy it.

[31] It is important to note that any organization functioning within the global economy will be bounded by existing economic structures which seek to maintain the current, unequal balance of power between nations. The work of PATH, while bounded by the existing structures, seeks to incentivize and facilitate shifts in the emerging diseases paradigm to allow for greater access to necessary medicines, equipment, and technologies through program implementation and policy advocacy.

[32] The state of Andhra Pradesh lies along the south-eastern coast of India and is the fourth largest in terms of area and the fifth most populous. PATH's program sought to increase the equitable distribution of immunization between the relatively well-served urban populations to the critically under-served rural populations of the state.

[33] The CVP was launched in 1998 and funded from a 100 million dollar grant from the then William H. Gates Foundation. "The CVP's continuing mission is to promote equal access to new and lifesaving vaccines worldwide. We accomplish this by creating new tools and procedures that result in safer, more effective immunization programs—programs that protect more children with more of the vaccines they need." (PATH 2004 (2), 1). It is important to note that, since the funding source for this program came from a private foundation that is heavily embedded in the global aid work community, the agenda for the CVP may have been tailored by the pharmaceuticalization of global aid work and the emerging diseases world view.

here: Increase overall infant immunization from 58% to 85%; Improve vaccine logistics, management and supervision; Ensure safe injections for all vaccinations; Ensure technical and financial sustainability through local partnerships; and Adopt better disease control strategies.[34] The objectives outlined above will be critiqued through with the perspective of a feminist ethic of care and the four components of care ethics outlined by Tronto. In addition, my analysis of the Andhra Pradesh program will include aspects of care across distance, the emerging diseases world view, the pharmaceuticalization of global health, and the definition of health as a human right.

Under the umbrella of the CVP, the Andhra Pradesh Immunization Initiative began in the year 2000. The design of the Andhra Pradesh Initiative is such that the program will continue after the initial period of PATH's involvement has come to a close. This longevity is ensured through partnerships with national and regional governments, local health workers and international organizations, PATH ensures sustainability and longevity of integrated health delivery programs such as the Andhra Pradesh Immunization Initiative. PATH and the local Ministry of Health worked side-by-side to build a dependable, long-lasting immunization program with widespread coverage. In fact, the program in India was conceived with the end goal of becoming completely sustainable. The Government of Andhra Pradesh and PATH agreed that the government would begin to incrementally take on the cost of the program year-by-year until the government took on the full cost of the program and PATH's personnel stayed on as technical advisors alone. At the center of the Andhra Pradesh campaign is the understanding, clearly stated by PATH, that "...time-limited health projects have a habit of collapsing after the initial progress has been made and celebrated...the immunization improvements were tightly woven into the fabric of the state's health system, to ensure their longevity" (PATH 2008, 3). The fact that PATH speaks specifically about the need for integrated health delivery systems and sustainability indicates that PATH's approach to global health has longevity and is, in essence, careful and caring.

[34] This information was taken from PATH's article "Strengthening Health Systems through Procurement" and was published in June of 2008 by PATH.

PATH's efforts combine vertical health delivery programs with horizontal efforts to bolster existing national health systems while targeting specific vulnerable populations or diseases that need timely intervention. The notions of social justice within the context of health care and health access are addressed through the sustainable nature of the Andhra Pradesh program and the continual dialogue between PATH's health workers and the Government and health workers of the Indian state. As Farmer writes, "…a social justice approach should be central to medicine and utilized to be central to public health. This could be very simple: the well take care of the sick" (Farmer 2005, 144). While many barriers to health care and access remain in the nation of India, PATH's program in Andhra Pradesh acts in an essentially caring way. The concept of care has been revalued and made visible through active partnerships with the public. In addition, the Andhra Pradesh Immunization Initiative illustrates PATH's commitment to health as a human right and their work towards achieving this goal through the provision of competently caring integrated health delivery systems. Though the agenda of international development is set by major players within the neoliberal global market place, the work done on the ground has resulted in the implementation of a highly sustainable integrated healthcare system which has continued to provide preventative primary care and targeted immunizations to the majority of the population of Andhra Pradesh.

Conclusion: Reflecting of the work of PATH

Is humanity better served by waging wars on individual diseases? Or is it better to pursue a broader set of health goals simultaneously - improving hygiene, expanding immunizations, providing clean drinking water - that don't eliminate any one disease, but might improve the overall health of people in developing countries?

Robert A. Guth, "Gates Rethinks His War on Polio"

Through an examination of PATH's Immunization Initiative in Andhra Pradesh, India, I employed the framework of a feminist ethic of care to assess the ways in which PATH's program, and integrated health delivery systems in the work of international health development, do caring work. My literature review examined the academic work of five key components of this paper: The rise of neoliberalism; the

feminist ethic of care; care as an issue of social justice; the geographies of development; and health delivery strategies (in a global context). Drawing from this scholarship, I shed light on the broad issue of vertical versus integrated health delivery systems within the larger framework of history and political economy. Next, I introduced the organization that I focused on in my research, PATH: A Catalyst for Global Health, and examined their work using Tronto's four components of care ethics. Following this broad examination of PATH, I narrowed my focus to PATH's work with the Government of Andhra Pradesh to create and implement a sustainable Immunization Initiative. The Andhra Pradesh Immunization Initiative was critiqued using a feminist ethic of care and Tronto's four key components of care ethics. In addition, I linked the work of the Immunization Initiative back to the larger debate in the international aid community around the use of vertical health delivery programs versus integrated health services programs.

My research on PATH has left me with many questions regarding the construction of geographies of development and narratives of need within the international aid community. The notion of care as social justice brings to bear the work of Farmer, Lawson, Pogge, King, and other cited throughout this paper. However, without unbiased analysis of international programs of aid and development, the privatized nature of international development will continue and the unequal power relationships which predicate the need for aid and assistance will be perpetuated. I am drawn back to a quote taken from the Preface of Roy's work *Poverty* Capital, "The study of power is also fraught with ethical issues, in this case the ethics of intimacy – of complicities and entanglements that are part of the world of development institutions…" (Roy 2010, xi). Faced with the overwhelming issues of health, human rights, structural violence, and the geographies of development and power, I can only hope that through continued scholarship and research I will be able to do my part to advocate loudly for the value of care as a global necessity and not a private privilege.