LIGHTEN THE BURDEN OF THIRD WORLD HEALTH

INTERNATIONAL CONFERENCE

THE NEW WORLD ORDER: A CHALLENGE TO HEALTH FOR ALL BY THE YEAR 2 000

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HOSTED BY:
International People's Health Council (PHC), National Progressive Primary Health Care Network (NPPHCN) and South African Health & Social Services Organisation (SAHSSO)

THE NEW WORLD ORDER: A CHALLENGE TO HEALTH FOR ALL BY THE YEAR 2000

Proceedings of the Conference held at the University of the Western Cape in Cape Town, South Africa

Papers Presented

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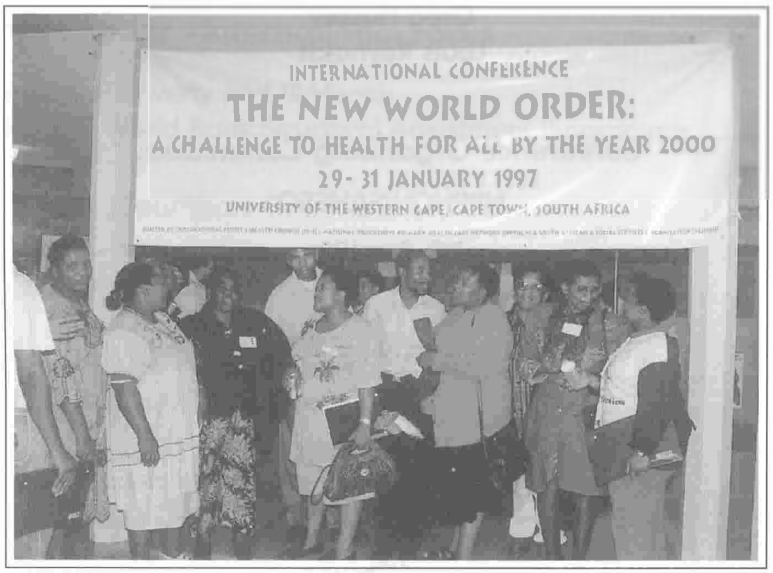

International People's Health Council (IPHC)

National Progressive Primary Health Care Network (NPPHCN)

The South African Health and Social Services Organisation (SAHSSO)

Compiled and edited by:

Mohamed Jeebhay
Greg Hussey
Louis Reynolds

Conference Organising Committee:

NPPHCN/SAHSSO

P.O. Box 192
Gatesville
7700
South Africa

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Table of Contents

Introduction

Challenges facing "Health for All"

Primary Health Care Experiences: Obstacles and Successes

The New Economic Order - International Focus

The New Economic Order - South African Context

International Responses to The New Economic Order

Lessons and Strategies

Appendices

Introduction

BACKGROUND TO THE CONFERENCE ON: THE NEW WORLD ORDER - A CHALLENGE TO HEALTH FOR ALL BY THE YEAR 2000

Conference Organising Committee
South Africa

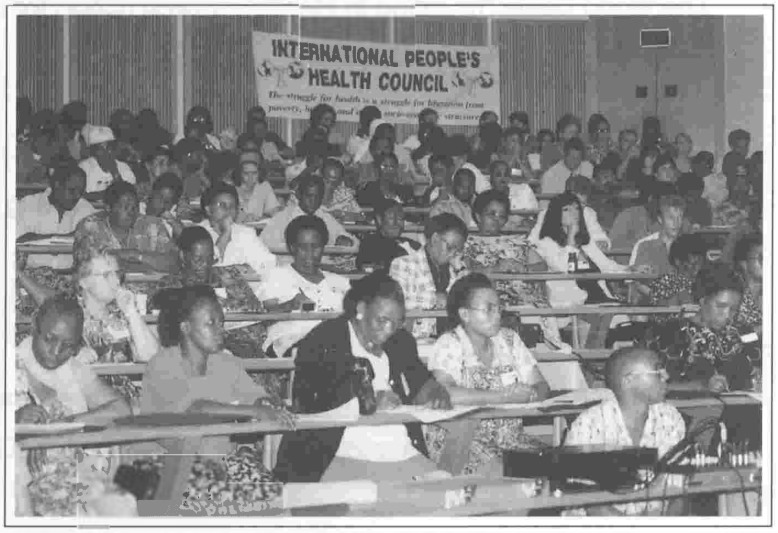
Why a Conference on Primary Health Care in South Africa?

The New World Order has resulted in restructuring of the health systems internationally. In South Africa vigorous activity to restructure the health care system toward one based on equity and the primary health care approach is under way.

However, this process is being influenced increasingly by internal and external agencies with differing orientations. These activities are being informed by the current international health policy discourse which is increasingly dominated by bilateral donor agencies and the World Bank.

The comprehensive primary health care approach which addresses the social, economic and political determinants is under threat internationally. It is timely, therefore, that more than two years after the inauguration of South Africa's first democratic government, the host organisations stage this international conference. A new democratic South Africa could play an important role in reasserting the centrality of a developmental approach to health.

The conference aimed to provide an opportunity for organs of civil society, such as community-based organisations, non-governmental organisations, trade unions, women's organisations and civic organisations, to come together, reconstitute and develop a coherent vision and strategy for dealing with the challenges they face in realising these policies. In this way we hope to develop capacity among civil society to engage with governments and their agencies in promoting a progressive perspective on health policy and practice.



Official opening of "The New World Order" Conference

Over 400 delegates from all over the globe attended the conference, making it a historic moment for the struggle toward primary health care. We hope that health workers will imbibe the lessons and embrace the strategies developed at this conference in promoting health for all into the next century.

ABOUT THE CONFERENCE . . .

Mohamed Jeebhay

Conference Organising Committee

South Africa

Conference Objectives

- Share grassroots experiences of progressive NGOs, groups and individuals involved in Primary Health Care projects
- Examine the current state of health NGOs and the challenges facing them locally and internationally
- Examine the impact of political transformation and the new economic order on health policy implementation
- Publicise and promote progressive health policies and lobby for their implementation
- Promote SAHSSO and NPPHCN's perspective on Primary Health Care in South Africa
- Build the IPHC and its Africa network

Conference Themes

- The challenges facing Primary Health Care
- Health for All: innovative local programmes and global strategies
- The Global Crisis: economic structural adjustment programmes and environmental destruction
- The World Bank: "Investing in Health" or prescription for underdevelopment?

Structure and Content

Session 1

Overview: The New World Order & the challenges facing Primary Health Care

Session 2

Primary Health Care in action: "Stories of Change"

Session 3/4

The New Economic Order: An International Perspective and South African Manifestation: Growth, Employment and Redistribution (GEAR)

Session 5

International responses to the New Economic Order

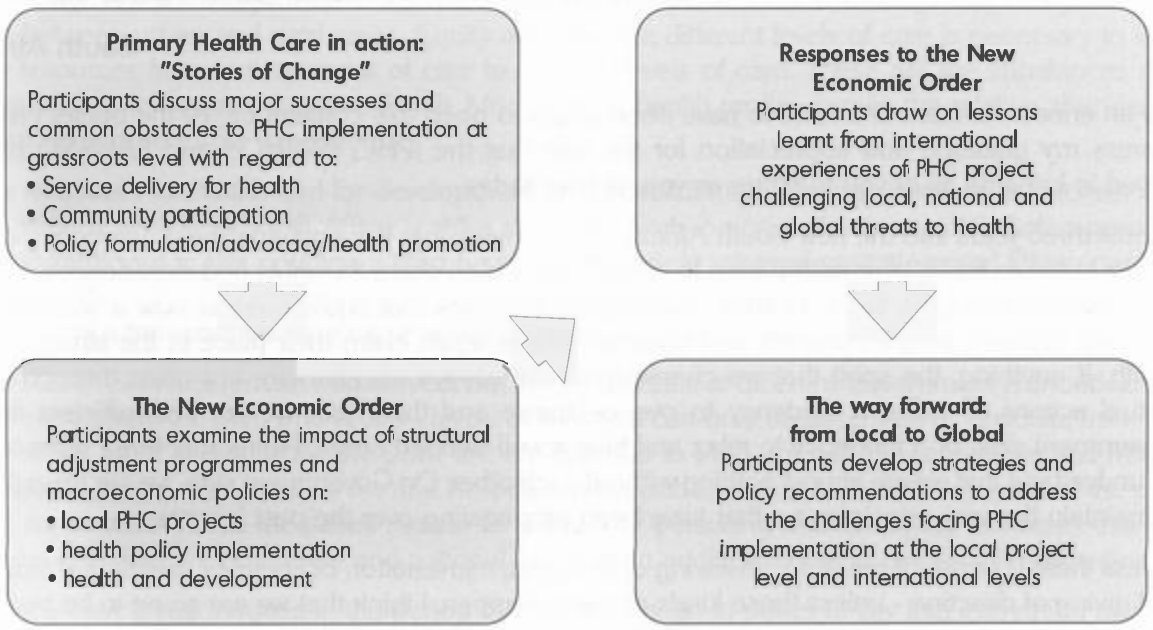
Session 6

The way forward: From Local to Global

Session 7

Ratification of policy recommendations

Process



CONFERENCE OPENING ADDRESS

Minister Ebrahim Rasool

Western Cape Provincial Minister of Health and Social Services

South Africa

It is an enormous honour for me to have been asked to open this conference. At the outset I must express my gratitude and appreciation for the role that the IPHC, NPPHCN and SAHSSO have played in bringing all of you together as you sit here today.

Almost three years into the new South African Government, into the post-apartheid democracy that we are trying to build, your enthusiasm to come here and to share thoughts and experiences, to air your problems, to raise some of your expectations indicates that again there is now a willingness amongst ordinary people, activists and communities to again claim their place in the struggle for health. If anything, the spirit that we characterise, not always intentionally, but often through our mutual actions, is either a tendency to over-centralise and think that we are self-sufficient from Government side, or a tendency to relax and take a well-needed break. I think that three years later we understand that we are almost nothing without each other. On Government side, we are struggling to maintain the very principles we that have been propagating over the past few years.

Unless there is constant pressure, reviewing of thoughts, rejuvenation of energies, building of morale and giving of direction - unless those kinds of things happen, I think that we are going to be people who will miss each other. At the end of the day we may invest as much as we want to in health, but essentially I think we will be missing the broader message within which this conference is located and which this conference tries to inject into the process of delivering health in this country, and elsewhere in the world.

You come to South Africa at an interesting time. After the birth of democracy and the defeat of Apartheid in its political form, we now have the task of meeting legitimate expectations of many of South Africa's people. These are embodied in the ANC health plan and health policy which was formulated prior to the formal taking of Government in this country. It is that policy, based on the primary health care approach which emphasises community participation not only in the area of service delivery, but also in demanding that skills, knowledge and resources that are necessary for health and development, be developed.

From left: Maria Hamlin-Zuniga, Refik Bismallah, Minister Ebrahim Rasool and Ivan Toms at the conference opening

The Primary Health Care Approach is a policy based on democratising decision-making from local to provincial to national level. It is a policy that

Please note that this paper is an edited transcription of the paper delivered at the conference.

has placed equity at its core (equity has probably been the defining debate over the last three years in this country). That does not mean that we have been able to understand and apply it properly, because to a large extent there are various imbalances and our struggle for equity continues. There is a struggle for equity between different racial groups, with a need to shift resources from the previously advantaged communities - the white community - to black communities. At a national level, there is a need to provide an equitable allocation of our resources amongst different provinces, and between urban and rural areas. Equity amongst the different levels of care is necessary to shift our resources from tertiary levels of care to primary levels of care. These are the imbalances and inequities which even today give South Africa a poor health profile despite the relative abundance when compared to our neighbours.

Our resources for health and for development are maldistributed. The gap between the richest and the poorest people in South Africa is still a stark one. Forty percent of economically active persons are unemployed in this country; a third have access to only minimal sanitation; and fifteen percent have access only to untreated and non-reticulated water. Thus the struggle for equity is a struggle that needs a tremendous amount of acceleration.

Our Health Services remain fragmented, not simply in terms of different Government authorities, but also particularly the rich, who receive levels of care that can only be described as obscene from the private for profit sector, while the poor are condemned to long queues to see over-worked health workers in under-resourced clinics and hospitals in the public sector. This is still a legacy of the past that we sit with. These inequities remain as a result of persisting and emerging obstacles that we increasingly find are both local and national in nature in addition to being global and international.

We may have been tempted in the period that we have been in power to say that everything that we inherit by way of problems are South African in character. There are local and national obstacles that we face. The fundamental issues of power and control over resources and institutions still remain a major issue. The private sector which represents half of the health GDP in this country only serves twenty percent of the population. Within the public sector specialist care consumes over fifty percent of the budget in South Africa. Health facilities remain run by unrepresentative boards and management. The problems of the South African transition are also manifestations of a broader international trend. We are operating in a situation where the political right are dominant and radical in the ways in which they are changing the face of the earth. The left, to a large extent, have been made defensive and often conservative in the way in which we try to hold on to those gains that we have won over few decades for many of the ordinary people of this world. Within this alignment there is a massive onslaught against the notion of the welfare state, which implies access to benefits such as health, welfare and other developmental benefits. Our response would either be to enter the trenches of that battle, to defend people against poverty, to defend the welfare state and what it means for health and welfare and other services, or to defend the welfare state as a limited redistributive measure. On the other hand we could enter that debate and help to rethink that welfare state fundamentally and to recognise that it also has elements of, for example, patriarchy as opposed to full participation on an equal basis by all citizens. It should be recognised that the welfare state is also based on a dispensing model as opposed to a developmental model. So I think it becomes almost incumbent on all of us to enter that debate in a fundamental way and not simply to act as people who try to conserve a welfare state as a limited redistributive mechanism within our societies.

The global obstacles are becoming obtrusive. There is this growing dominance of the international financial institutions, as has been mentioned, in determining the fate of the world's people. Their policy recommendations are felt daily by more and more of the poor. The gap between rich and poor is increasing all the time. Even in the health sector we are seeing widening differentials in the delivery of health. We are seeing escalating environmental degradation, diseases of poverty and powerlessness persist, forgotten diseases re-emerge and new diseases appear.

Since our health policy in this country was laid out prior to the elections in 1994, other policies have been developed to face some of the realities that our country is experiencing. The macro-economic plan is one such example. Some feel that this economic plan is a local manifestation of the dominant global trends and will dictate the development agenda and constrain the implementation of health policy.

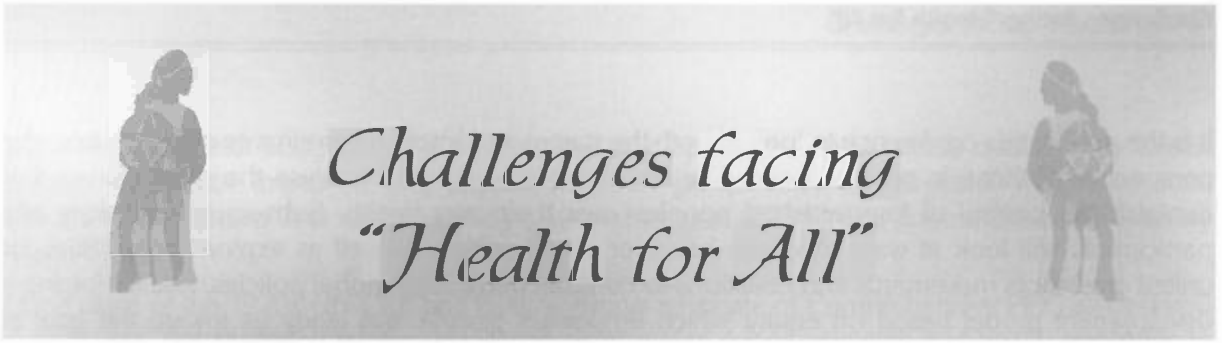
One of the anomalies, the seeking of an identity, the seeking of a niche on the political spectrum, the seeking of a position on the developmental spectrum is that South Africa is busy with a macro-economic plan, but in seven of the nine provinces in this county, health has been fully funded. Only in two provinces where the ANC is not in control is the recurrence of health deficits a recurring factor. I think it shows that the debate is there, that we are busy debating it, and this conference comes at an opportune moment to help that debate because I think that we are still in shifting sands, we are still in a split identity about what we should be investing in and how we should be going forward. We could at this conference throw up our hands in despair, or we could say that there is this flux and let us try to influence it. I would urge you to engage in the latter.

This conference could either be an opportunity to reorganise the slogans and the rhetoric or we could use it as an opportunity to understand the new world order and to engage it by being self-critical as well. Progressives, as I have said, cannot simply become bent on conserving what we have managed to gain for ordinary citizens.

A story that I often tell to more conservative people to convince them to embrace the direction of change that is brought about by the new Government's policy, is a story of a man who late one night walks down the street and under a street lamp he sees someone crouching, looking for something. He goes up to this person and says "did you lose something, are you looking for something?", and the man says "yes, I lost my car keys." And he says "are you sure your lost them here", and the man replies "no, I do not think I lost them here, but this is the only place where the light is shining."

I would urge that story is as appropriate for all of us as we gather here in progressive numbers because I think that unless we start going out of our traditionally lit up areas, we are not going to offer real solutions to the national and international context. We have got to be prepared to rethink fundamentally. It is precisely the kind of issues that have been raised in your programme and agenda that we would urge you to fundamentally grapple with and to rethink.

We look forward to hearing your deliberations, to receiving your recommendations and your action plans. It is my pleasure, in recognition of the urgent need for your wisdom, to declare this conference officially open. I thank you.



Challenges facing "Health for All"

KEYNOTE ADDRESS

David Werner

Health Rights and International People's Health Council

United States of America

> *"Not until the creation and maintenance of decent conditions of life for all people are recognised and accepted as a common obligation of all people and all countries–not until then shall we, with a certain degree of justification, be able to speak of mankind as civilized."*
>
> Albert Einstein, 1945

Introduction

As we approach the Year 2000, the international goal of Health for All grows increasingly distant. More than ever before, world health is determined by the politics of transnational power. The Post-World War II development model, based on meeting all people's basic needs, has steadily been eroded. It has been replaced by a development paradigm based on top-heavy economic growth. The New World Order, governed by the forces of a globalised market economy that increasingly frees itself from social responsibility, is widening the gap between rich and poor, between and within countries and regions.

Current trends in health policy, both in underdeveloped and overdeveloped countries, are part of this regressive global trend and must be examined within that context. Although health care has long been acclaimed a basic human right, in recent years formal health services have become increasingly inaccessible for growing numbers of people. The reason is largely economic. At the same time, poverty is deepening in many nations, rich and poor, and the costs for basic health care are being systematically shifted from the public sector to the individual consumer.

Since the early 1980's the income gap between rich and poor has been widening between and within countries. Today over one billion persons–one in five people–try to survive on less than one dollar per day.[1] In many countries, minimum wages have fallen so low that they do not cover the family's basic food needs.

Too often high-level planners get so absorbed in macro issues of health economics that they lose sight of the micro (or human) issues. They focus on how health ministries faced with shrinking budgets can function "cost effectively", rather than on how impoverished families can cope with falling wages, growing unemployment, rising costs of food, health services, and other essentials.

It is the goal of this conference to look at both the macro and micro determinants of health, from the perspective of those in greatest need. The first speakers will try to analyse the global forces that diminish the control of impoverished peoples over their own health. Subsequent speakers and participants will look at ways to create healthier communities, as well as explore possibilities for united grassroots movements and coalitions to confront pernicious global policies, and for forging a development model based on equity, which empowers people and leads us toward the goal of Health for All.

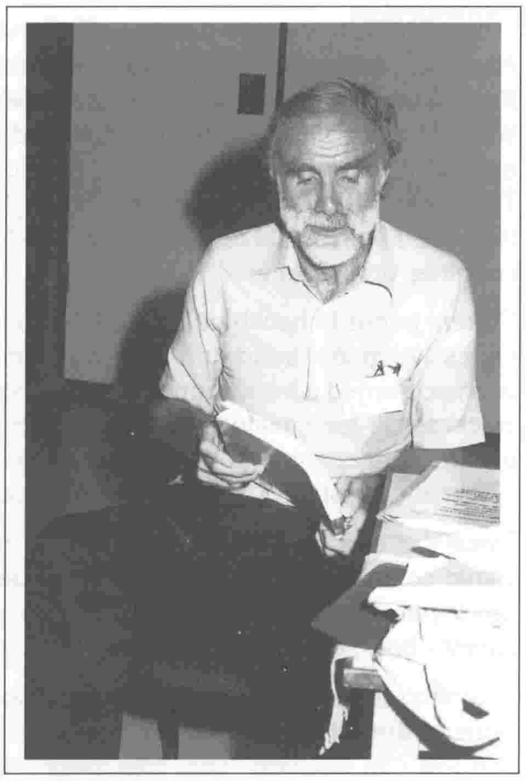
The Birth and Death of Primary Health Care (PHC)

The concept of Primary Health Care was introduced in response to wide recognition that the Western medical model, as practiced in the Third World, was failing to adequately improve levels of health. A potential breakthrough in global health rights took place at the International Conference on Primary Health Care, held in 1978 in Alma Ata, USSR (Kazakhstan). The conference, sponsored by WHO and UNICEF, was attended by ministers of health from more than 100 countries. Virtually all of the 134 nations represented subscribed to the goal of "Health for All by the Year 2000".[2] Furthermore, they affirmed the WHO definition of health as "a state of complete physical, mental, and social well-being".[3] This potentially revolutionary approach was articulated in the Alma Ata Declaration.

Thus, Primary Health Care was conceived as a comprehensive strategy that would not only include an equitable, consumer-centred approach to health services, but would address the underlying social and political determinants of health. It called for accountability of health workers and health ministries to the common people, and for social guarantees to make sure that the basic needs–including food needs–of all people are met. In recognition that socially progressive change only comes through organised demand, it called for strong popular participation.

Unhappily, the high expectations of Alma Ata have not been met. Today, 19 years later, it is painfully evident that the goal of Health for All is growing more distant, not just for the poor, but for humanity. Some critics say that Primary Health Care has failed. Others protest that it has never really been tried.

Strategically, there have been three major events that have sabotaged the revolutionary essence of Primary Health Care: 1) the introduction of Selective Primary Health Care at the end of the 1970s, 2) Structural Adjustment Programs and the push for User-financed Health Services, introduced in the 1980s, and 3) the take over of Third World health care policy-making by the World Bank in the 1990s. All three of these monumental assaults on Primary Health Care are a reflection of the prevailing regressive sociopolitical and economic global trend.



David Werner giving the keynote address

Selective Primary Health Care

No sooner had the dust settled from the Alma Ata Conference in 1978, when top-ranking health experts in the North began to trim the wings of Primary Health Care. They asserted that, in view of the global recession

and shrinking health budgets, such a comprehensive approach would be too costly. If any health statistics were to be improved, they argued, high risk groups must be "targeted" with a few cost-effective interventions. This new politically-sanitised version of PHC was dubbed Selective Primary Health Care.

At the close of the 1970s UNICEF had been a strong advocate of Comprehensive PHC as declared at Alma Ata. But frustrated by the unwillingness of major donor agencies and health ministries to seriously promote such a radical model, and pressured by the socially retrograde political climate of the 1980s, UNICEF soon compromised. It began to advocate Selective PHC as being more "realistic." Through its so-called Child Survival Revolution–which some critics called a counter-revolution–UNICEF focused on four interventions known as GOBI (Growth Monitoring, Oral Rehydration Therapy [ORT], Breast Feeding, and Immunisation). UNICEF later attempted to broaden its limited package of health technologies to GOBI-FFF (adding Food supplements, Female education, and Family planning). But in practice, in most countries PHC became even more selectively reduced to the twin engines of Child Survival: ORT and Immunisation.

The global Child Survival Campaign quickly won high-level support. For those in positions of privilege and power, it was safe and politically useful. It promised to improve a widely accepted health indicator, child mortality, while it prudently skirted (except in rhetoric) the social and economic inequities underlying poor health. Not surprisingly, many health professionals, governments, and USAID quickly jumped on the Child Survival bandwagon. Even the World Bank–which had previously not put much investment in health–began to lend its support.

But technological solutions can only go so far in combating health problems whose roots are social and political. Predictably, the Child Survival initiative has had less impact than was hoped. Over 13 million children still die each year (roughly the same number as 15 years ago, although the percentage is somewhat reduced). Most of these deaths still are related to poverty and undernutrition.

It has become increasingly clear that reducing child mortality through selected technological interventions does not necessarily improve children's health or quality of life, especially if the interventions do little to combat poverty and improve living standards. During the 1980s a disturbing pattern began to emerge in the health indicators of some poor countries: while child mortality rates dropped, undernutrition and morbidity rates increased. Such a pattern bodes an ominous forecast. And sure enough, in the late 1980s and early 1990s, in many countries the decline in child mortality rates slowed or halted, and in several countries (especially in sub-Saharan Africa) child mortality has been increasing.[4]

Equally disturbing, the two most heavily promoted child survival technologies are proving difficult to sustain. Since the start of the 1990's, there has been a backslide both in Oral Rehydration Therapy usage and Immunisation coverage.[5]The recent decline in immunisation and corresponding increase in polio cases are shown on the two graphs from UNICEF's State of the World's Children Report, 1994 (see figures 1 and 2). As for Oral Rehydration, even Egypt's national programme–long upheld as the great success story–has in the 1990's experienced a sharp decline in the usage rates of packets of Oral Rehydration Salts: from more than 50%, down to 23%.[6]

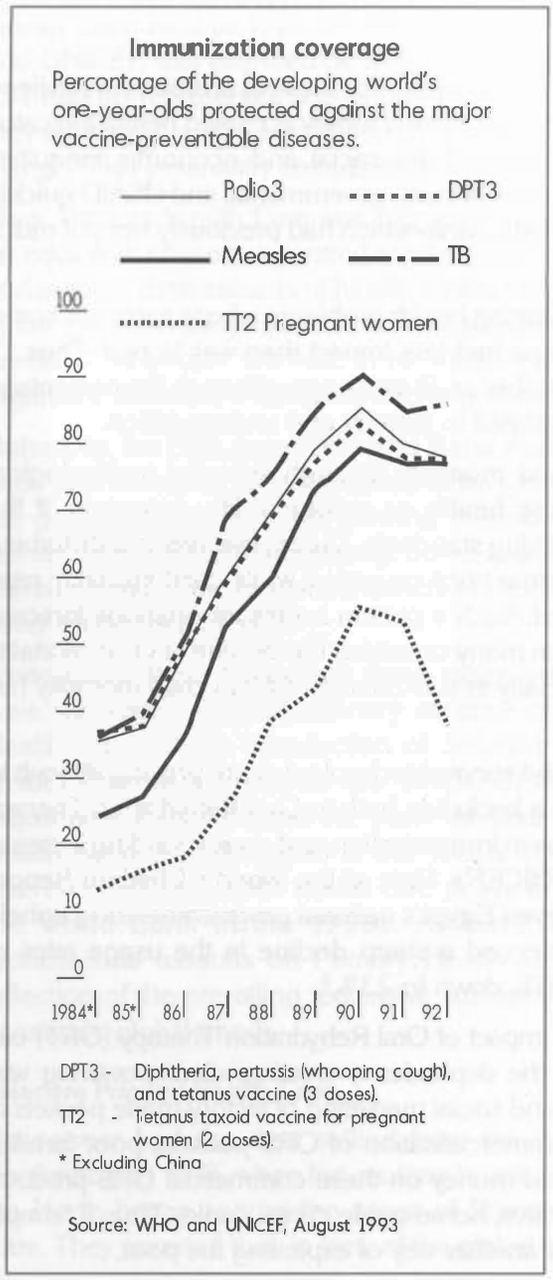
The disappointing and in some countries diminishing impact of Oral Rehydration Therapy (ORT) can be explained by a combination of factors, including the dependency-creating, disempowering way ORT was introduced: namely through the production and social marketing of factory-made packets of Oral Rehydration Salts. With the privatisation and commercialisation of ORS packets, poor families have been brainwashed into spending their limited food money on these commercial ORS products rather than using potentially more effective, less expensive, home-made cereal drinks. Thus a "simple solution" for child survival has been converted into yet another way of exploiting the poor.

Structural Adjustment Programs

The next big assault on Primary Health Care has been the introduction, during the 1980s, of Structural Adjustment Programs (SAPs), which I just mentioned.

Structural adjustment programs (SAPs)–engineered by the World Bank and International Monetary Fund (IMF)–are, in essence, a way of making poor people pay for irresponsible lending by the rich in the North to the rich in the South. By the start of the 1980's poor countries were faced with staggering foreign debt. Huge interest payments offset any benefits from economic growth. As Third World economies began to falter, Northern banks withheld new loans, and scores of countries went into a

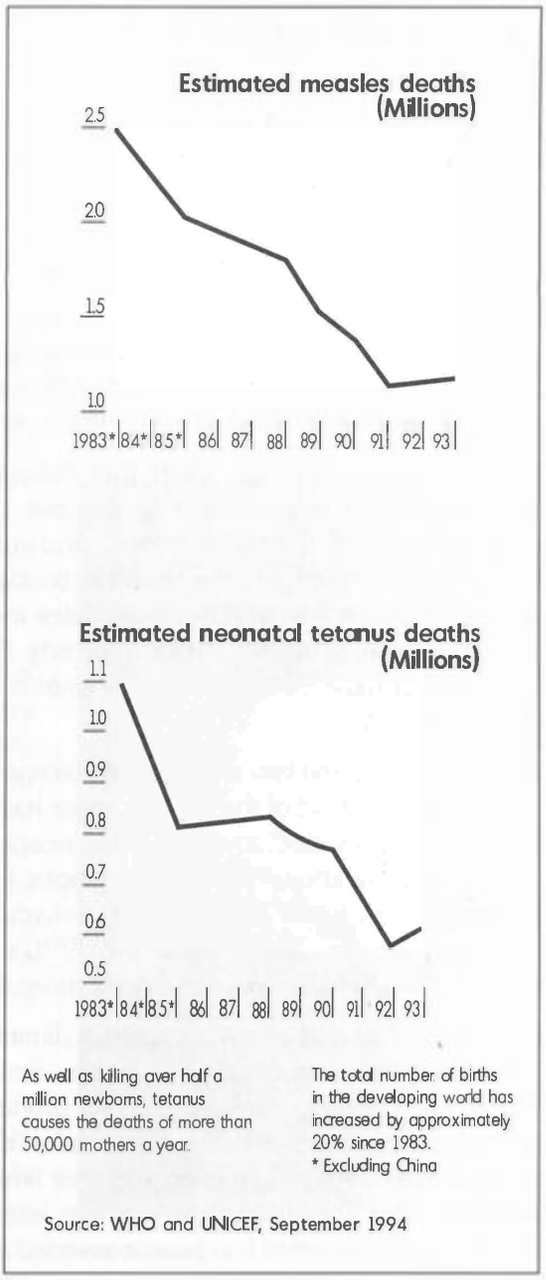
Figure 1: Global immunization coverage



DPT3 - Diphtheria, pertussis (whooping cough), and tetanus vaccine (3 doses).
TT2 - Tetanus taxoid vaccine for pregnant women (2 doses).
* Excluding China

Source: WHO and UNICEF, August 1993

Figure 2: Global deaths: measles & tetanus (millions)



As well as killing over half a million newborns, tetanus causes the deaths of more than 50,000 mothers a year.

The total number of births in the developing world has increased by approximately 20% since 1983.
* Excluding China

Source: WHO and UNICEF, September 1994

fiscal tailspin. Some–beginning with Mexico in 1982–announced they simply could not pay. The banks, with billions of dollars in loans to poor countries, feared economic collapse if debtor countries defaulted on their loans.

Then the World Bank and IMF came to the rescue (primarily of the Northern banks). They gave countries in crises bail-out loans to keep them servicing their huge debts and hopefully to restore economic growth. But strings were attached to these loans, mainly in the form of Structural Adjustment Programs. In brief, SAPs were designed to stream-line poor country economies so as to free up money for servicing foreign debt, and to bind poor countries into international trade accords that favour big business and "free market" interests in the North. SAPs have usually included the following components:

- cutbacks in public spending
- privatisation of government enterprises
- freezing of wages and freeing of prices
- increase of production for export rather than for local consumption
- reducing tariffs and regulations while creating incentives to attract foreign capital and trade
- reducing government deficits by charging user fees for social services, including health

Such policies inevitably hit the poor hardest. Budgets for so-called "non-productive" government initiatives such as health, education, and food subsidies have been ruthlessly slashed, while bloated military expenditures have mostly been left untouched. Public hospitals and health centres are sold to the private sector, pricing their services out of reach of the poor. Falling real wages, food scarcity, and growing unemployment all join to push low-income families into worsening destitution.[7]

The overall impact of adjustment has been hotly debated. At first the World Bank and IMF denied that SAPs have hurt the poor. (This is like the tobacco industry saying there is no proof that smoking causes lung cancer). More recently, the Bank has conceded that adjustment may have caused temporary hardships for low income families, but that such austerity is necessary to restore economic growth. Ignoring the historical record, the Bank still seems to think that by helping the rich get richer, the benefits will somehow trickle down to the poor.

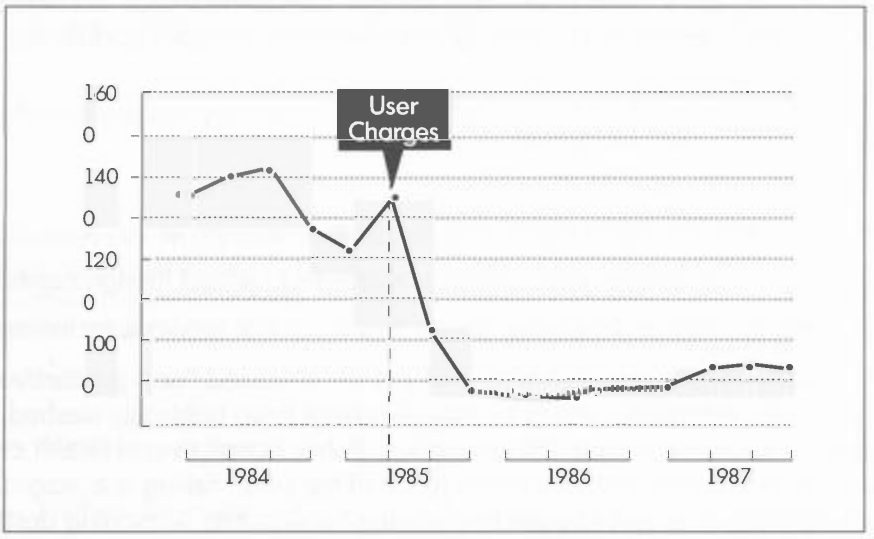
But the evidence is overwhelming that structural adjustment, linked with other conservative trends in recent years, has caused a major set-back to Third World health.[8] The World Bank defends its strategies with reports and graphs showing that over the past 30 years Third World health has steadily improved. However, these reports shrewdly downplay the fact that in many countries improvements in health have slowed down or stopped since the mid-1980's, and more so in the early 1990's.[9] In some countries rates of under-nutrition, tuberculosis, cholera, STDs, plague, malaria, and other indicators of deteriorating conditions, have been drastically increasing.

In spite of a modicum of development aid from the North, in the 1990's more than $60 billion net flows each year from the poor countries to the rich. GATT and recent "free trade" agreements are doing more to increase than decrease this inequity. Today, the income of the richest 20% of the world's inhabitants is 140 times as great as that of the poorest 20%. Across the world the gap between rich and poor has grown 30% in the last 10 years. Although enough food is produced in the world to feed all people adequately, according to the United Nations Development Programme (UNDP) nearly one quarter of the worlds' people do not get enough to eat.

User-financing and cost recovery schemes, together with privatisation of public health services, are among the adjustment policies mandated by the World Bank and IMF. UNICEF has tried to make its cost-recovery scheme–the Bamako Initiative–user-friendly and community controlled (see UNICEF's Adjustment with a Human Face, 1987).[10] But many such schemes have serious–and perhaps life-threatening–drawbacks. Poor families are willing to spend their last pennies to care for their sick

children. But just because they are willing to pay for medicines does not mean they can afford to pay for them. Because the poorest families get sick most often and tend to require more medication, they often carry more than their share of costs for the health post. While Bamako has provisions to charge less to the poorest of the poor, such safety nets work better on paper than in practice.

Figure 3: Outpatient attendances at Dwease Health Post, Ghana, before and after introduction of user charges in 1985



Studies in some countries have shown that when cost-recovery has been introduced, utilisation of health centres by high risk groups has dropped. For example, in Kenya the introduction of user fees at a centre for sexually transmitted diseases caused a sharp decline in attendance and an increase in untreated STDs.[11] Similarly, user charges were closely correlated with a significant decrease in health post usage in Dwease, Ghana (see figure 3).[12]

Whatever their short-term impact, the introduction of user financing has disturbing long-term social and ethical implications. It represents a retreat from progressive taxation, where society takes from the prosperous to benefit the least fortunate, in a sense of fairness and sharing. Placed in historical perspective, when decision-makers begin to inflict destitute, undernourished people with an increased portion of health-related costs, this is a great step backwards. It means that for those in greatest need, health care is no longer a human right.

Investing in Health: The World Bank's takeover of health policy planning

The World Bank's 1993 World Development Report, Investing in Health, has put the last nail in the coffin of the Alma Ata Declaration.[13] Turning Health into Investment would be a better title, for the Bank takes a dehumanisingly mechanistic commercial view of both health and health care. When stripped of its humanitarian rhetoric, its chilling thesis is that the purpose of keeping people healthy is to promote economic growth. Were this growth to serve the well-being of all, the Bank's intrusion into health care might be more palatable. But the 'economic growth' which the Bank consistently promotes as the goal and measure of "development" has invariably benefited large multinational corporations, often at great human and environmental cost.

The World Bank tells us it has turned over a new leaf: it now recognises that sustainable development must take direct measures to eliminate poverty. Yet the Bank has so consistently financed projects

and policies which worsen the situation of disadvantaged people that we must question its ability to change its course. A growing number of critics suggest that perhaps the most effective step the World Bank could take to eliminate poverty would be to eliminate itself.

On first reading, the Bank's strategy for improving health status worldwide sounds comprehensive, even modestly progressive. It acknowledges the economic roots of ill health, and states that improvements in health are likely to result primarily from advances in non-health sectors. It calls for increased family income, better education (especially for girls), greater access to health care, and a focus on basic health services rather than tertiary and specialist care. It quite rightly criticises the persistent inequity and inefficiency of current Third World health systems. Ironically, in view of its track record of slashing health budgets, the Bank even calls for increased health spending. So far so good.

But on reading further, we discover that under the guise of promoting an equitable, cost-effective, decentralised, and country-appropriate health system, the World Bank's key recommendations spring from the same sort of structural adjustment paradigm that has worsened poverty and lowered levels of health.

According to the Bank's prescription, in order to save "millions of lives and billions of dollars" governments must adopt "a three pronged policy approach of health reform":

1. Foster an enabling environment for households to improve health.
2. Improve government spending in health.
3. Facilitate involvement by the private sector.[14]

These recommendations are said to reflect new thinking. But from the "fine print" in the text of the Report, we can restate the policy's three prongs more clearly:

1. "Foster an enabling environment for households to improve health" is a return to "trickle down" development. Policies for economic growth must take priority. Family health will improve when household income starts to rise.
2. "Improve government spending in health" means trimming government spending by moving from comprehensive service provision to a number of narrow vertically planned programs, selected on the grounds of cost-effectiveness: in other words, a new brand of selective primary health care. It also means user charges, requiring disadvantaged families to cover the costs of their own health care, despite the fact that for many it will prohibit the use of health care services.
3. "Facilitate involvement by the private sector" means turning over to private, profit-making doctors and businesses most of those government programs that used to provide free or subsidised care to the poor. In other words, privatisation of most medical and health services: thus pricing many interventions beyond the reach of those in greatest need.

So we find the Bank's new health policy is old wine in new bottles: a rehash of the conservative strategies that have systematically derailed Comprehensive Primary Health Care–but with the added shackles of structural adjustment. In essence, it is a market-friendly version of Selective Primary Health Care, which includes privatisation of medical services and user-financed cost recovery.[15] As with other Selective PHC schemes, it focuses on technological interventions and glosses over the social and legislative determinants of health: issues such as abandoned children and legalisation of abortion. One reviewer (David Legge) observes that the World Bank Report is "primarily oriented around the technical fix rather than any focus on structural causes of poor health; it is about healthier poverty".[16]

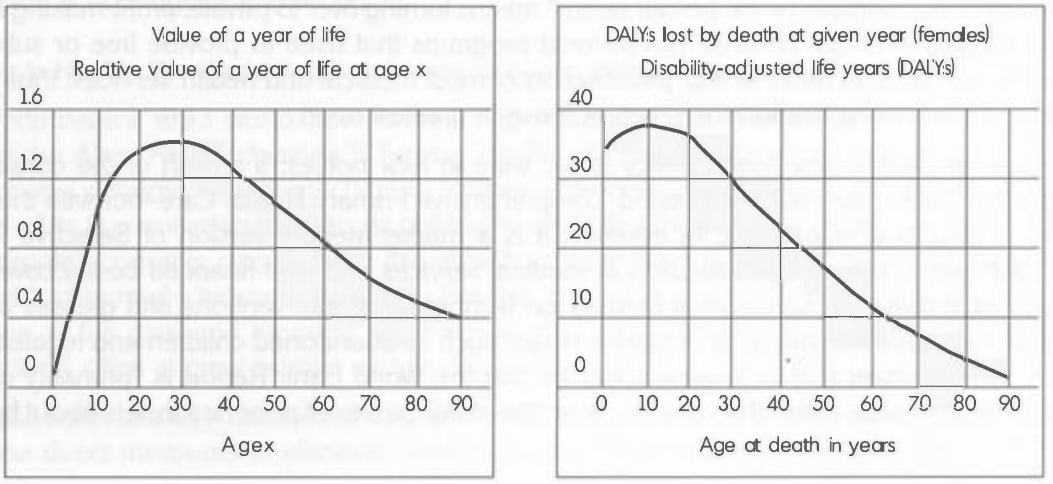
The Bank prioritises health interventions by calculating their relative cost effectiveness. This is measured by the number of Disability Adjusted Life Years (DALYs) saved through different interventions. The cost of each intervention is weighed against the person's potential 'productivity' (i.e., contribution to economic growth). Each disease and ailment is classified according to how many years of productive (disability free) life the individual loses as a result. The Bank has studied and prioritised 47 different public health and clinical interventions, expressing their benefits in DALYs achieved. For example, leukaemia treatment is not cost effective, only 1 DALY being saved for $1,000, while Vitamin A supplementation achieves nearly 1 DALY for $1.

In calculating DALYs, years of productive life lost are weighted according to age and work potential. Hence children and the elderly have lower value than young adults, and presumably disabled persons who are unable to work are awarded zero value and therefore have little or no entitlement to health services at public expense. The very term Disability Adjusted Life Years is an affront to disabled persons. (The DALY prioritisation method, which authoritatively deprecates disability, has the stench of eugenics. Disabled activists need to join with health rights activists to protest this potentially neo-fascist policy.)

The Investing in Health Report advocates that governments should favour an environment that enables households to improve health. But to do this, it does not call loudly for fairer wages or stronger labour unions. Instead, as always, it recommends economic growth policies backed by structural adjustment programs which, it claims, will eventually raise income per capita. In making this recommendation, the Bank ignores the fact that in many countries with SAPs average per capita income has plummeted. Even in countries whose economies have partially recovered, most gains have been pocketed by the wealthy; poor people's real income has tended to decline.

With its call for "greater diversity and competition in the provision of health services, promoting competitive procurement practices, [and] fostering greater involvement by non-government and other private organisations" the Bank's new policy for the Third World sounds suspiciously like the health care model of the United States. It argues that private health care for individuals gives more choice and satisfaction and is more efficient. But there is little evidence to support this claim. The US health system, dominated by a strong profit-hungry private sector, is by far the most expensive in the world, yet US health statistics are the worst among the Northern industrialised nations. Indeed, Washington D.C, with its large low-income population, has poorer child and maternal mortality rates than Jamaica.[17] Several US inner cities have immunisation rates as low as 10%, and for the last several years deaths from measles in the US have been increasing.[18]

Figure 4 Source: World Bank 1993 World Development Report



The commercial medical establishment and some large NGO's have celebrated the World Bank's Investment in Health strategy as a 'breakthrough' toward universal, more cost-efficient health care. But most health rights activists see the report as a masterpiece of disinformation, with dangerous implications. They fear the Bank will impose its recommendations on those poor countries that can least afford them. With its enormous money-lending capacity, the Bank can force poor countries to accept its blueprint by tying it to loans, as it has done with structural adjustment.

It is an ominous sign when a giant financial institution with such strong ties to big government and big business bullies its way into the health care field. Yet, according to the British medical journal, Lancet, the World Bank is now moving into first place as the global agency most influencing health policy, leaving the World Health Organisation in weaker second place.[19]

Despite all its rhetoric about alleviation of poverty, strengthening of households, and more equitable and efficient health care, the central function of the World Bank remains the same: to draw the rulers and governments of weaker states into a global economy dominated by large, multinational corporations. Its loan programs, development priorities, and adjustment policies have deepened inequalities and contributed to the perpetuation of poverty, ill health, and deteriorating living conditions for at least one billion human beings.

The World Summit on Social Development, March 1995

We have looked at the three major assaults on Primary Health Care: Selective PHC, Structural Adjustment, and the World Bank's takeover of health care policy making. As we have seen, all of these assaults are part of a socially regressive trend which favours powerful economic interests at enormous human and environmental costs. Fuelling this trend is the globalised free market system which pushes for cutbacks and privatisation of public services, a roll-back of progressive taxation, deregulation of giant corporations, and overall, a reduction of collective responsibility in meeting the basic needs of society's less fortunate members.

As we know, health is determined more by social and political factors, by relative equity in distribution of resources–in short, by who has power over whom–than it is by health services per se. For this reason, Primary Health Care was conceived as a comprehensive strategy which called for greater social equity and strong popular participation. In essence, it was a call for a fairer, more just social order.

One would suppose that the World Social Summit held in Copenhagen in March, 1995, would reinforce this call for a fairer, healthier social order, and open the path for a comprehensive, equity-oriented approach to Primary Health Care as envisioned at Alma Ata. Indeed, on the surface, much of the rhetoric of the Summit's "Declaration and Call for Action" appears to support this thesis.

But alas, on close examination, we discover that the official Declaration, while it calls loudly for alleviation of poverty, ends up recommending what are basically the same inequitable macro-economic development policies that have deepened poverty. Indeed, the Declaration has much of the same double-speak as does Investing In Health and other public documents of the World Bank.

The disillusionment felt by many participants in the Non-Government Forum of the Social Summit was expressed by Peggy Antrobus of Development Alternatives with Women for a New Era, as follows:

The social summit in Copenhagen has served mainly to expose the unwillingness of our governments and international institutions to confront ... current socioeconomic and political structures that are perpetuating poverty, injustice, and environmental degradation everywhere on the world. Some of us dared to dream that this summit might open the door to a recognition that strategies adopted to deal

with such problems over the last 30 to 40 years have not worked, and that it is time for a new approach. However ... we are left with a declaration that despite progressive rhetoric promises only a continuation of the neo-liberal policies that many of us have come to see as the core of the problem.

A Call for Organised Protest Against Unhealthy Socio-Economic Policies

The future of Primary Health Care–as a comprehensive approach to the "physical, mental, and social well-being" of all people–is not something that will be mainly determined by health workers or even the medical establishment. Currently, health policy is largely dictated by the World Bank and the economic power structure it represents. If an equitable approach to health care is ever be realised, it will be contingent upon what amounts to a global revolution: a coalition of concerned and disadvantaged persons working at local, national, and international levels for a socially healthier and more progressive world order.

Although the obstacles are colossal, there are encouraging steps in this direction. In various parts of the world, concerned groups are attempting to engender a broad-based protest against the pernicious policies of the World Bank and IMF. Covering a broad critical analysis, "50 Years Is Enough" is an international coalition organised around the 50th anniversary of the World Bank and IMF. Including scores of environment, development, religious, labour, student, and health groups, it represents an unprecedented worldwide movement to reform these international financial institutions. At the same time, many groups and networks around the globe are working on health and development issues from a grassroots perspective, trying to listen and respond to what people need and want. They are attempting to create broad public awareness of our current global crises, and to organise a groundswell of activists to exert pressure from below on the world's policy making bodies. Two such grassroots coalitions based in the South are the Third World Network centred in Malaysia, and the International People's Health Council, based in Nicaragua.

Also, at the recent Social Summit in Copenhagen, over 800 non-government organisations and people's movements from both North and South joined in protest of the official Declaration. They drafted and signed The Copenhagen Alternative Declaration which calls for fairer distribution of resources and a restructuring of the socio-economic world order in such a way that permits poor and disadvantaged people to have a stronger say in the decisions that determine their well-being. While this alternative declaration was hurriedly written and is flawed, it is a step toward a united stand to put the well-being of all before the selfish enrichment of a few.

In conclusion, the future of Primary Health Care at the national and international levels remains precarious. However, today's "global regression" is stimulating the rebirth of primary health care in its unofficial, pre-Alma Ata form. In a growing number of countries there is a re-emergence of community-based initiatives that are truly run and controlled by disadvantaged groups, who assert that "the struggle for health is a struggle for liberation from unjust social structures." In past decades these grassroots primary health care movements were often part of national liberation struggles, as seen with the barefoot doctors in revolutionary China, the Community-Based Health Network in the Philippines under Marcos, and the Brigadistas de Salud under the Somoza dictatorship in Nicaragua. In organising and unifying people around their urgent health problems, and in raising awareness about their social causes, these popular health initiatives have helped to mobilise a groundswell of resistance to structural violence and a demand for "health in the hands of the people." Such health movements on occasion have helped to spearhead the overthrow of unjust regimes, and to sow the seeds for healthier, more equitable, more genuinely democratic national governments.

Today there is a gradual resurgence of this sort of revolutionary primary health care movement. However, new strategies are needed to confront new, more ubiquitous obstacles. Rather than being part of national liberation struggles, today such movements must join in a global liberation struggle.

It is urgent that all of us concerned with the health and rights of disadvantaged people become familiar with the human and environmental costs of a development paradigm that puts economic growth for a few before the well-being of all. Never has the need been greater for a coordinated global effort demanding that world leaders and policy-makers be accountable to the whole of humanity. The future of Primary Health Care, if there is one, is inextricably tied to the future of humanity.

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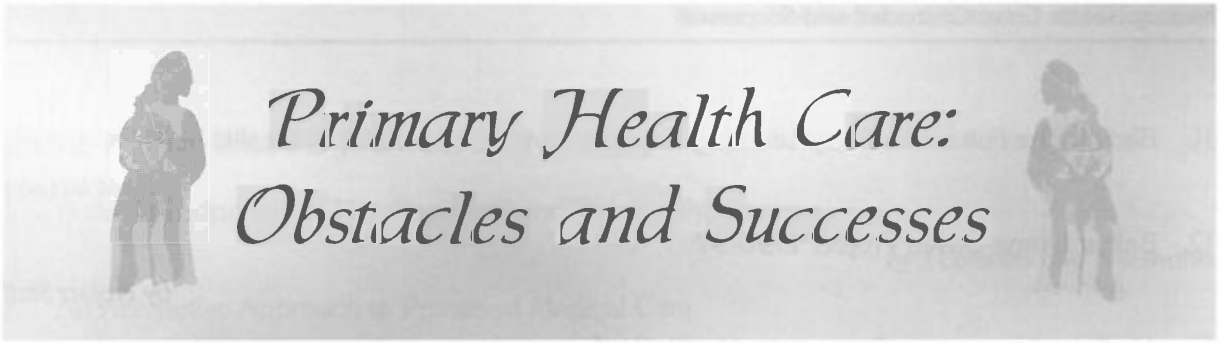

STORIES FOR CHANGE : SUMMARY OF POSTER , ORAL, DRAMA AND AUDIO-VISUAL PRESENTATIONS HELD IN PARALLEL SESSIONS

List of Stories

THEME 1: HEALTH SERVICE DELIVERY

1. Trained TBAs as Front Line Decision Makers in Primary Health Care Implementation Through Women's Empowerment and Democratisation Process: An Experience in Arua District, Uganda

   by Bakoko-Bakoru Zoe

2. Mozambique: An NGO's Experience on Health

   by Tierenzinha Da Silva

3. Histories of Change: Primary Health Care That Makes a Difference

   by Clinica Popular Tlapahtialcalli

4. I Survivedthe Battering and Women

   by Mary Sandasi

5. Empowering young people with essential health information in the case of rural based projects in Kenya and teacher training in Tanzania.

   by John Birchall

6. Developing a District-based Health Care System in the Free State Province

   by C Househam

7. Planning for Empowerment: Peoples' Campaign for Decentralised Planning in Kerala

   by T M Thomas Isaac and K N Harilal

8. A Project to Assess the Comprehensive Health Needs of Children in Unregistered Crèches of Deprived Communities on the Cape Flats, Western Cape, South Africa

   by S Yasin-Harnekar, M Mankazana and M Fred

9. The Workers' Clinic of the Industrial Health Research Group

   by M Jeebhay, D Edwards, S Kisting and H Mtwebana

10. Training Community Health Workers for Community Mental Health Care

    by Z Memela, N Ngwenya, I Peterson, H Subedar and A Parekh

11. Back to the Future: Two-way Learning Experience within the Territory Health Services

by MMcLean

12. Belhar Home-Based Project 1996-97

by Project Staff

13. My Experiences as a Community-Health Worker

by E Matrose

14. Kerala Model of Health- From Success to Crisis

by B Ekbal

15. Transition to Primary Care

by K Keil

16. Transformation Project in Three Provinces Strengthening Reproductive Health Services

by K S Tint

17. Health Workers for Change: A Joint Initiative to Improve the Quality of Care with Health Workers from the Departments of Health and Welfare in the North West, Northern Cape, and Northern Provinces of South Africa and the Women's Health Project

by S Varkay

18. Story of the Student Health Centre at the University of Venda

by B K Davahana

19. Home Visits by the SACLA Rehabilitation Project

by T Lorenzo and N Lawana

Poster presenters discuss their experiences with primary health care projects

THEME 2 : COMMUNITY PARTICIPATION

1. Building Partnerships: The Masiphatisane Training Programme

   by T Lorenzo and N Lawana

2. An Alternative Approach to Privatised Medical Care

   by D Naidoo and P Pather

3. The Development of a Community Health Workers Programme at Mfuleni

   by Western Cape Community Partnership Project

4. New Hopes for Health in the Lingelethu Township

   by B Lostile and Z Ntwana

5. Where are Women in Community-based Health Care?

   by J A Adonga

6. Healing Business

   by C Giles and D Bub

7. Hundreds of Women Write a Book: The History of the South African Women's Health Book

   by K Xaba

8. The Story of The Valley Trust

   by L Pitt

9. The History of Midwifery in Canada

   by F Shroff

10. An Innovative Training Programme for Primary Health Care Nurses in South Africa

    by C van Deventer

11. An Community-Academic Partnership Around Environmental Health Issues

    by H Viergotine

12. The Malindi Crèche Story

    by R Booi

THEME 3: HEALTH PROMOTION/POLICY/ADVOCACY

1. A Day Care Centre for Disabled Children Operated by the SACLA Rehabilitation Project

   by T Lorenzo and N Lawana

2. The Role of Black Culture and Religion in HIV Prevention

   by P Molefe

3. The Radio Experience: Radio Zibonele in Khayelitsha

   by B Meyer

4. The Story of the NPPHCN Media and Training Centre

   by G Urgioti

5. The Frankdale Environmental Health Project

by N Mohamed

6. Health Cities: The Glasgow Experience - Danny Morrison Health Project

by Martin Coyle

7. The Story of Philani Nutrition Centres

by Staff of Philani Nutrition Centres

8. A Report on Community-Based Health Programme in Mosvold Health Ward

by D Mbali

9. Community-based Woman to Woman Peer Education

by T Molefe

10. Approach to the Control of an Epidemic of Dysentery with Limited Resources in Mukono District, Uganda

by Z Karyabakabo, N Nyakaana, D Ndungutse, E Tumushabe and M White

11. The Optimal Management of Asthma

by Primary Health Care Education Unit

12. The Story of the Women's Health Conference

by M Stevens

13. The Abortion Policy Process: A Reflection

by The Women's Health Project

14. The Youth Development Programme as a Primary Health Care Site

by C Nomba

15. Using an Afterschool Programme as a Vehicle for Social Change in the Community

by L Christians

Abstracts of Stories

THEME 1: HEALTH SERVICE DELIVERY

1. *Trained TBAs as Front Line Decision Makers in Primary Health Care Implementation Through Women's Empowerment and Democrasation Process: An Experience in Arua District, Uganda*

by Bakoko-Bakoru Zoe
Uganda

The election of trained traditional birth attendants (TBAs) in women's councils has resulted in them taking up greater responsibilities within their communities to improve social services like health care, education, social welfare, poverty reduction, as well as empowering their communities to take responsibility to solve problems within their capacity. Their primary functions are information networking, advocacy and mobilisation.

The active participation of TBAs in women's councils is vital because these structures identify needs, share ideas and form linkages between communities and the national level policy decisions. District records highlight the positive impacts of this dual functionality for TBAs. Antenatal attendance increased from 78 percent to 90 percent over a two year period. Pit latrine coverage increased from 20 percent to 45 percent during six years. In summary, by widening the responsibilities of TBAs, they are playing a greater role in the implementation of PHC at the village level and strengthening the women's movement in Uganda.

2. *Mozambique: An NGO's Experience on Health*

by Terenzinha Da Silva
Mozambique

At the conclusion of the civil war in Mozambique, many crises that had been latent in society emerged. The most important of these crises were: the socioeconomic crisis marked by rapid urbanisation and inequitable distribution of resources, the cultural crisis, and an institutional crisis, which meant that new reform proposals and laws were never implemented. Although the state health sector is responsible for delivering health services to 99 percent of the population, it is not able to fulfill its mandate due to a lack of funding. As a result, only about 40 percent of the population have access to public health services.

National NGOs are relatively young in Mozambique, but they have improved the delivery of health and other social services. PROGRESSO operates in 16 localities in the Northern Provinces. They focus on health, education, agriculture and credit. The project assists the local health sector by supporting the training of health workers and traditional midwives, helping to rehabilitate health infrastructures, providing basic equipment and transport, and supporting local cultural groups. In conclusion, there is optimism within the NGO community that civil society will fulfill its role as the defender of basic human rights.

3. *Histories of Change: Primary Health Care That Makes a Difference*

by Clinica Popular Tlapahtialcalli
Mexico

In 1987, six public health workers established a popular clinic in the village of Tepoztlan in collaboration with local community members. The project was intended to demonstrate that people can administer an integrated PHC service and that they have a right to receive high quality service. At the outset, the clinic removed certain charges for its services, gave the community an opportunity to run the clinic, and mobilised the community to demand better service from the public sector. During its history, the clinic has widened its activities into the political sphere.

The experiences of this project have shown that people have the capacity to manage their own affairs. It is also difficult but important to link macroscopic policy changes to microscopic actions. In addition, people have learned that health issues must be linked to a broader struggle. Health promotion does not have to fit into the medical hierarchy below other health professionals. These people can be health activists who are more senior to health professionals. People-driven initiative can and must compete with the public and private medical establishments. Donor funding can hijack the agenda of a project and mould it to meet their own. NGOs need to search for alternative sources of funding to alleviate the dependence on foreign funding.

4. *"I Survived the Battering" and "Women"*

by Mary Sandasi
Zimbabwe

The authors relates her personal experiences as the victim of prolonged spousal abuse. She documents the trauma and confusion that accompany this painful experience. Finally, she shares how she dealt with the situation and tells of her ultimate victory. Her second paper examines the challenges facing women in developing countries. Literacy is a major challenge to women, which prevents their employment and inhibits their independence. Within the workplace and at home, women are exposed to sexual harassment and abuse. Beyond these issues, women are subjected to violence and are economically disadvantaged. She concludes by encouraging women in the developing countries to take up the struggle seriously regardless of their race, colour or class.

5. *Empowering young people with essential health information in the case of rural based projects in Kenya and teacher training in Tanzania.*

by John Birchall
England

The South Gem Health Programme involves 12 out of 15 schools within its locality in Kenya. The programme involves more than 7,400 pupils between age 6 and 14 and 150 teachers. Participants were taken through the entire strategic planning cycle. The programme began with awareness sessions and workshops for all participants, continued through problem identification and development of interventions. The activities included the production of teaching materials on communicable diseases and pit latrines. Finally the project was monitored and evaluated by all participants. Tree nurseries were established, gardening projects were initiated, 15 pit latrines were constructed and the programme has become largely self-sustaining. Unfortunately, the turnover of both teachers and students was quite high mandating the repetition of many activities.

The Vikindu Project in Tanzania will concentrate on providing trainee teachers with a basic health care manual. It is hoped that they will take this material back to their schools and share it with their fellow teachers and pupils. The material will address the prevention and treatment of health issues faced by children and adolescents. This project is still in the earliest phase and results are not available.

6. *Developing a District-based Health Care System in the Free State Province*

by C Household
Department of Health, Free State Province
South Africa

The Free State Province in South Africa shared its experience in the implementation of the national policies concerning the district health system. The province has been divided into six regions and fourteen health districts. Within the province there are 80 local authorities and 4 district councils. The province is still grappling with the process of decentralising authority to the district level. Provincial management were deciding whether to create statutory district health authorities or transfer authority to local governments. Much progress has been made in the implementation of various aspects of the district system. A draft provincial health bill has been written, concrete steps are being taken to involve communities and practical restructuring of human resources has begun. This paper documents progress made by the public sector in translating theory into practice. Their experiences hold valuable lessons for government and civil society.

7. *Planning for Empowerment: Peoples' Campaign for Decentralised Planning in Kerala*

by T M Thomas Isaac and K N Harilal
India

Despite the widely acclaimed advantages to decentralised planning and political commitment to it, the actual planning process in India has remained very centralised. Recently, block level planning has been proposed as an antidote to centralisation. Previous efforts at decentralised planning in India had failed because of the absence of popular representative administrative structures at the local levels. As a response to this lesson learned, the Kerala State Planning Board has resolved that municipal bodies draw up Ninth Plan schemes within their respective areas. They are estimating that 35 to 40 percent of the Ninth Plan would be comprised of local schemes. For this to happen, elected officials must be made aware of their responsibilities, officials must be persuaded to participate in the local planning processes, other experts must be co-opted into the process, and the masses must be mobilised to participate.

The Peoples' Campaign seeks to harness the energy of mass movements in Kerala to strengthen the economy. Thus far, the Campaign has broken some of the cynicism within the state towards the development process. It has helped to move planning beyond politics. There has been ownership of the process by local authorities. Finally, the Campaign has unlocked a tremendous amount of previously latent human resources at the local level.

8. *A Project to Assess the Comprehensive Health Needs of Children in Unregistered Crèches of Deprived Communities on the Cape Flats, Western Cape, South Africa*

by S Yasin-Harnekar, M Mankazana and M Fred
South Africa

This is a proposal for a developmental project to establish baseline data; to direct subsequent interventions; to meet the health needs of children under six in unregistered crèches. The proposed areas where the project will be conducted are Mitchell's Plain, Guguletu and Langa. Previous research has found that few children attending unregistered crèches have completed the full course of EPI coverage. This data and the lack of support for these crèches put these children in the high risk group as defined by the World Health Organisation.

The first phase of this project has three major components. A comprehensive health assessment of the children will be conducted. Knowledge and practices of teachers and principals will be assessed in terms of child development and health promotion. Finally parents knowledge and awareness of health care for their children will be tested. Based on the results of phase one of the project, appropriate interventions will be developed in partnership with the crèches and parents. It is envisaged that the interventions will include educational and health promotion workshops.

9. *The Workers' Clinic of the Industrial Health Research Group*

by M Jeebhay, D Edwards, S Kisting and H Mtwebana
Industrial Health Research Group
South Africa

The Workers' Clinic was established by the Industrial Health Research Group in 1989 to provide occupational health services in the Cape Metropolitan area. It is a multi-disciplinary clinic, staffed by occupational health doctors, industrial hygienists, sociologists and media workers. The goals of the service are to:

- promote occupational health status of workers in the Cape Town Metropolitan area
- provide a comprehensive regional occupational health service
- provide a surveillance system for monitoring sentinel events or clusters of occupational diseases or injuries.
- develop the capacity of trade union officials to effectively deal with occupational health problems.
- promote the development of a network of providers dealing with occupational health issues.

In summary, the Workers Clinic model has been one of the few successful worker-based regional efforts to provide integrated and comprehensive occupational health services.

10. *Training Community Health Workers for Community Mental Health Care*

by Z Memela, N Ngwenya, I Peterson, H Subedar and A Parekh
South Africa

The need to restructure the mental health care system in South Africa in order to integrate it into the larger health care system was identified several years ago. The Community Mental Health Project in

the KwaDedangendlale community in KwaZulu Natal is attempting to do this. KwaDedangendlale is a semi-rural community with high unemployment and poverty rates. In terms of health resources however, it is better resourced than many other areas in the province. It has a primary health care centre which provides a number of specialists services, including community psychiatry. In addition, there are many community health workers operating in the area which extends health services beyond clinic walls.

This project attempted to determine whether the role of community health workers could be expanded to make them gatekeepers for mental health services as well as physical health services. Specifically, the training programme for CHWs was evaluated to determine whether it successfully prepared them for this role. The evaluation found that CHWs perceived that the training was very successful and realised changes in their attitudes and practices.

11. Back to the Future: Two-way Learning Experience within the Territory Health Services

by M McLean
Australia

This paper presents an example of a working Primary Health Care model where Aboriginal and Western cultures are exchanged. As an example of this exchange, staff at the health centre provide traditional bush medicines to both Aboriginal and non-Aboriginal patients. This spirit of cooperation results in a holistic and multidisciplinary approach to health and health care. In order to assess the effectiveness of this model, a research project was conducted at the health centre measuring the efficacy and use of traditional bush medicines for common skins conditions. Although the results of this research are not yet available, there are some preliminary findings on the benefits of this two-way process. It has increased interaction and understanding between the two cultures and broadened the communities and the health workers' perspectives on health care.

12. Belhar Home-Based Project 1996-97

by Project Staff
South Africa

The Home-based Educare Project is a non-profit organisation providing home care to 60 children under six who are not able to attend centre-based programmes because of their low socio-economic status. The programme has one Coordinator and 6 Home visitors who are involved in child development, preparation of children for school, and social development for the families. The programme accomplishes these objectives by forming a trusting relationship with the family, helping to reduce family stress levels, providing one-on-one modelling of parent-child interactions and training on parenting skills, connecting families to external resources and supports, and monitoring families over time. A Home visitor visits each family each week for 90 minutes to address the child's developmental needs and to develop the family's support network. The project has successfully improved the relationship between educational institutions, health providers and families.

13. *My Experiences as a Community-Health Worker*

by E Matrose
South Africa

This woman was working as a nursing assistant before she was retrained as a community health worker. In her daily experiences she comes across many children who are begging for money on the streets of the township where she lives outside Port Elizabeth. Instead of ignoring these children she visits their families to understand their situation. Often she finds single parents who are unemployed. She refers them to the Department of Welfare to receive social assistance. In addition, she has visited the RDP forum in the community to raise the issue of street children with them. While they were sympathetic they did not have sufficient resources to take care of all these children. She is working with street committees and other CHWs and Operation Hunger to ensure that the children's basic health and nutritional needs are met while the community develops a longer term solution to the problem.

14. *Kerala Model of Health - From Success to Crisis*

by B Ekbal
India

Kerala is the southernmost state in India with a population of 30 million people. For many years, Kerala has been internationally recognised for its high standards of health and educational development. More than 90 percent of the population is literate. The infant mortality rate is 11 and the life expectancy for women is 72 years and men 70 years. These statistics are equivalent to developed countries even though per capita health expenditure is only $25 per year. The primary reasons for the success of the Kerala model for health care are the high literacy rates especially among women, progressive land legislation, organised movements among vulnerable groups, public distribution of food, and an easily accessible health system.

Recently, the Kerala model has come under threat due to rapid increases in the private health sector, causing a dramatic increase in health spending. In spite of these spending increases, a growing percentage of the population does not have access to health care. The author suggests that a potential solution to this crisis is greater public participation in the planning process at the local level. He argues that this will give the community more power over how its health system is structured. This proposal is described in detail in another story.

15. *Transition to Primary Care*

by K Keil, Medicins du Monde
South Africa

This story describes the transition of a health project from an emergency health project offering curative services to a community-driven primary health care project. These changes reflect larger changes taking place in South Africa and present a model for other community initiatives. The project was founded in 1984 when Medicins du Monde, a French NGO, was asked to provide emergency medical treatment for people living in Botshabelo, who were protesting incorporation into Qwa Qwa Homeland. After the community successfully won its battle to remain within South Africa, MdM continued to operate its clinic to treat anti-apartheid activists.

In 1992, the Mass Democratic Movement decided to shift the focus of its efforts from curative services available at the "protest" clinic to primary health care. Staff were reoriented to the PHC approach. A community diagnosis was completed and a community health worker programme was established. Structures were also created to promote intersectoral collaboration and participatory management. According to the author, the community health diagnosis was essential to the success of this transition. With the move to the district health system in South Africa, this programme is in the process of being integrated with the public sector. Another Community health diagnosis is underway to inform this process.

16. Transformation Project in Three Provinces Strengthening Reproductive Health Services

by K S Tint
Women's Health Project
South Africa

This eighteen month project focuses on developing the public sector reproductive health services in the North West, Northern Province and Northern Cape. The primary aims of the project are to develop systems for comprehensive quality reproductive health services and to enhance the capacity of health workers to operationalise these systems. The project is being implemented through an incremental approach building on the systems and staff currently in place. Thus, the first step for each province was to conduct a situational analysis of their reproductive health services.

Based on the results of these analyses, three interventions were planned: workers for change workshops, Women to Women peer education workshops, and in-service education, gender and health workshops. Although this project has faced some obstacles, the first phases have seen positive impacts on managerial staff and health workers in the three provinces. It is envisaged that through the improved capacity and morale, the project will be able to develop reproductive health systems for each province by mid 1997.

17. Health Workers for Change: A Joint Initiative to Improve the Quality of Care with Health Workers from the Departments of Health and Welfare in the North West, Northern Cape, and Northern Provinces of South Africa and the Women's Health Project

by S Varkay
South Africa

Health workers for change is a strategy that aims to improve client-provider relationships and relationships between service providers and management by involving health workers in the processes of transformation. This story describes one aspect of a larger project to develop comprehensive reproductive health services in the North West, Northern Cape, and Northern Province. The strategies of the workshops were to provide a series of diverse activities to stimulate group discussion among health workers and to use qualitative research to document health workers opinions on various aspects of quality of care. A total of 820 workers were exposed to the workshops, using a training of trainers technique.

An evaluation of the project found that health workers accept the need for changes in the health system. Problems in the health system become magnified as one moves lower in the health system, thereby impacting the quality of care provided to communities. Health workers admitted that their behaviour deterred some people from using the system. Managers and health workers need to participate in the changes that are taking place if the quality of care is going to be improved. Finally, more democratic management principles need to be adopted to ensure that health workers take ownership of the health system. The preliminary results of this project demonstrate the need for effectively involving people for changes to take effect. It also presents a potential training model to help health workers participate in change to improve the quality of care.

18. Story of the Student Health Centre at the University of Venda

by B K Davahana
South Africa

The University of the Venda is a historically black university situated in the Northern Province. The university's student health centre began operating in 1981. Initially, the clinic was established without clear aims or objectives. The university simply provided some funding and an unused facility that had to be converted into a clinic. The first step was to conduct a survey of the health needs of the university and students. It became clear from this research that students needed education on the importance of health and its relationship to their life objectives.

In looking back over the past 15 years, the clinic is now well established at the university. It has widespread recognition among students. They now value the clinic and actively participate in its work. Now that the clinic is secure, the next challenge is to develop supportive relationships with other departments on campus to address health in a holistic manner. This story of the student clinic holds lessons for other universities and other communities as they attempt to develop a comprehensive health service from scratch.

19. Home Visits by the SACLA Rehabilitation Project

by T Lorenzo and N Lawana
SACLA Rehabilitation Project
Philippi, South Africa

As part of its comprehensive programme to meet the needs of children with disabilities, the SACLA Rehabilitation provides regular home visits to disabled children living in Khayelitsha.

The primary objectives of these visits are to:

- develop home programmes related to the prevention of secondary problems caused by the impairment or disability.
- provide emotional support to mothers in accepting the disability of their child
- provide assistive appliances where possible or refer cases to the proper authority.

THEME 2 : COMMUNITY PARTICIPATION

1. Building Partnerships: The Masiphatisane Training Programme

by T Lorenzo and N Lawana
SACLA Rehabilitation Project
Philippi, South Africa

The SACLA Rehabilitation Programme has been exploring ways to integrate persons with disabilities into the district health system development process in South Africa. Their aims was to build a stronger partnership between health provider and person with disabilities to develop a disability support system within the district health system. They identified two primary objectives for this effort to integrate the work of various NGOs and the public sector in this area and to develop the capacity of person with disabilities. Initially, they held a four day introductory workshop to begin this process. At this workshop a disability forum was establish to take the process forward. The broad functions of the forum are to:

- develop network and referral systems
- raise disability awareness
- access resources for community-based disability projects
- advocate and lobby government on disability issues

The major lessons learnt during this process are that change is a very slow process when it is trying to shift power relationship between patients and providers. This process evokes fear in people. This project has only started to develop the capacity of disabled persons. There is still considerable need in this area. Finally, politicians, health providers, and many community members have not been sensitised to the issues facing the disabled. More education work is needed to see that the issues of the disabled are on the public agenda.

2. An Alternative Approach to Privatised Medical Care

by D Naidoo and P Pather
Sikhaya PHC Project
South Africa

The authors propose an alternative health system to the one proposed by the Department of Health in South Africa. Their primary objection to the proposed system is that it envisages significant roles for the private sector and health professionals. The authors view these ideas as antithetical to the Primary Health Care (PHC) approach. They argue that health should be viewed as an indication of the general well-being of the community rather than the absence of disease within individuals. The test of the new system is whether it addresses the physical and social development and empowerment of communities.

They propose an alternative health system based on the PHC approach that address the socio-economic causes of ill health. This system focuses on the process of development as well as its outcomes. They place great emphasis on health education for empowerment of the community to ensure that it is fully able to participate. All of the resources in the community would be used, in

particular the human resources. The ultimate aims of the alternative system is to move away from task orientation towards qualitative evaluation and personal effectiveness in bringing about changes. The system would not be judged on how many visits were made, but on how many mothers were able to read and whether the children's nutritional status had improved.

3. *The Development of a Community Health Workers Programme at Mfuleni*

by Western Cape Community Partnership Project
Bellville, South Africa

This story shares the experiences of one Community Health Worker (CHW) working in an urban township outside of Cape Town. Her first task was to conduct a needs assessment of the community in partnership with health workers at the local clinic. This proved to be very difficult because the community was not aware of the role and function of CHWs. They could not understand a health worker that did not have medicines. In order to develop a better relationship with the community, she shifted her focus to identify their basic developmental needs.

She has been conducting health education workshops on clean water and sanitation and health promotion, including food preparation and proper nutrition. These activities are in addition to her role in supporting the health system in its immunisation campaigns and the control of endemic diseases. From her experiences, she has learned that communities must be actively involved in any process if it is to be successful. Through the efforts of CHWs, an increasing number of community members are using the health services.

4. *New Hopes for Health in the Lingelethu Township*

by B Lostile and Z Ntwana
National Progressive Primary Health Care Network Training Centre
Athlone, South Africa

In 1996, the National Progressive Primary Health Care Network Training Centre in the Western Cape was approached by the Surplus Partnership Project to provide training for a community health committee in the Lingelethu township outside Malmesbury. The committee received their initial training during November 1996. One of their first activities was to ask the local authority for funding for CHWs to work in the community. The committee asked the Training Centre to help them prepare their motivation to the local council. As a result of the negotiations around CHWs, there is a strong working relationship between the community and the local authority.

5. *Where are Women in Community-based Health Care?*

by J A Adonga
Action Afrika Hilfe
Uganda

Within the African context, the traditional gender perspectives have historically limited the participation of women in public activities. This story describes the efforts of an NGO working with the Sudanese refugee population in Northern Uganda to increase women's participation in community-based health

care. The Action Afrika Hilfe (AAH) has been working with Sudanese refugees since 1993. The health programme is supported by the UNHCR, the Ugandan government and AAH.

Although African women traditionally carry the burden for overseeing the health needs of their families and their communities, they are very rarely chosen to serve on committees and other community structures. In Sudan, women are allocated one seat on the committee. This NGO used the structure of refugee camps in Uganda to significantly increase the number of women on each health committee and their responsibility for health issues. In order to reduce conflict with men on the committee, AAH sensitised them to women's roles in terms of maternal and children's health. The principle achievements of this experience are increased participation by women, improved acceptance of MCH services, better record keeping, improved attendance at antenatal clinics, and improved nutritional status within the refugee camps. Finally, this experience has helped to reduce men's resistance to women's involvement in health issues.

The role of women in community-based health care is highlighted by Ms J Adonga from Uganda

6. *Healing Business*

by C Giles and D Bub
Community Counselling and Training Centre
Manenberg, South Africa

This story relates the experience of how an NGO providing mental health services in a township outside of Cape Town has become financially self sufficient through its involvement in economic development projects with the community. The Community Counselling and Training Centre was established in the 1980s as a community centre for the residents of Manenberg who had been forcibly removed from their homes. The community requested a programme to address mental health issues. In response to this need, an individual counselling programme was established. In addition, the centre held a group meeting each month for community residents to discuss the broader needs of the community.

At these meetings, three basic needs were identified: child development, women abuse and poverty. Programmes were established in each of these areas in partnership with the community. It soon became clear that these activities could not be sustained only through foreign grant funding. CCATC decided to establish business making products from recycled materials. They worked in collaboration with businesses and government to get the materials and more than 1,000 members of the community have contributed their time.

CCATC has learned that social and economic development in a community are slow processes. Time must be allowed for the community to develop its capacity. In addition, if an NGO wants to serve a community, it must be financially healthy and not dependent on foreign donors. Finally, they have learned that health issues cannot be separate from political and economic issues within a community. Thus, a healing business needs to be blended with traditional mental health services to fully meet the needs of the community.

7. *Hundreds of Women Write a Book: The History of the South African Women's Health Book*

by KXaba
Women's Health Project
South Africa

From its establishment in 1991, the Women's Health Project (WHP) wanted to produce a book on women's health that was written by women for women. WHP began a wide consultation process in 1992 asking women what issues they would want such a book to cover and what it should look like physically. The first two chapters of the book, on violence against women and STDs, were drafted and piloted widely. The final book was 516 pages with 471 contributors and was completed over four years. It is now widely available in bookshops throughout South Africa.

The Women's Health Project has learnt through this experience that even women who are described as ignorant can contribute to writing a book. Too often others present the views of these women. The process of writing this book demonstrates that these women are articulate and quite capable of speaking for themselves. The entire process unlocked lots of untapped energy. It was not always possible to translate this energy into performance of the desired tasks, but this enthusiasm did allow many women to share their intimate stories with the authors.

8. *The Story of The Valley Trust*

by L Pitt, The Valley Trust
South Africa

With its roots in KwaZulu-Natal's Valley of a Thousand Hills, the work of the Valley Trust is one of South Africa's finest examples of rural development with particular emphasis on primary health care. The imaginative solutions and principle developed by this project during more than 40 years of experience are being shared with underserved communities throughout South Africa through an extensive training and support programme. The Valley Trust was started in 1953 as an attempt to bring health care services to this rural area. During its tenure, the project has always approached the needs of the community in a holistic manner.

With its integrated approach to nurturing a healthy quality of life among underserved and developing communities, the Valley Trust was able to anticipate the issues highlighted in the Reconstruction and Development Programme. Its training and production methods in sustainable food production and plant use are widely recognised. In addition, the practical training, the Valley Trust offers research opportunities and conference facilities. In many ways, the Valley Trust represents the successful implementation and growth of a community-based development programme.

The Valley Trust is currently embarking on a programme to model some critical aspects of the district health system. In order to achieve this goal, it is developing a reorientation programme for health workers toward the PHC approach. It is also establishing new posts in the community to foster the development of community health committees. Finally, it is facilitating the creation of a district management team. Through these changes, the Valley Trust hopes to present a successful model of a health district with an emphasis on community participation and health promotion.

9. *The History of Midwifery in Canada*

by F Shroff
Ontario Midwifery Education Programme
Canada

Despite recent encroachments by allopathic physicians into child birth, Canada has a long and rich history of midwifery. This story brief outlines the important role that midwives played within the health systems of the aboriginal peoples of Canada. These traditions were overwhelmed by the introduction of European medical practices. Currently, however, Canada is experiencing a growth in the number and an increase in the acceptance of midwives by women and by the government. Midwifery has recently been included in the state-regulated and financed health system in the province of Ontario. The addition of this service is quite remarkable given the current budgetary constraints on the Canadian health system.

This recognition by the state has caused division among proponents of midwifery. Some are excited that they have been recognised, seeing it as the culmination of many years of advocacy and lobbying. Others view it more cynically, suggesting that midwifery is merely being co-opted by the system. This will destroy the very elements that separate it from allopathic, western medicine. In summary, this story highlights the inherent tensions that occur within a profession that has been outside the system is invited to join it.

10. *An Innovative Training Programme for Primary Health Care Nurses in South Africa*

by C van Deventer
Primary Health Care Education Unit, Tshilidzini Hospital
Northern Province South Africa

Traditionally primary health care nurses in South Africa view themselves as clinic-based practitioners, primarily responsible for providing curative services to the community. As a result, prevention, health promotion, and community development are often overlooked. This story relates an innovative training programme developed at one hospital in the rural Northern Province of South Africa that matches PHC nurses with local villages for a one year period. The objective of this training was to help the student nurses to gain experiential knowledge of community development and health promotion.

Through its experiences during the past five years, the PHC Education Unit and the student nurses have learnt that the needs of every community are different. In one community, it may be a new crèche while in another village a football field or pit latrines are needed. The project has unlocked the potential of these communities to begin to meet their own needs. The process of change, however, is very slow. It has improved the relationship between communities and health workers by reminding health workers that they do not have all of the answers. Finally, the experience has broaden the perspective of health workers that health is more than medicines and clinics it is about addressing the socio-economic causes of ill health.

11. A Community-Academic Partnership Around Environmental Health Issues

By H Vergotine
Western Cape Community Partnership Project
Bellville, South Africa

As part of a community upliftment and empowerment programme, the Peninsula Technikon has embarked on a project to educate residents in an urban township about the proper utilisation of water and sanitation. This project represents a partnership between the academic institution and the community through the Nceduluntu Environmental Development Project (NEDEP). Within the Mfuleni community, there is a very high incidence of diarrhoeal disease. Four out of every ten people attending the Mfuleni clinic suffer from diarrhoea. NEDEP believes that the majority of these cases are caused by the poor quality of water and sanitation in the area. An executive committee has been established to develop interventions to address these environmental issues. NEDEP is currently planning activities to raise awareness in the community.

Although there has been widespread enthusiasm for this project within the community, it has faced many problems. Service providers have not shown enough interest in it. There are insufficient funds to address the underlying causes of these environmental problems. Despite these obstacles, the project has learnt many lessons about community involvement. They fully recognise the importance of actively involving the community from the outset on their own terms. These lessons will help them to overcome the obstacles that they face.

12. The Malindi Crèche Story

by R Booi
Western Cape Community Partnership Project
Bellville, South Africa

The author recounts the story of how her community built a crèche for its children. She lived in the Mfuleni township, located outside of Cape Town. She had always been active within the community, serving on street committees.

During one of these meetings in 1992, someone raised the issue of the number of young children wandering the streets during the day. One of the committee members offered her shack as place to start the crèche. Then they recruited volunteers from the community to work at the crèche. The community then approached the Child Welfare Society who agreed to provide pans, dishes, cutlery, and food. Seventy children attended the crèche regularly. She soon realised that it was not healthy for all of these children to stay in a shack with toilets or water so they moved to the job creation centre. This building was very cold, causing illnesses in the children and the volunteers. At that time, the Western Cape Community Partnership Programme did a needs assessment of the community and recommended the creation of a new building. They helped raise money to build the wooden structure and provided some equipment. The crèche is functioning well, but the number of children attending has grown to 110.

Through these experiences the author has learned that one needs patience and endurance to work with communities. It is not an easy path to follow. She also learnt that one must work with available resources to change things.

THEME 3: HEALTH PROMOTION / POLICY / ADVOCACY

1. A Day Care Centre for Disabled Children Operated by the SACLA Rehabilitation Project

by T Lorenzo and N Lawana
South Africa

In 1992, the South African Christian Leadership Association (SACLA) began a community-based project to provide day care services for disabled children to allow their mothers the opportunity to seek for employment to support their families. The project began informally with women in the community volunteering to look after these children. SACLA has worked in partnership with the government and other NGOs to establish day care centres in the community.

The major success of this programme thus far is the mother's ability to organise themselves in order to access resources for this project. In addition, parents have developed management skills through serving on the management committee of the centre. The children also receive greater stimulation through play and interaction with other children and their nutritional status has improved. The project has not been without its problems, which include power struggles between parents. The lack of transport and resources in the area has made it difficult to provide the maximal service to the children. The primary goal for the future is to improve communication between parents, convenors and committee meetings so that they can address the problems in partnership.

2. The Role of Black Culture and Religion in HIV Prevention

by P Molefe
Thuthuka Community Engineering and Development
Port Shepstone, South Africa

This story attempts to examine the role of black culture and religion in the lies of young people and its implications for HIV prevention. Within traditional black culture, premarital sex was discouraged for both women and men. Women were expected to be virgins at the time of the marriage to receive the full price. Men were discouraged from touching women before marriage to maintain their good name and that of their families. Although there was no law preventing pre-marital sex, societal norms and values were clear. Young people were allowed to make their own choices, but they were aware of the consequences.

In pre-industrial black culture, there was a firm belief in a Supernatural Being who was responsible for misfortunes and illnesses to a family. With colonisation, this traditional views was replaced by Christianity, which was quite different to traditional African beliefs. This dualism has created confusion for young people. As a result, they have abandoned religion altogether and begun to imitate sophisticated foreign cultures in their sexual experimentation. Thus, there is a need for sexuality education in schools, churches, and other youth organisations with an emphasis on ubuntu. Within this education, facts about sexuality need to be communicated as directly and truthfully as possible.

3. *The Radio Experience: Radio Zibonele in Khayelitsha*

by B Meyer
NPPHCN Media and Training Centre
Observatory, South Africa

This story describes the establishment of a community radio station in Khayelitsha, a peri-urban community 26 km outside Cape Town in South Africa. In 1992, a day clinic was built in the community to meet their health needs. In addition, the community elected 18 community health workers to meet its health needs. It soon became clear that even with the facility and the CHWs, it was not possible to reach all of the people living in the area. Thus, the community decided to use radio as a means to communicate PHC messages to the people. Radio represented a less expensive and more accessible to communicate with a large population with low literacy rates.

A basic broadcasting studio and transformer were assembled in a cupboard in the clinic and the CHWs were trained to produce PHC programmes. In March 1993, broadcasts started. The station presented PHC programmes every Tuesday to approximately 20,000 people. The station operated illegally because community radio stations were not authorised in South Africa at the time. After the 1994 elections, an Independent Broadcast Authority was created to give licenses to community radio stations. Zibonele received its official license in 1995 and now broadcasts 19 hours per day five days a week to 1 million people.

The mission statement of Radio Zibonele best captures the spirit of this project.

"We are a group of volunteers with diverse skills, who have formed a Community Radio Station owned, managed, and programmed by the community of Khayelitsha. Our concern is to enhance the quality of life through improving the health standards of our people. All those we serve are affected by poor health and poor environmental conditions. Radio Zibonele is committed to sharing skills and information through honest processes, hereby empowering the community of Khayelitsha for better life."

Conference delegates visit Radio Zibonele - a radio station broadcasting primary health care messages to over a million residents of Khayelitsha in Cape Town

4. *The Story of the NPPHCN Media and Training Centre*

by G Urgioti
NPPHCN Media and Training Centre
Observatory, South Africa

This story presents the experiences of the National Progressive Primary Health Care Network (NPPHCN) Media and Training Centre (MTC) over the last four in developing adequate and relevant primary health care media using participatory methods. The MTC is structured in four units: radio, print, research, and administration. Each unit works individually or together in separate geographic and operational areas. Amongst these units, there are six major projects that the MTC is currently involved with. Radio Zibonele is a community-based radio station operating in Khayelitsha, a peri-urban community about 26 miles from Cape Town. The MTC helped to establish this station and trained CHWs to work as health reporters.

In Pella, a small Moravian community 60 km outside Cape Town, the MTC conducts ongoing training for the local radio unit, enabling them to produce PHC radio programmes. The community also writes and produces its own monthly, PHC newsletter. In addition to these specific projects, the MTC provides radio training to PHC radio producers throughout the Western Cape. The print unit is responsible for publishing the Networker, the official newsletter of NPPHCN. This newsletter includes health educational information, current health issues, and experiences from community health projects. The research unit conducts research in support of the activities of the print and radio units. In summary, the MTC's experiences over the past four years have validated their original philosophy that PHC media must be a participatory process in order to be effective.

5. *The Frankdale Environmental Health Project*

byN Mohamed
Environmental Advisory Unit
Cape Town, South Africa

This story recounts the experiences of one environmental health project to improve the safety and to gain support and acceptance of formalised waste picking. In South Africa, waste picking has long been established as a survival strategy among the poor. In Frankdale, a squatter settlement of about 150 families 35 km outside Cape Town, waste picking constitutes the primary source of income as people sell and use items salvaged from the dump. There are, however, many dangers involved in waste picking such as cuts, skin rashes, and food poisoning. In 1993, a crisis developed in the Frankdale community, when throat lozenges were sold to school children, causing mass food poisoning. The Environmental Advisory Unit (EAU) of the University of Cape Town convened a workshop on safe waste picking.

As a result of this workshop, a simple pamphlet on safe waste picking techniques was developed jointly by the community and academics. In addition, the EAU began working to integrate these waste pickers into the formal waste management process. They have held discussions with the government about formalising these positions with adequate pay and safe working conditions. Through this process, the EAU hopes to change government policies toward waste picking on landfills. In a developing country such as South Africa, it is vital that subsistence waste picking is dealt with in a constructive and humane manner.

6. *Healthy Cities: The Glasgow Experience - Danny Morrison Health Project*

by Martin Coyle
Danny Morrison Health Project
Glasgow, Scotland

Drumchapel is a large sprawling housing estate on the periphery of Glasgow. Initially it was viewed as a 'chance for a fresh start', however by the mid 70's due to the decline in industry and manufacturing, there was wide scale unemployment and poverty. This had a devastating effect on the males and their environment. Statistics reflect that 54% of working age males were not in paid employment and consequently they felt marginalised and lacked a sense of worth and responsibility. Other factors such as social inequities in health, the widening schism between rich and poor, the erosion of men's social and personal identity as a result of protracted unemployment and gender inequalities, contributed to the men being marginalised. Research also indicated that men living in Drumchapel are one and a halftimes more likely to die under the age of 65 than men in the rest of Scotland. The combination of these factors led to the impetus for a movement aimed specifically at men and men's health.

The aims of the programme were: to raise awareness; influence male attitude to health; influence male lifestyle; help men to take control of their own lives and to deliver a new model of primary health care. In 1987 Glasgow became one of four U.K. cities to join the European Healthy Cities Network. By 1990 Drumchapel Community Health project became the first community pilot project in Glasgow. By August 1995 the Danny Morrison Health project (named in memory of one of the original volunteers) set out to: establish a drop-in service offering an open door to men seeking advice with all health matters; carry out health assessment needs of men in the area; develop and publish a survival pack for men covering a range of issues and to develop a new collaborative model for men's health services.

The main successes of the project has been the ability to raise awareness that men's health matters, and by extension men's health affects his family and community. The Men's Health Needs Assessment has been a great success in that it highlighted the health needs of the men and gave them a voice not normally available to them. Also, the process of empowering oneself is evident in that a group of men from a background of limited opportunity got together and established the Danny Morrison Health Project. Lastly, the project has provided access to a variety of new skills and training.

The main problems of the project were: a lack of understanding of the holistic definition of health; working in and understanding a new environment (men were previously labourers); role changes; working with short term funding; lack of trained staff; not seeing results which led to motivation crisis and finally the lack of space and materials for various activities.

The lessons that the project brings to the table are the following: the project has to have the buy-in of those who will benefit, that is they have to think that it is important; men can build positive health by taking personal responsibility for their own well being; through talking to other men they can tap new sources of emotional power that has a direct bearing on the quality of their own health; a hierarchy of involvement needs to be established for empowered participation and empowerment cannot be a pre-conceived role determined by health professionals. Other lessons include the need to overcome the 'dependency culture'; support from stakeholders needs to be more than verbal; there needs to be a movement from curative to preventative health; and short term funding is not the answer. We need to make demands on government rather than display passive acceptance since the process of change is slow and requires stamina and belief.

The solutions, though not foolproof are: to be aware of pressures on own health; to establish and work within a partnership with clients; to recognise and respect different experiences; to resist posing own perceptions of needs on clients; to view one's role as facilitator and enabler rather than expert; and to share one's knowledge and skills to empower - not to control.

7. *The Story of Philani Nutrition Centres*

by Staff of Philani Nutrition Centres
Khayelitsha, South Africa

This story presents an overview of a community-based health and nutrition programme operating in several squatter communities outside Cape Town, South Africa. The Philani Nutrition Centres were first established in 1980 on the initiative of women health workers in Crossroads. Since then, Philani has expanded to develop an educare programme and an employment project. The majority of staff members are drawn from the local communities, providing close linkages with the surrounding communities. In fact, sixty percent of the current staff began their association with Philani through participating in the nutrition or rehabilitation programmes. Philani is committed to the protection of the rights of each child to proper nutrition and health care and the right to grow and develop their full mental and physical potential.

Out of this commitment to children, the need has grown to provide employment opportunities for mothers through a weaving project. The employment project revolves around a training programme in weaving that is offered to all destitute mothers attending the centre. Weaving instruction takes place at each centre where rag mats are woven from waste fabrics and sold throughout Cape Town. In 1995, Philani opened a weaving factory to be run by women as an economically independent venture. The Educare Programme provides stimulation for children in the community to develop their intellectual capacity. It is staffed by women in the community and provides additional employment opportunities for them. These experiences reflect the successful implementation of an integrated strategy to address the health and nutritional needs of young children living in poor, urban communities.

8. *A Report on Community-Based Health Programme in Mosvold Health Ward*

by D Mbali, Amatikulu Centre
Nyoni, South Africa

This story reports on the progress of one community-based health worker programme in the KwaZulu-Natal Province of South Africa. The Mosvold Community-based health worker programme began in 1985 as a result of research results that found high levels of malnutrition and other preventable diseases. There are currently 141 CHWs, who were democratically elected by the community, working in the Mosvold health ward. Each CHW receives between 6 and 12 months training in preventive health care and community development. This training is conducted with the full support and participation of the community. Once trained, the CHW's main role is to make home visits, educating people on health matters. They also organise income-generating projects and self-help groups. Finally, they provide care and support to individuals with chronic diseases such as hypertension or TB.

During the past 12 years, the CHW programme has had a tremendous impact on the health of the community. In 1985, there were no mobile clinics for children under five, but now there are 28 clinics serving these children. The number of residential clinics has increased from four to six with three more under construction. There is greater community participation in health and development projects such as vegetable gardening, creches, and money saving clubs. Patient/provider relationships and follow-ups have improved dramatically. Most importantly, the health knowledge and health status of the community have improved. These changes reflect the positive impact of CHWs on a community.

9. *Community-based Woman to Woman Peer Education*

by T Molefe
Women's Health Project
South Africa

This story examines the potential effectiveness of peer health education as an alternative to clinic-based health education in Mpumalanga Province in South Africa. Through its consultation with women throughout the country, the Women's Health Project determined that there was a need for basic health information to be disseminated to women in communities. Traditionally, the clinic staff are too busy to provide enough health information. Thus, they attempted to train lay persons from the community to act as peer educators for other women. A group of facilitators was identified from two villages, Kildare and Newington in Mpumalanga. These 12 women attended a one-week training workshop in Johannesburg to prepare them to run workshops on women's bodies, cancer of the cervix, and AIDS.

They returned to their communities and conducted 15 workshops reaching 186 other women. The participants reported that they had gained much information and were very comfortable receiving information from their peers. This project demonstrates that it is possible to use peer facilitators as an alternative to clinic-based health education. The sustainable of such an effort is difficult as no remuneration was given to the facilitators and there was limited money to buy refreshments for the workshops.

10. *Approach to the Control of an Epidemic of Dysentery with Limited Resources in Mukono District, Uganda*

by Z Karyabakabo, N Nyakaana, D Ndungutse, E Tumushabe and M White
Uganda

This story details the importance of conducting basic epidemiological research to control an epidemic. In January 1995, a case of dysentery was reported in Naminya Village close to the source of the Nile. The initial investigation confirmed that there was a dysentery outbreak in the area. Samples from one of the two water sources in the village contained high levels of E coli contamination. The contaminated spring was closed for use and a education campaign on clean water and sanitation was conducted in the village by the water and sanitation committee and the local leaders. Even after the spring was cleaned, however, cases of dysentery were discovered in the village. In addition, patient responses to medication was poor.

A team from the MPH programme of Makerere University conducted a case control study to identify the cause of the outbreak and risk factors for its spread, to suggest ways of controlling the epidemic, and to prevent future outbreaks. The research team found that the epidemic was spread from person to person because of poor hand washing practices. They also found one strain of disease was resistant to certain antibiotics. As a result, another health education campaign was started focusing on hand washing practices. This information was shared through the Ministry of Health to other regions and district to limit the further spread of the disease. This experience demonstrates the potential value of research to control and prevent epidemics.

11. *The Optimal Management of Asthma*

by Primary Health Care Education Unit
Tshildzini Hospital, South Africa

This story describes the efforts of a group of rural health workers in South Africa to take the initiative to improve the quality of health services provided to their community. Rural health workers often feel powerless to effect changes within the health system. In this case, the problem they faced was finding the optimal management of asthma. As they assessed the situation, they found that there was a need expressed by health workers for a new chart to interpret peakflow measurement more easily and accurately to better treat the patient.

The Primary Health Care Education Unit initiated a participatory research process to design a new type of asthma chart. They held numerous meetings with doctors and nurses to determine the best format for the new chart. Once they had written a draft, they approached a pharmaceutical company for funding to pilot test it in the region. Based on providers' comments, they further revised it. The final chart is currently being used as part of comprehensive training on the treatment of asthma.

From these experiences, the PHC Education Unit has learned that it is important to involve people throughout the process. This will enable them to take ownership of the final result in this case the asthma chart. One danger, however, is that the emphasis of the project will shift from the overall goal, which is to better manage asthma patients, to the design, colour and format of the new tool.

12. *The Story of the Women's Health Conference*

by M Stevens
Women's Health Project
South Africa

This story describes the process through which the Women's Health Project organised a national health policy workshop for women in 1994. The Women's Health Project was established in 1991 by the University of the Witswatersrand. During its initial consultation period, women suggested that the project convene a national workshop after three years. In 1993, the Women Health Project consulted with its constituencies to ensure that they were still interested in this concept and found that there was still strong support. They convened a conference committee composed of representatives of mass-based organisations, who were interested in women's health issues. Although it was difficult to coordinate this committee for many reasons, for the conference to be a success, it was important for organisations to mobilise their constituencies.

A set of draft policy positions on key issues were formulated by a series of work groups before the conference. These documents were circulated to delegates two months in advance, giving them the opportunity to discuss them and come to the conference with mandates. The conference was a tremendous success with 400 delegates from all over South Africa. At the conference, there was much interlearning among the delegates. The final policy positions were forwarded to the relevant government departments and most have been incorporated into their policy documents. This experience demonstrates the difficulties and the power of a participatory policymaking process.

13. *The Abortion Policy Process: A Reflection*

by The Women's Health Project
South Africa

This story documents the lobbying efforts of one non-governmental organisation, the Women's Health Project, to liberalise abortion legislation in South Africa. Under the previous legislation, abortions were legal under very limited restrictions. As a results, the vast majority of South African women receiving legal abortions were white. The lobbying process began at a national Women's Health Policy Conference in December 1994, where the delegates endorsed a series of recommendations to expand access to termination services. The lobbying process was strengthened by the deliberations of the International Conference on Population and Development in Cairo and the Beijing Conference on Women. At both conferences, termination of pregnancy was placed within the context of reproductive health services.

The Women's Health Project worked closely with the Ad Hoc Select Committee on Abortion convened by Parliament to examine this issue. They facilitated the participation of many women in the hearings and assisted the Committee in drafting its final report. This report included many of the recommendations from the earlier Women's Health Policy Conference. Then, the Women Health Project assisted in establishing the Reproductive Rights Alliance, a consortium created to take this issue forward. They continued to work as an organisation conducting research and designing programmes to improve the quality of reproductive health services in three provinces. They also organised women to testify at the public hearings conducted by the National Assembly's Health Portfolio Committee and assisted the Committee in drafting amendments to the bill. The Choice on Termination of Pregnancy Act was passed in October 1996 and implemented as of 1 February 1997.

The experiences of the Women's Health Project on this issue reflect a larger concern in South Africa that white and affluent women dominated both sides of this debate. Poor, black, and rural women were largely marginalised during the consultation and lobbying processes. They also reflected that within the "Pro-Choice" alliance, people and organisations have many different agendas and styles of working. This made coordination and synergy difficult to achieve.

14. *The Youth Development Programme as a Primary Health Care Site*

byC Nomba
Western Cape Community Partnership Project
South Africa

This story focuses on the manner in which a developmental project is planned in partnership with a community. Specifically, it reviews the needs assessment, development of project goals, strategic planning, and implementation of a youth development programme. A general workshop was held in the community of Belhar for the community to identify and prioritise their needs. At this workshop, participants voiced concern about the youth of the community, particularly regarding youth sexuality and teenage pregnancies. Further workshops and focus groups with youth were held to clarify and unpack these issues. Within youth sexuality, the following issues were identified:

- fragmentation of services for youth;
- increasing rates of teenage pregnancy leading to school dropout;
- lack of information about human sexuality;
- lack of recreational facilities;

- high levels of substance abuse; and
- obsolete vocational guidance system.

A funding proposal was drafted to develop a programme to address these issues. After further consultation within the community., it was funded by the Kellogg Foundation. The programme is now being implemented. One of the primary lessons learned from this experience is that a needs assessment should not be a once-off process. There is a ongoing need to ensure that the project is meeting the needs of different sectors of the community. Although this process is time-consuming, it will ensure that all stakeholders take ownership of the process because it is addressing their needs and issues.

15. *Using an Afterschool Programme as a Vehicle for Social Change in the Community*

by L Christians
Western Cape Community Partnership Project
South Africa

This story describes the efforts of one community to establish an afterschool programme for children. Belhar-East is a small community located outside of Cape Town. It experiences very high rates of crime and child abuse. After numerous meetings with community residents, it was decided to develop an afterschool programme for children. The project is supported by academic institutions, the public health services, and the Western Cape Community Partnership Project. It currently operating with eight volunteers drawn from the school and the community..

The programme has made a positive impact on children's perceptions of themselves. One ten year old boy recognised that drugs were harming his body and decided to stop using them. The afterschool programme fills an important role for these children as many of the parents work long hours and are not able to spend as much time with their children as they would like. Although the programme has been successful thus far, its impact could be increased significantly through greater community participation.

OBSTACLES FACING PRIMARY HEALTH CARE PROJECTS

Summary of Workshop Group Discussions

Intersectoral Collaboration

- Poor intersectoral collaboration.
- Need of progressive political structure for development and health.
- Lack of co-ordination of NGO's, community and government.
- Male participation.
- Clash between medical model and health promotion paradigm.
- Resistance by doctors - not wanting to legitimise midwives.
- Attack on activists.
- Men - women must be allowed to make decisions.
- Religious settings.
- Need to inform parents and children via social structures.
- NGO's, unions and other health related groupings - poor consultation and liaison.
- Institution-based treatment approaches - lack of intersectoral and multidisciplinary team approach, especially for problems like nutrition deficiencies.
- Involve more people in projects.
- Difficulties in mobilising people (those participating are not necessarily those in need).

Resources

- Lack of a steady source of resources.
- Large industrialists not providing facilities and migrant workers with different culture/s and language.

Conference participants engage in lively discussion around the obstacles and successes they encounter in their projects

- Fragmentation of health services.
- Infrastructure e.g. transport.
- Lack of formal education and illiteracy.
- Mobility and accessibility.
- Economic constraints.
- Financial logistics - poor government funding of projects, lack of money of CHWs, donor funding with defined terms.
- Poor involvement due to lack of time for working individuals, especially wage earners and men due to supposed lack of time.
- Poor dissemination of information by health workers.
- Disabled people not supported.
- Sustainability of resources.
- Relief aid e.g. money does not solve problems.
- Capacity of community based health programmes and Department of Health.
- Funds.

Health workers

- Lack of primary care network.
- Attitudes of health workers.
- Red tape at point of delivery.
- Training in illness not wellness.
- Pre-occupation with addressing remuneration problems and low priority of health needs.
- Programmes are imposed by health professionals on communities.
- Problems of pressure and time on health professionals.
- Lack of recognition of CHWs and their knowledge.
- Local projects not national.
- Lack of understanding of the PHC concept:
    - that PHC stops at clinics and does not extend to communities
    - communities being 'acted on' e.g. in research without feedback
    - professionals determining the limits of PHC
    - medicalisation of PHC by professionals and committees
    - lack of flexibility in government health systems
- Service needs to be comprehensive and not fragmented and consumer unfriendly.
- Increasing demand for PHC and CHW services, but no money.
- Definition of PHC.

Professionalism

- Poor involvement of professionals.
- Lack of respect for voluntary workers.
- Codes of conduct and support structures for CHWs often not in place.
- Standard and evaluation - can this be uniform?
- Mindset of health workers.
- Professional dominance - control participation.

Socio-economic (community) factors

- Low socio-economic status of target population.
- Lack of resources - poverty and other economic factors.
- Increase in population in the area.
- Specific diseases due to the environment.
- Conflicts in community and impact on work of community based health programmes.
- Political violence.
- "Abuse" of NGO's and community based health programmes.
- Community expectations.
- Audit / evaluation - literacy levels of community.
- Strategies needed in areas where violence, drugs and gangs exist.

Bureaucracy

- Provinces and national are not delivering, sometimes blocking.
- NGO's also impose programmes on communities from funding policy.
- Transformation and restructuring process is slow - nil enabling mechanisms for NGO's.
- Lack of funds and access to funds lead to project collapse.
- Lack of infrastructure in rural areas.
- Lack of decentralisation.
- Government.
- Legislative obstacles.
- Power struggle between government and NGO's.
- Politicisation of health programmes.
- Failure of articulation of costs vs. benefit to various stakeholders (professional and community).
- Process with regard to management slows down once communities are involved, therefore, professionals have to learn to work at the community's pace.
- Policies of Government- what does decentralisation mean? Unwilling civil servants, bureaucracy.

Sustainability

- Continuity.
- Health workers feeling threatened/ defining roles.
- Ignorance of people - must speak to people on an ongoing basis.
- Funding from government is lacking.
- Funding and financial realities - sustainability and inequitable resource allocation.

Communication

- Clarification of the term 'participation'.
- Communication gaps / ineffective communication.
- Understanding the role and function of community based health programmes.
- Gender empowerment.
- Accessibility of partners.
- Communication problems.

SUCCESSES EXPERIENCED BY PRIMARY HEALTH CARE PROJECTS

Summary of Workshop Group Discussions

Reaching the community

- Community organisation.
- Facilitation of behavioural change.
- Putting health as a priority by the community.
- More involvement of the community in health programmes.
- Small initiatives - more effective.
- Acceptance of immunisation programmes by community.
- Focus on household and environment.
- Formation of community health committees, expressing the will and needs of people.
- CHCs are getting health professionals involved in communities.
- Communities are feeling empowered: committed to actively deepening democratic process at all levels.
- Education of youth, involvement of parents.
- Value of going back to cultural roots, traditional birth attendants and healers.
- Direct involvement of community.
- Culturally sensitive projects.
- Community participation in decision making.
- Communities and professionals are beginning to agree on common issues.
- There is more community involvement and participation in health programmes.
- There is increased capacity of communities to solve their own health problems. This has led to various organisations realising their goals e.g.
    - improvement of health status of communities
    - increasing clinic attendance
    - alleviating malnutrition
    - increasing health care for the mentally ill at community level
- Increased awareness at grassroots level to demand that their health needs be addressed by their elected councillors and lobby and sensitised politicians.
- Acceptance of community - empowering community with regard to their rights.
- Access to the community - reaching the people.
- Investment of the community.
- Place role of community correctly with government.
- Professionals tend to underrate the capabilities of communities.
- Community participation - its importance has been realised, but problems exist everywhere.
- Helenvale (Port Elizabeth) - communities can take part in addressing their health needs.

- Water and sanitation needs can be adopted by communities and addressed.
- Must listen to communities as they have something to share.
- Increase in community-based health programmes.
- Mobilisation and bringing together people-based efforts.
- Empowering community.
- Community integration rather then solely community participation.
- Impact on communities.

Health Care Personnel

- Commitment of project team.
- Training of health personnel in PHC is occurring.
- Capacity building.
- Re-orientation of health personnel.
- Redefinition of PHC.
- Inclusive/integrated approach.
- Changing attitudes.
- Perseverance of workers.
- Attempts at integration (co-ordination) of services e.g. dental and nutrition.
- Attitudes begging to change for better - local authority officials approachable and helpful.
- Working with students.
- Client comes first.
- Health committees and professionals need to work together.
- CHWs and their importance.
- Drugs are not the only way to deal with disease.
- Ordinary people through training can bring health to the people.
- Spread of PHC.
- Developing a unified and integrated intervention.
- Collaborative training initiatives.
- Initiation of PHC training - UWC, UNITRA.
- Participation two-fold - community and professional.
- CHWs - relations increase with service providers.
- Multidisciplinary approach.

Education

- Negotiated entry and transparency.
- Managed to bring health care to previously disadvantaged communities.
- Change of attitudes through education.

- Introduction of PHC courses in tertiary education.
- Recognition of importance of other stakeholders in health related issues.

Role of women

- Women's participation
  - availability
  - traditional caring roles
  - sharing experiences/information
- Maintain contact / avoid communication breakdown.
- Commitment of people to institute change
  - Women taking an active role, often as leaders
  - Women elected to Parliament
  - Changing men's attitudes
- Women in rural areas have access to maternal health services.
- Empowerment of community members in promotion of health, especially the women.
- Role of women in health is important - examples from Uganda.
- Involvement of women and empowerment of women in the team.

The process of change

- Training programmes - capacity building.
- Good record keeping of TBA's.
- Decreased IMR.
- Sustainability of project.
- Attempts at increased availability of health services to undeserved areas and increased development of district health services e.g. by Cuban doctors.
- Multidisciplinary and intersectoral approaches starting to be utilised e.g. Zimbabwe's experience in handling problems related to nutrition.
- Reduced levels of certain diseases.
- Making new SA more real - found a new role.
- Media - involvement of people in media to make it effective.
- A developing model of PHC - CCATS where a business focus has been adopted to ensure self sufficiency.
- Local situations or problems are not very different from national picture.
- PHC can be equally applied in urban as in rural areas.

The New Economic Order - International Focus

THE GLOBALISATION OF POVERTY AND ILL-HEALTH - ASSESSING THE IMF-WORLD BANK STRUCTURAL ADJUSTMENT PROGRAMME

Michel Chossudovsky
Department of Economics, Faculty of Social Sciences
University of Ottawa
Canada

Since the early 1980s, the "*macro-economic stabilisation*" and "*structural adjustment*" programmes imposed by the IMF and the World Bank on developing countries (as a condition for the re-negotiation of their external debt) have led to the impoverishment of hundreds of millions of people. Contrary to the spirit of the Bretton Woods agreement which was predicated on "economic reconstruction" and stability of major exchange rates, the adjustment programmes have largely contributed to destabilising national currencies and ruining the economies of developing countries. Internal purchasing power has collapsed, famines have erupted, health clinics and schools have been closed down, millions of children have been denied the right to primary education. In several regions of the developing World, the reforms have been conducive to a resurgence of infectious diseases including tuberculosis, malaria and cholera. Since the late 1980s, the IMF-World Bank "economic medicine" has been imposed on Eastern Europe, Yugoslavia and the former Soviet Union with devastating economic and social consequences.

An international panel of speakers discuss health and the New Economic Order From left: Abdulrahman Sambo, David Sanders, John Seaman, Pamela Zinkin (chairperson) and Michel Chossudovsky

Since the mid-1980s, the impacts of structural adjustment including the derogation of the social rights of women and the detrimental environmental consequences of economic reform have been amply documented. While the Bretton Woods institutions have acknowledged "*the social impact of adjustment*", no shift in policy direction is in sight. In fact since the late 1980s, the IMF-World Bank policy prescriptions (now imposed in the name of "*poverty alle-*

viation") have become increasingly harsh and unyielding. Moreover, these reforms–when applied simultaneously in more than one hundred countries–are conducive to a "*globalisation of poverty*", a process which undermines human livelihood and destroys civil society in the South, the East and the North.

With the formation of the World Trade Organisation in 1995, a new "*triangular division of authority*" between the IMF, the World Bank and the World Trade Organisation (WTO) has unfolded. The IMF has called for "*more effective surveillance*" of developing countries' economic policies and increased coordination between the three international bodies.

Under the new trade order (which emerged from the completion of the Uruguay Round at Marrakesh), the relationship of the Washington-based institutions to national governments is to be redefined. Enforcement of IMF-World Bank policy prescriptions will no longer hinge upon *ad hoc* country-level loan agreements (which are not "*legally binding*" documents). Henceforth, many of the clauses of the structural adjustment programme (eg. trade liberalisation and the foreign investment regime) will become permanently entrenched in the articles of agreement of the new World Trade Organisation (WTO). These articles will set the foundations for "*policing*" countries (and enforcing "conditionalities") according to international law. The WTO articles violate fundamental peoples' rights, particularly in the areas of foreign investment, bio-diversity and intellectual property rights. The WTO's mandate consists in regulating World trade to the benefit of the international banks and transnational corporations as well as "supervising" (in close collaboration with the IMF and the World Bank) the enforcement of national trade policies.

The IMF/WB/WTO Menu

The same "menu" of budgetary austerity, trade liberalisation and privatisation is applied simultaneously in more than 100 indebted countries. Debtor nations forego economic sovereignty and control over fiscal and monetary policy. The Central Bank and the Ministry of Finance are re-organised (often with the complicity of the local bureaucracies), State institutions are undone and an "economic tutelage" is installed. A "parallel government" which bypasses civil society is established by the international financial institutions (IFIs). Countries which do not conform to the IMF's "performance targets" are black-listed. While adopted in the name of "democracy" and "governance", the structural adjustment programme requires the strengthening of the internal security apparatus: political repression with the collusion of the Third World elites–supports a parallel process of "economic repression".

So-called "*governance*" and the holding of multi-party elections are added conditions imposed by the donors and creditors. Yet the very nature of the economic reforms, precludes a genuine democratisation, i.e. their implementation invariably requires (contrary to the "spirit of anglo-saxon liberalism") the backing of the Military and of the authoritarian State. Structural adjustment promotes bogus institutions and a fake parliamentary democracy which in turn supports the process of economic restructuring.

Throughout the Third World, the situation is one of social desperation and hopelessness of a population impoverished by the interplay of market forces. Anti-SAP riots and popular uprisings are brutally repressed. For example in Caracas in 1989, President Carlos Andres Perez, after having rhetorically denounced the IMF for practising "an economic totalitarianism which kills not with bullets but with famine", declared a state of emergency and sent regular units of the infantry and the marines into the slum areas (*barrios de ranchos*) on the hills overlooking the capital. The Caracas anti-IMF riots had been sparked off as a result of a 200 percent increase in the price of bread. Men, women and children were fired upon indiscriminately: "*The Caracas morgue was reported to have up to 200 bodies of people killed in the first three days ... and warned that it was running out of coffins*".

Unofficially more than a thousand people were killed in Tunis, January 1984: bread riots were largely instigated by unemployed youth protesting the rise of food prices in Nigeria: 1989, the anti-SAP student riots lead to the closing of six of the country's universities by the Armed Forces Ruling Council in Morocco: 1990, a General Strike and a popular uprising occurred against the government's IMF sponsored reforms; Mexico 1993: the insurrection of the Chiapas Indians in Southern Mexico, protest movements in the Russian Federation and the storming of the Russian parliament in 1993, and so on, the list is long...

Economic Repression

Structural adjustment is conducive to a form of "economic genocide" which is carried out through the deliberate manipulation of market forces with devastating impact. It is comparable to forced labour and slavery during various periods of colonial history. Structural adjustment programmes directly affect the livelihood of more than four billion people. The application of the structural adjustment programme in a large number of individual debtor countries favours the "internationalisation" of macro-economic policy under the direct control of the IMF and the World Bank, acting on behalf of powerful financial and political interests (eg. the Paris and London Clubs, the G 7). This new form of economic and political domination–a form of "*market colonialism*"– subordinates people and governments through the seemingly neutral interplay of market forces. The International Creditors and Multinational corporations entrust the Washington-based international bureaucracy with the execution of a global economic design which affects the livelihood of more than 80 percent of the world's population. At no time in history, has the "free" market–through the instruments of macro-economics operating at a World level–played such an important role in shaping the destiny of "sovereign" nations. The restructuring of the World economy under the guidance of the Washington based financial institutions and the new World Trade Organisation (WTO) increasingly denies individual Third World countries the possibility of building a national economy. The internationalisation of economic policy transforms countries into open economic territories and national economies into "reserves" of cheap labour and natural resources. The application of the IMF economic medicine tends to further depress World commodity prices because it forces individual countries to simultaneously gear their national economies towards a shrinking World market.

In parallel with this "remoulding" of the global and national economies, the dominant economic discourse has, since the early 1980s, reinforced its clutch in academic and research institutions throughout the World. Critical analysis is strongly discouraged, the dominant economic dogma admits neither dissent nor discussion of it main theoretical paradigm. Similarly, Third World intellectuals are increasingly enlisted in support of the neo-liberal paradigm and the internationalisation of economic "science" unreservedly supports the process of global economic restructuring. Moreover, whereas the IMF-World Bank sponsored reforms accentuate social and income disparities between and within nations. The realities of World poverty are increasingly concealed by the blatant manipulation of income statistics. The World Bank "estimates", for instance, that in Latin America and the Caribbean only 19 percent of the population is "poor" - a gross distortion when we know for a fact that in the United States (with an annual per capita income of $20,000) one American in five is defined (by the Bureau of the Census) to be below the poverty line.

Policing Countries Through Loan "Conditionalities"

Because countries are indebted, the IMF and the World Bank can oblige them through the so-called "conditionalities" of the loan agreements to "appropriately" redirect their macro-economic policy in accordance with the interests of the international creditors. The objective consists in enforcing the

legitimacy of the debt servicing relationship while maintaining debtor nations in a strait-jacket which prevents them from embarking upon an independent national economic policy. While the circumstances of the "adjusting" countries differ markedly, the same economic recipe is applied worldwide. The adoption of the Fund's prescriptions under the economic stabilisation package is not only conditional for obtaining loans from multilateral institutions, it also gives "the green light" to the Paris and London Clubs, foreign investors, commercial banking institutions and bilateral donors. The evidence suggests that countries which refuse to accept the Fund's corrective policy measures face serious difficulties in rescheduling their debt and/or obtaining new development loans and international assistance. The IMF also has the means to disrupt a national economy by blocking short-term credit in support of commodity trade.

Invariably, substantial reforms will be required *prior* to the negotiation of a structural adjustment loan. The government has to show the IMF that it is "seriously committed to economic reform" before loan negotiations can take place. This process is often carried out in the context of a so-called "IMF Shadow Programme" in which the IMF provides policy guidelines and "technical advice" to the government without any formal loan support. The Shadow Programme applies to countries whose economic reforms are considered (in IMF jargon) "*not to be on track*" (eg. Peru under Alberto Fujimori (1990-91) or Brazil under Fernando Collor de Mello and Itamar Franco (1990-94)). "*Satisfactory performance*" under the Shadow programme is considered necessary, before the formal negotiation of a loan agreement. Once the loan has been granted, policy performance is tightly monitored on a quarterly basis by the Washington institutions. The disbursements can be interrupted at any time if the reforms are not "on track", in which case the country is "back on the black list" with the danger of reprisals in the area of trade and capital flows.

In many indebted countries, the "sovereign government" is obliged under its agreement with the Washington-based institutions to outline its priorities in a so-called "*policy framework paper*" (PFP). Although officially a government document determined by the country, the PFP is written under the close supervision of the IMF and the World Bank according to a standard pre-set format. There is, in this context, a clear division of tasks between the two sister organisations. The IMF is involved in key policy negotiations with regard to the exchange rate and the budget deficit. The monitoring of a country's economic performance by the IMF provides the basis of so-called "IMF surveillance activities" over members' economic policies. The World Bank, on the other hand, is far more involved in the actual reform process through its country-level representative office and its numerous technical missions. Moreover, the World Bank is also present in most of the line ministries: the reforms in health, education, industry, agriculture, transportation, the environment, etc. are under its jurisdiction. Moreover, since the late 1980s, the World Bank closely monitors the structure of public expenditure through the so-called *Public Expenditure Review* (PER). The composition of expenditure in each of the ministries is under its supervision.

Destroying a nation's currency

Destroying the national currency is a key objective of IMF-World Bank intervention: currency devaluation ordered by the IMF is conducive to abrupt price hikes and a dramatic compression of real earnings while at the same time it dramatically depresses the cost of labour (expressed in US dollars). The currency devaluation is usually demanded as a pre-condition before the negotiation of a structural adjustment loan. In Sub-Saharan Africa, the devaluation of the CFA franc imposed by the IMF and the French Treasury in early 1994, rather than constituting "*a means of eradicating rural poverty*" as claimed by the donor community, compressed (with the stroke of a pen) the real value of wages and government expenditure (expressed in hard currency) by fifty percent while massively redirecting State revenues towards debt servicing. The impact of devaluation was brutal and immediate: the

domestic prices of food staples, essential drugs, equipment, etc. skyrocketed. It is worth recalling that in Nigeria in the 1980s, the steep increase in the price of soap which resulted from the devaluation of the Naira was the cause of a high incidence of certain types of skin disease.

While the devaluation triggers inflation and the "dollarisation" of domestic prices, the IMF obliges the government to adopt a so-called "anti-inflationary programme". The latter is predicated "*on a contraction of demand*" instrumented through the dismissal of public employees, drastic cuts in social sector programmes and the de-indexation of wages. To achieve this objective, strikes are outlawed and tradeunion leaders are arrested. (The levels of wages in indebted countries are as much as seventy times lower than in the OECD countries).

Engineering the collapse of state investment

The reforms also trigger the collapse of public investment. Precise "ceilings" are placed on all categories of expenditure. The State is no longer permitted to mobilise it own resources to build public infrastructure, roads or hospitals, etc. The creditors not only become the "brokers" of all major public investment projects, they also decide in the context of the "*Public Investment Programme*" (PIP) (established under the technical auspices of the World Bank) on what type of public infrastructure should or should not be funded by the "donor community". The control of public investment by the donors not only contributes to the demobilisation of domestic resources but also to the enlargement of the external debt through the system of international tender (and "competitive bidding") which allocates the entire execution of public works projects to international construction and engineering firms. Large amounts of money are skimmed off into a variety of consulting and management fees. Local construction companies (whether public or private) tend to be excluded from the tendering process although much of the actual construction work will be undertaken by local companies (using local labour at very low wages) in separate sub-contracting deals reached with the transnationals.

The World Bank "Helps the Poor"

The Bretton Woods institutions claim to be firmly committed to the alleviation of poverty. So-called "*targeted programmes*" earmarked "*to help the poor*" combined with "cost recovery" and the "privatisation" of health and educational services are said to constitute "*a more efficient*" way of delivering social programmes. So-called "*sustainable poverty reduction*" under World Bank guidance is predicated on slashing social sector budgets and redirecting expenditure on a selective and token basis "*in favour of the poor*". As the State withdraws many programmes under the jurisdiction of line ministries will henceforth be managed by the organisations of civil society under the umbrella of the Social Emergency Fund (SEF). The latter also finances the "*social safety net*", eg. severance payments and/or minimum employment projects earmarked for public sector workers laid off as a result the adjustment programme. An entirely separate and parallel organisational structure unfolds, various non-governmental organisations (NGOs) funded by international "aid programmes" gradually take over many of the functions of local level governments whose funds have been frozen as a result of the structural adjustment programme.

Small scale production and handicraft projects, sub-contracting for export processing firms, community-based training and employment programmes, etc. are set up under the umbrella of the "social safety net". A meagre survival for local-level communities is ensured while at the same time containing the risk of social upheaval. The "*social emergency fund*" established (on the Bolivia-Ghana model) constitutes an institutional mechanism for "*the management of poverty*", while the State's public finances are dismantled. The Social Emergency Fund constitutes a useful policy framework for "*managing poverty*" and attenuating social unrest at minimal cost to the creditors.

In Sub-Saharan Africa, "*targeting*" in favour of so-called "*vulnerable groups*" has largely been responsible for the collapse of schools, health clinics and hospitals, while providing a semblance of legitimacy to the Washington-based institutions. Freezing the number of graduates of the teacher training colleges and increasing the number of pupils per teacher are explicit conditions of World Bank social sector adjustment loans. The educational budget is curtailed, the number of contact-hours spent by children in school is cut down and a "double shift system" is installed: one teacher now does the work of two, the remaining teachers are laid off and the resulting savings to the Treasury are funnelled towards the Paris Club of official creditors.

These initiatives (implemented in the name of "poverty alleviation"), however, are still considered to be incomplete: in Sub-Saharan Africa, the donor community has recently proposed a new imaginative ("cost-effective") formula which consists in eliminating the teachers' meagre salary altogether (in some countries as low as 15-20 dollars a month) while granting small loans to enable unemployed teachers to set up their own informal "private schools" in rural backyards and urban slums. Under this scheme, the Ministry of Education would nonetheless still be responsible for monitoring "the quality" of teaching.

Structural adjustment destroys health care

As a result of massive budget cuts under the structural adjustment programme, health centres are unable to meet operating costs and maintenance and renewal of equipment is neglected. Economic reforms have also contributed to reducing the overall availability of medical personnel in hospitals and health centres due to low pay and poor working conditions. A recent study points to the exodus of human capital including doctors and nurses from Africa. The brain drain from Africa was estimated at some 30,000 middle level, high level and professional workers between 1984 and 1987.[1] A similar pattern is occurring in several Latin American and South Asian countries.

In some cases, government salaries are not disbursed and health centres were obliged to close down due to the stoppages of water and electricity. There has been a notable deterioration of maternal and child health care since the early 1980s in many developing countries as a result of the contraction of public expenditure in the health care sector. In many countries in Sub-Saharan Africa, the functioning of the public sector and government departments is paralysed: civil servants are not paid enough to cover their transport to and from work, government departments, including the Ministry of Health, lack the resources to meet current administrative costs.

Cost recovery and user fees

According to the World Bank, State subsidies to health are said to create undesirable "market distortions" which "*benefit the rich*". Moreover, according to the World Bank's most recent "estimate" (contained in its 1993 World Development Report entitled "*Investing in Health*"), an expenditure of 8 dollars per person per annum is in any event sufficient to meet acceptable standards of clinical services. Moreover, user fees for primary health care to impoverished rural communities should be exacted both on the grounds of "*greater equity*" and "*efficiency*". These communities should also participate in the running of the primary health care units by substituting the qualified nurse or medical auxiliary (hitherto paid by the Ministry of Health) by an untrained and semi-illiterate health volunteer.

With the exception of a small number of externally funded "showpieces", health establishments in Sub-Saharan Africa have *de facto* become a source of disease and infection. A study assessing the impact of user fees on utilisation of health facilities in Ashanti-Akim and the Volta region of Ghana suggests that utilisation rates dropped substantially after the introduction of the fees in 1985.[2] In the

Ivory Coast it is estimated that the imposition of user fees resulted in a decline of consultations of 39 percent for children and 15 percent for adults as well as a shift into self-care and/or the services of traditional healers (Anyiam and Stock, 1991, p. 21). In Swaziland, the introduction of user fees was conducive to a decline in attendance in government health facilities of 39 percent.[3]

In Peru, the hike in user fees in hospitals implemented alongside the 1990 stabilisation programme was conducive to a dramatic decline of internal admissions (in an urban hospital in Cusco by as much as 80 percent; external consultations declined by more than fifty percent).[4]

The example of Vietnam

In Vietnam, the most immediate impact of the structural adjustment programme was the collapse of the district hospitals and commune-level health centres. Until 1989, health units provided medical consultations as well as essential drugs free of charge to the population. The disintegration of health clinics in the South is on the whole more advanced where the health infrastructure was only developed after Re-unification in 1975. With the reforms, a system of user fees was introduced. Cost recovery and a free market sale of drugs was applied, the consumption of essential drugs (through the system of public distribution) declined by 89 percent, pushing Vietnam's pharmaceutical and medical supply industry into bankruptcy.[5] By 1989, the domestic production of pharmaceuticals had declined by 98.5 percent in relation to its 1980 level, with a large number of drug companies closing down. With the complete deregulation of the pharmaceutical industry, including the liberalisation of drug prices, imported drugs (now sold exclusively in the "free" market at exceedingly high prices) have now largely displaced domestic brands. A considerably "down-sized" yet highly profitable commercial market has unfolded for the large pharmaceutical transnationals. The average annual consumption of pharmaceuticals purchased in the "free" market is of the order of one dollar per annum which even the World Bank considers to be too low.[6] The impact on the levels of health of the Vietnamese population were dramatic.

The government (under the guidance of the donor community) has also discontinued budget support for the provision of medical equipment and maintenance leading to the virtual paralysis of the entire public health system. Real salaries of medical personnel and working conditions have declined dramatically: the monthly wage of medical doctors in a district hospital is as low as 15 dollars a month. With the tumble in State salaries and the emergence of a small sector of private practice, thousands of doctors and health workers have de facto abandoned the public health sector. A Survey conducted in 1991, confirms that most of the Commune-level health centres have become inoperative: with an average staff of 5 health workers, the number of patients had dropped to less than six a day (slightly more than one patient per health worker per day).[7]

Since the reforms, there has also been a marked downturn in student admissions to the country's main medical schools which are currently suffering from a massive curtailment of their operating budgets.

A WHO study confirms that the number of malaria deaths in Vietnam increased three-fold in the first four years of the reforms alongside the collapse of curative health and soaring prices of anti-malarial drugs. What is striking in this data is that the number of malaria deaths has increased at a faster rate than the growth in reported cases of malaria suggesting that the collapse in curative health services played a decisive role in triggering an increase in malaria deaths. These tendencies are amply confirmed by commune level data:

> *"The state of health used to be much better, previously there was an annual check-up for tuberculosis, now there are no drugs to treat malaria, the farmers have no money to go to the district hospital, they cannot afford the user fees"*[8]

The World Bank candidly acknowledges the collapse of the health system (the underlying macro-economic "causes", however, are not mentioned):

> *"[d]espite its impressive performance in the past, the Vietnamese health sector is currently languishing... there is a severe shortage of drugs, medical supplies and medical equipment and the government health clinics are vastly underutilised, The shortage of funds to the health sector is so acute that it is unclear where the grass-roots facilities are going to find the inputs in the continue functioning in the future"*[9]

Whereas the World Bank concedes that the communicable disease control programmes for diarrhoea, malaria and acute respiratory infections "*have [in the past] been among the most successful of health interventions in Vietnam*", the proposed "solutions" consist in the "commercialisation" (and commodification) of public health as well as the massive lay off surplus doctors and health workers. Wages of health workers should be increased within the same budgetary envelope: "*an increase in the wages of government health workers will almost necessarily have to be offset by a major reduction in the number of health workers.*"[10]

Conclusion

Throughout the developing World and in Eastern Europe and the former Soviet Union, there is a consistent and coherent pattern: the IMF-World Bank reform package constitutes a coherent programme of economic and social collapse. The austerity measures lead to the disintegration of the state, the national economy is remoulded, production for the domestic market is destroyed through the compression of real earnings, health and educational programmes are dismantled. In turn, there has been a resurgence of a number of communicable diseases which were believed to be under control.

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"INVESTING IN HEALTH": FOUR YEARS ON

John Seaman

Save the Children Fund (SCF)
United Kingdom

For SCF and many other NGOs the 1993 World Development Report (WDR), "Investing in Health", was a cause of dismay. At a stroke it appeared to dismiss all the investment by Governments and NGOs since the 1978 Alma Ata primary health care (PHC) declaration. Taken at face value the report proposed a shift from the PHC commitment to equitable, locally controlled and sustainable systems of basic health care to a policy based on the priorities of international experts, with the primary objective of the cost-effective use of resources. A lengthy response, attached, was made by the SCF to the World Bank at that time.

The worst features of the WDR seemed to us to be two. Firstly, the proposal was to put the provision of health care, beyond some minimum to be provided by the State or through charity, on the same economic basis as any other commodity. Government resources would be allocated on the basis of the "disability adjusted life year" (DALY) in order to maximise the "health return" on expenditure; other services would be available to the extent that the patient could pay, or NGOs and Churches might provide free services.

In the twenty or so poorest countries, chiefly in Africa, which have health budgets in the range of $1-3/person/year it was evident that, carried through to practice, such a policy would mean effectively no services for the poor. Assuming that the DALY would prioritise immunisation, some national budgets were scarcely sufficient to provide this alone.

Secondly, there was no discussion in the WDR as to how the funding gap for the provision of basic services in the poorest communities might be met. The financial argument in the WDR was that the total health funding i.e. the sum of Government, external donor and private provision, in many countries was sufficient to provide the basic service envisioned. The cause of under-provision in health was therefore to be found in the inefficient use of resources. The SCF view was that this argument was spurious. Donor funds were frequently spent without reference to and sometimes in conflict with Government policy e.g. the verticalisation of immunisation, area-based projects, capital projects which entailed greater recurrent costs for the Government etc. Although it was true that in some countries the sum of all known expenditure was sufficient to provide basic services for all (e.g. Uganda), in reality the resources were not available to the health services which depended largely or wholly on the national health budget and could often find no more than starvation wages for health workers and grossly inadequate material supplies.

Clearly, many poor countries have no effective basic health services. However, the most pessimistic reading of the WDR - a major international political statement - implies that the combined denial of health services to the poor has become an officially acceptable ideology. As and if, but not until, poor countries and poor people became richer could they have access to health services. The public argument was that the problem was inefficiency and that the international effort should now be directed to 'capacity building' and other remedies for this. The most optimistic view we could take of the WDR was that at least it contained an attempt, possibly the first from a major organisation to calculate the true cost of providing basic services.

SCF Experience since 1993

In fact, major international policy documents are rarely as important as they seem when first published. Even after a short period of four years it is clear that our early pessimism was not wholly justified and that events have turned out in a rather different, and in some cases more positive way than we feared. With hindsight, it is easy to see that the World of even four years ago seemed, at least for those steeped in PHC, a dangerous place. Just after the end of the Cold War, with structural adjustment in full and unobstructed flow, and the economists in seemingly absolute control of international ideology it seemed almost inevitable that in the poorer states all social policy might give way to a pattern of commerce and charity.

However, it is clear that the international system has continued to change and to adjust rapidly and in a variety of ways, and that the worst expectations of 1993 have not in our experience occurred. Quite what has occurred since 1993 in international policy terms is not known in any formal sense - the position is different in each country; each observer has a different perception and in some countries the question of health policy has been muddied by war, major political change and other events. But the SCF experience, largely in some of the poorer countries in Africa, South and South East Asia (but excluding many of the former Eastern Bloc countries where the experience has often been very different) and of close observation of the international system suggests that the current situation, although far from satisfactory-huge populations remain without any access to useful health care - is, in some basic policy respects, at least better, and more hopeful, than it was in the mid to late 1980's.

The reasons for this are beyond the scope of this note and can be no more than a conjecture, but I would identify three main underlying drives. Firstly, is the reality which follows any revolutionary change. Forcing through the basic reforms of ESAP and the 'democratisation' was perhaps comparatively straightforward. But these reforms, (if in fact they ever achieve their intention of making countries and people more prosperous), are proving slow to deliver. Mass personal and state poverty and the lack of health services remains a current problem, and the practical difficulties of improving this situation remain much the same as before. Secondly, donors are now under very different pressures. Both the quantity and the political prominence of international aid have fallen sharply. The basic political priorities of aid during the cold war - crudely to buy political advantage - have gone, and (to the extent that a much reduced aid budget is directed to the poorest countries at all), it is, for the first time in decades, a priority for many donors to use this effectively. Many of the donors have themselves gone though major internal restructuring, often towards the decentralisation of budgets and decision making. Lastly, (and perhaps paradoxically), there is an increasing tendency for external donors to accept and work with Governments - or more precisely those Governments that have embraced reform - on less directive and conditional terms than before. This is perhaps because Governments are (post reform/ by definition) more acceptable to the donors; the political pressure on donors and therefore the sense of urgency, is less; and because now, as always before, there is no real alternative if the aim is to build national systems.

Whatever the reasons, our experience has been that since 1993 the evolution of the donor/national Government relationships has often been more in the direction for which SCF and others have wanted than toward the aims of the WDR. It is difficult to find a case, at least in Africa, where our chief concerns around the WDR can be observed in practice. This is not to say that the health problems of the poor countries, particularly in respect of health financing have been solved; that can only occur when the poor become richer and control their own policies. There is arguably now a greater consensus amongst the various players - Government, donors and NGOs than before about what should be done. In many instances a move towards the more efficient use of resources; and a realism about the practical constraints and time required which was not evident pre WDR.

Our impressions are that:

1. There is a wide, if still less than universal acceptance that in the poorest countries the only practical and economic way in which basic services can be provided is through some national system. The donor tendency to the 'verticalisation' of services with the aim of showing short term results which was so evident in the 1980's has sharply diminished.
2. In many countries donor funding is increasingly co-ordinated with, one may assume, an improvement in the efficiency with which resources are used.
3. In some countries donors are increasingly willing to meet recurrent costs, even if only through indirect means, for example, by providing budgetary support to Government to ensure the continuity of specific projects, where these cannot be met locally.
4. An increased trend to accept and to support local NGOs and other organisations and to bypass the larger international NGOs.

However, limited resources remain the basic problem of the provision of health in poor countries

HEALTH AND STRUCTURAL ADJUSTMENT IN RURAL AND URBAN ZIMBABWE

David M. Sanders
Leon A. Bijlmakers
Mary T. Basset

Public Health Programme
University of the Western Cape
South Africa

Introduction

Reports and studies from a number of sources including government health ministries, UNICEF, non-government agencies and even sections of the World Bank point to significant welfare reversals over the past decade in many countries implementing structural adjustment programmes (SAPs). These reports are contradicted by the World Bank's 1993 World Development Report which maintains that adjusting is more beneficial to health and welfare than non-adjusting, and that any negative impact is limited and temporary.

This paper outlines the process whereby SAPs are likely to affect health, and, using the case of Zimbabwe, provides empirical evidence for such effects. The implications for population health in countries including South Africa, adopting similar macro-economic measures, are raised.

Economic Change, Health Care and Health Outcomes

Any examination of the impact of the relationship between macro-economic change, including structural adjustment programs, and health should be informed by an understanding of the economic, social and technical factors influencing health outcomes. The disease burden and pattern experienced by the peoples of underdeveloped countries are strikingly similar to those of nineteenth century Europe, i.e. they are primarily diseases of underdevelopment and poverty, not a feature of warm climates in the tropics. Industrialised and urbanised sections of underdeveloped countries experience disease patterns more akin to those dominant in the industrialised countries.

Historical and contemporary experiences have shown that there is a definite but complex relationship between economic growth on the one hand and health status on the other. In general, sustained economic growth over the long run does lead to improved health and nutritional status: in the now-industrialised countries the large and sustained decline in mortality has been accompanied by reductions in morbidity (disease) and malnutrition, and largely preceded any effective medical interventions. There is not, however, a direct correlation between health and nutrition indicators and GDP per capita levels, because improved income distribution - even at low income levels - can accelerate improvements in health, e.g. in China and Sri Lanka. In the short term, the inter-relationship is even more complex. There are examples of countries in which high growth has been associated with a decline in health status as reflected by the normal indicators (Brazil), but equally there are cases where severe economic decline has been associated with significant improvements in health status (Chile, Tanzania). An understanding of the relationship requires a fairly detailed study of the particular circumstances in which economic changes take place and within the context of which health status is determined. In particular, issues of access and equity are of primary importance.

Factors influencing health outcomes include economic and environmental influences as well as direct health sector interventions. Thus, it is useful to categorise these factors into two broad groups: those originating outside and those originating inside the health sector. Evidence from many countries shows that income is probably the most important of the outside factors. For example, a Zimbabwean study found that variation in children's nutritional status was explained principally by the socio-economic status of parents (education, economic activities, income and housing status). Since education and housing status are themselves strongly correlated with income, this suggests that income is a primary determinant of nutritional status. Other factors originating outside the health sector include social inputs, such as education; environmental inputs, such as access to clean water; and general economic measures, such as food rationing, subsidies and so forth. Factors originating inside the health sector are the usual range of health care provision, for example, hospitals, health services, health personnel, and immunisations.

Although health sector inputs may be the most obvious determinants, the effects of non-health sector inputs are probably more important. Whilst it is relatively easy to achieve rapid improvements in health measured by standard quantitative indicators (which are in reality disease indicators), sustained improvements in the quality of life are more difficult to produce and measure. For instance, certain indicators, such as infant and young child mortality rates, may be rapidly improved by selective primary health care interventions (e.g. immunisations) targeted at these high risk groups. There is, however, little evidence to suggest that improved nutrition levels, for example, can be maintained by the application of such technical packages in the absence of more general improvements in access to resources.

It must also be noted that different time frames apply to the appearance of changes in both sets of indicators. For example, whilst changes in food prices and health service take-up rates may occur quite quickly and be readily assessed and documented, changes in mortality and morbidity rates, and in nutritional status, are both more problematic to monitor, and become evident only in the medium- to long-term: short-term changes may thus reflect processes operating before the implementation of SAPs.

Finally, another major problem in assessing the impact of SAPs is the poor quality and often the unavailability of data on mortality, morbidity and nutritional status, especially in the poorest countries where economic decline has often been most severe.

Given the foregoing, it is clear that in assessing the impact of structural adjustment on health services and health status, it is necessary to analyse the impact of factors operating both inside and outside the health sector, and that a range of health indicators must be examined. These indicators must be monitored over both the short- and long-term.

The Components of Structural Adjustment Programs and their likely effects

Economic Structural Adjustment is the process of responding to (often severe) imbalances in the economy, particularly deficits in a country's balance of payment, usually by adopting measures which expand exports, reduce imports, or otherwise attract foreign exchange to a country. Often, measures to curb a government deficit by increasing government revenue or reducing expenditure are also involved. These actions involve changes in the structure of the economy. Structural Adjustment Policies are a set of policies towards the goal of structural adjustment. The implementation of such policies has become a condition for the receipt of significant financial assistance (usually in the form of loans) from the International Financial Institutions (World Bank and International Monetary Fund). These loans are used primarily to offset balance of payments deficits i.e. foreign debts.

In general, structural adjustment programmes consist of three sets of components. The first group of structural adjustment policy components are those things which influence the balance of payments. These include:

- Devaluation of the local currency, both formal and informal:
  - Formal devaluation is carried out by allowing the local currency's value to slide against international currencies such as the dollar or pound.
  - Informal devaluation is implemented by lifting price controls and freezing wages which results in people not being able to buy as much with their money. In effect, wages are lowered.
- Restrictions on borrowing from the IMF.
- Balance of payments controls. Some governments have imposed stringent restrictions on dividends and foreign exchange.

The resulting wage cuts and price increases affect a number of factors outside the health sector which influence health, such as how much food a family can buy – the single most important factor – and people's ability to pay for housing and other services.

The second group of components are government budget policies, primarily consisting of reductions in public spending on health, education, social services and food subsidies. Reduction in social sector spending means not only reduction in budget allocations to the health sector; it also is accompanied by 'cost recovery', the introduction of user charges. Essentially, cost recovery means that health care that used to be free in many countries is now charged for.

The last component of structural adjustment is called 'trade liberalisation'. Previous restrictions on trade are removed (for example, tariffs are reduced). This together with the devaluation of local currency, is aimed at increasing exports from poor countries to rich. Trade liberalisation also includes incentives for foreign investment, such as rolling back government regulations that restrict the freedom of action of foreign business. At the same time, loans are made available (often through the World Bank) so that poor countries can import goods from the West. The liberalisation of trade opens up markets in the South, and allows the middle class in the South to enter the market.

The Zimbabwe Study

The Economic Structural Adjustment Programme (ESAP) was formally introduced in Zimbabwe in October 1990, but started in earnest in March 1991 after a meeting with foreign aid agencies and the World Bank in Paris. The framework of ESAP was spelt out in the January 1991 document: Zimbabwe: A Framework for Economic Reform (1991-95). The ESAP package, as outlined in this document, contains the standard features of IMF/World Bank economic reform strategies, including, inter alia (GOZ, 1991 a): a reduction of the budget deficit through a combination of cuts in public enterprise deficits and rationalisation of public sector employment; trade liberalisation, including price decontrol, and deregulation of foreign trade, investment and production; phased removal of subsidies; devaluation of the local currency; enforcement of cost recovery in the health sector and introduction of cost recovery for education.

Economic, Health Service and Health Changes

a) Economic changes

Between independence in 1980 and 1991, the performance of the national economy fluctuated considerably. In the immediate post-independence period, Zimbabwe's real income as measured by

the gross domestic product (GDP) per capita rose to a peak of ZWD 484 in 1981, then slightly fell to ZWD 477 in 1982 and then declined further to fluctuate around ZWD 453 until 1990. Average real earnings in the formal sector (excluding agriculture) rose from ZWD 2213 per annum in 1979 to a peak of ZWD 2758 in 1982. After that, they declined to ZWD 2091 in 1987. The boom in the first two to three years after independence was clearly followed by a stabilisation period that lasted until 1990, when the real per capita income was about the same as that in 1980. Some of the economic indicators for Zimbabwe for the period 1988 to 1993 are summarised in Table 1.

In accordance with the aims of the ESAP, the Zimbabwe dollar was devaluated against all major foreign currencies. The biggest devaluation came in early 1993, when the local currency was allowed to depreciate by 35 per cent over less than three months. In August 1992, subsidies on super-refined maize meal were completely removed while those on roller meal and bread were reduced. In June 1993, maize marketing regulations were liberalised and the last subsidies on maize meal and bread were removed, after which bread riots broke out in some urban areas. Table 1 also shows that the official inflation rate had mounted to 46.3 per cent in 1992, whereas the inflation rate for food was estimated at 72.6 per cent. For 1993 the figures were estimated at 20.0 per cent and 24.5 per cent respectively.

This is further illustrated Figure 1 and Figure 2.

Table 1: Economic indicators for Zimbabwe (1988-93) [1]

	1988	1989	1990	1991	1992	1993
Domestic product:						
Real GDP (1990, in million ZWD)	4143	4332	4426	4641	4284	4357
Real GDP per capita (in ZWD)	453	459	455	462	413	407
Prices (1980=100):						
CPI (December) [2]	281.8	321.9	377.8	489.6	716.4	834.2
Inflation rate		14.2%	17.3%	29.0%	46.3%	20.0%
Food CPI	302.0	364.7	435.4	572.2	984.5	1182
Food inflation rate		17.3%	19.4%	31.4%	72.6%	24.5%

[1] *adapted from GOZ, 1993b*
[2] *Consumer Price Index*

b) Health service changes

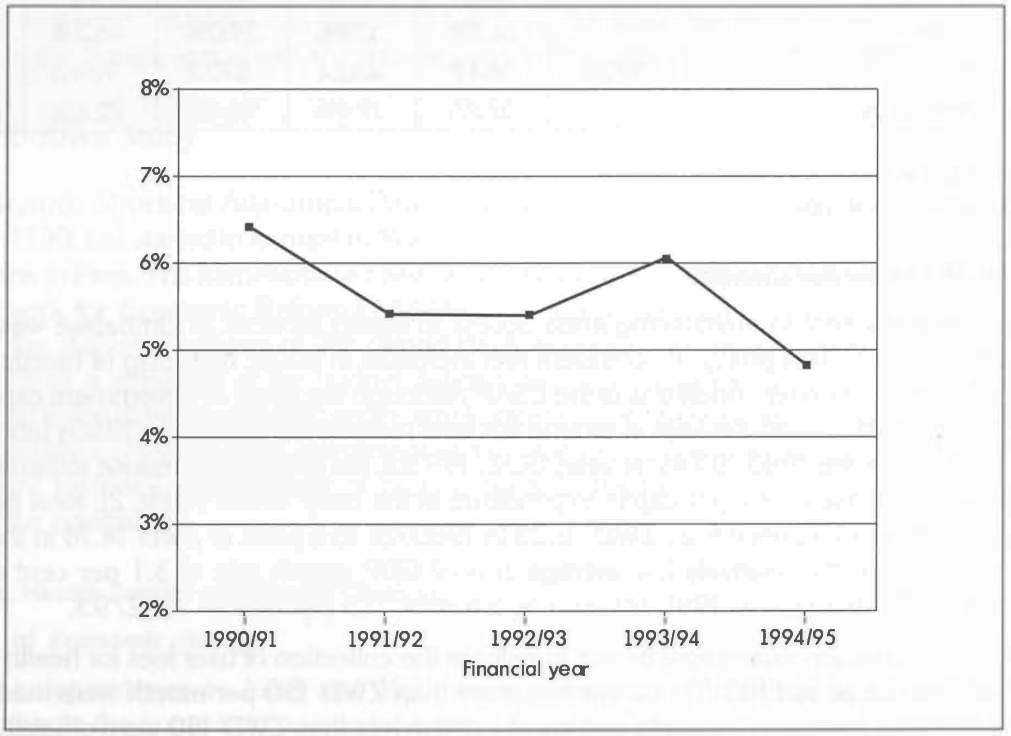
Government commitment to maintaining mass access to health services in Zimbabwe was beyond question in the 1980s. This policy of consistent real increases in public financing of health services could not be sustained under conditions of the ESAP. Although the share of government expenditure allocated to the health sector was kept at around the level maintained during the 1980s (about 6 per cent; 5.9 per cent for the 1993/94 fiscal year; GOZ, 1993b), the pressure to reduce expenditure led to a significant decrease in real per capita expenditure in the early 1990s (Table 2). Real per capita expenditure on health had risen from ZWD 10.25 in 1980/81 to a peak of ZWD 14.78 in the 1990/91 fiscal year, despite the relatively low average annual GDP growth rate of 3.1 per cent over that period. It fell by 17.9 per cent in 1991/92, and by a further 11.5 per cent in 1992/93.

In 1991, the Zimbabwean government began to enforce the collection of user fees for health services which it had introduced in 1985. Those earning more than ZWD 150 per month were made to pay for health services. Unemployed people and those earning less than ZWD 150 were officially entitled

Figure 1: Real per capita recurrent expenditure Ministry of Health

source: Chisvo and Munro (from CSO)

Figure 2: Health budget as a percentage of the total government budget by year



to free treatment. A letter from the local councillor or from a social welfare officer could serve as proof of eligibility for free treatment. A new regulation, announced in November 1992, raised the income level for free treatment from ZWD 150 to ZWD 400 per month. Shortly afterwards, in January 1993, the government abolished fees at rural health centres and most rural hospitals, in order to alleviate the effects of the 1991/92 drought on rural populations. It should be noted, though, that most council and mission clinics continued charging fees. In June 1993, user fees were reintroduced at rural government health facilities.

Several other policy changes with regard to user fees were introduced in the course of 1994 and 1995. The most dramatic changes occurred in January 1994 when a huge increase in charges for all services was effected, and in March 1995 when fees at rural health centres were abolished.

Table 2: Government expenditure on health (1988/89-1992/93) [1]

	1988/89	1989/90	1990/91	1991/92	1992/93
GOZ Health Budget					
Nominal expenditure (million ZWD)	329.0	421.4	566.8	631.4	802.5
Share of total budget	6.0%	6.5%	6.8%	5.7%	6.0%
Real expenditure (1990, million ZWD)	403.1	453.0	513.4	433.9	396.3
Real per capita expenditure (ZWD)	12.39	13.50	14.78	12.14	10.74
Change(%)	+1.9%	+9.0%	+9.5%	-17.9%	-11.5%

[1] *adapted from GOZ (1993b) and Chisvo and Munro (1994)*

c) Health status changes

During the 1980s, infant mortality (children under one year of age) in Zimbabwe declined from pre-independence levels of 120 to 150 per thousand live-births, to 61 by 1990. Child mortality (children one to four years) declined from 40 per thousand in 1980, to 22 in 1990 (UNICEF, 1994). However, mortality figures started to rise in the late 1980s and on into the 1990s, reversing the gains made in the previous decade. This trend is attributed to several factors that reinforce each other: the declining per capita expenditure on health and the declining quality of health services, the drought, the HIV/AIDS epidemic and the general deterioration in living conditions for large segments of the population.

No negative trend has been observed with respect to child nutritional status. UNICEF (1994) reports that several sources indicate that overall malnutrition levels remained remarkably consistent during the period 1989-92. The proportion of children who have a low weight for their age remained relatively high at 15 to 20 per cent in all age groups. The proportion of *stunted* children in a national random sample survey conducted in 1992 was nearly 30 per cent during the first and second years of life and between 20 and 25 per cent during the third and fourth years of life. Malnutrition is not evenly distributed throughout the country, though. It is more prevalent in the drought-prone provinces of Matabeleland North and South and Masvingo. Also, a rural child is almost twice as likely to be malnourished (as measured by mid-upper arm circumference) as a child from an urban high density area.

Government's response to alleviate adverse effects of ESAP

The government of Zimbabwe recognised that "... during the period of transition, certain population groups would be adversely affected by the changes in the economic environment ..." and it therefore "... resolved to protect and support the vulnerable, particularly during the hardships associated with

the initial phase of the ESAP ...". In this spirit, a Social Dimensions of Adjustment programme was designed. The objectives of SDA were (GOZ, 1991 b) to effectively target and design programmes for disadvantaged groups over the economic reform period, while minimising costs to the treasury, by maximising participation and support from third parties, notably NGOs, employee organisations, employer organisations and local authorities.

The major areas targeted for action were employment and training; targeting of food subsidies; cost recovery and social services; and monitoring and evaluation. To co-ordinate the first three activities, a Social Development Fund (SDF) was established to operate two main programmes, namely the Employment and Training Programme (ETP) and the Social Welfare Programme (SWP). Both programmes were to be coordinated by the Social Welfare Department of the Ministry of Labour, Public Service and Social Welfare. The SWP mainly involved the targeting of subsidies in the areas of food, health and education.

While the SDF measures were intended to work as a safety net to protect the vulnerable, their implementation was hampered by a number of factors. Recognising that the impact of the SDF was minimal, especially in non-urban areas, the government launched a new *Poverty Alleviation Action Plan*, in October 1993.

Methodological Considerations

The current project was designed with a view to monitoring and documenting the changes taking place during the structural adjustment process in Zimbabwe. Through the project, started in 1993, about two years after inception of the ESAP, an attempt has been made to collect as much data as possible that reflect the changes that have occurred since 1990/91.

The serious drought that hit Zimbabwe, as well as most other parts of Southern Africa, in 1991/92, has definitely had its impact on the government's ability to implement ESAP. It has also complicated attempts at pin-pointing the specific impact which structural adjustment has had so far on the population's health status and people's ability to cope with ESAP. These developments pose some methodological questions. Some of the issues which must be taken into consideration in conducting research related to structural adjustment and its impact have been highlighted in an earlier publication (Bijlmakers et al., 1996). While the economic reform programme in Zimbabwe was expected to have a major impact on almost every economic and social sector, it is extremely difficult to isolate out and attribute causality to the effects of such a programme. Therefore, the focus of research has, more feasibly, been directed at monitoring the extent and nature of change in the health sector during the period of economic reform, as well as at monitoring change at the household level. The selection of indicators to be used for monitoring purposes has been based on the understanding that the economic reforms are likely to have an influence on both factors *inside* the health sector (health budget, staffing levels, accessibility of services, availability of drugs, quality of services, etc.) as well as on factors *outside* the health sector (education, environment, government subsidies, food prices, etc.). In addition, changes in health services and health status were to be assessed by both *process* and *outcome* indicators. Indicators have ultimately been chosen on the basis of the criteria that they were likely to be easy to measure meaningfully, and that they were likely to be indicative of immediate (although not necessarily immutable) change, particularly at the household level.

Objectives

The general objective of the research was to measure the changes occurring in health and health services during the implementation of the structural adjustment programme, through the monitoring of selected indicators.

The specific objectives of the research were:

a. To determine whether any changes occurred in employment status, sources of income, total household income, households' ability to save and indebtedness.

b. To determine whether any changes occurred in people's health-seeking behaviour in terms of utilisation of health services and other forms of care in case of illness; and to assess the role of factors such as cost and perceived quality of services in making choices.

c. To determine households' food production, purchasing and consumption patterns.

d. To identify and describe the strategies used by people to cover major expenses, specifically for health care.

e. To determine the extent to which households benefited from external assistance, specifically free health services and other social welfare assistance under the Social Development Fund.

f. To monitor the nutritional status of under-five year old children and, if any change is observed, to identify the possible causes.

g. At health facility level, to determine whether any changes occurred in utilisation of specific health services and to explore the possible reasons for these changes.

h. To determine whether any changes occurred in the pattern of illnesses with which patients presented at health institutions, and whether any changes could be detected in mortality rates.

i. To uncover perceptions of both the general public and professional health workers to issues related to professionalism of health workers and quality of care.

j. To promote the utilisation of the findings of the study in policy making at national level, as well as in planning and management of health services at provincial and district levels.

Study sites

To address the objectives, time series comparisons needed to be made between equivalent seasons in successive years. The research period was initially limited to two years (1993 and 1994), but was later extended into a third year (1995). The research was conducted in one urban and one rural area. Chitungwiza was chosen as the urban site, while Murehwa district was selected as the rural area.

Chitungwiza is a large conurbation situated about 30 km south of central Harare, the capital city of Zimbabwe. The city was established in the mid-1970s to accommodate the rapid urbanisation resulting from the changing nature of the economy and the escalating war of national liberation. Few economic opportunities exist in Chitungwiza and many of the employed people commute to and from Harare on a daily basis. The official population of Chitungwiza, according to the 1992 census, was 274,912, of which 49.8 per cent were females (CSO, 1994). Thirty-nine per cent of the population was below 15 years of age, while only two per cent was 60 years or older.

Murehwa district is located in Mashonaland East province, with Murehwa growth point situated at about 70 km to the north of the provincial capital Marondera, and at about 80 km to the east of Harare. The district comprises mainly communal farming areas and a small commercial farming area (Chitowa), that are administered by a rural district council. According to the 1992 census, the population of Murehwa district was 152,505, of which 52.2 per cent were females (CSO, 1993). Forty-eight per cent of the population was below 15 years of age and seven per cent was 60 years or older.

Chitungwiza is served by one hospital, which is administered directly by the MOHCW, and four municipal clinics, administered by the Chitungwiza Town Council. Murehwa District has two hospitals, one of which is owned by the Catholic mission (St Paul's hospital at Musami mission), and 12 rural health centres, of which five are owned by the Government, six by the rural district council and one by the mission. The district receives long-term technical and financial health sector support from Medicus Mundi Belgium (MMB), a non-governmental organisation.

Methods

In terms of data sources, the research project relied on households, as well as the hospitals and clinics in each of the two study areas. A baseline household survey was conducted in May-June 1993 through interviews in more than 300 households in Chitungwiza and another 300 households in Murehwa district. The study was restricted to households with one or more children aged 12 to 59 months whose weights and heights were measured annually. The survey was repeated in May-June 1994, and in May-June-July 1995 among the same households. Information was collected on household composition and housing situation; employment status and sources of income; rural holdings; household expenditure; ability to save and indebtedness; illness episodes and health seeking behaviour; expenses incurred in seeking treatment; satisfaction with treatment; deliveries and antenatal clinic attendance; and nutritional status of children. From the hospitals and clinics data were collected on a variety of indicators covering the period January 1991 to June 1995. Focus group discussions with community members in both Chitungwiza and Murehwa district were held in 1993-94, to discover their perceptions of standards of health services, observations of any recent changes in these, ideas about the possible causes of these changes, and suggestions about what might be done at the local level in response to the situation. In addition, another series of focus group discussions was held with nursing staff of the clinics and hospitals in the two areas, to investigate their experiences with service delivery to patients and raise ideas about strategies that might be adopted in response to any negative influences on clinic and hospital functioning.

Results

A selection of the most pertinent findings from this research are presented below:

a) Changes in Household Economic Situation

Table 3 shows a frequency distribution of the sources of income reported by each household in 1994 and 1995 as "the major source of income". Wages form the major source of income for about two-thirds of the Chitungwiza households. For Murehwa district the decrease in sale of crops as the major source of household income is striking: from more than half of the households to less than a

Table 3: Major sources of income for Chitungwiza and Murehwa district households in 1994 and 1995

	1994	1995
Chitungwiza	(N=281)	(N=266)
Wages	67.6%	65.8%
Vending and trading	17.1%	9.0%
Remittances	6.0%	4.9%
Other sources [1]	9.3%	20.3%
Murehwa district	(N=278)	(N=289)
Sale of crops or garden produce	51.1%	23.2%
Remittances	27.0%	38.8%
Wages	6.8%	14.5%
Other sources [1]	15.1%	23.5%

[1] *Other sources of income include: small-scale manufacturing, crocheting and knitting, maintenance work, brick moulding and construction work, motor mechanics, shop keeping, house rents, pensions, etc.*

quarter. This was due to the poor harvests in 1995, which were caused by poor rainfall. As a result, remittances became the most frequently cited major source of income. The share of "other income sources" and wages was also higher than in 1994. Not less than 15 per cent of the households in Murehwa district cited brick moulding or building as their major source of income in 1995. This activity appeared to have become even more important than wages.

There has, in addition, been a steady diversification in reported sources of income in Chitungwiza households since 1991. The proportion of households that rely on one source of income has fallen from about two-thirds in 1991 to about a quarter in 1995. In Murehwa district, the number of sources of income were highest in 1994. This is illustrated in the figures shown below:

Figure 3: No. of sources of income in Chitungwiza households by year

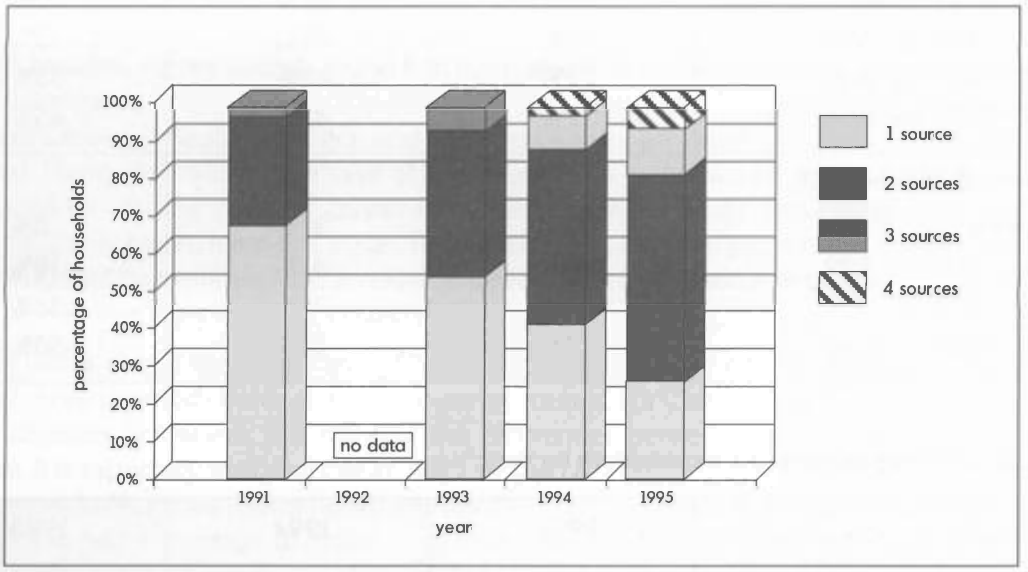
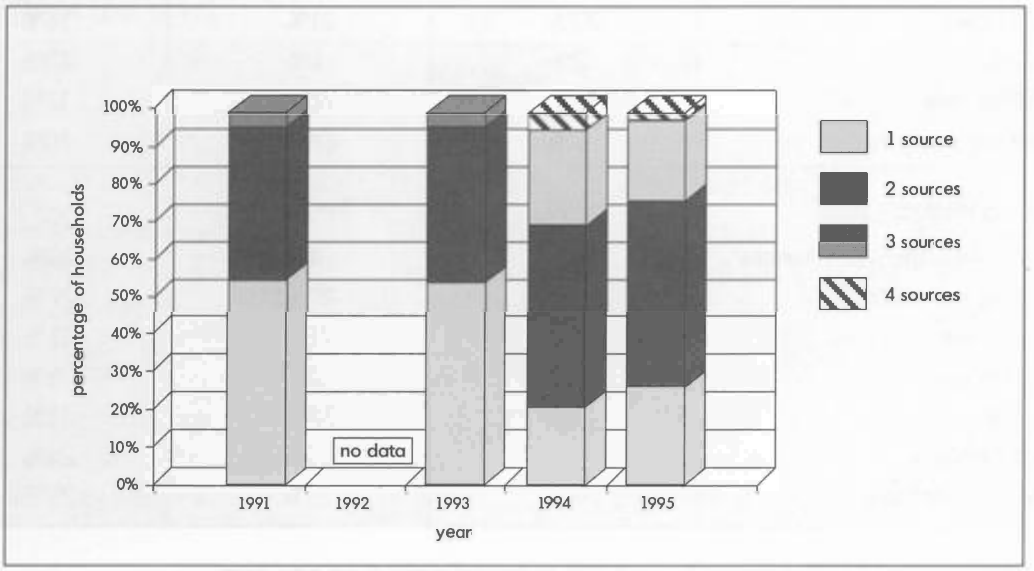


Figure 4: No. of sources of income in Murehwa district households by year



In the 1995 survey efforts were made to estimate total monthly household income from the cash income reported by the interviewees. In terms of the reported change in 1995 household income compared to 1994, a decrease in income was reported relatively more frequently among the low income categories, whereas increase in income was reported more among the high-income categories. This strongly suggests that the income gap has grown during the period of structural adjustment.

Table 4: Reported change in household income by income category in Chitungwiza and Murehwa district (1995)

	Decrease	No change	Increase
Chitungwiza (N=251)			
less than ZWD 400	48%	32%	20%
ZWD 400 to 999	45%	42%	13%
ZWD 1000 to 1999	26%	42%	33%
ZWD 2000 or more	12%	43%	45%
Murehwa district (N=252)			
less than ZWD 400	54%	39%	8%
ZWD 400 to 999	40%	41%	18%
ZWD 1000 to 1999	31%	34%	34%
ZWD 2000 or more	13%	38%	50%

Table 5: Types of reported major expenditure by year [1]

	1993	1994	1995
Chitungwiza	(n=141)	(n=119)	(n=104)
furniture/electrical appliances	58%	25%	24%
building materials	17%	12%	17%
school fees	30%	21%	16%
funerals	2%	8%	13%
medical care	-	26%	17%
other expenditure	3%	24%	30%
Murehwa district	(n=77)	(n=107)	(n=93)
furniture/electrical appliances	27%	4%	10%
building materials	47%	21%	27%
school fees	25%	21%	11%
medical care	2%	6%	6%
funerals	-	28%	11%
seeds/fertiliser	-	20%	24%
other expenditure	-	16%	28%

[1] *Totals exceed 100% as some households reported more than one item*

As far as expenditure was concerned, major expenditures were reported by around 40 per cent of the Chitungwiza households in each of the three survey years. In Murehwa district almost the same percentage reported major expenditures in 1994 when harvests were good, but in 1993 and 1995 it was significantly less.

The major reported expenditures are shown in Table 5.

Expenditure on funerals was not reported at all in 1993, which was probably due to the way the question was phrased in the Shona language. In 1994 more than a quarter of the households in each of the two study areas said they had incurred major expenditures on funerals. The amount of money spent on funerals varied hugely: between 15 dollars and four thousand dollars in Chitungwiza, and between five dollars and three thousand dollars in Murehwa district. The respective median amounts were 400 dollars and 150 dollars. These are considerable sums given the levels of household income. It is estimated that the annual expenditure on funerals forms 36 to 38 per cent of a month's income.

The 1993 baseline survey already found that the majority of households in both study areas (79 per cent in Chitungwiza and 73 per cent in Murehwa district) were no longer buying certain food items because of expense. Meat, bread, rice and cooking oil were the most frequently mentioned items in this regard. Ninety-one and 73 per cent of the households in the two respective areas reported they had reduced the consumption of certain food items. Here the main items mentioned were bread, cooking oil, meat, maize meal and sugar. Remarkable was the high proportion of urban households (31 per cent) that had reduced the amount of **sadza**[1] that they consumed. In Murehwa district, this was the case in five per cent of all households.

The table below shows the proportion of households that claimed not to have had enough food in the two 12 months periods between the three survey rounds. For Chitungwiza there is a slight indication that the situation got worse, but none of the differences between the two periods is statistically significant. It is especially worrying that in 1995 six per cent claimed they had experienced a shortage of maize meal. In Murehwa district both the proportion of households that experienced food shortages and those that had a shortage of maize meal more than doubled between 1994 and 1995. Not less than 13 per cent of the households claimed they did not have enough maize meal for some time in the course of the year. This again can be attributed to the poor harvests because of drought.

Table 6: Households claiming food shortage during the 12 months period prior to survey (1994 and 1995)

	1994	1995	Significance of difference
Chitungwiza	(N=281)	(N=266)	
Periodic food shortage	23%	25%	Not significant
Food shortage during whole year	14%	16%	Not significant
Shortage of maize meal	3%	6%	Not significant
Murehwa district	(N=278)	(N=289)	
Periodic food shortage	8%	18%	$p<0.001$
Food shortage during whole year	2%	1%	Not significant
Shortage of maize meal	6%	13%	$p<0.01$

Information about the number of daily meals, the frequency of meat consumption and the availability of basic grocery items was obtained for Murehwa district households only in the 1995 round of interviews. Twenty-seven per cent reported they did not always have three meals per day. This includes three per cent of the households who usually had two meals. Forty per cent of households said they had meat less than once a week; 30 per cent had meat once a week; 14 per cent had it twice a week; and 16 per cent had it three times a week or more often. Of a list of six basic commodities, which included cooking oil, body soap and soap for washing clothes, five per cent of the households had none of these items available at the time of interview, and 25 per cent had only one or two items available. This further illustrates the precarious financial situation of a large proportion of the households in the rural area.

b) Changes in Health Service Utilisation

Among those who went to a public health facility in Chitungwiza, the proportion of patients who paid for the services received declined over the years, although not significantly in statistical terms. In 1995 still more than half of the patients were paying. In Murehwa district there was a huge decline in paying patients between 1994 and 1995. This is attributed to the abolition of fees at rural health centre level in early 1995. The 19 per cent who still paid a fee in 1995 did so at one of the hospitals.

The table (below) shows the actual amount of money that was paid on average by patients visiting a public health facility. The average cost of treatment in Chitungwiza almost doubled between 1993 and 1994. Whereas the fees at the Chitungwiza municipal clinics in 1993 were 1.50 and 3.60 dollars for children and adults respectively, the actual cost of treatment that was incurred was more than six dollars on average. There are three reasons for this: firstly, some patients incurred higher costs as they went to the hospital rather than one of the clinics; secondly, drugs were usually not included in the consultation fee, so they were charged for separately; and thirdly, some patients were referred from the clinic to a private pharmacy, and incurred extra costs for drugs.

Table 7: Consultation fees[1] and actual average cost of treatment incurred by those going to public health facilities, by year (in ZWD)

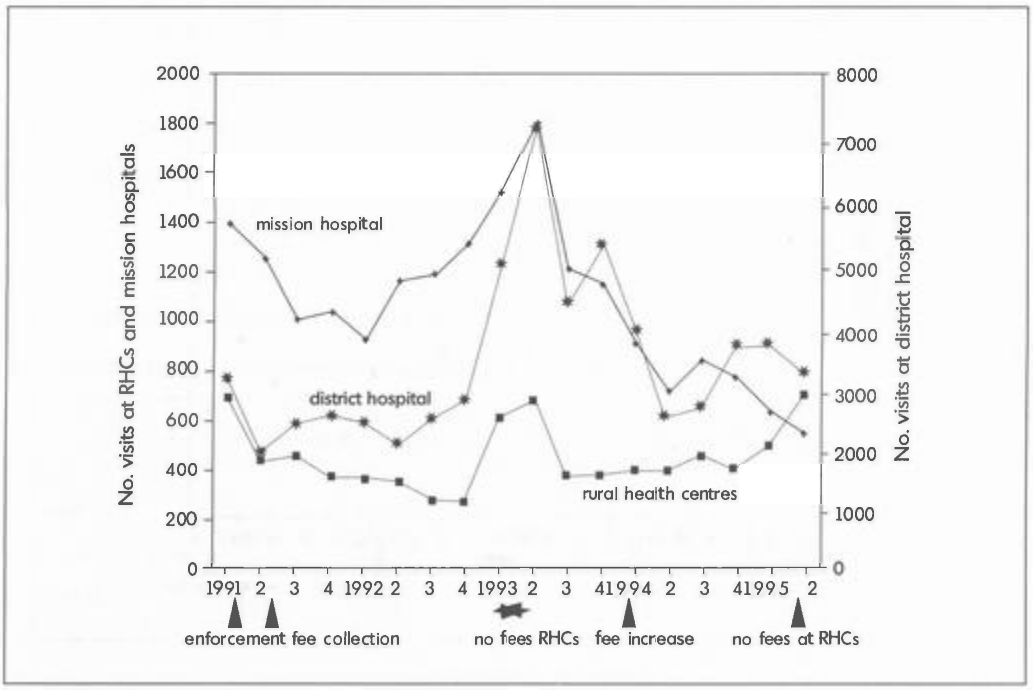
	1993	1994	1995
Chitungwiza			
Children's consultation fee	$ 1.50	$ 8.00	$ 8.00
Adults' consultation fee	$ 3.60	$ 16.00	$ 16.00
Average cost of treatment	$ 6.20	$ 12.00	$ 10.59
Murehwa district			
Children's consultation fee	$ 1.00	$ 3.00	nil
Adults' consultation fee	$ 1.50	$ 6.50	nil
Average cost of treatment	$ 6.67	$ 8.2	$ 12.68

[1] *Consultation fees are those charged at municipal clinics (Chitungwiza) and rural health centres (Murehwa district)*

In Murehwa district, the average cost of treatment also increased considerably over the three years, rising to almost thirteen dollars in 1995, or almost twice the fee charged at rural health centres. This is mainly because most of those who paid went to one of the two hospitals in the district, which charge consultation fees of 17 dollars for adults and 8.50 dollars for children.

The figure shown below illustrates the trends in the number of new patients who visited the outpatient departments (OPD) of Murehwa district hospital, the mission hospital and the average rural health centre, respectively, over the four and a half year period.

Figure 5: First OPD visits in Murehwa district by quarter (1991-1995)



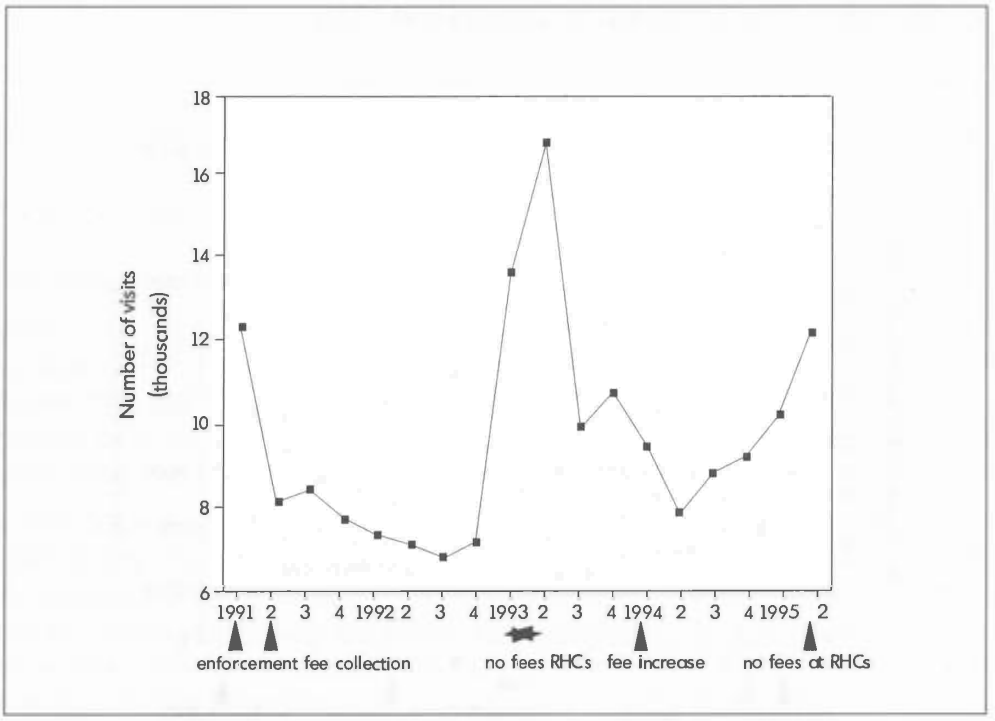
It clearly shows that attendance levels at rural health centres (RHCs) increased in the first half of 1993, when no fees were charged. There were actually more than twice as many patients seen as in late 1992. It is likely that the drought and the free distribution of food and meals for children under five years of age also attracted more patients, but those events covered longer periods than the six months during which there were no fees. The higher level of OPD attendance was exactly during this period. Between mid-1993 and early 1995, attendance levels were slightly higher than in 1992. In the second half of 1995 outpatient visits to RHCs rose by more than a third. This again can be attributed to the abolition of fees in March 1995.

At the district hospital attendance levels were very high in early 1993, which must be attributed to the combined effects of drought and the free health services at rural health facilities. During that time, the waiting times for patients at the hospital OPD were excessively long. Attendance levels started to fall in late 1993, before the huge fee increase of January 1994. The second half of 1994 showed a slight recovery. At the mission hospital, attendance levels fell during the whole of 1991 and into 1992, when user fees were increased twice. They increased during the 1992 drought year, with a peak in early 1993, similar to what happened at the district hospital. After mid-1993 attendance has been falling almost continuously to reach a level below that of the average RHC. This is remarkable, because the mission hospital used to receive two to three times more patients than the average RHC.

With the fee increase in January 1994, the Ministry of Health and Child Welfare (MOHCW) planned to strengthen the referral system. Figure 6 shows that OPD attendance at the hospitals, which had started falling already, dropped even further. However, the expected corresponding increase in RHC attendance did not happen until March 1995, when fees at RHCs were abolished.

The total O.P.D. attendance for the whole district is shown in the figure below:

Figure 6: Total of first OPD visits for Murehwa district as a whole by quarter



It is clear that there is a strong association with changes in user fee policies: the enforcement of fee collection in 1991, the temporary abolition of fees at RHCs in 1993, the January 1994 fee increase and the abolition of fees in March 1995.

Table 8 gives an overview of the maternity fees that were reported as having been paid in four different time periods. In Chitungwiza the proportion of women paying maternity fees has decreased over the years, to about two-third in 1995. In the rural area, this has not been the case and in the 1995 survey 97 per cent of the women who delivered at health facilities reported to have paid maternity fees.

Those who paid in Chitungwiza saw the fees almost double between 1993 and 1994 to 120 dollars. Compared to what most women paid five years earlier, the increase was as much as eight-fold. The fee increase in Murehwa district was much more modest: most women paid ten or 12 dollars, but those who delivered in one of the hospitals paid 60 dollars.

The majority of women who had a baby between mid-1994 and mid-1995 claimed they booked for delivery (and paid the maternity fee) when going for ante-natal care (93 per cent in Chitungwiza, 90 per cent in Murehwa district). However, there is strong evidence that home deliveries in Murehwa district are on the increase. Table 9 shows that the proportion of home deliveries has increased steadily from an estimated 18 per cent in the period 1988-91, to 38 per cent in 1995. In Chitungwiza there is no such trend, although a record ten per cent of the reported deliveries in 1994 did not take place at a health institution.

Of the 14 home deliveries reported by interviewees in 1994, three were from families who were members of the Apostolic Faith who generally refuse modern medical care. In 1995, five out of 16

women who had home deliveries were Apostolic Faith members. This suggests that the majority of women who have home deliveries (70 to 80 per cent) have reasons other than religious ones for not having their babies at a health institution. Distance from home to the clinic (especially in rural areas) and financial constraints seem the most plausible reasons.

The evidence from this research, therefore, is that in Chitungwiza the huge increase in maternity fees has *not* led to a corresponding increase in home deliveries. But in Murehwa district home deliveries have increased *despite* a much more modest increase in maternity fees.

Data gathered at health facilities in Murehwa reveal that the total number of deliveries reported by all health institutions combined has not changed significantly over the years, as shown in the figure.

Home deliveries were not reported previously, but since mid-1994 most health facilities have been reporting the home deliveries that they had knowledge of. The data suggest that 15 to 20 percent of all deliveries do not take place in health institutions, but this is an under-estimate as surely not all home deliveries are reported. In 1993, the number of home deliveries reported by RHCs was more than half the number of deliveries conducted at the RHCs themselves (56 per cent). For the period

Table 8: Maternity fees paid at health facilities by period [1,2]

	1988 - 1991	1992 - mid 93	mid 93 - mid 94	mid 94 - mid 95
Chitungwiza	(n=243)	(n=69)	(n=39)	(n=33)
women paying fees	87%	87%	74%	66%
mean fee paid	$ 51	$ 64	$ 126	$ 119
mode	$ 15	$ 65	$ 120	$ 120
Murehwa district	(n=202)	(n=98)	(n=39)	(n=39)
women paying fees	89%	91%	82%	97%
mean fee paid	$ 22	$ 21	$ 28	$ 42
mode	$ 7	$ 7	$ 12	$ 10

[1] *n = number of women who booked and/or delivered at health institutions*
[2] *Fees do not include ward fees which are due when staying overnight in the hospital or clinic*

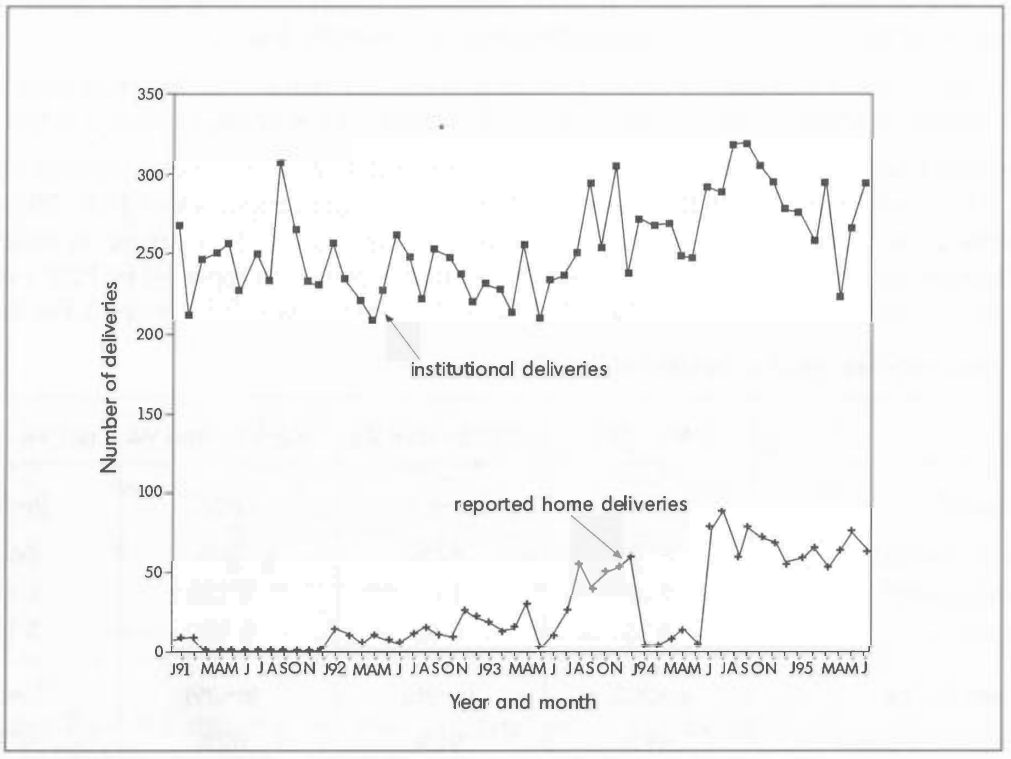
Table 9: Home deliveries as a proportion of total reported deliveries in Chitungwiza and Murehwa district, by period

	1988- 1991[1]	1992- mid 93	mid 93- mid 94	mid 94- mid 95[2]	Significance of difference
Chitungwiza	(n=259) 4%	(n=72) 4%	(n=42) 10%	(n=34) 3%	Not significant
Murehwa district	(n=217) 18%	(n=100) 21%	(n=42) 24%	(n=43) 38%	p=0.06

[1] *Data for 1998-91 were obtained in the 1993 base-line survey*
[2] *Place of delivery was not reported in 1995 for four Chitungwiza households and three Murehwa district households*

July 1994 to June 1995, this was no less than 82 per cent. Although it is hard to speak of a trend, because of incomplete reports, this suggests that the number of home deliveries may be as high as, or even higher than the number of deliveries that take place at RHCs.

Figure 7: Institutional and reported home deliveries in Murehwa district



c) Changes in Child Nutritional Status

The total number of children with valid and complete measurements in all three survey years is 190 for Chitungwiza and 216 for Murehwa district. This corresponds to 52% and 59% of the original samples at baseline in the two respective areas.

A paired analysis of growth data was done. This implied that for each child with at least two sets of anthropometric measurements, the differences in Z-scores were calculated for both the height-for-age and the weight-for-height indicators. Thus, the mean change in Z-scores was calculated between 1993 and 1994, as well as that between 1994 and 1995. In addition, the mean change over the entire two year period (1993 to 1995) was calculated.

Table 10 shows that in Chitungwiza height-for-age improved significantly between 1993 and 1994 ($p<0.01$), but remained almost unchanged in the year thereafter. Overall, the improvement between 1993 and 1995 is statistically significant ($p<0.01$). Weight-for-height, on the other hand, deteriorated in the first year ($p< 0.05$), but partly recovered in the second year. A slight improvement was detected over the two years, but this was not statistically significant. In Murehwa district, height-for-age improved significantly in both years, with an overall gain in Z-score of almost half a point over the two year period ($p<0.0001$). The improvement between 1994 and 1995, however, should be attributed in part to the high loss to follow-up of stunted children. The mean weight-for-height severely deteriorated in the first year ($p<0.0001$). Despite a small recovery in the second year, the overall change over two years is still significantly negative ($p<0.01$).

Table 10: Absolute change in nutritional status in Chitungwiza and Murehwa district, by indicator and by age category (paired data) [1]

	Mean change in Z-scores		
	1994 versus 1993	1995 versus 1994	1995 versus 1993
Chitungwiza	(n=241)	(n=215)	(n=224)
Height-for-age			
24-35 months	+ 0.362	+ 0.155	
36-47 months	+ 0.090	- 0.186	+ 0.164
48-59 months	+ 0.226	+ 0.018	+ 0.124
60-71 months	+ 0.275	- 0.086	+ 0.117
72-83 months		+ 0.215	+ 0.530
Overall	+ 0.236 (p<0.01)	- 0.002 (not significant)	+ 0.219 (p<0.01)
Weight-for-height			
24-35 months	- 0.261	- 0.080	
36-47 months	+ 0.149	+ 0.133	- 0.122
48-59 months	- 0.151	- 0.036	+ 0.147
60-71 months	- 0.348	+ 0.060	- 0.063
72-83 months		+ 0.420§	+ 0.152
Overall	- 0.143 (p<0.05)	+ 0.111 (not significant)	+ 0.018 (not significant)
Murehwa district:	(n=256)	(n=247)	(n=277)
Height-for-age			
24-35 months	+ 0.239	+ 0.455	
36-47 months	+ 0.078	+ 0.335	+ 0.550
48-59 months	+ 0.191	+ 0.194	+ 0.356
60-71 months	+ 0.409	+ 0.139	+ 0.287
72-83 months		+ 0.250	+ 0.694
Overall	+ 0.211 (p<0.01)	+ 0.254 (p<0.001)	+ 0.459 (p<0.0001)
Weight-for-height			
24-35 months	- 0.279	- 0.040	
36-47 months	- 0.456	- 0.079	- 0.300
48-59 months	- 0.415	+ 0.143	- 0.432
60-71 months	- 0.335	+ 0.191	- 0.157
72-83 months		+ 0.206	- 0.209
Overall	- 0.372 (p<0.0001)	+ 0.089 (not significant)	- 0.283 (p<0.001)

[1] *Ages are as calculated for the year first mentioned in the heading of each column*

Discussion of Main Findings

The findings can be summarised in three main categories: changes in household economy, changes in health service utilisation and changes in health outcomes, as evidenced by changes in nutritional status.

a) Changes in household economy

Compared to the previous year (1994) a decrease in household income was reported by about a third of the urban households and 42 per cent of the rural households, but these figures were much higher in the lowest income categories, as well as among the de jure female headed households in the rural area. Comparison of the data from the three survey rounds showed that household income sources had been diversified in Chitungwiza between 1991 and 1995. In Murehwa district the reported number of household income sources had increased strongly between 1993 and 1994, but showed a slight decrease between 1994 and 1995. Diversification of income sources was done primarily by taking on a wider range of informal activities. Growing maize had become significantly more popular in Chitungwiza, where new food growers were found to produce mainly for their own consumption. Self-sufficiency in maize, however, fell significantly between 1994 and 1995. In Murehwa district it fell to just 30 per cent of all households, compared to 76 to 80 per cent in the previous two years. The pattern of household expenditure in both rural and urban settings had also changed. Funerals accounted for an increasing proportion of expenditure in Chitungwiza, which accompanied a decline in expenditure on medical care, school fees and household furniture and electrical appliances. In both areas people also reported reduced expenditure on clothing, use of transportation and consumption of food.

With regard to food consumption, a decline was found in both the quality and the quantity of food. Spells of food shortages within the household in Chitungwiza appeared to be more common and of longer duration than in Murehwa district, although in the rural area the situation in 1995 had become much worse compared to the previous year. About three-quarters of households in both areas reported they no longer bought certain food items because of expense. Particularly meat, bread, rice and cooking oil had become luxury items. More than a quarter of the households in Murehwa district in 1995 reported they did not always have three meals a day, while 40 per cent said they had meat less than once a week. The high proportion of urban households which in 1993 had reduced the amount of *sadza* (the main staple food) that they consumed was alarming: 31 per cent.

While significant proportions of households in Murehwa district benefited from food aid in 1993 through the Child Supplementary Feeding Programme and the Food-for-Work Programme, this was no longer the case in 1994 as these programmes were stopped in between the first two survey rounds. Very few households reported having received assistance from social welfare organisations in the urban setting: less than five percent in each of the three survey years received assistance with school fees , food money or blankets. In the rural setting four to six per cent received assistance in 1994 or 1995, mostly in the form of fertiliser and/or seeds. It is clear that, five years into the ESAP era in Zimbabwe, the "targeted assistance" is still very far from finding its target. There is no evidence that the new Poverty Alleviation Action Programme, which was designed on the same basis as the SDF, has had a significant impact on the living conditions of those hardest hit by the economic decline, as the proposed measures hardly involve any structural changes that may improve the plight of the poor.

b) Changes in health service utilisation

Clinic-based monthly statistics confirmed that out-patient attendance responded strongly to changes in user fee policies, with total outpatient attendance in both the urban and the rural area falling dramatically after the January 1994 fee increases.

There is also strong evidence that home deliveries in the rural area are on the increase. In 1995, a record 38 per cent of the women who gave birth did not deliver at one of the health institutions. While Chitungwiza residents experienced a two-fold increase in fees between 1993 and 1994 to ZWD 120, those in Murehwa district saw a much more modest increase. The combined effects of the increase and the strict collection of maternity fees has obviously contributed to the increase in home deliveries in the rural area, which has also been confirmed by the clinic-based statistics.

c) Changes in child nutritional status

Some highly significant changes were found with regard to child nutritional status. The overall prevalence of stunted growth, which reflects long-term adverse influences, seemed not to have changed much in Chitungwiza, while in Murehwa district it seemed to have declined. It is concluded that the negative influence stemmed from the period 1991 to mid-93, and that the drought of 1990-92 could have caused nutritional stress which by 1993 was being reflected as stunting. Children in the rural area had to some extent been able to recover from stunting between 1994 and 1995. The prevalence of acute food deprivation, as indicated by higher levels of nutritional wasting, increased between 1993 and 1994 in the rural area, and declined between 1994 and 1995 in the urban area. The analysis of paired observations indicated that the levels of wasting between 1993 and 1994 deteriorated both in Murehwa district and in Chitungwiza. The deterioration in the rural area was very severe in all age categories. This indicates short-term deficiencies, or significant nutritional stress. Unlike in the urban area, the deterioration in the rural area was hardly reversed between 1994 and 1995. In other words, the children in the rural area had become more skinny between 1993 and 1994 and they remained skinny between 1994 and 1995. This is attributed to the combined effects of poor harvests due to drought, economic depression and possibly HIV-associated disease.

Conclusions and policy implications

The issue of the social impact of structural adjustment has attracted a lot of attention since the mid-1980s, notably after the publication of the much cited work *Adjustment with a Human Face* by Comia et al. (1987). Some have claimed that there is little evidence of the existence of any general rule with respect to "winners" and "losers" in the adjustment process (for example, Azam, 1994). Others are more outspoken, not least the World Bank itself, the most powerful advocate of structural adjustment.

The 1994 World Bank policy research report *Adjustment in Africa - Reforms, results and the road ahead* investigated 29 countries in Sub-Saharan Africa that were undergoing structural adjustment some time between 1987 and 1991 (World Bank, 1994). The report asserts that (page 7):

> *In African countries that have undertaken some reforms and achieved some increase in growth, the majority of the poor are probably better off and almost certainly no worse off. The poor are mostly rural (sic!), and as producers, they tend to benefit from agricultural, trade and exchange rate reforms and from the demonopolisation of important commercial activities. As consumers, both the urban and the rural poor tend to be hurt by rising food prices. But adjustment measures have seldom had a major impact on food prices in either the open market or the parallel market, which supplies most of the poor.*

This view is clearly much too optimistic, and it is not supported at all by the findings of the current research, neither by work done by others. In a very comprehensive, and probably the best review so far of studies on the impact of structural adjustment on the health of mothers and children, Costello et al. (1994), in their report *Human Face or Human Facade*, convincingly conclude that

> *.... there is indicative evidence that adjustment has had a negative effect on welfare...*

and

> *... at the same time there is little evidence for the proposition that adjustment promotes sustainable economic growth (at least in low-income countries), which is central to the view that the social costs of adjustment are temporary and off-set by long-term benefits.*

The authors find it

> *... equally questionable that 'safety net' programmes have had more than a marginal effect in limiting the impact (of adjustment).*

They state that very few studies have attempted to document the changes undergone by households in Sub-Saharan Africa over any length of time during structural adjustment periods. This is because, on the one hand, it is difficult to measure the social impact of structural adjustment, and on the other hand, the possibilities to do research were limited as few countries had not yet implemented structural adjustment programmes when social change became a topic of interest. With regard to the latter, Zimbabwe was an exception and therefore it offered the almost ideal setting to study the social and health dimensions of change at the household level.

The changes that are documented in this report concern the period when Zimbabwe went through its early and intermediate phases of economic structural adjustment (up to mid-1995). There is strong evidence that there has been a serious economic degradation of the poor in both urban and rural areas in Zimbabwe, and there is no sign that this process has come to a halt. It has also been demonstrated that very few households receive assistance from the SDF.

The traditional gap between the rich and the poor appears to have widened and a substantial part of the population is no longer able to cope with the adverse effects of economic decline. This calls for a revision of the targets and strategies of the economic structural adjustment programme that is being implemented in Zimbabwe. Secondly, the government's failure to protect the health sector from budgetary cut-backs and to guarantee high quality and affordable services at the primary level of care since ESAP was introduced in 1991, appears to have had a negative impact on households' welfare. It is therefore suggested that more resources be made available for primary health care facilities. Maternal services (antenatal and delivery care) should be provided free of charge, as well as all other outpatient services at primary care centres in poor urban areas and not just rural, where they are now free.

The results of this research, which is ongoing, are disturbing and confirm the fundamental importance of socio-economic influences on health. The policy implications for countries implementing structural adjustment programmes are clear. Although South Africa is not (yet) a recipient of World Bank or International Monetary Fund assistance and, therefore, not required to implement a S.A.P., the recent macro economic reforms introduced as part of the Growth, Employment and Redistribution Programme (GEAR) are strikingly similar to the components of structural adjustment. Consequently close monitoring of social and economic changes as well as changes in health service utilisation and health status would seem appropriate.

End note

1 Sadza is the staple food in Zimbabwe, which is made of maize meal

THE NIGERIAN HEALTH AND HUMAN RIGHTS SITUATION IN THE CONTEXT OF STRUCTURAL ADJUSTMENT

Abdulrahman Sambo

National Universities Commission
Abuja, Nigeria

Introduction

Nigeria came into existence as a political entity in 1914 with the amalgamation of the then Northern and Southern British Protectorates. It is one of the largest countries in Africa with an area of 923,768 sq. kilometres, an estimated population of over 100 million in 1997 and consists of over 250 ethnic groups and tribes. The three major tribes, are the Hausas in the North, Igbos in the Southeast and Yorubas in the Southwest. The rate of natural increase is 3.0% while life expectancy at birth is 53 years. The population doubling time is 22 years. Of the total population, children below the age of 15 constitute about 59%.

This paper attempts to examine the health status of Nigerians and the human rights situation in the country in the context of structural adjustments. The first section looks at the political and economic situations in the country and the introduction of Structural Adjustment Programmes. The second section examines the effect of these factors on the health and human rights of Nigerians, while the third and final part proposes some changes that need to occur within the context of the current situation in the country.

Political situation

Nigeria attained independence from Britain in October 1960 and experienced its first military coup in January 1966, the sequel of which was a bloody civil war from July 1967 to January 1970 when the south-eastern part of the country attempted to succeed. As part of the measures to redress the political crisis that led to the civil war, the country was divided into 12 autonomous states in 1967 and local government authorities were created in 1975. Today there are 36 states in the Federation with a Federal Capital Territory and 775 Local Government Councils. The main reason for this large number of states and local councils was to decentralise government to bring it nearer to the people at the grassroots level. Since independence 37 years ago, the country has had 10 heads of state, 7 of them military. One of the civilian heads of state was only in office for about 80 days. For the 37 years of independence, the military have ruled for about 28 years. All the 36 states of the federation are currently ruled by military administrators while the local government councils are headed by civilian administrators.

The most serious political crisis the nation went through, apart from the civil war, has been the annulment of the 12th June 1993 Presidential elections, the aftermath of which brought the present military regime to power in November 1993 and from which the nation is yet to recover. A transition programme to hopefully return the country to a democratically elected government in 1998 has however been put in place.

Socio-economic situation

About 65% of Nigerians live in rural areas. A great majority of these rural dwellers are either subsistence farmers or depend on informal sector employment for survival. Adult literacy rate for males and females are 62% and 40%[1] respectively, while primary school enrolment is about 64%.[2] 75% of the population in urban areas have access to safe drinking water. The corresponding figure for the rural areas is 41%, giving a national figure of 47%.[3] The GNP per capita for the country is USD 300.[3] The GNP per capita average annual growth rate between 1965-1980 was 4.2% while between 1980-1992 was -0.4%.[3]

At independence, Nigeria's economy was solely based on agricultural export production with little industrial base. Immediately after independence, crude oil became the main export commodity for the country. Nigeria is an exporter of the highly coveted "Bonny light" crude oil. The oil crisis of the early 70's resulted in a large transfer of wealth to Nigeria - the so called oil boom years. Oil exports then contributed more than 90% to the GDP. The oil glut of the late 70's and 80's compelled the country to take a 2.4 billion dollars loan to check the worsening balance of payment situation.[4]

In 1982, Nigeria incurred current account deficits of about 8% of GNP. Nigeria's volume of crude oil export was cut by 50% between 1980 and 1983 and the commodity was over priced leading to loss of sales. This, coupled with a decline in non-oil exports led to a fall by 60% of the dollar value of Nigeria's export.[5]

The search for solutions to the economic crisis in the early to mid eighties ranged from increasing the debt-service ratio, debt rescheduling, financing budget deficits through bank loans, to the introduction of the Structural Adjustment Programme (SAP) in September 1986.

Such a programme basically involves:

(a) Trade Liberalisation

(b) Currency devaluation

(e) Curtailment of imports and reduction in public sector spending including removal of subsidies.

(d) Commercialisation and privatisation of some public enterprises.

These measures had and continue to have drastic effects on socio-economic status of the majority of Nigerians. Currency devaluation, introduction of minimum wages and removal of consumer subsidies have greatly reduced the purchasing power of the people. Curtailment of public sector expenditure has led to cut-back in social sector financing, especially health and education. This trend is seen in almost all states of the Federation. Enrolments in primary schools have been declining mostly because parents would rather keep their children at home to contribute to the family-coping strategies through informal employment. Another factor resulting in the decline of enrolments is the lack of any economic benefit to acquiring education and in many cases inability of the parents to pay for their education.

A decrease in school enrolment leads to an increase in the number of children in informal sector employment which range from street trading/begging to teenage prostitution.

Structural adjustments and health

The health status of Nigerians is similar to most other developing countries. The introduction of SAP however, has led to a worsening of the health and nutritional status of the people. This is reflected in the poor nature of the major health indices as shown in the table below:[6]

This demographic and health survey clearly indicates the general and poor health status of Nigerians and the dramatic differences across regions and social groups.

Table 1: Major Health Indices for Nigeria

Background Characteristics	Under 5 Mortality	Infant Mortality	Under 5 Stunted	Diarrhoea Prevalence	Total Fertility Rate	Adolescent Fertility
Residence:						
Urban	129.8	75.4	35.0	11.7	5.03	17.4
Rural	207.7	95.8	45.5	19.6	6.33	32.7
Region:						
Northeast	214.6	87.7	51.9	23.9	6.53	50.2
Northwest	244.4	109.8	50.4	25.7	6.64	46.2
Southeast	143.7	82.7	36.6	12.2	5.57	16.7
Southwest	167.2	84.6	35.6	8.7	5.46	10.8
Mother's Education	210.1	95.9	48.1	20.1	6.50	52.1
Some Primary	191.1	97.5	38.6	14.4	7.17	26.6
Completed Primary	137.7	79.8	39.7	17.2	5.57	21.2
Some Secondary	149.8	92.9	35.9	12.7	5.07	8.2
Completed Secondary	77.3	48.6	23.1	8.9	4.18	12.2
Total	191.0	91.4	43.1	17.9	6.01	28.3

Source: Federal Office of Statistics 1992 and Demographic and Health Survey

SAP has also brought to the nation a changing pattern of disease. Diseases associated with poverty and other consequences of structural adjustment are on the increase including Sexually Transmitted Diseases (including AIDS), Tuberculosis and other vaccine preventable diseases are all on the increase. The country recorded its first case of AIDS in 1986 and by 1992 the prevalence of HIV was 1.4%. This increased to 3.8% by 1994.[7] The prevalence showed wide differences among socio-economic and age groups. A survey of workers in the sex industry showed HIV infection prevalence of 22.5%. The corresponding figure for STDs and TB patients were 8.9% and & 7.8% respectively.[7] Of particular concern however, is the age groups most affected, 15-19 years for females and 20-29 years for males and the large pool of susceptible people due to the large population of the country.

Immunisation coverage for the six childhood preventable diseases has also shown a drastic fall from about 90% in the early 90s to less than 30% in 1995.[8]

Structural adjustment has been having negative effects on the health and nutritional status of Nigerians mostly through the following :

Decrease in public social spending including health and education

This led to the introduction of 'reform' within the health system which in the Nigerian context meant the introduction of user charges in public hospitals. Even though the budgetary allocation to health had been increasing, in real terms it had actually been decreasing. A 1992 study showed decreasing per capita health expenditure over the years by all the three tiers of government as shown in the table below.[9]

Table 2: Per Capita Health Expenditure, Federal Government and Selected States (in 1987 Naira)

Government Level	1985	1986	1987	1988	1989	1990	1991	Average 1985-91
Federal	3.15	4.90	4.02	3.54	2.31	3.77	3.90	3.66
Average State	8.42	8.23	9.05	6.12	5.23	6.85	6.08	7.18
Akure LGA	1.23	1.16	1.54	2.28	2.35	2.32	3.52	2.06
Total	12.80	14.34	14.61	11.94	9.89	12.94	13.50	12.90

Sources: Thomas 1992 a-d for States (Benue, Kano, Lagos, and Plateau); Federal Ministry of Health and Social Services; Akure Local Government Estimates.
Expenditures adjusted to 1987 Naira using Consumer Price Index.

Introduction of user charges has led to a drop in hospital attendance all over the country. Patients now rely more on traditional healers or visits to local drugstores for treatment of diseases. It is not uncommon to see patients taking half the doses of drugs prescribed to them (including antibiotics) either as a cost-saving measure or because that was all they could afford. The consequences include the emergence of drug resistant infections which have already been witnessed. The impact of this is seen more in patients with STDs, Tuberculosis and Malaria. Inappropriate treatment of STDs has been shown to be a predisposition to acquiring HIV infection.

Reduction in budgetary allocation to health in real terms is also posing a serious threat to the purchase of vaccines, drugs and dressings which are mostly imported. This has attributed to a drastic decline in the immunisation coverage for children and pregnant women. The worsening situation in the public health system has resulted in an unprecedented increase in private medical practice mostly beyond the reach of the poor.

Within the educational sector, fees and levies have been introduced leading to a drop in total school enrolment especially at primary level. The net effect is that more and more children are dropping out of school, a situation that would have serious repercussions to manpower production and socio-economic development of the country.

Rising unemployment across the country with more people living below poverty line, and expansion in informal sector employment which in the case of women includes prostitution

Similarly, the country is witnessing a large scale rural-urban immigration leading to congestion in the cities and increased prevalence of diseases associated with overcrowding like meningitis. Just last year, the country had one of the worst meningitis epidemic in recent times. Urban congestion also places severe stress on the already cash strapped social services like water supply as evidenced by a high incidence of water-borne diseases like typhoid fever and gastroenteritis. Rural-urban migration has also been shown to be a contributory factor to the spread of HIV and AIDS.

Removal of subsidies especially on fertiliser and petroleum products

Lack of fertiliser or unaffordable cost of the commodity has severely affected agricultural production in the country. Diminished agricultural production, emphasis on cash crops and poverty have been having serious negative effect on nutritional status of children and pregnant women in particular. Apart from causing higher mortality, malnutrition before birth or early childhood reduces a person's capacity to take advantage of additional employment opportunities.[9] Malnutrition

among Nigerian children is significantly higher than in most other developing countries. A Federal Office of Statistics survey in 1990 found that 43% of Nigerian pre-school children are chronically malnourished.[9]

Removal of subsidies on petroleum products led to an over 700% increase in the pump price of petrol with resultant hyper-inflation and increase in cost of transportation. For the poor living in rural areas, this means inability to afford transport fare to the cities/towns to attend hospitals.

Currency devaluation in a bid to stimulate exports has resulted in escalating costs of imports including drugs and vaccines

This has added to the high cost of health care in the country. Similarly, the policy has led to an astronomical level of inflation and severe decrease in the purchasing power of the people.

Human Rights and SAP

The first direct effect of SAP on the human rights situation in Nigeria was in 1988 when the citizens under the co-ordination of university students embarked upon a nationwide demonstration against the economic measures introduced by government (the 'SAP RIOTS'). This led to the killings of a number of people mostly students by soldiers and the police who were drafted to restore 'law and order'. Similarly, demonstrations and more killings occurred in 1989. In response to the widespread riots, government introduced 'SAP relief packages' exclusively targeted at the civil servants who only formed about 1% of the population.

Decreasing agricultural production and increased reliance on crude oil as the main export earner led to increased exploitation of the commodity with serious consequences on the environment and health of the people due to degradation of agricultural land and pollution to rivers thereby affecting their main livelihood - fishing and farming.

Protests against the environmental effects of crude oil exploitation was sometimes seen by the government as a threat to its economic policies and such protesters were termed economic saboteurs. But human rights should be seen beyond the interpretation given to it in Nigeria i.e. freedom of speech and expression. While it is true that the degree of press freedom in the country is far better than most other African countries, fundamental human rights should be viewed in all its ramifications. This would include among others, the right to:

- education (which is suppose to be free and compulsory at primary level in the country)
- food and nutrition
- health care
- shelter

The economic crisis and SAP as highlighted earlier have drastically affected these fundamental rights. Of recent, however, the human rights situation in the country has taken a 'bashing by the international community principally as a result of the 'Ogani crisis'. But these crises are political in nature (and not directly related to structural adjustment) following the annulment of the June 12th presidential elections.

Conclusion

Structural adjustments as prescribed by the IMF, have been shown in many studies not to have led to the expected economic recovery in most of the countries that implemented the programme. It has

rather led to a further widening of the gap between the rich and the poor and the near-total wiping out of the middle class. Various measures were put in place to ameliorate the burden of SAP on the poor. In Nigeria, 'relief packages' to cushion the effect of SAP were introduced to civil servants. Such measures include an increase in some allowances to workers, increasing the minimum wage and setting up of some infrastructures and institutions that execute projects mostly in the rural areas. Examples of such institutions include the Directorate of Food, Roads and Rural Infrastructures (DFRRI), Oil Mineral Producing Areas Development Commission (OMPADEC) and recently, the Family Support Programme (FSP).

The current military administration has since coming to power in November 1993 'abandoned' SAP - at least the IMF prescribed version. The country doesn't take foreign loans anymore and has introduced some economic measures that have arrested the falling value of the local currency. Budgetary allocation to social sectors have been improving in real terms (due to stabilisation of the exchange rate). The removed subsidy from the petroleum products is now being revamped back into the social sector through a Petroleum Trust Fund which was set up by government recently. The benefits of all these measures, however, go to the upper class rather than those intended for. The only solution to the socio-economic problems facing the country with its resultant effects on the people would be to establish a truly representative democratic government that is answerable to the people. Socio-economic factors that lead to unemployment, rural-urban migration, landlessness, school drop-outs, poverty and the place of women in society must equally be addressed for any meaningful development in the health and well being of the people.

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GLOBALISATION OF AGRICULTURE AND THE GROWTH OF FOOD INSECURITY

Vandana Shiva

Research Foundation for Science, Technology and Ecology
India

Can *Globalisation of agriculture provide food security?*

The Draft Plan of Action for the UN Food Summit to be held in Rome in November categorically states that 'trade is vital to food security'. The reference here is not to the local or national trade in food which has been taking place for centuries, but to global free trade in food which is being pushed by Structural Adjustment Programmes (SAP) and the Uruguay Round of GATT.

Trade liberalisation and globalisation of agriculture is meant to increase production of food, increase efficiency of food production, improve the economic situation of farmers and improve patterns of food consumption. However, the evidence presented by the experts at the international conference on "Globalisation, Food, Security and Sustainable Agriculture" held in Delhi on 30th and 31st August showed that globalisation was deepening food insecurity world-wide.

In country after country trade liberalisation is leading to a decline of food production, productivity, conditions for farmers in the North and in the South, coupled with food insecurity for the consumers of both the North and the South.

External liberalisation vs internal liberalisation

External liberalisation

Liberalisation of agriculture can be either internal or external. External liberalisation is characterised by foreign trade and foreign investment-driven liberalisation. External liberalisation serves the external interests. Agricultural liberalisation under SAP is an example of such external liberalisation. It consists of the following elements.

- liberalising fertiliser imports and distribution as well as deregulating domestic manufacturing and the distribution of fertilisers
- removing land ceiling regulation
- removing subsidies on irrigation, electricity and credit and creating conditions to facilitate the trading of canal irrigation water rights
- deregulating the wheat, rice, sugarcane, cotton and edible oil and oilseed industries
- dismantling the food security system
- removing controls on markets, traders and processors, and subsidies to co-operative's
- abolishing the Essential Commodities Act
- abolishing the general ban on futures trading
- abolishing inventory controls

- abolishing selective credit controls on inventory financing
- treating farmers' co-operatives on an equal footing with the private sector.

The above elements of the SAP are methods for removing centralised control over agriculture and consolidating it further in the hands of Agribusiness Transnational Corporations (TNC's) such as Cargill, Pepsico etc; who are emerging as the new Zamindars, controlling not just land use, but water use and seeds.

The Agreement on Agriculture of the World Trade Organisation (WTO) is another example of external liberalisation. Agriculture has never been part of GATT. It was introduced during the Uruguay Round. The Agreement on Agriculture has three sections :

- Export competition or export liberalisation
- Market access or import liberalisation
- Domestic support or reduction of domestic subsidies

In addition, the Agreement on Sanitary and Phyto Sanitary Measure as well as the Agreement of Trade Related Intellectual Property Rights (IPR's) also affect agriculture and food security.

Internal liberalisation

Internal liberalisation of agriculture is liberating agriculture in the direction of ecological sustainability and social justice. This includes:

- freeing agriculture from high external inputs such as chemical fertilisers and pesticides and making the transition to sustainable agriculture based on internal inputs for ecological sustainability
- freeing farmers from capital intensive farming and debt
- freeing peasants from landlessness
- freeing farmers from fear of dispossession by monopolies of land, water and biodiversity
- freeing the poor from the spectre of starvation by ensuring food as a human right
- freeing rural people from water scarcity by ensuring inalienable and equitable water rights
- freeing knowledge and biodiversity from IPR monopolies
- rebuilding local food security, reinvigorating local markets

Internal liberalisation of agriculture is a pre-condition for food security while external liberalisation undermines food security.

The health and nutrition dimension

Without safe and nutritious food free of health hazards there can be no food security. Food security is a human rights issue from all the above perspectives. It includes the right to resources, the right to work, the right to cultural diversity, the right to health and the right to information.

Globalisation of agriculture is violating all components of food-related human rights. The rights of small producers to land, water and biodiversity are being violated by undoing land reform, by privatisation of water, and by monopolisation of seed and plant genetic resources through (IPRs). Ecological rights of all citizens are being violated by the spread of ecologically destructive industrial and factory farming methods. The right to work of small producers is being violated by the destruction of their livelihoods. The right to cultural diversity is being violated by the spread of an unsafe and

unhealthy culture practised by many international companies. The right to health is being violated by factory farming methods and food processing methods that promote disease and ill health. The right to information is being violated by denying consumers the right to know what they consume. 'Reports from the Planet' presented at the conference gave detailed analysis and experiences of how globalisation is leading to the violation of the universal right to food security.

In her welcome address on Globalisation and Food, the author of this paper said that "the US and the other industrialised countries of the North are trying to change the meaning of food security from being a fundamental human right to participation in global markets, which excludes the large number of poor without adequate purchasing power". They are also trying to redefine food security to exclude food safety issues. Food security has always meant adequate, safe, nutritious and culturally appropriate food. While this meaning was inscribed in the earlier draft plans of action, it has been removed in the current draft (of the World Food Summit).

The fallacy of the "comparative advantage"

The logic of comparative advantage argues that a nation can enhance efficiency in resource use and hence, net welfare by producing and exporting commodities in which it is relatively efficient, and importing commodities in which it is not. However, there are five reasons why the theory of comparative advantage is fallacious when applied to food security in the context of globalisation :

1. Comparative advantage works when capital is nationally rooted and does not have free mobility across national borders. The structure of comparative advantage therefore breaks down in the free trade regime with free mobility of capital.
2. When it is more profitable to grow flowers than foodgrains, comparative advantage leads to a decline in food production globally. Every country needs food and no single country can substitute for the collapse of domestic food production and the consequent food insecurity in other countries, since food production unlike automobiles and T.Vs, is limited by land availability and climatic factors.
3. The category of 'efficiency' depends on the context in which it is measured. Financially efficient systems can be ecologically inefficient, and efficiency with respect to labour inputs is totally different from efficiency with respect to capital inputs.
4. The financial calculus used for the comparative advantage calculation in food is based on a fictitious and fixed 'international price'. Food prices are not stable and fixed. They are a function of imports and exports. When a large country like India stops domestic production and imports large quantities of a particular commodity on grounds that it is cheap on the international market, the international prices go up by the very fact of importing, undermining the comparative advantage. Prices can also be manipulated by the TNCs that have monopoly control on food and grain trade.
5. In free trade, it is not countries but corporations which export and import, and what is deemed 'efficient' for corporations need not be efficient for the countries in which they operate.

Globalisation and food insecurity in the South: - Shrimps, Flowers and Hunger

Field studies show that trade liberalisation is generates food insecurity on at least three levels. It is leads to:

- a transfer of resources from peasants to industry, displacing small farmers and creating new poverty as unfair contracts lock them into a new form of bondage

- a shift of land use from the production of staple foods to luxury and non food crops (cash crops) such as shrimps and flowers for exports
- a removal of food subsidies, lowering domestic consumption, and increasing food exports.

Resources and livelihood insecurity linked to alienation, the production insecurity linked to the decline in food production, and the consumption insecurity linked to the decline in consumption are all leading to food insecurity. A paper on Globalisation and Agriculture in India by this author, Ms Radha Holla and Ms Kusum Menon illustrated through field studies how food production was being undermined by trade liberalisation policies. Food growing land is being diverted to non-food crops such as flowers or luxury commodities such as shrimp. Farmers are being displaced on a massive scale and natural resources are being over exploited. Corporatisation of agriculture, which is being pushed under trade liberalisation as a successor of the Green Revolution, is leading to new poverty for small farmers, as unequal and unfair contracts lock them into a new form of bondage. Farmers of Punjab who, were contracted by PepsiCo to grow tomatoes received only Rs.0.75p per kg while the market price was Rs.2.00. First the farmers rejected PepsiCo and PepsiCo has abandoned Punjab and sold its tomato processing plant to a subsidiary of Levers.

Declining areas under foodgrains production

Dr Amitava Mukherjee, Executive Director, ACTIONAID India in his paper on International Trade and Food Security confirmed that the area under food crop production in India is on the decline, as is evident from the fact that the index for area under food grains (1981-82)= 100) declined from 100.7 to 97.3 between 1990-91 and 1994-95, while the index for the area under non-food crops increased from 120.0 to 125.7 during that period. Production of coarse cereals and pulses, the main food for the poor has shown a declining trend. As reported by Dr. Sulabha Brahme, the total production of cereals has declined from 10.74m tons in 1990-91 to 9.60 million tons in 1995-96 while the total requirement has increased from 13.74 to 14.08 million tons in the state of Maharashtra. In Gujarat, as reported by Dr. Darshini Mahadevia and Dr. Indira Hirway, the area under food grain has declined from 4.6 m.ha in 1990-91 to 4 m.ha in 1993-94. Tihe area under wheat has declined from 71 m.ha to .48 m.h while the area under jowar has declined from .853m.ha to .376 m.ha.

Dr. Abhijit Sen of Jawaharlal Nehru University illustrated how liberalisation of domestic production and consumption of food is declining. Removal of food subsidies has led to a decrease in the purchase of food from the public distribution system. The off-take of rice had declined from 10.1 metric ton in 1991-92 to 6.9 metric ton in 95-96. Tihe off-take for wheat has gone down from 8.8 metric ton to 3.8 metric ton. While agricultural exports as a percentage of total exports had gone down from 19% to 16% cereal exports had gone up from 1.4% to 3.4%, indicating that exports were increasingly based on the creation of domestic food insecurity.

Aquaculture

Dr. John Kurien of the Centre for Development Studies, Trivandrum, elaborated how industrial aquaculture and fisheries are promoted with bilateral and multilateral aid for 'short term parking' of international capital in a specific location for a period of time during its race for profits. Tihis 'rape and run' industry is also based on the enclosure of the common resources of coastal communities. Tihey pose a threat to existing patterns of food production which imply a direct threat to national and local food security since the production feeds into the international luxury demand for humans and pets of affluent countries.

In 1992, Mexico imported 20% of its food. In 1996 it was importing 43%. Eating "more cheaply on imports is not eating at all for the poor in Mexico". One out of every two peasants is not getting enough to eat. In 18 months since NAFTA, the intake of food has been destroyed by 29%. 2.2 million Mexicans have lost jobs and 40 million are in extreme poverty.

The Kenyan experience

Dr. Regassa Feyissa, Director of the Biodiversity Institute Ethiopia said Africa was being treated merely as a cheap source of labour. Kenya was importing 80% of its food, while 80% of its exports were accounted for by agriculture. In Kenya, grain imports have risen, subsidised by the European Union, undermining local production and creating poverty by oversupply. In 1992, EU wheat was sold in Kenya 39% cheaper than the same wheat was purchased by the E.U from European farmers. In 1993, it was 50% cheaper. In 1995 Kenyan wheat prices collapsed through oversupply. All this in a country which was self-sufficient in the 1980s.

Dr. Kamal Malhotra Co-Director of FOCUS on the Global South referring to South Korea reported how the country had shifted from food self-sufficiency 40 years ago to dependence on the US today. During the five-year period from 1986 to 1991 agricultural imports in South Korea went up from US$1.8 billion to US$5 billion. In the Philippines, acreage under rice was declining, while it was increasing under cut flowers. 350,000 rural livelihoods will be destroyed by shifting from corn, rice and sugarcane to cut flowers and vegetables for export. The import of 59,000 metric ton under the minimum access requirement of GATT will displace 15,000 families annually.

The experience of the United Kingdom

Referring to massive growth of food insecurity in Britain, Dr. Tim Lang, Professor of Food Policy at Thames Valley University said there were mountains of food in his country and miles of Super Market shelves but many Britons could not afford an adequate diet due to rising unemployment and declining social welfare. One-fifth of the population is classified as not being able to afford a nutritious diet. Poverty, he said, was a reality even in rich countries.

Five companies control 70 per cent of the food market in the UK. There is growing food insecurity even in rich countries as food systems become more centralised. The distance for shopping for food had increased from 2 miles to 5 miles, increasing "food miles" embodied in food and creating a motorway food system. Globalisation is expected to double the CO^2 emissions through increased transportation, leading to more unpredictable fluctuations in climate which undermine food security. The Environmental Minister of Denmark Mr. Svend Auken while opening the First Organic World Exhibition in Copenhagen, had stated that 1 kg of grapes imported from South Africa to Europe contributes to 10.5 kg of CO2 emissions. This is obviously not an efficient food system. Long distance transport and intensification of agriculture are linked. Tim Lang said that Britain had shifted from a policy for small farmers to a policy against farmers. The British model of farming, where farmers were systematically thrown out of agriculture was being spread to other parts of the world.

The Mad Cow disease, he said, was the result of intensification of agriculture. The disease which had affected dairy cows and beef cows, totally undermined UK.'s beef trade and had led to the extermination of 1,65,000 cows because of the risk of the transfer of the infection to humans. The farmers, he said, were now questioning intensification of agriculture, adding that the big lesson for the public was that you cannot squeeze nature to maximum. Mad cow disease was challenging free-trade, as 'passports' for sources of beef were becoming necessary to regain consumer confidence. "We must stop intensification. We must re-inject food security in the system", Tim Lang said.

Philip Lymbery, from Compassion in World Farming, UK. said the repercussions of Mad Cow Disease were going to be immense. It proved the pitfalls of factory farming. Since World War II, half a million farmers had disappeared following the corporatisation of agriculture in UK. Displaying slides, he showed how cattle were reared in inhumane conditions. In UK. alone, he said, 600 million broiler chickens were raised annually. They were kept in cages too small for their-well-being, with the result that 75 per cent of the chickens were dying of heart failure. In intensive dairying, male calves were useless and were kept in inhumane conditions in a cage until they are six months old and are then ready for slaughter. They are then exported. One of the biggest popular movements in UK. has emerged as a result of this violence to male calves.

Russia

In Russia, as reported by Vera Matusevich, Agricultural Economist, World Bank, Russia, production and consumption of food has dramatically declined as a result of trade liberalisation and transition to a market economy. One third of Russians are now below the poverty line. 50% of food is being imported. Production has declined by 33% between 1990 and 1995. The livestock sector has declined by 40%. Meat production fell from 8.3 million tons in 1992 to 5.9 million in 1995. At the same time, import of meat increased from 1.4 metric ton to 2.1 metric ton. In 1995 imported meat accounted for about 25% of all meat consumption. These imports are concentrated in big cities which account for 70% of retail turnover. Mafia's, linked to trade, are dumping contaminated food on Russian consumers. Free trade in food has implied the growth of trade in low quality food, replacing the healthy, nutritious, and culturally diverse diets of people. Food security includes access to safe food. However, food safety is being systematically excluded in the Food Summit documents.

The globalisation of agriculture is in fact merely corporatisation of agriculture. Kristin Dawkins, Director of the Research Institute for Agriculture and Trade Policy of United States said the US government had led the world in promoting globalised monopolies through international trade agreements, assisted by such bullying tactics as unilateral leveraging of its vast markets. She said under encouragement from the US government, food corporations controlled US agriculture and were now attempting to control world agriculture. Dawkins said in 1994-95, ten cents out of every food-dollar spent in the United States went to Philip Morris and another 6 cents went to CongAgra. Four companies (IBP, ConAgra, Cargill, and Beef America) sold 87 per cent of all slaughtered beef. Two companies, i.e. Kelloggs and General Mills sold two thirds of all ready-to-eat breakfast cereals. Campbells sold 73 per cent of all canned soups. Frito-Lay sold 85 per cent of all corn chips and 40 per cent of all potato chips. Craft, which is owned by General Foods, sold more than half of all sliced processed cheese.

Squeezing farmers off the land

Small farmers are paying the price for this corporatisation. They are treated as dispensable in the US. and the dispensability of the small farmer is now being globalised through trade liberalisation. As Kristin Dawkins reported in 1962, the Committee on Economic Development which advised the White House, recommended the displacement about two million of the present farm labour force, plus an equal number to a large part of the new entrants who would otherwise join the farm labour force.

Kenneth Boulding, an agricultural economist from the University of Michigan, described their plan bluntly: " The only way I know to get tooth paste out of a tube is to squeeze, and the only way to get people out of agriculture is likewise to squeeze agriculture. If the tooth paste is thin, you don't have to squeeze very hard, on the other hand if the tooth paste is thick, you have to put real pressure on it". A.V. Krebs, Director, Corporate Agribusiness Research Project, and author of "Corporate Reapers" reports that in 1990 nearly 22 per cent of US. farm operator households had incomes below the official poverty threshold, twice the rate of all US. families. In 1993, over 88 per cent of the average

farm operator household income was derived from off-farm income. From 1982 to 1993 the index of prices received by farmers rose only 7.5% while the index of prices paid by farmers for inputs multiplied over threefold to 23 per cent. As Krebs queried, "Is it any wonder that our farmers during the period from 1990 to 1994 saw an almost minuscule 1.98 per cent return on their investment?" Is it any wonder that from 1987 to 1992 in the US. farm entries dropped to less than 67,000 per year, while exits averaged 99,000 per year resulting in the net loss 32, 000 farms a year.

In the India Consultation preceding the conference, Dr. B.D. Sharma, ex-Commissioner, Scheduled Castes and Scheduled Tribes, and ex-Vice Chancellor of Northeastern Hill University, had stressed how hidden disinvestment in agriculture was built into SAPs through which rural production systems were being disinvested of human and natural capital. Financial investment in the agricultural sector by agribusiness and corporations has created new forms of dispossession for small and marginal farmers and landless agricultural workers. Though agriculture provides the material and capital base for industry in India, agricultural wages are far lower than wages in the urban sector, and the costs of inputs that farmers buy from the industrial sector are much higher than the prices they get. The embodiment of labour in agricultural produce has been devalued by either treating family farm labour as of zero value because it is free and by paying farm workers much lower wages than the minimum survival wages. As a result, peasants are being pushed off the land. Their uprooting is being facilitated by policies that are transferring rural capital from farming communities to private investors. This migration of both capital and labour from agriculture is the real disinvestment in agriculture. The current policies of the government, allowing corporatisation of agriculture will result in the last 30% of the population, the poorest, being wasted out. 'Farming has been made a non-viable occupation; farmers have been made a dispensable commodity.'

In contrast, Mr. Jakhanwala, Secretary, Ministry of Food and Civil Supplies, stated that 'if the small farmer is no longer viable, let him disappear.' Mr. Jakhanwala put forward the government position on trade liberalisation and corporatisation of agriculture. While Dr. Bandopadhyay, ex-Secretary, Government of India and Chairman, Indian Institute of Management, Calcutta, in his speech, gave evidence that equity and productivity were positively correlated, Mr. Jakhanwala insisted that 'we cannot produce more through increased equity. Let more food be produced in any mode. Then, separately, let poverty be removed. We have to separate poverty alleviation and food security from productivity increase.' He justified the transfer of resources from small-holders to corporations and industrialists on grounds that 'higher production needs inequity because larger farmers are more efficient'.

The difference in the viability between the small but more productive farm and the large but less productive farm is the difference in the relative factor prices available to the small holder and the large investor. For the large investor, capital and natural resources are cheap but labour is costly. For the small holder, labour is cheap while capital and natural resources are costly. Policies favouring the rich improve their factor prices. Policies could however also be created which improve the viability of the small farmer. Dr. Bandopadhyay said that corporatisation of Indian agriculture was not necessary from the productivity aspect. On the contrary, he said, 'corporatisation has to be prevented to prevent depeasantisation and the death of India'. To ensure the survival of India's peasants, who are the only guarantee for India's food security, the right to work has to be recognised as a fundamental right. This was stressed both by Mr Bandopadhyay as well as Mr. Mishra, Secretary, Ministry of Labour.

The myth of the unproductive small farmers: Which productivity? Whose efficiency?

The main argument used for the industrialisation of food and corporatisation of agriculture is the low productivity of the small farmer. But as Dr. Bandopadhyay pointed out even the World Development Report (WDR) has accepted that small farms are more productive than large ones.

In Brazil, the productivity of a 0-10 ha farm was $85/ha while the productivity of a 500 ha farm was $2/ha In India, a 0-5 acre farm had a productivity of Rs.735/acre while a 35 acre farm had a productivity of Rs 346/acre. The state of Bengal was showing the highest rate of growth of 6.5% for agriculture as a result of land reform, while the rate of growth for India was a mere 3%.

Even biologically, small diverse farms have higher productivity than large monoculture farms as long as multiple yields are taken into account. Productivity of monocultures is low in the context: of diverse outputs and needs. It is high only in the restricted context of output of 'part of a part' of the forest and farm biomass. For example 'high yield' plantations pick one tree species among thousands, for yields of one part of the tree (e.g. pulp wood). 'High yield', green revolution cropping patterns pick one crop among hundreds e.g. wheat for yields of one part of the wheat plant (only grain). These high partial yields do not translate into high total (including diverse) yields. Productivity is therefore different depending on whether it is measured in a framework of diversity or uniformity. Biodiversity-based productivity measures show that small farmers can feed the world because in terms of multiple yields they have high productivity. An article in 'Scientific American' has developed this approach further, and has shown how the economic calculations of agricultural productivity of the dominant paradigm distort the real measure of productivity. By leaving out the benefits of internal inputs derived from biodiversity as well as the additional financial and ecological costs generated by purchase of external inputs to substitute for internal inputs in monoculture systems.

In a polyculture system, five units of input are used to produce 100 units of food, thus having a productivity of 20. In an industrial monoculture, 300 units of input are used to produce a 100 units of food, thus having a productivity of 33. The polyculture system which has been called "low yielding" and hence incapable of meeting food needs is therefore sixty times more productive than the so called "high yielding" monoculture. The relevant measure for food security is nutrition per acre, measured in all its diversity, not yields of grain per unit labour. In non-sustainable systems, even the output based on high external inputs was not maintainable. Quoting Mr Obaidullah Khan, Head of FAO's Regional Office for Asia and Pacific, Martin Khor of Third World Network said that the intensive model of Green Revolution agriculture was not sustainable due to rising costs and falling yields.

As in the case of crop production, industrial fisheries and aquaculture also consume more resources than it produces. As Dr. John Kurien pointed out, in 1988, global shrimp aquaculture consumed 1,800,000 tonnes of fishmeal derived from an equivalent of 9 lakh tonnes wet-weight fish. It is further estimated that by the year 2000 about 5,700, 000 tonnes of cultured fish will be produced in Asia. The feed requirement for this will be of the order of 1.1 million tonnes of feed. This is equivalent of a staggering of 5.5 million tonnes of wet-weight fish, nearly double the total marine fish harvested in India today. Fishmeal provides the crucial link between industrial aquaculture and industrial fisheries since the fish used for fishmeal is harvested from the sea through trawlers and purseseines which totally deplete marine stocks. This falsifies the often used argument by the agencies like the World Bank that promotion of aquaculture is like moving from hunting and gathering to settled agriculture in fisheries and will reduce the pressure on marine resources.

In spite of all evidence pointing to the high diversity, productivity and sustainability of small family farms, globalisation is wiping out these efficient systems, and replacing them with unhealthy industrialised food system under corporate control. Sustainability and equity are both built into small producer based food systems, which also use resources sufficiently. However, these ecologically efficient systems are being wiped out by reducing their resource base through policies related to trade liberalisation.

Alienation and monopolies on land, water and biodiversity

Land, water and biodiversity are the natural resources that make agriculture possible. Trade "liberalisation" policies are leading to the alienation of these resources from peasant communities and the concentration of their ownership.

Land

The last five years of economic "reforms" in the agricultural sector have in effect been an undoing of the earlier reform process which were guided by values of social justice and equitable distribution of resources. While the positive protections afforded to small farmers and poor consumers and to self reliance in food for the country have been removed, the "reform" package has increased the tendency to centralise control over agriculture. The most significant instrument of social justice in independent India had been the land reform legislation in different states to ensure equitable entitlement to land and to prevent concentration of land ownership. Under World Bank Structural Adjustment pressure, combined with the greed of a new breed of absentee landlords or "zamindars", industrialists, agribusiness corporations, speculative investors, land reform laws in every state are being undone, alienating the land from small producers and cultivators, swelling the ranks of the landless, the dispossessed, the unemployed. Karnataka has amended the Land Reforms Act of 1961, which undoes the radical reforms that made the tillers the owners of the land and prevented non-agriculturists from becoming absentee land owners. The amendments reintroduce leasing, allow the non-agriculturists and industrialists to own land, and remove land ceiling for aquaculture, horticulture, floriculture and housing industry. The land reform amendments have been described as Predatory Capitalism and Legalised Land Grab.

Dr Sulabha Brahme reported that the government of Maharashtra has relaxed restrictions on conversion of agricultural lands to non-agricultural land. The agricultural Land Ceiling Act has been amended to permit large land holdings. This has led to a skyrocketing of land prices. Between 1991-1995, prices of land in villages around Pune have increased six-to-ten tonnes - from Rs.300,000 per/ha to Rs.1.5 to 2.5 million per hectare. In the banana growing district of Jalgaon, the land values have increased during the last five years by two to two and half times. The new land policy announced by Gujarat Government seeks to remove a major hurdle in the commercialisation of agriculture and the introduction of new zamindari. Feudalism was abolished in Saurashtra in 1950 and tenancy rights were given to girosdors (poor cultivators) . The new land policy is snatching away the land from those who had been empowered through land reform legislation of independent India.

Dr. Mahadevia and Dr. Hirway showed how land legislation has been changed in Gujarat. According to the Gujarat Land Acquisition Act, those possessing or intending to possess agricultural land should be staying within eight km. limit of the land. This restriction was introduced to check the concentration of agricultural lands in the hands of few and those not engaged in agriculture. This law has been amended, and the restriction of 8 km. on purchase of agricultural lands was removed on March 31, 1995. The second amendment in land legislation allows the alienation of lands from those who received it under and redistribution policy. These lands were not saleable to ensure that the livelihoods of the poor were protected. About 2.1 million landless peasants had received an entitlement to 2.5 million acres in Gujarat through land reforms which have been undone through the new amendments. Almost a quarter of such lands have been sold in rural areas around Ahmedabad. The state government has also declared a policy through a Government Resolution of August 9, 1994 that village commons (called wastelands) will be leased out for horticulture, plantations, and other agricultural purposes to corporations. For the first two years no lease money will be charged, after which Rs.25/acre will be charged in the third year. As a result of these changes, area under food crop in Gujarat has declined from 5.2m.ha in 1990-91 to 5.1m.ha. in 1993-94 and area under non-food crops has increased from 5.3m.ha to 5. 5m.ha.

Water

Trade liberalisation is also leading to the privatisation of water. The World Bank policy paper of liberalisation of agriculture recommends the creation of 'markets in tradeable water rights'. It is argued that 'if rights to the delivery of water can be freely bought and sold, farmers with new crops, or in new

areas, will be able to obtain water provided they are willing to pay more than its value to existing users, and established users will take account of its sale value in deciding on what and how much to produce'. This institution of tradeable water rights is a guarantee for diverting water from small farmers to large corporate super-farms. Tradeable water rights will lead to water monopolies. In the logic of the market, tradeable rights have a tendency to be sold to the highest bidder and will hence lead to water-power linked to concentration of wealth. It will also lead to over-exploitation and misuse of water, since those who deplete water resources do not have to suffer the consequences of water scarcity as they can always buy water rights from other farmers or move to other regions. Besides, aggravating the already severe ecological crisis in water resources, Tradeable water rights will destroy the social fabric of rural communities and create discord and disintegration. The social breakdown in Somalia can be traced, in part, to the privatisation of water rights according to the World Bank policy. Tradeable water rights are based on the assumption that no ecological or social limits should be placed on water use. Such use without limits leads to abuse. The World Bank proposals on tradeable water rights are a prescription for social and ecological disaster.

For instance, the section on reforms in irrigation sector in the new Agriculture Policy of Karnataka talks of a shift from a "top down to bottom up" approach. The privatisation and tradeable water approach, is definitely a bottom up policy, but not in the sense of democratic control. It is bottom up since it moves the control over water resources upwards from small and marginal farmers to large corporations and agribusiness interests who can buy up the 'water equity shares' of 'water users associations', and establish monopoly control on water. This has already happened in Sri Lanka, where export corporations have purchased shares from farmers, thus leading to displacement of farmers from agricultural activities and livelihoods.

Biodiversity

Intellectual Property Rights (IPRs) regimes are enabling corporations to have monopoly control over seeds and biodiversity. Seeds have been evolved by farmers over centuries. However, seed corporations are declaring seeds to be their "intellectual property". Dr. Regassa Eeyissa highlighted the struggle over seed and "farmers' rights" at the Leipzig conference on Plant Genetic Resources. This author reported on cases of biopiracy with regard to the patenting of neem and turmeric.

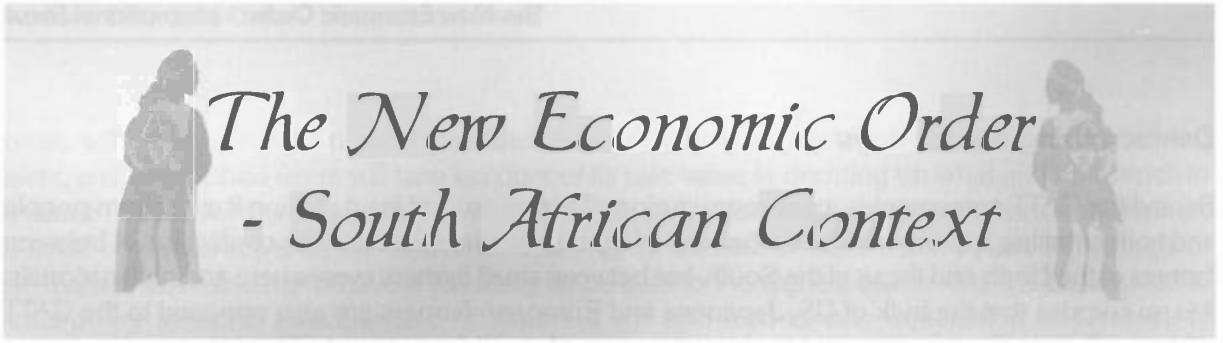
The session on Biodiversity and Biotechnology elaborated how IPRs will encourage monopoly control of plant material by TNCs and undermine food security in the biodiversity rich third world. W.R. Grace has patents on Neem which will deprive third world farmers of access to ecologically safe pest control. Agracetus, a subsidiary of Grace, has broad species patents for soya bean and cotton. These patents, put in the hands of a single corporation, has the monopoly over what we grow on our farms and in our gardens. The myth of low productivity of diversity based small farms is also being used to promote genetic engineering. In her paper on Biodiversity and Biotechnology, Beth Burrows called genetic engineering "a form of Structural Adjustment but directed by Ciba Geigy and Monsanto rather than by the World Bank and IMF". The monopoly control over resources will increase even more dramatically if investment is fully liberalised. The corporations pushed for trade liberalisation of agriculture under the Uruguay Round of GATT. They are now demanding total freedom of investment as a right. As Martin Khor of the Third World Network stated, now the industrialised countries were threatening to launch a new Uruguay Round at the WTO Ministerial Meeting to be held in Singapore at the end of the year. The biggest issue was the Multilateral Investment Agreement, under which no country would have the right to screen foreign investment. Corporations wanted the right to enter and establish themselves with 100 per cent equity, total freedom to repatriate profits. They could buy farmers, land, set up plantations and fisheries and also undertake livestock rearing.

Democratising the food system

Behind the GATT agreement is a raw restructuring of power around food : taking it away from people and concentrating it in the hands of a handful of agro-industrial interests. The conflict is not between farmers of the North and those of the South, but between small farmers everywhere and multinationals. It is no surprise that the bulk of US, Japanese and European farmers are also opposed to the GATT reforms - these reforms are meant to drive the mass of small farmers out of business.

In the third world, most small farmers are women, though their role has remained largely invisible and has been neglected in official agriculture adjustment programmes. "Free trade" as constructed in the GATT is based on the denial of freedom of rural women to produce, process and consume food according to local environmental, economic and cultural needs.

Democratising the food system involves the rebuilding of local food security as a basis for national food security. Democratising the food system also involves a shift from monocultures to diversity. It involves a shift from an obsession with dollars per acre to a concern for nutrition per acre. Democratising the food system involves the democratic right of consumers to know what they eat. This includes the right to labelling of genetically engineered and chemically processed foods. Democratising the food system needs to be based on internal liberalisation rather than external liberalisation. Democratising the food system involves putting people and nature, not trade, at the centre of food and agricultural policy.



IMPLICATIONS OF THE NEW MACRO-ECONOMIC FRAMEWORK (GEAR) FOR DEVELOPMENT IN SOUTH AFRICA

Rob Davies

Chairperson of the South African Parliament's National Assembly
Portfolio Committee on Trade and Industry
South Africa

The subject of my talk is about the Government's Macroeconomic Policy, the growth employment and redistribution programme which was adopted last year (GEAR). In fact this programme was only adopted fairly recently and I think it's too early at this point to say what the actual impact on the ground will be in terms of development. All I could do at this point is to basically say that I think the kind of study which Dave Sanders and colleagues have carried out in Zimbabwe is precisely the kind of monitoring which I think we need in South Africa. I think that the bases and resources exist to carry this out.

I say that because, as the Chairperson indicated, there is not only one document that is meant to inform Government's economic policy, there is also the Reconstruction and Development Programme, (RDP) which was the basic programme on which the Government came to power. I think that the RDP, defined a whole series of projects, programs and priorities for Government over the five-year period. It defined an approach toward the issues of growth and development. It basically says, and I quote from the document :

> *"The RDP is based on reconstruction and development being parts of an integrated process. This is in contrast to a commonly-held view that growth and development or growth and redistribution, are processes that contradict each other. Growth, the measurable increase in the output of the modern industrial economy, is commonly seen as the priority that must precede the development. Development is portrayed as a marginal effort of redistribution to areas of urban and rural poverty. The RDP breaks decisively with this approach."*

In other words, I think what the RDP was saying, (and I think that this vision remains valid in the case of South Africa and most other developing countries) unless there is sustainable economic growth, which is an increase in the output of goods and services, there will not be sustainable development, that is an improved standard of living of the people. Simultaneously, unless there is development-orientated growth, the conditions will not be created for sustained and sustainable growth in South Africa. I think that the basic issues of redistribution, development and improving living standards of the people in the country, are absolutely essential to creating the conditions that are necessary for economic growth.

Please note that this paper is an edited transcription of the paper delivered at the conference since Rob Davies' paper was not available at the time of printing.

What I'm actually going to clarify then, rather than talk about the impact or implications so much, it is quite important to understand at least two or three things about the GEAR. Firstly, I am going to talk about the context under which the GEAR was adopted, secondly, the main features or elements of GEAR, and thirdly some of the issues which have been posed by the GEAR.

First of all, the context. I think that this conference is quite well-named in the sense that very clearly the new international order or new international disorder, as it is sometimes known, has clearly impacted on South Africa and has influenced the shape of the GEAR, there is no question about that. I think it's also important to understand that the GEAR was intended to address at least two significant problems in the domestic economy and was therefore partly driven by at least two domestic considerations.

The first one was that it was recognised at the beginning of 1996, and it was said in a speech by the President, that what South Africa was experiencing and had experienced in the year and a half since the elections in 1994, was this phenomenon of jobless growth. In 1995 for the first time we actually had an increase in economic growth above the increase in the growth in population. It was the first time in about two decades. If we look at the employment figures, the employment growth in 1995 was only about 0,7%, much less than the rate of economic growth, and in fact the number of new jobs that were being created was much less than the number of new entrants onto the labour market. If you look at what happened in 1996, the situation got worse. According to the Reserve Bank quarterly bulletin for September 1996, and I quote from it:

> *"Relentless cost-cutting by South African producers to maintain and expand market share in an increasingly open and competitive business environment had contributed to a fall of 2.5% in private sector employment since the beginning of the current recovery in economic activities."*

That was in 1993/1994. So, there has actually been a contraction in employment and what is happening is that we are producing a jobless growth. The GEAR was partly based on a series of economic modelling exercises, whose base is the subject of enormous debate. I don't want to go into that, but the base scenario which I think most of us would say is essentially correct points to two things: firstly that the kind of growth which seemed likely from projections from 1995 into the next five years would not yield the kinds of job creation that would be necessary to absorb the number of new entrants into the labour market. From the beginning of last year there was a whole discussion and debate about what was necessary to achieve a higher rate of growth and a higher rate of job creation. The second thing was that of the budget deficit. The inherited budget deficit left by the old regime is very large, and naturally is impacting on the size of the public debt. The public debt in 1994 was about R190 billion. Although the deficit was coming down, the rate of reduction was only about half a percent every year, and there was an addition to the public debt of the year. It was projected for this year, before the GEAR, to have been likely to lead to a public debt

A local panel discuss the impact of the New Economic Order in the South African context. From left: Patrick Bond, Rob Davies, Pauline Khuzwayo (chairperson) and Brian Ashley

of the size of about R311 billion which would have resulted in debt service costs of about R34 billion. Public debt is a problem that anybody who wants to propose an alternative to the GEAR has to take very seriously how do we deal with this issue? I actually do think it's a real issue.

The second factor is improving efficiency of delivery and effecting reprioritisation. It has often been said that the total expenditure priorities such as health and education, when you examine them in the overall terms as a percentage of the RDP, they are not particularly low by the standards of comparable countries. The major problems are the way in which this money is spent is not according to the kinds of priorities that are defined in the RDP vision. They are also not yielding the kind of results in terms of improvements in the human condition that are considered necessary. There are many, many examples and I think that a sense of this as an increasing problem was also underlined by GEAR.

The third factor very clearly is the impact of the international order. We've heard a lot of discussion about the International Monetary Fund (IMF) and World Bank and about going to them and taking out a loan, subject to conditions and so on and so forth. Perhaps what South Africans did not understand was that there are probably many routes to subject oneself to the same kind of pressures in the newly emerging global order. Making a mess of your macroeconomic management and having to go cap in hand to the IMF is not the only route in which we can come under these pressures to conform to the policy agenda, which is known as the "Washington Consensus". We are living in an era of what is generally known as "globalisation" and although I think that these trends were probably evident from the end of the Second World War, in recent years they have taken on new forms and acquired new meanings.

Particularly important as a part of this process for us I think, has been the globalisation of currency markets. The integration of currency, that is foreign currency markets into a single, globalised system, is also facilitated by the spread of computer technology. I think very few South Africans noticed our integration into this. It came at the end of 1994 when the Financial Rand was abolished and trading for non-residents in the Rand currency became a possibility. We were no longer shielded from the pressures of these market trends through the Financial Rand mechanism, and basically what happened was that this fuelled an in-flow of capital which was quite substantial during 1995 and up to the early part of 1996, partly sustained by the Reserve Bank's policy of holding up very high interest rates. The thing that we learned thereafter was that this was basically short-term in-flow of what is known as "hot money". When perceptions changed and particularly when there was a perception that the Rand was over-valued, there was a massive out-flow of this foreign capital, which provoked a currency crisis and a decline in the value of the Rand. Without doubt this is one of the most important, you can call them discipline or subordination mechanisms, that exist because coupled with it was the message that foreign investors and the foreign currency markets had no confidence in the Government and that there was a need for a new policy.

All of these firstly, are actually built into the GEAR and influenced it in a number of different ways. The GEAR was based on a modelling exercise; a team of economists got together with assumptions of their models, which are not actually well-known, and this itself has been a point of controversy. They produced a level scenario which says that "business as usual, carry on as in the past," would not yield the kind of job creation that was necessary, and in order to achieve this level of job creation it was necessary to push up the growth rates from around the plus/minus 2% average (which was forecast under business as usual,) to 6% by the year 2000. So they produced a series of policies which were intended to yield that result.

Here are the main policies. The first and most important one is that it envisages a reduction in the budget deficit from the 5.1% of gross domestic product, which was budgeted for the 1996/1997

budget to 4% in 1997/98. Government has indicated that this target will be reached and I think we can rest assured that the budget deficit, for this year is not likely to be more than 5.1%. I also think that it's a foregone conclusion that the budget which was presented in March this year will not budget for more than 4%.

Secondly the GEAR envisages an acceleration of already planned tariff reductions. There was a process of reducing tariffs, partly in accordance with the World Trade Organisation requirements and partly domestic policy. Instead of reducing them to a level of 8.8% of imports, the GEAR envisages reducing them a bit further, to about 7.6%.

The next thing it envisages is a so-called "National Social Agreement". We hear a lot less of this now but it is one of the elements of the document. Government was to commit itself to social delivery under the RDP, and the GEAR document at least on paper, commits itself (or re-commits itself) to the achievement of many of the RDP targets. Among other things, it's meant to be part of a national social agreement with labour that would commit to a number of these targets. In return for this there was some envisaged wage restraint, I think we've seen much less of that. There were also supposed to be tax incentives in return for price restraint. The tax incentives have been introduced, but I don't remember when business committed itself to price restraints.

Then there is an envisaged reduction in interest rates and I think there are a couple of other things which are quite significant here. The model envisages a 3-fold increase in public sector and parastatal investment: although it talks about an overall reduction in the budget deficit, it does actually talk about an increase in public sector investment, including such things as municipal infrastructure programs and so on. There is a re-commitment to the national framework agreement as far as the restructuring of State assets is concerned and then there is a declared re-commitment to many of the RDP deliveries.

Let me move on from the contents to describe some of the implications. The first point is that the model does not guarantee that, if we adopt the policies which I have described, we're going to get 6% growth and 400 000 new jobs by the year 2000. The model rests on a series of assumptions. One of these is that there will be something like a 5-fold increase in private foreign direct investment. Basically it is driven by a number of forms of investment, including public sector investment. It also hopes to draw in additional foreign direct investment. It is dependent on being attractive to foreign investors and that this would contribute towards an increase in foreign direct investment.

It is quite important to see how it has been received. It has generally been welcomed by many of the major business circles, the IMF, the World Bank and so on, but welcomed as a first step. We are in a period in which the impact of globalisation, the strength of these institutions are likely to be felt in the form of increasing pressures to conform to the agenda of the Washington Consensus. I think we can clearly see which issues are immediately on the agenda. There is strong pressure to end remaining currency control, there is only currency control for residents and there is very strong pressure to end exchange control. There is a recognition that this will be likely to engender an outflow of capital and so the suggestion is made that a pre-emptive loan from the IMF might be appropriate to finance such a move. There is definitely pressure to move in this direction.

Another demand which has been heard with increasing frequency is that there needs to be a more vigorous and more determined privatisation programme than the National Framework Agreement provides for. The third important issue is the demand around so-called labour market flexibility. This means that large parts of the working force, (and I think that if we didn't have such a strong trade union movement it would be the whole of the working force) should be exempted from the provisions of the Labour Relations Act and the protections therein, basically, on the assumption that if it's easier to fire workers somehow or other, more businesses will hire them.

In conclusion, I would like to outline a few issues that need to be looked at and engaged with. The first of these is around the budget issue. As I said earlier, Government has very firmly committed itself to the overall deficit reduction target and I think that will be met. There are two important possibilities. A reduction in the deficit, which involves a reduction in State expenditure, can either lead to across-the-board-cuts in all major sectors (including sectors which are priorities) or it can become a spur towards a re-prioritisation. What is beginning to emerge now is a stronger debate in South Africa which needs to be given additional voice. Reform towards greater transparency in the budget process and towards an ability to set priorities in accordance with the agreed national priorities of the country as a whole, is long overdue. We are going to be seeing much more debate and discussion around the necessity for budgetary reform this year. The possibility is also there, within the GEAR framework, to take up the questions of RDP delivery. The reasons for the slow delivery in many of the social services, is that the programme itself envisages that there will be improvement in this regard. The programme is intended to be a macroeconomic framework to make the RDP more effective. The social impact of the programme should be measured through the kind of careful research of the sort we saw in the Zimbabwe case, not only in the health sector but in the other sectors. Such research that could contribute very usefully to a debate about the likely impact.

HOMEGROWN STRUCTURAL ADJUSTMENT: IMPLICATIONS FOR SERVICES DELIVERY AND PUBLIC HEALTH

Patrick Bond

National Institute for Economic Policy
South Africa

Introduction: The tyranny of economics

At the time of writing, as superficial confidence in the economy is increasing, it is crucial to begin with some hard facts. As data released in the March 1997 Budget Review shows, the Finance Ministry's Growth, Employment and Redistribution (GEAR) strategy was already evidently failing within six months of its June 1996 launch. Economic growth in 1996 was more than 10% lower than what GEAR predicted, and fixed investment nearly 20% lower. The real value of the rand fell by 16% in 1996, far worse than the 8,5% decline predicted in GEAR at mid-year. With the main interest rate (the Bank Rate) pushed up by 2% during 1996 (reaching 17% by year-end), and inflation at 7,4% during 1996, the average real (after-inflation) rate of interest charged by the Reserve Bank exceeded 9%, far higher than GEAR's 7% 1996 prediction. Worst of all, job creation was negative in 1996, a far cry from the 126 000 new jobs predicted in GEAR.

Indeed GEAR must fail even on its own terms, because of the contradictions involved in applying "homegrown structural adjustment" to an economy characterised by a stagnant private sector shedding jobs at a record rate, a strong labour movement, the highest real interest rates in South Africa's history, the lack of competitiveness of many manufactured products in global markets (and the low historic world price of raw materials and agricultural products), and most government departments' failure to implement those aspects of the Reconstruction and Development Programme (RDP) that would have provided balance by raising levels of consumption and production by poor and working-class South Africans.

What does this programme, and its failure, imply for health and social policy in post-apartheid South Africa? This paper considers not only how "neo-liberal" (free-market) policies have permeated national economic management, but how the same approach is encroaching upon social policy, particularly in relation to infrastructure and services. Primary health care is at present perhaps the only major exception to the government's new Golden Rule that all state services must be priced at "cost-recovery" levels. Yet the fact that crucial services such as water, sanitation and electricity are being subjected to cost-recovery principles has negative implications for infrastructure investment, for usage, and ultimately for public health as well. The paper concludes by positing some of the alternative approaches to macroeconomic management that would release the balance of payments and fiscal constraints that appear to have hamstrung progress on the social policy front.

GEARing down

GEAR is based on a combination of economic models, including those of the Reserve Bank, Development Bank of Southern Africa, World Bank and Stellenbosch. All are extremely orthodox, with biases that favour neo-liberal policies and that treat markets as reliable, well-functioning institutions. In June 1996, the models collectively predicted that if the desired policies were adopted, South Africa would reach 6% sustainable growth and create 400,000 new jobs per year by the turn of the century. Immediately, some of the assumptions in the model – particularly the exchange rate, level of

government revenues, willingness of workers to accept wage cuts, and extremely high levels of job creation in the wake of three years of 'jobless growth' – came into question. But in addition to the assumptions, GEAR's internal logic deserves a brief comment.

The new strategy began by labelling government spending – particularly 'consumption' expenditure on wages and services (which includes health and social expenditure) – as excessive. The overall deficit (the amount government borrows beyond what it raises in revenue) would be cut in half by 1999, with the social wage most likely to fall victim to cuts. Corporate and personal tax rates were also regarded as excessive, and future revenues would be enhanced through economic growth, increased efficiency in tax collection, taxation of retirement funds and higher excise tax rates for tobacco products. This meant that the potential for progressive income tax policies – where workers pay lower rates and the upper- and middle-classes pay higher rates – would shrink. With further income taxes cuts for the rich, the Finance Ministry would face pressure to raise more money instead from Value Added Tax, a regressive tax on consumption which leaves poorer people shouldering more of a burden for supporting government.

The Reserve Bank's control of the money supply and interest rates would continue unchanged. As noted at the outset, the Finance Ministry projected that the Bank Rate would fall to 7% in real terms within six months, to 5% in 1997 and 4% by 1998. But even if the projections had been accurate, 7 or 5 or 4% rates were still extremely high in historical terms.

The Finance Ministry was so confident of the macro-economic strategy's success that it promptly stepped up liberalisation of exchange-controls as applied to both foreign investors and South Africans. Foreign companies were now able to borrow locally much more easily and local institutional investors were granted much more scope to expand their international portfolios by exporting funds to foreign stock markets. Full exchange-control liberalisation continued to be the Finance Ministry's objective, and International Monetary Fund Managing Director Michel Camdessus took special pains to endorse the phased approach. Manuel continued to confirm that all remaining controls would be dismantled as soon as circumstances were favourable, notwithstanding what was sure to be a flood of money out of the country.

The Finance Ministry also anticipated the exchange rate (the value of the rand) to strengthen rapidly in the second half of 1996 and to stabilise at levels equivalent to the currencies of South Africa's main trading partners over the subsequent five years, a prediction that proved seriously flawed. Trying to offset more costly imports to some degree, the Ministry of Trade and Industry continued lowering tariffs so as to encourage competition from imports.

But even with cheaper imports due to trade liberalisation, the overall effect of economic dynamics would, GEAR predicted, lead to slightly higher inflation. Hence the Finance Ministry asked labour and business for support in maintaining the stability of wage and price levels.

Private sector employees were expected to lose 0,5% of their after-inflation salary this year (though public sector gravy train beneficiaries would be granted a 4,4% increase). Wage and price stability would, it was claimed, also be pursued through a broad national social agreement (although this has not been seriously negotiated so far).

In addition, rising productivity of workers and of capital required greater labour-absorbing investment and enhanced human resource development. Compared to South Africa's competitors, local firms scored poorly, and government claimed it would consider the feasibility of applying a mandatory payroll levy so as to increase the effective investment in training. Overall though, such strategies were often much more a matter of rhetoric than reality. GEAR contained none of the details necessary to determine whether assumptions about the benefits of human resource development for labour productivity were realistic.

There were other provisions in the strategy aimed at enhancing domestic fixed investment. New tax incentives for new manufacturing investments were part of a broader set of supply-side measures aimed at promoting investment and stronger export competitiveness. Others included a six-year tax holiday for pre-approved projects that meet job-creation and other criteria; the promotion of twelve sectorial clusters which are considered of high priority in our industrial policy; reform of industrial finance; and special arrangements for better access to international markets. Small and medium-sized enterprises would also receive added support.

Would such policies spur investment? Probably not, because the conditions for expanding the domestic market were not in place, and indeed the rate of GDP growth would, by all accounts, slow markedly in 1997. And while excess capacity was finally beginning to be used, there remained many closed plants and much mothballed equipment that could be restarted if a company wanted to increase production, without necessarily leading to new investments. Moreover, labour-saving investment continued to be the rule, with the multi-billion rand projects – Columbus, Alusaf, ISCOR retooling – characterised as extremely capital intensive.

Restructuring of state assets – government's euphemism for privatisation – was amongst the Finance Ministry's highest priorities, again with the objective of increasing efficiency and attracting new investment. The National Framework Agreement remained the basis for government and organised labour to air their differences, but notwithstanding the Agreement's non-operational status, government announced forthcoming privatisation and joint ventures in telecommunications, minerals and energy, agriculture, forestry, leisure and transport over the next nine months. The sale of six major regional radio stations had already been approved by Cabinet. Concern was repeatedly expressed by workers in such industries that their wages and jobs would come under enormous pressure, while consumers who had hoped for access to cross-subsidies for increased access to electricity,, telephones or recreation would be disappointed as more 'commercial' values predominated in parastatals, leading to increased price competition for the accounts of the major users and less interest in the low end of the market.

Infrastructure investment in question

The Finance Ministry also anticipated greater public sector investment, including better education and health services, housing, land reform and infrastructure for businesses and households. Yet if we look closely at the details – particularly regarding investment in basic needs goods and services – we find a surprising reliance on many demonstrably ineffectual policies.

Grand programmes to build a million houses have been hijacked by hostile banks and hesitant construction firms. Although more than 125 000 housing subsidies were delivered by government between 1994 and 1996, fewer than 25 000 of these included loans from banks that allowed people to build proper houses. In contrast, during the last year of apartheid rule, the National Party regime built 20 000 houses, because they didn't rely as much on commercial banks. The market-oriented approach adopted by the ANC government – cynically termed "toilets in the veld" by even Minister Sankie Nkondo-Mahanyale in 1995 – is "bank-centred", not people-centred, yet the banks not only failed to deliver loans at scale, but continue to "redline" (discriminate against) millions of black South Africans.

Other social policies are also under attack from neo-liberal principles. The Lund Commission agreed on budget constraints which slash the level of benefits to women-headed households. World Bank-designed land reform and restitution are proceeding at a snail's pace, leading to budget cutbacks in 1997. Even the best intentions – free primary health care for all, redistribution of educational resources, women's reproductive rights, youth recreation, attention to the needs of disabled people – are being foiled by lack of facilities in the townships and rural areas.

From a public health standpoint, one of the worst developments in social policy was that the Municipal Infrastructure Investment Framework (MIIF) was also designed, in the initial stages, by World Bank teams which resorted to their legendary stinginess. The RDP mandate for infrastructure was impressive – "The RDP integrates growth, development, reconstruction and redistribution into a unified programme - the key to this link is an infrastructural programme'. But experts from the World Bank, Development Bank of Southern Africa, Housing Ministry and even Jay Naidoo's RDP office, and later the Department of Constitutional Development (DCD, centre of inter-governmental funding relationships and hence infrastructure grants) decided upon several key principles:

- South Africa could not afford anything more than toilets in the veld (partially-serviced sites);
- that these be provided under conditions of increasing privatisation (which could soon entail as much as a tenth of all municipal services); and
- that even in urban townships with good access to bulk infrastructure provision in the general vicinity, service standards for households earning less than R800 per month would be cut dramatically: toilets limited to ventilated pit latrines, water reduced to yard taps (i.e., not within the dwelling), and electricity provided in the form an 8 Amp metered connection. (Indeed, the early 1995 World Bank version of the infrastructure framework called for communal taps and no electricity.)

Such low standards were imposed because the DCD consistently refused to consider desperately-needed cross-subsidies via national tariff reform for the ongoing (recurrent) costs required to pay for water, sanitation and electricity. This refusal to even consider the tariff financing mechanism that was explicitly mooted in the RDP dates to the late 1994 drafts of the infrastructure framework coordinated by the World Bank.

Can government sell an infrastructure package that includes a high proportion of pit latrines? Not only are indications grim in "African" and "coloured" townships that have already experienced bloody payment-related clashes with authorities (which are known across the Third World as "IMF riots"). These include Eldorado Park, where several people died in battles over excessive service charges in early 1997, or Tembisa in mid 1996 where a private security firm killed numerous protesters in a riot over transport costs. The politicised character of service charges is reflected in various kinds of urban municipal strife across the country, thus, in a bizarre shift that reflects residual apartheid-era arrogance and a misplaced culture of entitlement, white Sandton brats continue to boycott their rates.

But even more worrying than the occasional eruptions of popular alienation, and the fact that – according to the Finance Department in the 1997 Budget Review – more than 30% of all urban residents don't pay their municipal bills, is that the new national policy, the Municipal Infrastructure Investment Framework (MIIF), could, unless altered by political pressure, lead to an unending future of this sort of local strife.

Consider the household services most needed by the majority of South Africans: provision of electricity and water/sanitation. At present, there are 4.7 million people without access to an adequate supply of potable water and 8 million lack adequate sanitation. The big questions of who gets what and for how much, are being largely answered by a team of Department of Constitutional Development (DCD) staff and consultants. Electricity has been the preserve of corporate interests, so it is no surprise that even three years after liberation, Eskom charges large firms just R0,07 per kilowatt hour of electricity, compared to R0,23 per kilowatt hour for the average domestic user. Cross-subsidisation is urgently required.

Water may be different, because the Minister (Kader Asmal) appears genuinely interested in supplying a minimal amount (25 litres per day) of services to people free, through a "lifeline" mechanism. But at this writing it appears that he will be overruled by conservatives; one indication was the budget cut his department – often celebrated for best delivery – suffered in March 1997.

But if Asmal loses, the most disturbing part of MIIF is that because water use will be considered too expensive for the poor, DCD has decided that pit latrines will be supplied to 10% of the people that live in the "urban core," an area that includes existing and new townships, inner cities and traditionally white suburbs. Likewise, on what is called the "urban fringe" – areas like Botshabelo and Winterveld – DCD expects 86% of all residents to have pit latrines (in rural areas, the planned infrastructure standards are even lower for 90% of all households). Such percentages may be even higher, in the event that GEAR does not deliver and 25-35% of urban households continue earning under R800 per month. People who presently live in fully-serviced urban neighbourhoods but who earn below R800 may find themselves gradually displaced to ghettoes with inexpensive pit latrines, according to another DCD document on intergovernmental fiscal relations.

There are various political, social and economic problems associated with these dismal standards. First, it appears a recipe for resentment against local and provincial governments, which will be closest to infrastructure implementation. This is not only an issue of high political expectations, but also a matter of basic personal comfort and convenience. For example, the darkness that is required in a "ventilated improved pit latrine" – so that flies are attracted away from the loo – is known to cause fear in children, who defecate outside near the pit latrine instead.

Second, there are potential health problems. This is well understood internationally, for as a background paper to the United Nations Habitat Conference in 1996 noted, "Substandard housing, unsafe water and poor sanitation in densely populated cities are responsible for 10 million deaths worldwide every year, and are a major factor in preventable environmental hazards, which are responsible for 25% of all premature deaths worldwide." Although the MIIF's pit latrines are a major improvement compared with no sanitation, there would also be health benefits – mainly by reducing diarrhoea, a major killer of children – if government installed flush toilets and raised the standards of other forms of infrastructure. In particular, less time spent on treating illness would release more women's time for caring and productive activities.

In addition to the sanitation issue, concerns have been raised that the new infrastructure policy only provides low-income people with water piped to their yard, not inside the house. A variety of academic studies have reported a 40-80% reduction in infant and child deaths due to diarrhoea, thanks to the provision of piped water directly into the house.

Not only is it important to deliver water directly inside the home, it is also crucial to make sure that it drains away properly. Yet most people on the urban fringe (and 10% in the urban core) will not have drains, and will risk seeing water turning into dangerous puddles in their yards. A R300 "soakaway" will be provided to low-income families, but on average it is expected to remove 70 litres of waste water per person every day, which will be quite a challenge. According to David Sanders and Pam Groenewald of the University of Western Cape Public Health Programme, "In areas where water supplies have been improved without provision of waste water disposal the result has been a shift from one set of diseases to another." The same is true regarding inadequate stormwater drainage (another feature of MIIF for low-income areas).

There are also public health implications of inadequate electricity service levels (8 Amp supplies are not enough to provide for cooking and space heating), including continuing indoor air pollution from coal and wood, and associated acute respiratory infection, burns and paraffin poisoning. At present, there are estimates that over 3000 deaths per year can be attributed to lack of access to electrification. If electricity became the sole energy carrier in only half of potential households, this would lead to a 75% reduction in respiratory infections, 35 000 fewer burn incidents and 5000 fewer cases of paraffin poisoning.

In addition, public health is affected by road dust on untarred roads (which contribute an average of 16% to particulate pollution), and many transport deaths and accidents caused by low standards of roads would be preventable with higher levels.

Moreover, as Sanders and Groenewald conclude, "Many of the diseases related to poor infrastructure are contagious, and as such, have the potential to threaten the health of higher socio-economic groups in the vicinity, eg. cholera, malaria, dengue, filariasis, yellow fever and tuberculosis. It is shortsighted to provide a lower level of infrastructure when one considers the longer term potential for environmental degradation."

Third, environmental concerns have also arisen, in part because densely-packed pit latrines in urban areas are likely to contaminate local water supplies, requiring expensive purification. In areas with high water tables, dolomitic rock or other geotechnical flaws, pit latrines will be a disaster. Low quality stormwater drainage associated with the MIIF could also lead to flooding, erosion and the washing of human waste into surface water. There are also environmental effects associated with inadequate levels of electricity service, including continuing deforestation associated with the use of wood for energy.

Fourth, the costs of upgrading that must be done in the future – especially putting in a new water-borne sanitation – will be enormous. There are few successful cases of upgrading from pit latrines to flush toilets. The same is true for water pipes in rural areas. A recent evaluation of the Mvula Trust (which supplies water systems in poor communities) found, "It would be far better to plan for upgrading right at the outset. This will help prevent the kind of informal and under-financed upgrading which typically leads rapidly to system collapse. The per capita cost of schemes might rise somewhat, but will still remain well below the alternatives."

Fifth, the effect of MIIF on the apartheid city will cement and reproduce segregation. Urban pit latrines make it impossible to plan for social and class integration, because if a family with below R800 monthly income raises their income level and wants to pay for a flush toilet, they will be forced to move out of their community since individual upgrading is financially impossible. While early drafts of the policy ignored this entirely, the most recent acknowledges it to be a problem, but has no solution.

But in part because of grumbling from politicians, the early infrastructure policy – in which World Bank staff and local consultants completely ignored the RDP mandate to finance infrastructure through national tariff reform and cross-subsidies – has been improved in two ways. First, instead of communal taps, households will get taps in their yards, and instead of no electricity, a small supply powerful enough for a few light bulbs will be supplied. Second, low-income households may not have to pay R50 per month, as was initially suggested. A Finance Department fund (called the Inter-Governmental Grant) may possibly allow, during at least the short-term, a subsidy to pay for low-income households' basic consumption. But given the pressure self-imposed by GEAR, the Finance Department will likely reduce the intergovernmental subsidy fund from current levels of nearly R5 billion to a minimum amount (guaranteed by Cabinet recently) of R800 million per year. Such an amount won't be sufficient to cover most recipients, who will continue to face pressure from cash-strapped local authorities to pay for inadequate services. Worse still, there have been published reports that the World Bank will be invited in to assist with expensive infrastructure loans or guarantees, another blatant violation of the RDP's insistence on self-reliant development finance.

Certainly there should be enough government money available for a different approach, since Cabinet approved a 5-year target of spending 5% of the budget on housing, which would be R9 billion in 1998/9. Due to delivery problems caused by the bank bottleneck, the budgeted amount was just R4 billion for 1997/8. Regardless of whether decent housing is finally built, the infrastructure problem remains acute. When many households continue to get bills they can't afford for services that are not up to par, and when local governments fail to collect rates and service charges in townships, the most important point tends to get missed in the anger and finger-pointing.

That point, simply, is South Africa's inherited inequality, which is worse than any other large country on earth except Brazil. Such inequality must be addressed nationally (not just locally), through redistribution of resources away from the wealthy, who acquired them illegitimately during the colonial and apartheid eras. Hence Asmal is giving priority to charging white farmers (who drink more than half the country's water, mainly for free), pine and gum plantations (who drink another 15%), and big industry (10%). (Local cross-subsidies would leave out most of the major consumers.) Households use only 12% of South Africa's water, and of that 60% is used for watering gardens and filling pools in bourgeois suburbs, with a tiny proportion available for the majority's basic needs. Similar decadent consumption patterns exist in the electricity sector. Taxing big users slightly more to pay for a minimal supply of lifeline water/sanitation and electricity services to households – following which a much higher "graduated block tariff" could be applied, as the RDP suggests – is the antidote, and would also promote conservation.

But as it stands now, Asmal and others attempting to expand the social reach of government – like the Health Minister, Nkososana Zuma, whose offer of free primary health care stands in stark contrast to MIIF – are being undercut by the DCD's reliance on cost-recovery as the basis for service provision. Only pressure from the grassroots can reverse this latest neo-liberal assault on low-income people's living standards.

Pressure on health services

In this context, it is worth briefly examining policy decisions made in the Department of Health at national level, which show that an alternative approach that confronts the neo-liberal doctrine is feasible. On the one hand, the Health Department has failed, at this writing, to advance its programme in the area of pharmaceutical industry reform and national health insurance, and it has failed to stem the potentially devastating influx of "managed care" – essentially insurance company purchase of entire health systems – which has done so much damage to the cause of public health in the United States. Such failings are understandable given the balance of forces. Reflecting the highly-charged policy environment, an August 1996 editorial from the conservative Citizen newspaper confirms the modus operandi of those opposed to Health Minister Nkososana Zuma's agenda:

> *"We do not care for Dr Zuma's policy of socialising medicine in this country, of switching to primary health care and clinics and letting our hospitals become downgraded, her importation of Cuban doctors, some of whom are allegedly incompetent, and her forcing of young doctors into two-year post-graduate community service. But that has nothing to do with the issue. Dr Zuma can be judged in this instance only on the Sarafina 2 affair and the things she has done wrong in handling it. On that score, and on that score alone, she must be kicked out of the cabinet."*

In reality, although "socialising medicine" (i.e., a state-run, community-oriented National Health System) was at one point on the agenda of progressive South African health workers, this was gradually watered down in ANC policy documents first to national health insurance and then to the promise of free primary health care for all. This, along with a clinic building and upgrading programme, the Primary School Nutrition Programme, and reproductive rights represent the Department's most important breakthroughs. Notably, these have all been successful because they deviated from neo-liberal orthodoxy. The dominant philosophy was articulated in the RDP as follows: "The whole National Health System must be driven by the Primary Health Care (PHC) approach. This emphasises community participation and empowerment, inter-sectoral collaboration and cost-effective care, as well as integration of preventive, promotive curative and rehabilitation services."

Two subsequent Department of Health policy documents, Towards a National Health System and Restructuring the National Health System for Universal Primary Health Care, amplified the RDP

mandate in key areas: "Access to all personal consultation services, and all non-personal services provided by the publicly-funded PHC system will be free of charge to all permanent residents at point of service" although "where patients bypass PHC facilities and present at public hospitals for outpatient services, payment of an additional charge will be required, except in cases of emergencies, or where public PHC facilities are closed or not available." In many areas, the lack of clinics mean that PHC is de facto carried out at tertiary institutions. Their importance is further reflected in the appalling PHC record of the previous government, which necessitates tertiary care where preventative care would have precluded health status deterioration. Thus, since the 1994 election, the health care staff and hospital budget cuts that have been periodically announced, and often resisted courageously by health workers, negate the impression of progress and policy generosity on the PHC front.

Nevertheless, women have taken a major step towards equality by demanding and winning a hard-fought battle over reproductive rights, backed firmly by the national department. However, where women as direct sources of labour are concerned, progress has been far slower. The informalisation of employment has intensified the feminisation of poverty. To illustrate, whereas the RDP promised "the right to six months paid maternity leave and 10 days paternity leave" the Department of Labour's touting "regulated flexibility" in its controversial document, Employment Standards Statute: Policy Proposals, means only that "An employee is entitled to four months' maternity leave during which her security of employment is protected" and that "Every employee with more than one year's service is entitled to three days paid paternity or child-care leave during the year of the birth of the child."

What have the Health Department's generally (not uniformly) progressive policies translated to in practice? Since free health care for pregnant and lactating women and children under six was initially announced by President Mandela in his inaugural speech in May 1994, most provinces reported increases (between 20 and 50%) in attendance at public health facilities. The initial annual cost was R680 million, allocated on the basis of a needs-based formula. In April 1996 free primary health care was extended at the point of service to all who could not afford to pay. A 1995 study had documented that for 74 percent of African people, the cost of health services was a primary barrier to access.

In order to improve access to primary care, a major clinic building and up-grading programme was initiated in 1994. There was an inherited shortage of an estimated 1000 clinics (plus the need to replace 1000 others) in order to achieve a ratio of one clinic per 10,000 population – hence rendering meaningless the expansion of free primary services to many underserved areas.

The Primary School Nutrition Programme, which aims to address the problems of short term hunger, micronutrient deficiencies and poor nutritional knowledge, attitudes and practices, was implemented in September 1994. Given the need, the programme focuses on food provision to primary school children in rural and peri-urban areas. Since its inception about 5,5 million children in 15,871 schools have benefited from the programme. In addition, the programme resulted in the creation of about 9,000 employment opportunities and school attendance improved.

Such programmes cost enormous sums, and the Department of Finance has not proved amenable. The Health Department had planned to increase expenditure on primary health care from R4.873 billion in 1995-96 to R8.253 billion in 2000-01, representing average annual real growth of 8.3 percent. In contrast, real academic and regional hospital expenditures were expected to rise by 0.5 percent and 1.4 percent respectively. District hospitals, which received an increase in referrals from the PHC level, were anticipated to grow by about 2.1 percent in real terms annually. In addition to the shift of resources to PHC services, the formula for financial allocation to provinces was revised to correct historic imbalances which favoured the more urbanised and richer provinces of the Western Cape and Gauteng.

In sum, there have been major advances in health policy formulation in an attempt to redress the inequities of the past, between the races, between the urban and rural areas, and the vulnerable (notably the poor, women and children). Implementation of these policies has been uneven, and due to the nature and magnitude of the problems that confront the Department of Health, progress on many of the pressing issues will continue to be slow. In particular, the lack of intersectoral development programmes and projects – and indeed the drift toward neo-liberal policies in many related ministries – threatens to negate any of the gains from enhanced PHC delivery.

For as elsewhere in the world, South Africa's health problems arise as much from inadequate "basic needs" provision as from inadequate and inappropriately distributed health care inputs. As noted above, health status improvements will continue to be undermined by neglect of or insufficient provision of basic needs goods and services, including nutrition, housing, water and sanitation. Thus, the economic framework and development trajectory will itself influence health outcomes.

Further, the ability to implement most health programmes will depend on the active involvement of a conscious and participatory population. This has influenced the success and sustainability of immunisation programmes, nutrition programmes, disease control programmes, and the like across the world. Therefore, the political dimension of the country's development strategy will significantly determine the human infrastructure through which both development and health programmes can be implemented. Also, this will be important for intersectoral programmes, which are unlikely to be strong so long as they remain technical and top-down and not rooted in and demanded by organised communities.

Thus the Department of Health's progress has so far mainly been with respect to policies rather than on-the-ground reality. Where systems are functioning, they are mainly technically-driven. For example, the primary school nutrition programme risks remaining a food-handout programme, exploited by commercial food suppliers rather than a nutrition programme which starts to develop capacity in communities to address the underlying causes of undernutrition, including lack of household food security. Two examples of alternative approaches designed by non-governmental organisations in the Western Cape are community kitchens based at schools which have both generated some employment and provided cooked meals for schoolchildren at the start of the day; and child-to-child projects which entail schoolchildren identifying undernourished younger siblings and passing on information about nutrition to their parents. Yet such pilot projects remain unsupported by the Western Cape Provincial Nutrition Department which lacks the bureaucratic flexibility and resources to support these initiatives.

As ever, the future direction will depend upon the balance of forces between and among state fiscal managers, the private health sector, health workers and consumers (as represented by working-class organisations such as the trade union movement), in the context of the overall orientation of government to social policy. While the Department of Health is ahead of most other government departments and agencies, its ability to implement policies within a PHC framework (i.e. involving communities, mobilising other sectors, challenging inequities) will be constrained by the political and economic context within which it operates.

Can the economic constraints – particularly balance of payments (South Africa's relation with the international economy, which in turn now appear as the main determinant of interest rates) and the fiscal squeeze – be relaxed? Did the government consider an alternative to the neo-liberal macro-economic strategy?

Conclusion: Is there an alternative?

Whenever posing a more humane approach to economic and social policy, we typically confront the argument at the outset that there is insufficient money available in the fiscus. When considering this

issue, it is always useful to point out that the central state budget remains overwhelmingly weighted towards expenditure on useless and dangerous items. In 1997/8, for example, R40 billion of the R187 billion budget was allocated to repayment of state debt, the bulk of which was taken on during the apartheid era. While there are indeed local pensioners and bank depositors who unwittingly contributed to financing apartheid (through institutional arrangements they had no control over), and whose interests must be taken into account, some form of cancellation or rescheduling of domestic debt – especially the R50 billion held by banks and insurance companies – is now being placed on agenda by groups ranging from the South African Council of Churches (led by Catholic bishops) to the NGO Coalition to the South African National Civic Organisation. In addition, R10 billion is still allocated to defence spending each year, notwithstanding the total lack of any external threat to the nation's sovereignty.

In addition to cutting the budget in these two areas (and many others that reflect residual apartheid expenditures), additional state borrowing could easily increase the availability of funds for health-enhancing public investments. An infrastructure programme that provided water-borne sewage to all urban residents, for example, would cost R7 billion more than what MIIF has envisaged, which is well within reason and affordability. The cross-subsidies required to provide the basic lifeline water and electricity services discussed above are easily raised within each service sector without recourse to additional budget revenues.

Was growth through a more expansionary "fiscal" (spending) strategy of this type considered? Apparently not seriously, for government now contends that "even under the most favourable circumstances, this would only give a short term boost to growth since it would reproduce the historical pattern of cyclical growth and decline." Such a comment implies that, in contrast, the new strategy has outlawed the "business cycle," which is in reality the most permanent law of market economies.

"More importantly," warns GEAR, "in the present climate of instability a fiscal expansion would precipitate a balance of payments crisis." But government's strategy does not even consider a variety of interventionist tactics – four types are noted below – that could have substantially reduced the balance of payments constraint in order to allow greater fiscal expansion. This may be because most of the 16 economists who devised the strategy are from institutions such as the Finance Ministry, Development Bank of Southern Africa, World Bank, Reserve Bank and Stellenbosch Bureau of Economic Research, whose neo-liberal ideologies have proven ineffectual or downright oppressive, here and across the Third World.

For example, the Reserve Bank's November 1996 reaction to balance of payments shortfalls that in tum led to ever-larger local money market shortages was to raise the Bank Rate by 1%. This suggests the limits of the current policy approach and the need to consider other macroeconomic tools, used by many other states throughout history to address balance of payments pressure and money shortages, but apparently excessively unwieldy in Pretoria today.

First, leading officials could slow the drain on foreign reserves by cancelling or renegotiating the R90 billion outstanding apartheid-era foreign debt, delaying approval of capital flight by the major insurance companies, applying additional exchange controls and stamping down harder on illegal funds transfers. On such matters the Reserve Bank has been notoriously lax, indeed systematically corrupt (judging from high-level prosecutions and official investigations). After all, the RDP called for increased action against capital flight, but the Finance Ministry has thus far only loosened controls on the biggest institutional investors, who control hordes of speculative funds that should rather be seeking productive niches closer at home. And the financiers' constant insistence upon total liberalisation is by now widely regarded as an unpatriotic exercise in self-enrichment, since none can prove that a fully-convertible currency would encourage the much-desired inflows (foreign fixed investment, not hot money) that relaxation of controls on foreigners has not already achieved. Indeed, even the IMF last

year began to concede the need for new capital controls so as to prevent the kinds of hot money flows that melted Mexico down in 1994-95 and that were responsible for more than half of Johannesburg Stock Exchange trades last year and then for the run on the rand this year.

Second, the Ministries of Finance and Trade and Industry could reign in import profligacy – a crucial factor behind the slipping balance of payments and sliding foreign reserves – in two ways. Extra taxes could be imposed on consumption of luxury goods, which would have the effect of slowing both consumption of expensive foreign commodities and the depletion of hard currency reserves. This could be achieved through either a general tax on luxury goods (allowable under international trade law), or the general tax on imports which South Africa had in place until the March 1996 budget. In addition to taxing luxury goods, imports of capital-intensive equipment should also be slowed, in favour of an industrial strategy aiming to replace these with local machinery. No doubt imported machines and transport equipment (roughly than half the import bill) are desperately needed for new investment, but a disturbing amount of high-tech imports are labour-saving rather than labour-adding. In this sense trade policy also exacerbates the counterproductive biases – especially the missing middle of capital goods – intrinsic to what DTI director-general Zav Rustomjee calls, in his new book, South Africa's "minerals-energy complex." It is critical for the country to develop what are known as "backward and forward linkages" within local industry more vigorously, and to mop up the ever-larger pool of unemployed workers by deploying appropriate technology and labour-intensive approaches to production. (Only in public works construction and to a lesser extent through new investment tax incentives is this approach being taken even somewhat seriously.)

Third, the Ministry of Trade and Industry could delay or roll back its overall scrapping of import tariffs. South Africa is running far faster towards trade liberalisation than the World Trade Organisation has deemed necessary, and postponing tariff reform would dampen local demand for imports.

Fourth, in managing the money market shortage, Stals could "print money" to a limited degree (through various tools related to the Reserve Bank's sales and purchase of government securities). Or, alternatively, he could use his powers of financial market regulation to directly persuade – or force – commercial banks not to make available so much credit in so skewed a manner to the retail sector. The ironies of South Africa's "world-class" financial markets are lost on no one, for in spite of bank profits and JSE activity both hitting all-time records, low-cost housing policy continues to falter due to over-reliance upon banks and ownship bank branches and ATMs – urgently needed to foster savings – are scarce. And bankers unconscionably play Robin Hood in reverse by charging low-income bondholders 5% higher rates than the rich, again with the Housing Minister's approval. A much tougher, and more democratic, central bank would have not only firmly regulated banking behaviour, but would also have directed credit flows into areas requiring the greatest support, at below-market interest rates. Some say nationalisation would be required to accomplish this, given the character of private capital in South Africa (which may be true); whether or not this is the case, over the past four decades, East Asia provides various institutional examples of relations between the state and banking sector (nationalised, state-directed, state-influenced) to suggest that it is entirely feasible and sensible for the state to take greater control over domestic financial resources.

Having relaxed the balance of payments constraints through such techniques, a programme of fiscal expansion could be readily pursued. Again, this is not a particularly radical conclusion. Many governments learned a central lesson from the Great Depression – taught by the British economist John Maynard Keynes - which still-unseasoned ANC economic policy-makers have yet to understand: when private sector stagnation ensues (which it has in South Africa over a twenty-five year period), the state must play a strong role in economic stimulation, both with regard to regulating the private sector's activities and provoking greater expenditure through enhancing the ability of people to work and to consume.

So obvious is this argument to most economists who have had any exposure to Keynesian thinking, that even without invoking the four kinds of tactics outlined above, the World Bank came to the conclusion in its November 1993 report, Paths to Economic Growth, that South Africa could easily undertake a 12% deficit/GDP ratio for public investment that would rapidly generate fast growth and lead to a fiscal surplus within a few years. (Regarding the Bank's consistency in such matters, it is telling that when used in GEAR, the same World Bank model – and two Bank staff – was tortured sufficiently into confessing the opposite: that fiscal expansion was unsustainable. The earlier – perhaps more honest – report is also not entirely believable given that the Bank failed to specify the balance of payments constraint or suggest how to relax it.)

The four sets of tactics described above, plus fiscal expansion during times of stagnation, were standard operating procedures for the advanced industrial countries and the newly-industrialising countries during most of the post-war era. Only during the past fifteen years, as financial activity and commerce came to dominate production throughout the world, as neo-liberalism became a global phenomenon, and as conservative governments took power and dismantled other aspects of the state apparatus, were these gradually dropped from the repertoire of finance ministries, central banks and trade and industry ministries. They were dropped and various kinds of structural adjustment programmes were introduced instead, but not because the macroeconomic tactics had outlived their usefulness. Instead, the faddish laisser faire approach stems largely from pressure by international banks and corporations which had tired of saturated domestic markets and taken on greater global ambitions. These pressures gradually came to be transmitted through some of the nascent though extremely powerful world-state institutions: the IMF initially, the World Bank increasingly during the 1980s, and during the 1990s the World Trade Organisation (WTO, replacing the General Agreement on Tariffs and Trade). On this basis, the question is often posed, can South Africa resist?

The answer must be in the affirmative, not only because there are many unexplored spaces within the WTO (South Africa is outpacing the organisation and the rest of the world by voluntarily reducing tariffs faster than required, even though the sum effect of its tariff policies were not particularly onerous compared to dozens of trading partners, even the World Bank has conceded). In addition, thanks to popular pressure, the IMF and World Bank have largely been kept at bay, at least with respect to lending (although the influence of Bank staff in insider-sessions where policy gets decided, regardless of public debate, has been most insidious).

The problem, indeed, is that the message and the mechanisms of neo-liberalism are being carried effectively by local power-brokers, in particular the five largest conglomerates and financial empires which dominate more than 80% of the Johannesburg Stock Exchange (Anglo-De Beers, Rembrandt, Old Mutual, Sanlam and Liberty). In general, their interests are to deregulate the economy so as to lift barriers to their own profitability, to shift their internal firm resources from fixed capital into financial capital (which not only gets a higher return but is highly mobile), to liberalise exchange controls (so as to move apartheid-era wealth offshore), and to avoid the kind of commitment to building the country's productive structure that they had through most of the century. The "Brenthurst Group" which brings the titans of industry together has decisive influence with President Mandela. The mass media largely parrot a neo-liberal line of argument, partly as a result of ownership relations and partly because of the class-character of the (largely white, middle-class) media opinion-makers themselves. Breaking through this sort of hegemonic bloc appears formidable for those opponents in civil society, as well as residual progressives in the state.

But to invoke a different future, one in which basic needs are met, public health is truly a right and society witnesses a liberation in socio-economic respects that extends beyond a few tens of thousands of gravy train passengers, will indeed require a renewed struggle against the hegemonic bloc, to which we clearly must now add the top ANC economic policy-makers and the many unthinking politicians who have endorsed GEAR. Fortunately, there are exceptionally well-developed social

movements in South Africa which, although in a state of mild decay in some instances due to destaffing, defunding and misguided corporatist (deal-making) impulses, retain impressive political clarity and an insistence upon accountability from their politicians. This is perhaps a unique attribute, in considering not only post-colonial African movements, but those across the world. One reflection of their sophistication is the National Progressive Primary Health Care Network's position paper, "Macro-Economic Policy and its impact on Health, Development, Employment, Redistribution and Crime," which very sensibly takes forward the Keynesian perspective into concrete areas of action.

For those many primary health care workers who consider themselves to have far greater ambitions than mere Keynesian macro-economic fiddling, the historical political traditions to the left of the Keynesianism have also contributed enormously to understanding how the balance of forces can be radically overhauled when the existing economic system isn't delivering the goods, and how the "transitional demands" (as some revolutionaries term them) posed as an end-state by Keynesians are merely a first step. I think, however, there is still a consistency between demanding an end to homegrown structural adjustment, and engaging in struggle towards a future based on the socialisation and decommodification of primary health care, water, energy and so many other goods and services which at present are not getting to the majority due to the dominance of neo-liberal capitalism. To all of you, it is my honour to have been given a chance to present the recent twists and turns in some of the debates, as policy wonks in the Pretoria-Johannesburg nexus see them, and to get your feedback on how to become more effective in future advocacy.

The author thanks the following colleagues for background research and information on public health issues: George Dor, David Sanders, and Yogan Pillay.

THE CHANGING GOVERNMENT POLICY: FROM RDP TO GEAR

Brian Ashley

Alternative Information and Development Centre
South Africa

Like one of the speakers in the early sessions, I am going to concentrate on some of the political issues and that is probably going to mean that it is going to come across as pretty rhetorical. When we consider what has been said today in terms of the New World Order, then it is very obvious that there has been a failure of the free market system of which these policies are integral. To take one of the figures that David Werner quoted earlier today, where 358 people own the assets, the same as what half of the world's population earn in income. That is, in my mind a devastating critique of the type of New World Order which South Africa through the macro economic programme is seeking to integrate us into.

Many of you might recall during the heydays of Maggie Thatcher in Britain, she coined a little catch called Tina, 'There is no alternative'. When you consider that 16 million children are losing their lives because of hunger and curable diseases, when you consider what the South is taking in capital outflows, money is being transferred, capital is being transferred to the rich, industrialised North, when we consider that one billion people are starving in the midst of over -production of food, then I think you will accept the urgency of an alternative to Tina. In South Africa we have coined the term Temba, our own indigenous African alternative, because there must be an alternative.

Just the other day I was meeting one of the funders to ensure that our little centre could carry on doing its bit of work. I was in the process of explaining globalisation, the New World Order and its impact for development, when the question was posed to me so as to what the alternatives was? And since our name implies Alternative Information maybe he thought I could tell him what the alternative was. If I was asked that question 10 years ago I would have said our alternative is the Freedom Charter, it's Socialism, it's a people centred development Programme, it is the RDP.

Why do we feel uncomfortable saying that there are alternatives. Firstly it is probably the result of the ideological impact of these free-market policies; which are driven to tell us and always enforce in our minds that your alternatives are unrealistic, they are not possible. I think the little anecdote about the World Bank and the possible 12% deficit is a very good illustration of how there are alternatives, but it is a question of whose interests these alternatives serve in today's world.

Also we are extremely sceptical about alternatives, egalitarian alternatives, because we have to come to terms with the failure of most egalitarian projects. Whether it is the failure of so-called socialism in the post capitalist states of Europe, or the failure of social democracy, or the failure of the African Revolution, we say it has all failed, obviously we are at the end of history now. The free market is the best we have.

It is absolutely crucial that we resist throwing the baby out with the bath-water. It is clear, given the restructuring and transformation that has taken place in the World and South Africa, that we cannot simply say here is the doctrine or the blue print. We don't have that blueprint. So, my reply to the funder was, I'm not sure what the alternatives are, but there are certain elements or there is a framework within which we can consider an alternative/s.

There are lots of suggestions in terms of alternatives, both speakers here as well as abroad, in conjunction with a plethora of literature and documents that suggest alternatives at a global level. We don't have a sufficient knowledge of them.

Please note that this paper is an edited transcription of the paper delivered at the conference since Brian Ashleys' paper was not available at the time of printing

When we look at the GEAR Patrick Bond has already alluded to, there are alternatives at that level. If we take the example of current interest rates: given the Public Debt of R300 billion and apply a similar scale sized private debt, we are talking about a current interest rate of R30 billion being transferred to financial institutions per year. In other words, R30 billion is being taken from the poor and given to the rich. Is it possible to contemplate a massive reduction in South Africa to deal with the massive debt? If we brought down the interest rate by 5%, which a number of progressive economists suggests, the climate for productive investment would become feasible in economic terms.

Given these high interest rates, it is going to take a lot for you to take your money out of the financial sector, where you are getting huge returns and putting it at risk in opening new factories and so on and where you are not going to necessarily get the same type of returns. We can talk around budget deficits, about a more progressive tax regime which we could consider capital gains taxes and which would consider taxes on luxury items. We have to ask ourselves the question: if these different alternatives exist why are they so marginal? I think the earlier point that I was making about invested interest is crucial. Perhaps I can take this opportunity of illustrating how facile some of the responses to alternatives are.

There is a guru in the United States who was behind the whole notion of the lean, mean corporation, the down-sized corporation - Michael Hammer - is his name. Three years later he said that he has to rethink because they left out one very important element. What was the element? The people. They subsequently found that a 3% increase in the number of people employed raised the question of profits and accumulation for the corporation. I am attempting to illustrate how, when it suits a particular elite, things are possible, and when they don't they are unrealistic. I am suggesting that in terms of our framework, in considering alternatives we have to bear that in mind.

I think the real answer is rooted in existing power relationships. Why do we have this shift away from the Reconstruction and Development Programme, away from the developmentalist and redistributive policies, toward a neo-liberal policy which is not contained by market realities. We have to consider the context in which the GEAR was born, the impact of the New World Order as well as the impact of globalisation, the power of the big financial institutions, the transnationals and so on. In South Africa it is under the influence, the power, of those people who were privileged under apartheid - particularly the huge corporations which dominate and own the Johannesburg Stock Exchange. They are able to use their influence and power to ensure that policies allow them greater levels of profit, or use their strategic location within the economy and the bureaucracy to block progressive policies that our Government has already committed itself to. I am sure that all of us have examples from South Africa of the dismay we have in understanding why in this or that instance a policy that has been agreed to does not really see the light of day. Just to take the example of toxic waste. Here, in spite of the ANC's commitment against the dumping of toxic waste, and the involvement of the Green Coalition, the environmental movement in getting a resolution at the European Union which would seek to block further toxic dumping in South Africa, this is still continuing.

I think when we consider the way forward we need to do it from the perspective of the objective needs of our people. We need to go back, perhaps to the early Trade Unionists who have said that we reduce the day in the objective needs of the working people.

I think we have to locate the objective needs of people within the people's organisations. We must build strong people's organisations around many of the alternatives that have been mentioned, and the many progressive aspects of the Reconstruction and Development Programme. I think in such a proposal lies the means both of in terms of addressing the current social weaknesses of social organisation and movements in this country, but on top lies the hope that real alternatives can be fleshed out and given the type of substance that the type of research mentioned earlier in relation to what has been done in Zimbabwe. These alternatives are real and are capable of ensuring a different

type of society to the one that is declaring war on our children. Lastly we cannot do it in isolation of the global movements, the campaigns that are taking place to challenge the New World Order, the instruments of globalisation, the IMF, the World Bank, the World Trade Organisation and so on. We in South Africa must locate ourselves inside these movements and campaigns because it is not simply good enough to operate only at the local level.

International Responses to The New Economic Order

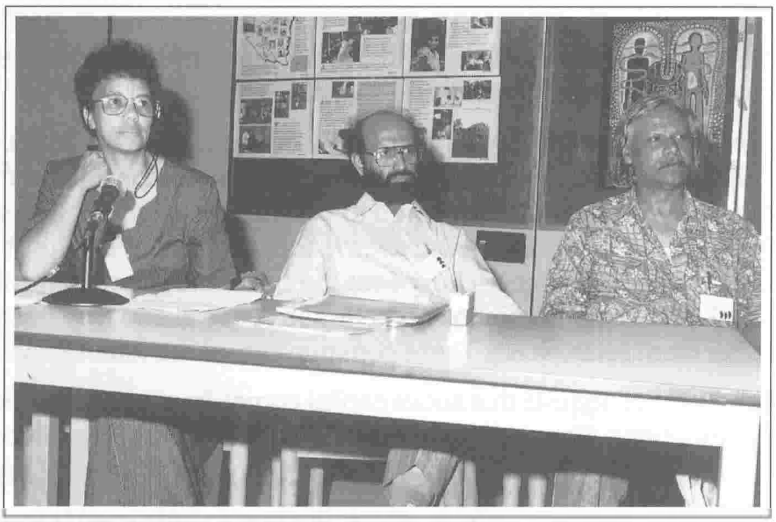
SOCIAL CAPITAL AND HEALTH DEVELOPMENT: RETHINKING PRIMARY HEALTH CARE AND HEALTH PROMOTION

Fran Baum
South Australian Community Health Research Unit
Department of Public Health, Flinders University of South Australia
Australia

Introduction

This paper argues that primary health care and health promotion need to change their focus if they are to contribute to progressive movements within the new world order. Critiques of primary health care and health promotion have been well articulated from a progressive perspective. These critiques have accused primary health care and health promotion of concentrating on selected diseases rather than offering a comprehensive approach, of being far too heavily based on behaviourism, of being paternalistic and of disempowering people (especially poor and marginalised people), of being dominated by professional perspectives on problems, of doing very little to tackle the underlying causes of illness and focusing on disease rather health.

At this conference we have heard detailed accounts of the impact of the new world order on peoples' health status around the world. My experience in Australia, where we are entering a period of new right governments, increasingly voiced public expressions of racism and a withdrawal of state funding from most community-based activities, (including legal services, health, welfare and education), is that community-based health workers need a new framework for action within which they can maintain the progressive values they believe in but still engage in some dialogue with the state. I think this framework



International Responses to the New Economic Order are discussed.
From left: Dawn Goodley (chairperson), B. Ekbal and Zafrullah Choudhury

may be emerging from the various theorists who are discussing ideas of social capital. This paper examines why these ideas may be relevant.

What creates health?

Progressive analysis of factors which create health (see for example Blaxter, 1990; Evans, Barer and Marmor, 1994; Wilkinson, 1996) indicates that they are rooted in the social and economic structures of society rather than health care services. Chief among these factors are the following:

- A reasonable standard of living that supports people in playing a useful role in society and maintaining social relations
- Relative equity in distribution of goods (income, housing, education, health care)
- Minimal hierarchy between people (evidence from the UK civil service studies suggests that hierarchy itself is bad for health)
- Healthy physical environment with minimal pollution of air, water, soil and food
- Social support and protection from unwanted isolation
- An engaged civic society in which people are able to participate (women's groups, social activity groups)
- Health services (but these play a minor role in creating health)

It surely follows that the core business of primary health care and health promotion should be working to bring about these conditions in society. A number of these processes can be conceptualised as building social capital. Yet the World Bank's Investing in Health only considered the importance of investment in terms of economic development. This contrasts with the *Alma Ata Health for All 2000* document that put far more emphasis on the notion of social investment for health.

What is social capital?

In late 1995 Eva Cox's Australian Broadcasting Corporations *Boyer Lectures* (Cox, 1995) sparked the imagination of many Australians with the concept of social capital and the potential she sees it has for balancing an over-concentration on the economic aspects of life. Social capital refers to the processes between people which establish networks, norms, social trust and facilitate co-ordination and co-operation for mutual benefit. In linking the terms 'social' and 'capital' Cox set out to persuade her audience that investing in the social fabric of society was as important as other forms of capital investment, especially financial capital.

Her ideas of social capital have built on work done in Italy by the American sociologist Putnam (1993 a & b). Over a period of twenty years he considered the reasons for the success of some regional governments compared to others. This suggests that strong traditions of civic engagement such as voter turnout, newspaper readership, membership of choral societies and literary circles, Lions clubs and soccer clubs were the hallmark of economically successful regions. In the regions which had active community organisations social and political networks were organised horizontally rather than hierarchically. These communities value solidarity, civic participation, integrity and reciprocity.

Cox (1995) suggests that social capital comes from people working together voluntarily in egalitarian organisations. She says:

> *"Learning some of the rough and tumble of group processes also has the advantages of connecting us with others. We gossip, relate and create the warmth that comes from trusting. Accumulated social trust allows groups and organisations, and even nations, to develop the tolerance sometimes needed to deal with conflicts and differing interests.*

Therefore we must put a high priority on growing social capital by offering opportunities for trust and co-operation."

There is nothing very complicated about social capital. It is really what most of us do each day when we interact with people, learn to trust them and then work together for some end. The crucial point is that it appears some societies are better organised and have a stronger history of providing opportunities for their citizens to engage in social capital building than are others. Crucial to the process is the establishment of trust between people (in fact the absence of trust between people may turn out to be a far bigger risk factor for ill health than lack of exercise, cholesterol or being over weight!). I suspect we don't know that much about trust. But most people would agree that it doesn't happen when people don't get together and either do things they enjoy together or work on some common project. Some people have argued that trust has an economic value. Coleman (1988, p.S100-S101) says that social capital comes about "through changes in the relations among people that facilitate action..... Just as physical capital and human capital facilitate productive activity, social capital does as well. For example, a group within which there is trustworthiness and extensive trust is able to accomplish much more than a comparable group without that trustworthiness and trust." So social capital is productive. The stock of social capital is trust, network and norms which support it. Once there is some investment in social capital it will tend to be self-reinforcing and cumulative. Successful collaboration on one enterprise will build up trust and networks that may then be used for other endeavours (Putnam, 1993a). Some have raised the question of whether using the term 'capital' is useful to a progressive agenda on the grounds that it may tend to re-inforce rather than challenge economic rationalism simply by using economic jargon. While there may be this risk, the use of the term in Australia, at least, has enabled the 'social' to be restored to public policy debates in a way that has not been evident in the recent past.

Applying the concept of social capital to primary health care and health promotion

So what becomes the aim of primary health care and health promotion with a shift from more traditional focuses to one of social capital building. The best examples of current practice are already doing this of course. See for example good development projects and community development in health initiatives. Social capital provides a new way of thinking about that work and one which attempts to engage with the over-reliance of economic factors in public decision-making. Imagine a world where on the TV each night instead of hearing about the Dow Jones and Financial Times index we heard about the levels of social trust and the number of new community groups that were springing up around the world. Imagine health services where the managers were interested in how much social capital you'd created that month rather than in how much money you'd saved.

Aspects of social capital building

- Participation: who, what, why? Who doesn't participate and why?
- Levels of trust
- Sufficient time to engage in civic activities
- Types of group activities
- Networks of links between people and groups which encourage active participation mainly outside the health sector but would include support groups
- Structures for building social capital (e.g. public meeting places, public broadcasting network, linking between state-funded and community organisations)

- Policy support for diversity and dissent
- The implications for primary health care and health promotion practice are:
  - A focus on groups and organisations rather than individuals
  - Intersectoral links become a central rather than optional extra
  - Needs assessment would address the issues of how to create communities with high levels of social capital rather than individual risk factors. Questions such as why do communities differ in their stock of social capital? How is social capital created and destroyed? What strategies for building (or rebuilding) social capital are most promising? How can we both utilise existing social capital and create it afresh? Can specific types of social capital be matched to different problems? (questions based on Putnam, 1993) become crucial. These questions are not tangible or easily measured but that does not mean they aren't important and primary health care and health promotion should become used to tackling them.
  - Primary health care and health promotion would not work by bringing in new programs or campaigns but would set about working with and strengthening the existing network and encouraging them to work on health issues wherever possible. The starting point would be how are you already addressing health, rather than what are your deficits.
  - Assist with creating structures (outside the home and work which encourage informal interaction and provide meeting places) and ideology which supports and invests in local initiatives for health promotion (i.e. the belief in the importance of society, civic engagement and trust between people).

I'm sure you can all think of examples of social capital in action from your home countries. Some from mine are:

- Cafes where local boarding house residents who have mental illness are allowed to sit for a long time even though they aren't buying much.
- Illness support groups which bring people together and provide mutual support to help cope with disease and negotiation through the health system.
- Choirs (e.g. Italian Women's choir from Perth) sense of joy, common experience and history.
- Youth environmental groups who work together on common environmental projects and learn to negotiate differences while working to achieve their own defined environmental goal.
- Group of residents who work with local community development worker to make their local park a safer place and then continue to work together on local issues of concern.
- A street in Semaphore, a working class suburb of Adelaide, where nearly all the residents decorate their houses with lights for Christmas and so the evenings leading up to Christmas turn into a spontaneous street party, with visitors and neighbours outside chatting and revelling in the atmosphere.

None of these things are exceptional. They are low key and small scale, but, in sufficient numbers, they can make the difference between a healthy and unhealthy society. Collectively, they are the social fabric and glue which hold societies together. Without this glue societies have a tendency to come unstuck.

Social capital also works at national levels. In South Africa you know this well through your amazing transition to a democratic government achieved by a process built on fragile trust. An essential requirement for the development of social capital appears to be that people have a common definition of need (whether it be at a local level such as a sporting club or a broad national threat such as

London during the Blitz) and agree on strategies to address that need. It follows that a crucial part of the process of social capital building is negotiation to gain agreement on strategies. A healthy society is one where disagreement is aired and discussed and worked through. In Australia our recent national debate on gun law control, following the Port Arthur massacre, has been an example of such a process. Each time people successfully negotiate their way through problems and find an acceptable compromise an investment is made in social capital for the future. Public health can play an important role in encouraging debate nationally, regionally and locally.

Social capital seems to have an increasing appeal. I have been careful to define it as something that rests on a state which nourishes and supports structures which develop interconnectedness and trust between people and sees its role as fostering the development of as many forms of social capital as possible. Social capital requires governments who will invest in it and who believe, in Coleman's (1988) words, that "social connectedness is a vital backdrop to effective policy". Yet it is necessary to be aware that the concept could (more sinisterly) be seen as one mechanism for the roll back of the state that has accompanied new right thinking and structural adjustment programs. If state investment of the structures that encourage social capital is not present then social capital is not likely to flourish. Consequently, the creation of social capital is likely to rely on strong and vibrant public services (especially in the health, welfare, housing and education sectors) which support the development of communities which are governed by values of trust and co-operation rather than competition and market forces. Also, trust and connectedness are not going to be present in a society which denies some of its people decent living conditions and have hierarchies that are considerable and increasing rather than declining. So, state policies aimed at the eradication of poverty and the pursuit of equity are essential stable mates of social capital.

For the future health promoters will need to work out ways of assessing community capacity for social building, discover how to develop creative partnerships and then use these as a mechanism to promote health and challenge unhealthy developments. The notion of social capital may prove to be one of the ways of challenging the unacceptable economic fundamentalism which dominates political thinking around the world.

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PEOPLE'S HEALTH PAYS THE PRICE FOR THE NEW WORLD DISORDER

DANILO BELTRAN

Health Alliance for Democracy (HEAD)
Philippines

The peoples of the world are now facing the worsening effects of intensifying global crisis. What the imperialists tout as the New World Order can aptly be called the New World Disorder. This has been spurred mainly by the worsening global crisis of capitalism. It is characterised by widespread economic disequlibrium among and within nations, world trade conflicts, rising poverty incidence and increasing concentration of wealth in fewer and fewer hands, joblessness and social discontent and armed conflicts in various countries.

While using the slogan of 'free competition', 'free market economies' and 'free trade', the evil forces behind the New Economic Order exert every effort to camouflage the reality and workings of monopoly capitalism and to impose on the oppressed peoples and nations worse conditions of neo-colonial dependency and subservience to imperialism.

The New World Disorder and the Semi-Colonial and Semi-Feudal System

The oppressed and the exploited classes in the Philippines, like the majority of the population in Third World countries, are suffering from the vigorous attacks of imperialism. With the removal of protective barriers to trade and investments through liberalisation, the removal of protective economic controls and the guarantee of free market and business operations through deregulation, the reduction in social spending and the transfer of assets and operations of government to profit enterprise through privatisation, the increased power of imperialist-controlled multilateral organisations like the WB, IMF, and WTO, and with the unbridled dominance or monopoly of TNCs in national and global economic activities, the New World Disorder can only mean perpetual underdevelopment for a semi-colonial and semi-feudal society like the Philippines.

Thus, the boastful claim to turn the Philippines into a 'newly-industrialising country' by the year 2000 and for it to become 'a new tiger economy in Asia' is a package of blatant lies. In fact, the Philippine government's continued submissiveness to the policies espoused by the WB, IMF and the WTO prevent industrial development and increase the agrarian character of this society.

There will be no 'brighter days' for the Philippine economy - at least not in the near future. Instead of 'economic recovery' as being repeatedly bragged by the current administration of President Fidel Ramos, the chronic crisis in an export-orientated, import-dependent, foreign-investment-led, debt-riddled and backward agricultural economy continues to deepen and worsen under the New World Disorder.

The immediate backlash of this economic disorder is seen in the workers' plight. The country's so-called 'growing' economy is also seeing a growing army of urban and rural job seekers. The number of unemployed workers increased in 1995 by 16.5%, or an additional 861 000 to the 8.6 million unemployed and underemployed workers in 1996. Even the Department of Labour and Employment admitted that there are job losses due to trade liberalisation under the GATT-WTO. The Philippines became a member of GATT-WTO in January 1995. Since then, there have been 51 cases of GATT-related losses in 1995 and 38 cases in the first quarter of 1996 alone. At least 131 000 workers lost their jobs in these incidents.

'Labour flexibility' measures are being adopted under the guise of promoting 'productivity', 'global competitiveness', 'manpower development' etc. Regular workers are retrenched and replaced with contractual workers. As early as 1992, an ILO study revealed that 73% of factories in the Philippines were already implementing various forms of flexible working arrangements. These include labour-only contracting, contract and casual hiring, piece-rate and part-time systems, rotation, extension of workweeks and other labour cost-cutting schemes.

The use of sub-contracting in the Philippines has resulted in the hiring of more child workers. The ILO estimates that there are 5 to 5.7 million working Filipino children aged between 5 - 17.

There are now about five to seven million Filipino migrant workers with no job security and labour protection whatsoever in their host country. Remittances from these overseas contract workers are being used to prop up the sagging economy.

Land monopoly and food insecurity are aggravated under the trade liberalisation policy. Only 1.2 million hectares of arable lands would be left for rice and com production while some 3.1 million hectares would be used for export crops. Massive land conversion and displacement of farmers are more rampant than ever. About 1.5 million farmers are losing their only means of livelihood.

There is no genuine industrialisation in the Philippines. The backward industrial production consists mainly of the processing and assembly type. Eighty-eight percent of the manufacturing establishments employ 10 persons or less. This manufacturing industry is import-dependent and foreign-investment-led.

The Philippines is also drowning in debt. Former President Corazon Aquino inherited a US$26 billion debt from Marcos in 1986. Despite the actual US$18 billion debt servicing made in the period of 1986 to 1991, Aquino ended her term of office in 1992 with a foreign debt amounting to US$29 billion. To date President Ramos has not yet finished his term of office but the foreign debt has been pegged at US$10.6 billion, or an increase of 40% from 1992 to 1996.

The PhP 165 /day minimum wage pegged in Metro Manila today could hardly cope with the PhP 372.21 daily cost of living as at August 1996. At the outset, 75% of Filipinos are still condemned to poverty.

While making sure that the pro-imperialist economic policies are in place, Ramos is unleashing his terror attacks against the people.

Ramos has always shown his commitment to abide by the policies of liberalisation, deregulation and privatisation and vowed to implement these policies even earlier than the schedule set by the WTO. On the other hand, he tries to hide the ill-effects of these policies and suppress growing discontent among the masses.

During the APEC Summit held in the Philippines in November 1996, the Ramos administration destroyed urban poor shanties in Metro Manilla, installed military restrictions in Central Luzon which prevented farmers and peasants from going in and out of their barrios and prevented them from harvesting their crops in farmlands near the Conference site. Furthermore, the administration placed the activities of people's organisations and their leaders under military surveillance and barricaded the way of a people's caravan in an attempt to suppress the organised people's effort against the APEC Summit and its policies which will surely give the TNCs more license to exploit our workers and to further plunder the rich natural resources of our country.

Ramos, a former military general, implementer of martial law during the Marcos fascist dictatorship and architect of total war policy during the Aquino regime, is systematically asserting his fascist agenda while utilising a deceptive democratic facade in the Government. He is using a so called 'peoples' initiative' in order to perpetuate himself in power through the recent campaign for charter amendment.

A national ID system is taking place in the Philippines while a number of anti-terrorism bills are pending at the Congress. In every given opportunity brought by economic and/or man-made crisis, Ramos is quick enough to seek emergency powers - and his Congress is loyal enough to provide him with what he needs.

The civilian bureaucracy is highly militarised. More than 50 military officers have been appointed to strategic government positions. Certainly, these officials who have easily changed their military uniforms overnight cannot easily forget their old militarist and authoritative way of governance. A martial law or a more discreet constitutional authoritarianism could be installed in the Philippines, without formally declaring it, at any time.

By wholeheartedly serving the interest of his imperialist masters, Ramos is trying to strengthen his political power - even if it could mean further suppression and repression of people's rights.

Side Effects of Economic Disorder to People's Health

The health of the Filipino nation is in a deeper crisis.

The health status of the majority of our population simply speaks for the unwanted side effects of economic policies prescribed by the WB, IMF, and WTO. Under the old and rotten social order, 'health for all' will never be achieved in the Philippines.

Contrary to their commitment to the Alma Ata Conference in 1978, the Government misappropriates the health budget. In 1994 the Department for Health spent PhP 108 per person or 30 centavos per person per day on health.

Poor Filipino families are continuously deprived of their right to health. The WB-IMF's Structural Adjustment Programme and the WTO's policies have severely affected the critical condition of our people's health.

As part of the WB-IMF's prescriptions to enhance the Philippines capability to pay its foreign debt through revenue collection, cutting of government spending and other forms of austerity measures, the Local Government Code was enacted into law in 1994. This has resulted in the decentralisation or devolution of health services to local government units. The responsibility to provide primary and secondary health care was transferred to the hands of corrupt local government executives and unresponsive politicians.

Furthermore, municipalities in the countryside feel the absence of medical and other health services. More people are dying unattended. There are cases of patients dying in a corridor of a hospital unattended. There are more cases of people dying in hospitals, with health professionals in attendance, due to the lack of availability of medical supplies and hospital facilities.

The decentralisation of health services also displaced and threatened the job security of 44 000 public health professionals and workers.

The current privatisation scheme is threatening the weakened and dying public health service. Contractualisation and agency-hiring has become a common practice in government hospitals.

Fee-for-services policies in the guise of cost recovery and user-fee schemes are implemented in all government hospitals. Patients are now being charged laboratory and professional fees as well as for other services which used to be free. These patients are the same people who are carrying the biggest burden in taxes and soaring prices of prime commodities.

Four speciality hospitals - the Lung Centre of the Philippines, Philippine Heart Centre, National Kidney and Transplant Institute and Philippines Children's Medical Centre are targeted for privatisation.

A conversion or re-integration programme is forcing lepers out of the Tala Leprosarium and mental patients out of the National Centre for Mental Health.

The government itself is now spreading scandalous information about inefficiencies and mismanagement in public health institutions targeted for privatisation. They do this to convince the people that health services would be better in the hands of private entities and if rendered in the framework of 'free competition'.

Other faces of privatisation schemes like restructuring, 'semi-privatisation' and co-operativisation are also being considered, especially in devolved public hospitals and health institutions.

Social Service institutions like the Social Security System and Government Services Insurance System are also up for sale.

The privatisation of health services in the Philippines is an outright abandonment of the government's social obligation to people's health.

Under the so called 'new economic order' health becomes a commodity for sale - hospitals and health facilities become investment ventures and services are rendered to make profit.

Challenges to Health for All

There is ample evidence that the health care status is affected by the present globalisation of the economy. In the era of the 'New World Disorder', the Filipino people are forced to pay for every health service they get. This is contrary to the promise of 'Health for All by the Year 2000'.

The Health Alliance For Democracy (HEAD), a political organisation of professionals, workers and students in the health sector in the Philippines, commits itself to rouse, organise and bring the sector closer to the struggle of the country's basic message, in order not to pay the bigger price of being a perpetual victims of imperialist exploitation and domination.

HEAD vehemently opposes privatisation and other economic policies imposed against the Filipino people. Its officers and members are taking the initiative in holding study circles and other education activities, information dissemination in schools and hospitals, public opinion making, participating in sectorial and multisectorial campaigns that expose and oppose policies affecting people's economic and democratic rights and actively participating in people's protest actions.

HEAD links its actions with hospital workers affected by privatisation schemes. While these workers form their own employees' unions, HEAD provides political education activities which enlighten them on the root causes of their problems, on the relationship of their issues and problems on the actual condition of the general masses.

HEAD unites with other nationalist people's movement health organisations and community-based health programmes in their aspirations for 'Health for All'.

We have begun these humble efforts, but much more has to be done.

We firmly believe that health for all will not be served on a silver platter. As long as imperialism through its instruments like the WB, IMF, WTO and its clients 'state' controls every aspect of society 'health for all' remains impossible. Health must be a product of people's concerted efforts in the struggle against imperialist domination. The struggle for health is the Filipino people's struggle for democracy and national sovereignty.

In this context, we challenge all the health activists in this Conference : extend your support for the advancement of people's struggles for genuine democracy and national liberation. The road to democracy and national liberation is the only way for nations dominated by imperialism and their local cohorts to read 'Health for All'.

Arouse, organise and mobilise the masses in our respective countries to expose and oppose all imperialist attacks that severely affecting their economic plight, their social well being and their right to health

To the IPHC:

"Let us unite and join the people's struggle against imperialist domination in the world!"

To the people of South Africa....

"Be more vigilant ..your struggle..

Our struggle has not yet completed!"

KERALA MODEL FOR HEALTH CARE : FROM SUCCESS TO CRISIS

B. Ekbal

Medical College Hospital, Kottayam
India

Kerala is one of the smaller states in India, comprising about 1.2% of the country's total area and supporting around 3% of its population. Geographically it lies in the South West Coast of India. Kerala has a long sea coast and is therefore connected via trade links to many western influences.

The modern state of Kerala was formed in 1957 by the amalgamation of the princely states of Travancore, Cochin and the Malabar district of the Madras province. The state is generally classified as backward in terms of its poor industrial development and faltering production of food grain. In per capita income, it ranks as one of the poorest cities in India.

In spite of the economic backwardness Kerala has attained remarkable achievements in health, comparable to that of developed countries. This is evidenced by the widely accepted health indicators like Crude Death Rate, Infant Mortality Rate and Life Expectancy (Table 1).

Kerala's achievements in the health field has been seen as something of an enigma by most analysts. Kerala achieved this high health status on par with that of the USA, spending roughly 10 dollar (US) per capita per year (Table 2). Kerala's achievement, in spite of the economic backwardness and very low health spending, has prompted many analysts to talk about the Kerala Model of Health as being worth emulating by other developing parts of the world.

Kerala can be said to have made the transition from a society with a high population growth rate, high crude death rate and high infant mortality rate to one with a moderate population growth rate, low crude death rate and a relatively low infant mortality rate. That this has come about without major economic restructuring of the society, sets it apart as a model of what is possible, within severe constraints of development in the health sphere.

There are many socio-economic conditions unique to Kerala which have made this health model possible. Kerala has a highly literate population (which has crossed 90% by 1990) compared to other Indian states. The high level of female literacy has to be given due credit when we look for explanatory factors. All over the world indices such as infant mortality have shown an inverse relationship with female literacy.

It is also to be noted that Kerala has nurtured a political climate wherein the rights of the poor and under privileged have been upheld and fought for. This was the result of a fairly long period of struggle for social reforms which emphasised the dignity of people who were considered socially 'inferior' and which later found expression in the secular-rationalist movements culminating in nationalist and socialist movements. One common thrust of all such movements was on education and the organisation of the downtrodden people. Government departments in Kerala have also given high priority to social welfare sectors such as education and health.

The popularly elected Communist Government during it's tenure period 1957-1959 implemented agrarian reforms, thereby ending feudal relationships in agriculture and giving land to the tillers. This improved the social and living conditions of the landless poor in the rural areas. This might have contributed to alleviating poverty among the agricultural labourers leading to an improvement in their health status.

The public distribution system of food through fair-priced ration shops throughout Kerala assures minimum food materials at relatively cheap cost to the people. This has guaranteed a certain amount of nutritional status to the poor, warding off poverty related diseases.

Apart from the socio-economic factors outlined above, the universally available public health system in Kerala has also contributed to the high health status of the people. Kerala has a three tier system of health care: the primary health care centres; Taluk and District intermediary hospitals and Medical Colleges with tertiary care centres, equally distributed both in the urban and the rural areas. Besides modern medicine, Ayurveda, Homeopathy and other alternative systems are very popular in Kerala.

The Kerala Model for Health, widely acclaimed by health analysts, has started showing a number of disturbing trends recently. Even though the mortality rate is low, the morbidity is high in Kerala compared to other states (Table 3), though there is a data gap in this regard. The NSS (1974) and KSSP (1987) studies confirmed these observations. Hence the KERALA Health situation was described as a 'low mortality high morbidity syndrome' (Panicker and Soman). It can be argued that when the expectancy of life increases there can be a corresponding increase in morbidity in terms of high incidence of cancer, heart disease, etc that affect the aged. However, in this regard the Kerala situation is peculiar in that the so called diseases of poverty like diarrhoea, hepatitis, etc are still prevalent in Kerala (Table 4). Hence the Kerala Health situation can also be described as 'low mortality infectious disease syndrome' since such diseases are not seen in places where the health status quo is as good as that of Kerala. Moreover, many epidemics that were thought to have been eliminated from Kerala, like malaria are definitely staging a comeback. Also contemporary epidemics like Japanese encephalitis which did not occur in Kerala, except sporadically, has also started appearing, as well as the modern killer disease AIDS.

The Public Health System is becoming alienated from the people and only 30% of the people from the lower income group seek medical help from the Government hospitals (Table 5). This is as a result of the decline in the quality of the health care in government hospitals. Lack of political commitment, bureaucratic inefficiency, corruption at various levels and the deterioration of the ethical standard of the medical profession have contributed to the deplorable state of affairs. This environment of the perceived inefficiency of the government medical facilities provided the impetus for the growth of private medical care. The number of beds in the government institutions grew from around 36 000 to 38 000 in the ten year period from 1986 to 1996, whereas in the same period, beds in private institutions grew from 49 000 to 67 500. This amounts to nearly 40% growth in the private sector beds versus nearly 5.5% in the government sector. In the case of doctors about 5 000 doctors work in the government sector whereas double the number work in the private sector (Table 6). More significantly, the private sector have far outpaced the government facilities in the provision of sophisticated modalities of diagnosis and therapy, such as CT Scans, Endoscopy Units, MRI Scans etc.

The privatisation of medical care is leading to over medicalisation and escalation of health care costs (Table 7). A case in point is the growing tendency for submitting patients of the higher income groups for Caesarean Surgery (Table 8). The net result is the marginalisation of the poor and it is estimated that at least 30% of the people are denied health care or find it extremely difficult to meet the health expenditure.

The changing health scenario in Kerala has prompted analysts like the present author to comment that the Kerala Model of Health Care is slowly drifting towards an American Model of health care. The hallmarks of the Kerala Model were the low cost and universally accessible health care. This is changing to an American Model where the poor are denied health care in the face of escalation of health care cost because of privatisation.

The implementation of New Economic Policy by the government of India is further deepening the crisis in all fields of life including health care. As per the recommendation of the World Bank, user fees were introduced in government hospitals ostensibly to charge the rich in order to help the poor. This system of private practice has resulted in the internal privatisation of the public sector. Also, the

private sector is encouraged to enter into curative care and diagnostics with tax exemption. The public sector drug industry in Kerala is now earmarked for disinvestment and privatisation.

It should be understood that the crisis in the health sphere is not confined to that field alone. Even though the multifaceted character of the crisis encountering the state is widely noted, the focus of attention of the relevant debate and studies has rightly been on the sustained poor performance growth of the productive sectors of the economy. The crisis in the productive sector is manifested in the virtual stagnation of the agricultural sector, deplorable lower levels of productivity of important crops, growing apathy among cultivators, structural decay of the industrial sector dominated by the ailing traditional industries, rapid deterioration of the power situation over burdening the fragile ecosystem etc. The threats faced by other aspects of social life are also equally severe. For instance, the deterioration in the quality services offered by the crucial service sector, such as education, public distribution and transport along with public health has emerged as a major problem. Incidentally, free or subsidised provision of such basic necessities was instrumental in raising the standard of living of the people of the state to levels comparable to those of even developed countries. It needs to be added that the stagnation of the productive sectors has worsened the fiscal position of the state and made it incapable of making any effective intervention. More importantly the crisis has also tended to strengthen the neo-liberal arguments which blame the people and their organisations. The contemporary crisis has already started affecting the redistributive gains of the past, the standard of living of the people and the very ideology of the unique democratic project of modernisation.

The silver lining in this situation is the demands of the People's Science Movements like KSSP (Kerala Sastra Sahithya Parashad) for a People's Health Policy for Kerala and the initiatives taken by the State Planning Board for decentralised Planning involving the local bodies. KSSP feels that the toning up of the health care system in the state and making it capable of taking on the burden of providing equitable, efficient and good quality health care needs concerted action from the political parties and other social movements. Re-instating the primacy of the government health services, with its emphasis on primary health care should form the basis of the health policy for Kerala. There should be some amount of social control of the private sector.

While the modern medical system dominates both in terms of supply and demand as well as in terms of the government expenditure, people seem to prefer in some measure the indigenous systems of medicine (mainly Ayurvedic) for certain types of ailments. While the indigenous system of medicine of homeopathy cannot be expected to replace medicine as the dominant mode of care in any contemporary society, the fact that these are demanded by the people at some time or other, point to certain felt needs in health care which cannot be adequately addressed by modern medicine. Thus, there is a need to support and nurture alternate systems.

There is a growing demand for the effective administrative and financial decentralisation of the health sector to tide over the bureaucratic inefficiency of the system. It is in this context that the newly constituted Kerala State planning board, of which the author is a member, resolved in its first meeting to initiate a People's campaign to empower the Panchayats (local bodies) and the municipal bodies to draw up the Ninth Plan (1997-2002) schemes within their respective areas of responsibility. It is hoped that 35 to 40% of Ninth Plan will consist of schemes formulated and implemented from below. Based on the total literacy movement, the campaign seeks to motivate and bring together elected representatives, officials, experts and the voluntary activists together local level development activities. The campaign is systematically organised starting with the Gramasabhas (ward conventions) in which people's aspirations are aired. This is followed by development seminars where solutions are on offer to people's problems which are later projected and prioritised with the help of the experts and people's representatives. Finally preparation of the five year plan is undertaken.

The campaign assumes importance also from the point of view of the contemporary crisis of Kerala's widely acclaimed development model. The focus of mass movements, which has made the Kerala Model possible, has so far been on the question of equity in distribution of wealth and income. But it is increasingly evident that the pursuit of equity cannot be sustained in the absence of economic growth. The question whether the organised strength of mass movements and the democratic consciousness they have generated can be utilised to accelerate economic growth, therefore, is assuming critical importance in the present juncture. The People's Campaign for the Ninth Plan represents such an initiative to make use of the legacy of collective social intervention and the strength of mass movements to meet contemporary crisis in development including that in health.

Fortunately Panchayati Raj now provides the possibility for the people to demand the resources to operate a health service in which they will play a dominant role and of which they will be the chief beneficiaries. All infrastructure, manpower production, training, distribution, production of drugs and equipment must conform to achieve this, and not in reverse as it is at present. Only thus can a cost effective, human and accountable health service be provided which is funded and operated by Panchayat with technical assistance of the health professionals. The available public health resources can be augmented by those who can obtain far better services of their worth rather than spending on private curative service. This system involves the entire community, and especially women, in their own health, not only curative care, but even more so in health education, as well as the prevention and control of the diseases which originate in their own environment. They have the greatest interest in improving the conditions which affect them and their children. This would also be an impetus to contribute to the overall improvement of their community.

Let us take the example of the most common cause of morbidity, namely water-borne diseases such as diarrhoea, dysentery, worms, cholera, infectious hepatitis and typhoid. Ensuring adequate and safe water supply varies from village to village and is primarily the role of the local community such as cleaning of wells, repairing the hand pumps, drainage of stagnant water and sanitation. This would not only drastically reduce the need for medical attention but the people themselves are also the best functionaries for prompt treatment of conditions like dehydration by oral rehydration therapy (ORT). This would reduce the need and cost of professional medical care which can be restricted to the care of a few difficult problems.

The Planning Board is allocating about 40% of the plan's fund to the local bodies. As far as health is concerned this has opened up tremendous possibilities since the primary health centres and the intermediary hospitals are already handed over to the local bodies. If successful, along with the other fields participating in health, Kerala may be poised for a second revolution in health leading to a Decentralised Model of Health Care.

Table 1: Kerala - Health status

Indicators	Kerala	India	USA
CDR	6.3	10	7
CBR	17.7	29	17
IMR	11	79	8
Life Expectancy			
Male	66.8	57.7	73
Female	72.3	58.1	79

Table 2: Kerala - Government Health Expenditure (40% of Total Health Expenditure - per capita)

1985 -86	Rs. 46.27	(1.3 US$)
1990 -91	Rs. 76.52	(2.5 US$)
1994 -95	Rs. 130.06	(3.7 US$)

** Per Capita Health Expenditure: 10 US$*

Table 3: Kerala - Morbidity

	KERALA 1974	INDIA 1974	KERALA 1987
Acute diseases	71	22	206
Chronic diseases	83	21	136

Table 4: Kerala - Morbidity according to social status

DISEASE	GROUP 1	GROUP2	GROUP3	GROUP 4
Diarrhoea	34	23	18	11
Fever	141	123	108	88
Tuberculosis	11	7	4	2
Asthma	18	17	15	2
Diabetes	1	2	6	11
Heart Disease	3	5	5	6
Hypertension	6	9	16	22

Group 1 - Poorest
Group 4 - Richest

Table 5: Utilisation of health sectors

Group	Public%	Private%
One	33	43
Two	25	50
Three	16	60
Four	8	66

Group 1 - Poorest
Group 4 - Richest

Table 6: Kerala - government and private sector

	Private	Government
No. of Institutions	4288	1249
No. of Beds	67517	42432
Doctors	10388	4907

Table 7: Health expenditure

Year	Consumer price index	Health expenditure
1991	100	100
1994	120	141

Table 8: Caesarean surgery

Total Delivery	11.9%
Group 1	9.3%
Group 2	12.0%
Group 3	11.3%
Group 4	19.3%

Group 1 - Poorest
Group 4 - Richest

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THE BANGLADESH INTEGRATED DEVELOPMENT PROJECT GONOSHASTA KENDRA

Zafrullah Choudhury

Bangladesh

Firstly I think I should introduce Bangladesh, since India is a vast country. Bangladesh in comparison looks like a small country, however we have a population of 120 million people. Its total surface area is 140 000 square kilometres, maybe equivalent to one or two states of South Africa - but remember we have 120 million people. Eighty five percent of the population are Muslim, about 12% are Hindus and the rest are Christian and Buddhist.

Secondly I'd like to elaborate a little about the organisation that is the subject of my talk. "Gonno-shasta"- "Gonno" meaning "people", "Shasta" means health and "kendra" means "centre"- so therefore - People's Health Centre.

Our story begins in 1971 when we were fighting against Pakistan. You may have noticed that to the West of India is Pakistan, which was divided into West Pakistan and East Pakistan. This division is in many ways a legacy from our history of colonialism, but I am at pains to point out that we cannot use the excuse of colonialism for the rest of our lives. East and West Pakistan, although with different cultural perspectives, are united by a common religion. West Pakistan in terms of area was almost five times the size of Bangladesh, but they have the population of half of Bangladesh.

In 1971, at the time of the war, I was a young doctor practising in England as a vascular surgeon. A group of us decided to go abroad, in retrospect we were no different from any other upper middle class, opportunistic students. At the time we foresaw that the country of Bangladesh was going to be a reality. So as soon as the war broke out we left England, and came to join the rebel forces for nine months. We were very fortunate, unlike South Africa, our war was very short one. Like a foetus born prematurely we have many problems.

India didn't want us to fight too long. They realised if Bangladesh become a socialist country, this could create problems for India as well. They helped us as effectively as they could, and a mere nine months later the country of Bangladesh was granted independence. In the space of nine months Bangladesh was born.

War has its own kind of advantages and perspectives. In war we discovered our own homeland again. As a people in a war, you realise that you may have a Masters degree and that many concepts you learned or acquired may be difficult for the ordinary person to understand. By ordinary person, I mean the majority of the peoples of Bangladesh like the people who work in the field, people who work in agriculture, common people. If a country and the peoples of that country want a better life then everyone has to do their bit. In theory it is easy but practically it is difficult to reach.

There is the example of Nacadema, a man from Japan who worked for Roche, a multinational corporation for all his life. Later, as a result of international politics, he became the Director General of WHO.

But even then the global situation is so bad. A person like Nacadema could not remain silent. Even he has to admit the advantage of having such technological advances. Even if these advances are not for the benefit of the vast majority of the people who are living in the rural areas outside the city.

Please note that this paper is an edited transcription of the paper delivered at the conference since Zafrullah Choudhury's paper was not available at the time of printing

In terms of health Bangladesh is no different from most Third World countries. Diseases such as diarrhoea, worms, skin diseases, upper respiratory tract infection, anaemia, malnutrition and eye disease are prevalent. Accidents is a very interesting word - most cases of domestic violence are recorded as "accidents"; as a result the concept of domestic violence does not exist. Violence against women is not mentioned in the media and families are not prepared to talk about it because it creates a negative impression of said family. We are not treating our women well, I am not treating my daughter well, but creating a negative impression is too strong a taboo, so we keep quiet. The medical profession, especially, know how to mask things; we know how to mystify our profession, how to take power, how to depower the people and to have all power amongst ourselves. So given the context the power or non-power, the word "accidents" is unacceptable.

How do we deliver health care? I confine myself to Bangladesh but I'm sure it will speak of the situation of most Third World countries; the only way to reach them is to take the health workers to the rural areas. Should we take the missionary approach as was the case of the Scottish and Dutch missionaries who came to South Africa? The people, usually those who live in the village, don't go to school. They cannot afford to go to school. In any case, schooling is not going to benefit them; success is not measured by levels of education. Now if we really have to deliver the goods, deliver health care, we have to train different sorts of people who live in the villages. It is a reality across the world, that doctors like to live in cities where there is nice weather, and good income. So Bangladesh is no different. The Bangladesh elite is smaller, there is no competition, so for obvious reasons they will not go outside their city.

Once the war was over, and we were a free people our lives were transformed. We realised that a country as divided as ours has little hope of survival. The country has to be equitable, people must have access to basic health needs. So in 1972 we took the village women who had never been to school but, it doesn't mean that as you have never been to school you may theoretically be illiterate, you may not be able to read and write, but you understand; in fact, you understand better than most of the people. Why better than most of the people? Because their survival depends on it - if you are not clever enough you will not survive. So you have to see, and hear things much better than anybody else. And especially women. They have to be doubly clever than the man to survive in this world!

So we realise we have to take the women, we have to train them, we have to empower them, if we want better health care. Because from time immemorial, the best foundation in health care was given by women. As the capitalist economy has taken over, health has become business. Every profession, if you look into our life when it is just the cooking it's the women. When it is a question of a chef in a five-star hotel it's the man!

But the problem is this. Our whole education, we have been for many years to schools and universities - they did not educate us. They did not allow us to communicate with the people. It did not teach us how to teach other people, how to share knowledge. Bangladesh as I have mentioned is an agriculture-based country- it is hard work with very little pay. 60% of the yearly food production in the agriculture sector, is done by women all over the world, but in terms of visibility it is the young men who are seen to be the food producers.

I want to show a bit of our villages where 85% of our people are living. We have rivers and plenty of water. More than 60% of the people's homes are like that (refers to slide)-a tattered home, that's all their belongings (very basic utensils), that's what the poor people have. Their cows are very important to them so they live right next to them and are their survival right. Here you can see the women are working (refers to slide). Here you have a girl aged five, working with her mother, at this age she contributes to the productivity of her family. They cannot afford to go to school, and the attaining of an education is superfluous, since it will not bring any real changes. Here you see a mother, daughter

and their cat. Here are two children - who looks after them? It is very nice to talk about universal primary education but food is the first priority, not education nor health. The girl will always be falling behind, although at birth she has a better chance of survival, but as the years pass on she does manual labour and there's no fun element in life. We are a poor country but the land is very rich.

The situation in India is no different from Bangladesh, although the country is much bigger. Dr Iqbal comes from a much bigger institute - I live in the rural area, he lives in a much bigger city. But the situation is same for both of us. Sixty-four percent of the Indian people, -in the case of Bangladesh it may be 72, -have no access to the Government health sector and to the health care. Either doctors are not available, or they find a living in the village difficult. So that's why anything between 60 to 70% of the people do not have access to modern health care.

I do not want to take up time by discussing the differences between modern and traditional. That is also another area where there are disparities and where exploitation is rife. We have trained the village women, and encourage them to cycle. Why cycling? Because a Muslim country is more conservative than a Western country and to break the shackles of tradition is an important step for women to reclaim power over their own lives. That is the first revolution. Here in Africa you may not understand the situation in Bangladesh and India - to encourage women to ride a bicycle is a big step forward.

The training of the health worker is very simple. We can train anybody who is not deaf and blind. For a good health worker you need to have two things, eyesight and hearing, and the rest you can learn very fast. If you have the rudiments in terms of education, that is, if you can read and write, you can be a health worker. As an example if you take the case of ante-natal care in a country where the mortality rate is high. How do you reduce it? If you were to ask the village women to come to Cape Town to see the health worker, only to be told by the health worker that an individual is suffering from pedal oedema as a result of the long arduous journey, many on principle will simply elect not to make the journey. So village health workers go and check the swelling of the legs. It is very simple - to check the swelling of the leg using a piece of string.

Take the example of blood pressure. You place the stethoscope in the proper place and then you pump it and wait for the sound to occur. That's when the hearing is good enough. And then look underneath the glass at the number. The number is 140 or 80. The first one is systolic, next one is diastolic. So then you write it. If you can write the number, that's it.

Another example is urine examination. If you're in the danger zone, there will be traces of protein in your urine. How do you check for protein? You can heat a few drops of urine - if protein is present it will coagulate as a result of the heat. It is so simple, you can do this simple test anywhere in the world, including an African village. It however needs the help of the medical profession, to demystify the profession and change mindsets. We are all responsible collectively for this and therefore it is our collective responsibility to forge a new way forward.

Again, with the example of tetanus. The traditional method is to give the baby a tetanus injection. The issues of child immunisation as well as breast feeding need to be contextualised. Within the traditional family unit, the mother-in-law is very important and could be utilised as a potential ally; the trick is to win them over and use them as a vehicle for the promotion of breast feeding.

Under a microscope, what do you see? It is a play of colours. Colours of red, blue and yellow. If you are not colour-blind you should be able to handle a microscope. It will take you two to three hours to be conversant with how to operate a microscope. You all know that, those who are in the medical profession, E.S.R. is the most important diagnostic aid. You hold it in a tube and wait up till one hour for the serum to settle.

The same health worker, this illiterate health worker, many of whom have never been to school. We have taught them how to operate within a medical context. A team of gynaecologists from the Johns Hopkins Clinic, were astounded by these health workers and remarked that they looked like doctors. Medicine cannot be the monopoly of a particular section of people. It is a question of training and demystifying training.

The schooling that occurs in the village is the best kind of schooling for the people. You don't need the trappings of a blackboard and bench - sustainability is the key. The scenario of a child passing on knowledge to another child, we have found is the best way for a child to absorb and retain knowledge. If you as a parent impress on your child what is good for your child, that child will automatically pass this on to another sibling.

We have trained women in various trades. Mention any trade and we would have some training in it. Historically women have been deprived of vocations that earn money in the real sense. So we thought if we really believe in empowering women we must give them a skill which has a better earning possibility. We have trained women within the context of agriculture, which is our lifeline. Health workers must know and understand the concepts so that they do not forget their own village and home.

THE EXPERIENCE OF NICARAGUA: REVOLUTION AND BEYOND

Maria Hamlin Zuniga

Global Co-ordinator, International People's Health Council
Nicaragua

In 1979 with the triumph of the Sandinista Liberation Front the revolutionary government defined health as a right of all the people and the responsibility of the state together with the organised population. During the decade of the 80s a National Unified Health System provided free and universal health care to broad sectors of the population. The commitment to Primary Health Care and the effectiveness of the community-based health campaigns were recognised by the World Health Organisation. Through massive immunisation and education campaigns community volunteers changed the concept of health for a few of the elite to that of health for all. New facilities were constructed, personnel were trained, polio was eradicated and health indicators improved considerably.

However, during the 80s the Nicaraguan Revolution was subjected to a long and devastating counter-revolutionary war supported financially (and morally) by the Government of the United States. Social programs - health, education, and social welfare - continued to have priority, in spite of the need for funds for defence. Nevertheless, the ability to maintain services was affected by the deliberate attacks against health and education workers, health facilities, and schools.

The elections in 1990 resulted in the defeat of the Sandinista Revolutionary Government, which was replaced by a broad-coalition government lead by Violeta Chamorro de Barrios. That government, which promised an end to the war and economic instability, was supported by the U.S. and other countries interested in the integration of Nicaragua and the other Central American countries into the process of globalisation and free and open markets. The economic cabinet was committed to an unquestioning implementation of neo-liberal economic policies defined by the World Bank and the IMF.

Table 1: Demographic and epidemiological profile of Nicaragua

- Life expectancy: 67 years
- Elevated rates of maternal mortality with considerable sub-registry
- Infant mortality: 49.8 per 1,000 live births
- High prevalence rates for transmitted and parasitic diseases
- Increased incidence of chronic diseases, accidents, and domestic violence
- Problems of disability and malnutrition
- Low economic income of the population: estimated at $496.00 per capita in 1993
- Estimated population 4.2 million
- Unequal population distribution with the major concentration on the Pacific Coast
- The rural population represents 48.3% of the total population
- Elevated population growth of 3.5% annually
- Fertility rate of 5 children per woman

Source: Nicaraguan Ministry of Health, 1996

The Nicaraguan Constitution states that the Nicaraguan people have the right to health and that the State will establish the basic conditions for health promotion, protection, and rehabilitation. The Chamorro government's National Health Policy, elaborated in 1993, recognises that health is a basic

right of the population, and that people should have access to integral health care. However, the policy stresses the ability of the people to elect their health services.

The Chamorro government began to initiate a wide-ranging process of transformation of the Health system with a redefinition of the health model, including decentralisation of services to the municipal level and the search for alternative financial support of the public sector. There has been an enormous impulse toward the development of the private sector and of an optional social security system, with the transformation of health into another market commodity.

The modernisation of the Health Sector in Nicaragua has been financed by the World Bank, the Norwegian Government, and the Nicaraguan Government. It is characterised by a strategy of decentralisation, and reorganisation including the proposal of a new Public Health law, with emphasis on SAP for the extension of services to the population. It also includes a programme to improve the quality of care, the participation of the community, and the modernisation of information systems.

So, what has happened?

SAPs and the pauperisation of Nicaragua

The implementation of the Structural Adjustment Programme in 1990 and the subsequent negotiation of the ESAF (Extended Structural Adjustment Facility) have been designed to reduce the external debt, one of the highest per capita in the world: six times the annual GNP.

Table 2: Gap between the rich and the poor

1992	27.3
1995	53.2

20% of the poorest household receive 1.07% of the wealth
20% of the richest households receive 52% of the wealth
Source: FIDEG

Table 3: Poverty as measured by unmet basic needs method

	1985	1993 - Total	1993 - Rural
Households in poverty	63.1%	75%	87.3%
Households in extreme poverty	12%	43.6%	60%

Source : FIDEG

Table 4: Poverty measured by the poverty line method

	1993
Poverty	56%
Extreme poverty	23%

Source: World Bank

The SAP has had a dramatic impact in all spheres, especially in health and education.

Principal health problems in Nicaragua

Access to basic services, among them health, is a fundamental right of all people. A country's just and equitable development is inconceivable without taking into account the integral health of its population. However, through the Structural Adjustment Programme, the groundwork has been laid for major deterioration in the population's health; subsidies for all basic services and products of primary necessity have been eliminated, eminently preventive programs such as "complementary food" programs were abandoned, and the coverage for the majority of health services to the population was reduced.

Table 5: Principal health problems in Nicaragua

GENERAL CONDITIONS

- Insufficient availability of potable water, with consequent consumption of water of poor quality
- Insufficient disposal and treatment of human wastes and residual water
- Insufficient collection, treatment, and disposal of solid wastes
- Non-existent urban zoning
- Persistent industrial contamination
- Deficient control of quality of foods, especially meat and milk products
- Frequent natural disasters: volcanic eruptions, hurricanes, tidal waves, earthquakes

Nutrition:

- Protein and caloric consumption is below the standard requirements and is deteriorating
- High prevalence of protein and caloric malnutrition in general and especially in under-5 year age group, being a direct cause of infant and perinatal mortality

HEALTH PROBLEMS

- Transmissible diseases that persist, increase and the risk of outbreaks and epidemics
- Acute diarrhoeal diseases and other infectious intestinal diseases
- Perinatal mortality related to the attention at birth and care of the newborn
- Acute respiratory infections
- Maternal mortality
- Preventable diseases
- Tuberculosis
- Sexually transmitted diseases
- Tropical diseases: Malaria, Dengue
- Rabies
- Cholera
- Leptospirosis
- Persistence of and increase in accidents and violence
- Problems related to development such as chronic malignant diseases and malignant neoplasms
- The number of disabled persons has increased
- Increased mental illness
- High incidence of occupational-related accidents and illnesses

Source: Government of Nicaragua, Ministry of Health, Report 1990-1995

The coverage of prevention and promotion programs in women's health dropped by 11%. Only 72% of pregnancies received prenatal care; the coverage of the "Uterine Cervical Cancer Control" programme also diminished by 63%.

According to the registries of MINSA, in Region I, maternal mortality shows extremely high figures: one in every 66 women of childbearing age dies due to pregnancy, delivery and port-partum causes. At a national level the maternal mortality index, according to the Women Health Network ranges between 159 and 300 for every 100,000 live births depending on the geographic location.

There is an under-reporting of deaths due to clandestine abortions because they may be reported as accidental deaths due to intoxication with pesticides or overdosage of malaria treatment, for example.

Violence-based morbidity and mortality have been increasing. According to police reports this kind of violence has unemployment and the presence of alcohol as common denominators.

According to National Police Registers a total of 176 persons committed suicide in 1996, an average of 14.6 per month. 135 males and 45 females, 124 were under 30 years of age. One person was a 14 year old girl in the Child-to-Child programme carried out by CISAS.

The principal causes of suicide were related to depressive-emotional and/or economic problems. Forms of suicide included hanging (76), and ingestion of poison (tablets used to preserve basic grains) (66). Firearms accounted for only 14 deaths. 34 other persons attempted suicide. This suicide rate represents a 33% increase in suicide since 1995.

As a consequence of the economic crisis and prevailing unemployment, the phenomenon of child labour began to grow starting in 1991. More than 400,000 children and adolescents involved in child labour. The government has defined no governmental policy for them.

It is calculated that by 1996 20,000 children were on the streets in different cities, in situations of grave risk, exposed to violence, mistreatment, sexual aggression and drug addiction.

Basic economic indicators (Tables 6-10)

Table 6: GNP per capita

1990	$467.00
1996	$438.00

** 25% of the internal necessities are met by external resources.*

Table 7: Percentage of the national health budget in relation to the GNP

1989	5.01
1990	4.97
1991	4.22
1992	4.15
1993	3.96

Table 8: Per capita expenditure for health ($US)

1989	35.02
1990	20.09
1991	15.50
1992	15.22
1993	16.51

Table 9: Per capita expenditure for education ($US)

1990	20.50
1995	18.50

Table 10: Illiteracy > 15 years

1990	23%
1995	30%

Elections 1996

In October 1996 elections were held in Nicaragua, the winner being Dr. Arnoldo Aleman, leader of the Liberal Alliance, and well-known Somocista, the followers of the military dictator overthrown by the Sandinistas in 1979. A new government was installed on January 10, 1997. This government promises to address property issues and to create sources of employment in order to stem the economic crisis. Most of the new government cabinet posts have been filled with older (even elderly people). Liberal Alliance members, many without the necessary education and background or experience to carry out their work in the present situation, are dominated by the new economic order.

The new Minister of Health, when meeting with the National Health Council, stated that the Liberals had election promises to keep. That would mean changes in the personnel in political posts and technical levels. On the 17th of January the Minister called for the resignation of all the Directors of the Ministerial Departments, 27 Hospitals and the 17 SILAIS or Regional Integrated Health Systems. Most of the personnel are fairly young, well-educated persons, technically prepared and recent graduates of the Masters Programme in the School of Public Health.

The World Bank and World Health Organisation have made considerable investments in the Health Sector, especially in management training. Obviously there will be a reaction on their part to the new developments. Several experts believe that this decision of the Government will lead to chaos and will not be sustainable over the next nine months.

In addition, there is particular concern on the part of both government and NGO personnel with respect to the position of the government as regards women's health and reproductive rights. The Minister of Education of the Chamorro government, a member of Opus Dei, the conservative right wing of the Catholic Church, who is very powerful in the Vatican, has been reappointed as the Minister of Education in the Aleman government. He and his close circle promote a gender and generational position that is in direct opposition to that of the progressive women's movement, and to the Platform for Action of the Cairo and Beijing UN Conferences.

Challenges

One of the main challenges that civil society, particularly the social movements,has before it is to participate in the drafting of our countries' social and economic policies so that integral and sustainable development for men and women is genuinely promoted.

Alternatives

- NGO sector development: Alternative health centres and programs
- Networking, especially among women: Women's Health Network, Anti-violence Network
- Participation in the National Health Council and on Joint Commissions: Maternal mortality, Breast-feeding Promotion Commission, AIDS Commission.
- Initiative for Nicaragua - Women and men discussing alternative plans and policy proposals in a variety of fields including environment, education, health, sustainable development, population, etc.
- International Networking

DEVELOPMENTS IN HEALTH IN RWANDA AFTER THE GENOCIDE

Vincent Biruta
Wilma Meeus (Former Advisor)

Ministry of Health
Rwanda

Background to Rwanda

General

- Small landlocked country dependent on transport by road/air
- Temperate tropical climate; four seasons with dry season from June till mid-September; 2/3 harvests/year
- Altitude varying between 1,200 and 2,000m, Volcanic area in North-West ("Country of the thousand hills")

Economy

- 85-90% subsistence farming
- Coffee and tea main exports, no major mineral deposits found
- GNP increased by 60% during 1980-1989, while per capita income during the same period increased by 10%
- Increased defence spending from 1990 onward

Demographics

- Population approx. 7 million inhabitants
- Population density highest in Africa, 300 400 INH/KM2
- Population increase approx. 3.5%, doubling every 20 years; fertility rate high i.e. 6.7 live births/woman (one of highest in world); post-war/genocide baby boom
- 50% of population below 18 years
- 70% of households female-headed

Political

- German and Belgian colonial past
- Independence from Belgium in 1962
- Centrally run by one party till 1994; Since July 1994 broad based transitional government
- Country is divided into 12 regions, 150 communes, 1,000 sectors and 8,500 'cellules'.

National Health Policy

Main Orientations of National Health Policy

- Integration of National Health Policy in the National Development Policy

- Equity
- Integrated Primary Health Care

Main Strategies

- PHC Approach
- Decentralisation District Health System
- Community Participation
- Human Resource Development
- Development of Pharmaceutical Sector
- Legislation: Medical and Nursing Councils, Private Sector, Pharmaceutical Sector
- Strengthening of Health Information System

Health systems

Health Services

- 286 Health centres, 32 District/Rural Hospitals, 3 Referral Hospitals and 1 Specialised (Psychiatric) Hospital, 134 Private Clinics
- Hospitalisation capacity, primary and secondary levels: 1 bed per 600 people (bed occupancy rate 35% at the Health Centre Level)
- Infrastructural development ambitious with big health centres and absence of standards for equipment
- Human resources inadequate in quantity and quality

Type of Services

- 48% Government-run health facilities
- 40% Church-owned health facilities
- 12% Private, mainly in urban setting
- Traditional sector with 1,500 traditional healers and unknown number of traditional birth attendants

Expenditure in Health Sector (Data from 1984)

Contributors	
• Domestic	50.2%
• Foreign/External	49.8%

MOH Budget (Data from 1984)

- 19.3% Primary Level, 60.3% Secondary Level , 20.4% Tiertiary Level
- Total expenditure on PHC[12] 1984 was 8% of total expenditure on Health and 20% of MOH Expenditure:
- Domestic 66% (Government 17%, Individuals 49%)
- Foreign/External 34% (Bilat/Multilat. 31%, NGOs/Missions 3%)

Equity Access

- 80% of population lives within 5km / 1 hour's walk from H.C.
- Cost Recovery system introduced early 80s by church-owned facilities and in 1989 by Government facilities; mainly drug revolving fund, charges for curative and preventative services, including MCH services

Situation after the war and genocide

- 80% of qualified human resources killed or became refugees, including 110 of 310 required medical doctors, 700 of 2,300 required nurses and 0 of 1,400 required midwives in country
- Senior Health Professionals have insufficient previous exposure to management and planning process
- Looting and destruction of health infrastructures and capital items on a large scale. Evaluation September 1994 calculated $30million required for physical rehabilitation and replacement of equipment and capital items of primary and secondary facilities
- 91 % of Health Facilities operational, 47% of infrastructures completely rehabilitated and 41% of Health Facilities are equipped according to standard equipment requirements (NB: standard equipment list introduced in 1994)
- 95% of Health Facilities re-introduced user charges
- GOR revenue extremely limited, economic recovery very slow => hea vy dependence on donor finance
- Donor funding channelled through multilateral and bilateral agencies and international NGOs

Challenges in the New Economic Order

- Continued instability in the Great Lakes Region
- National Health Policy programme = PHC, DHS
- The MOH budget 1996: 3.9% of GOR budget (=$0.7/INH./YR versus $12 recommended by the World Bank)
- Low motivation of Health Professionals
- Financing of Health System problem. New approaches necessary
- Planning process started, constrained by lack of experience and pressure of international community
- Donors have own agenda; focus on financing of parts of National Health Programme; irrational expectations of human resource development (too much funds for too few people with time for and experience in training)
- Emphasis of donors on capital investments; insufficient focus on recurrent costs.

THE STORY OF THE NATIONAL PROGRESSIVE PRIMARY HEALTH CARE NETWORK (NPPHCN)

Irwin Friedman

NPPHCN
South Africa

Introduction

- PPHC was formed in 1987 to oppose the damage Apartheid in health imposed on the people of South Africa
- Health care was fragmented into racial divisions
- Enormous disparities existed in wealth & health
- Unequal access characterised all services
- Tertiary care was promoted at the expense of PHC
- Quality private care was prized, the public sector despised

A Progressive Primary Health Care Approach:

- challenges society to address causes of poor health
- encourages community empowerment
- provides comprehensive quality health care
- demands concerned health worker practice
- prioritises disadvantaged people

International Responses to the New Economic Order
From left: Reno Morar, Martin Coyle, Vincent Biruta, Thabo Sibeko (chairperson), Irwin Friedman and Danilo Beltran

- recognises the importance of integrated care
- promotes collaboration across sectors & professions

PPHC is a network of organisations and individuals committed to:

- advocating a national primary health care system
- transferring appropriate skills
- encouraging sharing and exchanges
- providing practical support to members

How Did PPHC Start?

A large conference was called nationally, attended by hundreds of delegates. Initially organised in urban centres such as Cape Town, Johannesburg and Durban to oppose the propaganda and divisive programmes of the Nationalist Government, the Network sought to promote the concept of PHC as conceived at the Alma Ata Conference.

And then.... What Happened?

It soon spread to include participants from neglected and under-resourced areas and being part of the Mass Democratic Movement's drive for democracy. Several PPHC leaders were harassed, questioned and arrested by the Security Police.

From Conflict to Collaboration

The Network has passed through three distinct phases:

- 1987 - 1991 : Resistance - opposition to government
- 1992 - 1994 : Transition - preparation for governing
- 1994 - 1997 : Collaboration - working with government

Early Projects

Some of the activities with which the Network was involved from 1987 to 1991

- Service Development : Seed projects to initiate PHC
- Training : Capacity development to support PHC
- Networking : Bringing members together to share experiences
- Participation in the Mass Democratic Movement

Later Programmes

Activities in which the Network was involved as its reputation grew from 1991 to 1994

- Policy development : preparing policies in anticipation of changing government
- Advocacy : Pre-election advocacy
- National AIDS Programme : a large programme in 14 regions

- Community Health Training Centre: Based in Western Cape
- Media and Training Centre : Participatory media in the Western Cape

Current Programmes

Activities in which the Network has been involved since the 1994 elections

- Advocacy & Health Promotion
- Women's Health & Empowerment
- Youth Health & Sexuality
- Legislative & Policy Analysis
- Community Involvement in District Development
- Human Resources Development
- Participatory Research

These programmes are elaborated on in further detail below :

Health Advocacy

Seeks to transform progressive policy into participatory programmes

- Develops strategic alliances
- Lobbies government
- Utilises Media
- Mobilises popular support
- Based on concepts of health promotion
- The Current Campaign is to develop a national charter of Health Rights

Women's Health

Seeks to empower women to promote their own wellbeing

- Uses participatory methods
- Maternal & health issues form only part of the concerns
- The current emphasis of the programme is on economic empowerment

Youth and Sexual Health

Seeks to address priority issues in the lifestyle of young people

- Encourages young people to set the agenda
- Identifies the concerns of young people as the basis for the programmes
- Current emphasis is promoting communication between adults and youth on sexual matters

PHILA

Seeks Public Health Interventions through Legislative Analysis

- Analysis of government policies and bills

- Participatory research on high-priority topics
- Empowering communities to understand the legislative process
- Assists portfolio committees in national and provincial parliament
- Current emphasis is on strengthening the new proposed health act

Community Participation

Seeks to achieve active community involvement in the district development process

- Promotes community health committees and community health workers
- Assists in the participatory development of district health systems
- Current emphasis on developing consensus regarding practical approaches to give effect to community involvement

Human Resource Development

Seeks to skill workers, members and staff for health development

- People-centred management
- Participatory community development
- Compassion and accountability
- Conflict resolution
- Current emphasis is developing skills for district health systems development

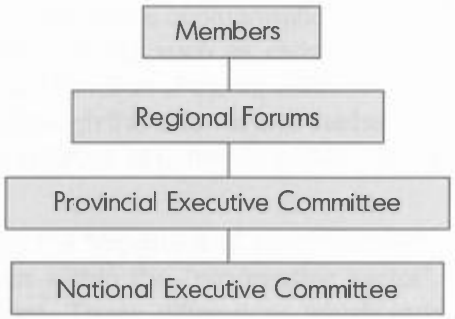
Participatory Research

Seeks to help people become active participants in discovering information important for their own development

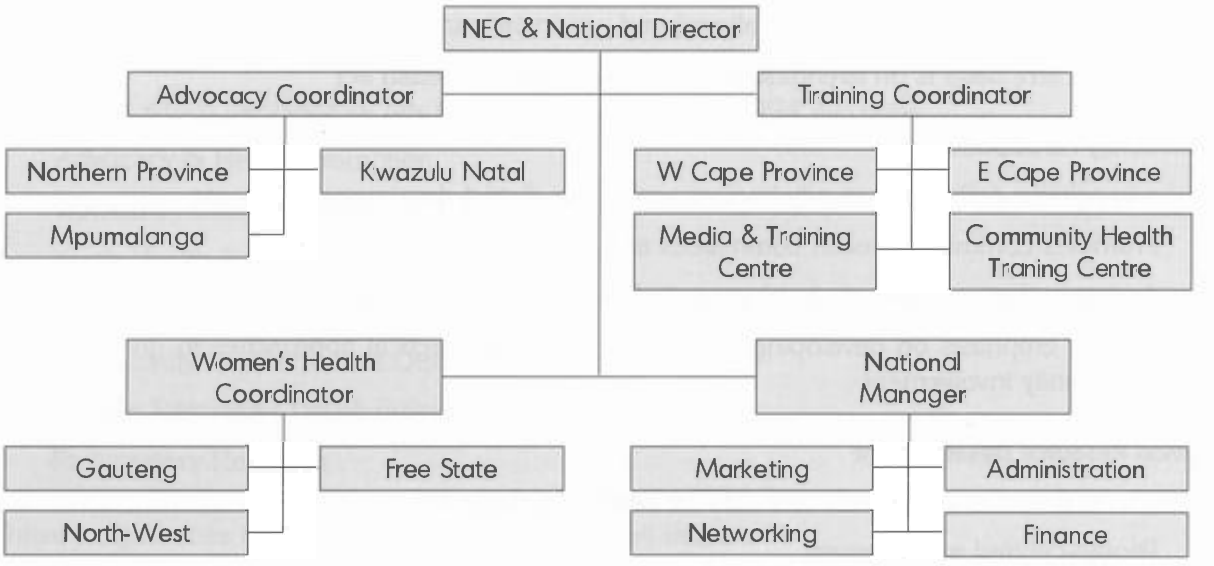
- Popularising participatory research methodology
- Evaluation of high-priority health programmes
- Current emphasis has been on community involvement and primary school nutrition programme

Organisational Structure

The organisation is accountable to grassroots members



Mutual Supervision is the principle



Who Supported the Network Financially?

- Henry Kaiser Family Foundation
- The W.K. Kellogg Foundation
- The Kagiso Trust in association with the European Union
- The Independent Development Trust
- USAID
- and many others

Looking Forward

A time for celebration

- In 1997 South Africa will pass an historic new Health Act that will make health available for all
- PPHC will turn 10 years old

THE SOUTH AFRICAN HEALTH AND SOCIAL SERVICES ORGANISATION (SAHSSO) EXPERIENCE

Reno Morar

SAHSSO
South Africa

The democratic changes in South Africa and the face of the new government have raised the expectations of the people of this country in looking forward to an improvement in their health and living conditions. Against this background of the new democracy, South Africa is still experiencing a rapid and turbulent process of reconstruction, transformation and development. The processes that are occurring present the progressive health sector in this country with major challenges which need to be critically addressed. These new challenges will never be met if organisations like South African Health and Social Services Organisation (SAHSSO) and National Progressive Primary Health Care Network (NPPHCN) do not look inwardly to analyse the phases that these organisations have passed through, and learn valuable lessons from these phases in order to address the complexities of the future. The decision about the future of SAHSSO as an organisation in its present form must take account of the realities that I will address in this session. I will trace the phases of the experience of SAHSSO for you in brief and extract from these phases lessons that were learnt. I will also highlight certain issues where action is urgently required in order to sustain the role of Non-Governmental Organisations (NGOs) like SAHSSO in whatever form we may be as we believe that NGOs in general have an even greater role to play at this historical juncture.

Apartheid Era

SAHSSO was formed in 1992, as a result a merger of South African Health Workers Congress' (SAHWCO), Health Workers' Society (HWS), National Medical and Dental Association (NAMDA) and the Organisation of Appropriate Social Services in South Africa (OASSSA) following the unity talks and the Unity Workshop at the People's Health and Welfare Conference in July 1991. The history of struggle in the health sector for each constituent organisation of SAHSSO goes back to the early 1970s.

During the apartheid era, the health and social service sector saw the formation of multiple "progressive" sectoral organisations and these organisations were formed within the context of the political struggle. This political struggle included the struggles of political organisations like the African National Congress (ANC), Azanian People's Organisation (AZAPO), Pan Africanist Congress (PAC), Unity Movement, South African Communist Party (SACP) as well as the trade union movements of Congress of South African Trade Unions (COSATU) and National Council of Trade Unions (NACTU). Thus progressive sectoral organisations through challenging apartheid policies in their particular areas were also at high risk of victimisation with the whole range of organisations fighting the apartheid system. Significant for the role of the organs of civil society such as civic organisation, NGOs, Community Health Committees etc. was the nature and function of the tripartite alliance of the ANC, SACP and COSATU. There was high expectation that through this alliance and the historical relationship developed through the years of struggle, the implementation of common policies and agreed policies would be the way of the new government.

In health and social service sector the "progressive" sector formed a small portion of the NGO sector of traditional organisations. Even within the "progressive sector", there were major and multiple differences between organisations. These differences which included clear distinctions between organisations were;

- based on political orientation and affiliation
- membership base with organisations either professionally-based or a wide base of different health workers within the same organisation
- in their orientation and activity in terms of service delivery, civic society, promoting the interest of their own professional members
- in their building alliances with and actively promoting the unionisation of health workers
- terrains of struggle of the organisation in terms of the public and private sectors

Critically though the most important focus, uniting factor and common denominator was the decades of struggle against an illegitimate apartheid regime which was supported by the capitalist forces, the presence of a ruthless military machinery and clear enemy. This gave the progressive sector a more defined opposition role to the existing order.

The formation of SAHSSO arose as a result of the following reasons:

- End of apartheid era and the eve of the new challenges where the struggle for democracy and the struggle in the health sector formed part of a broader movement in South Africa to develop active civil society structures. Generally it was agreed that the new organisation must be a politically-conscious organisation and the activities of SAHSSO needed to be within the understanding of the political economy of health. SAHSSO was not to assume any affiliation to any political organisation as SAHSSO per se and therefore had to be politically non-aligned. Individual members were clearly able to pursue their own political affiliation and bring into the structures of SAHSSO their own political understanding and reality.
- Restricted funding to a fragmented progressive health and welfare sector with competition for funds.
- Weakening/ less activity of members of SAHSSO due to feelings that :
  - the "Struggle was over", changing priorities
  - Members were burnt out, apathetic within the new political environment
  - Shift of members to political structures

This crisis was clearly located within the changing political scenario of the country with the unbanning of political parties in 1990.

The constituent organisations of SAHSSO during the apartheid era were involved in a range of activities and these included:

- Building a tradition of mass action around health issues such as the Health Charter Campaign, desegregation of hospitals
- Attempting to put health on the agenda of progressive organisations, political parties, civic structures and unions, and lobbying for health issues
- Community-based and community-organised health service projects, developing new models and new cadres of health workers for health care delivery
- Supplementary health care service delivery such as the Emergency Services Group, which addressed the health effects of politically-related oppression
- Developing progressive policy, strategies and directions for health and health care delivery with NPPHCN and other organisations
- Supportive to trade unions, for example National Education and Health Worker's Union (NEHAWU) and Health Worker's Union (HWU), which were active in organising health workers

The Transition (1992-1994)

Many of the reasons addressed previously as issues that resulted in the formation of SAHSSO played an even more significant role in this period. The previous mention of the significant shift of members away from SAHSSO to political party and civic organisational activity involved in building party structures for health, e.g. ANC Health Department, significantly impaired the structures and functions of SAHSSO.

The ever-decreasing membership base of SAHSSO and the organisation's loss of clear organisational identity, occurred as a result of the issues already mentioned. In addition, differences between the members of the organisations united in the Unity process began re-emerging and reshaping organisational activity, with some members not finding a home in the activities of SAHSSO. It become increasingly difficult for some members to see the activities of the organisation in the context of being politically non-aligned, yet taking a pro-active role in supporting the ANC Health Plan. It was also critical that the issue of the organisation reserving the right to campaign for its own policies and principles remained prominent. Different perspectives existed within SAHSSO about the potential and possible comprises that would and could occur within the process of negotiation in the formation of the Government of National Unity (GNU). Negotiated settlements by their very nature require the spirit of compromise and reconciliation which in itself is a terrain of struggle. Furthermore, members of previous organisations with a professional base with the need to ensure involvement in engaging in activities to meet the needs and challenges of that profession did not find the activities of SAHSSO meeting those objectives. Critically, the focus of the organisation could not directly take account of or meet the needs of professionals within the organisation, and differences of approaches and interests re-emerged.

Notwithstanding all the difficulties of the capacity of SAHSSO to actively engage, its role and activities were grounded in the following:

- Preventing unilateral restructuring of the health sector by the National Party government at all levels of administration, with members of SAHSSO actively working within structures formed to halt this process
- Further major research, policy formulation and development of progressive strategies to address key issues for the South African Health Care service with NPPHCN
- Contributions to policy, planning and strategies for political parties and civic organisations such as the ANC Health Plan, SACP health debates. Members of SAHSSO became involved with the preparations for the 1994 Democratic elections, with some members active participants within their party-political structures as well as civic organisations.
- Building the capacity of members and communities to participate in discussions of policy issues. Critique of health service functioning with participation in structures that encouraged, developed and trained Community Health Committees and Health Fora
- Finding and developing alternative models of health service delivery in conjunction with NPPHCN, for example SAHSSO projects such as the Trauma Centre, Povis project in KwaZulu-Natal

Many of our members contributed towards the development of the tripartite alliance's Reconstruction and Development Programme (RDP). The RDP document was unique and crucial in terms of the development of the principles, policies and direction that this would give our country. The document managed to successfully address the oft-quoted divide between competing interests in development where in the macro-economic framework of South Africa, growth and development would be achieved through redistribution and reconstruction. The RDP was also more people-driven and certainly harshly attacked the World Bank and its sister organisation the International Monetary Fund (IMF).

The debates within the organisation revolved around the important issues of locating the activities of SAHSSO within the organs of civil society and participating in various fora in order to engage mass-based formations such as SANCO. The activities would thereby strengthen SANCO in dealing with health issues. There were however distinct problems of organisational capacity in order to address even high-priority policy matters. SAHSSO recognised and had to accept that as an organisation, it was clearly not mass-based. Essentially, the membership consisted of core groups of health activists with limited capacity to effectively deal with many of the challenges of the health and welfare sector.

SAHSSO had to redefine the role of the organisation, in the context, to a very small membership of committed health activists as well as a changing external political environment. In addition, many of the NGOs which were previously considered as "traditional" NGOs in the health and social service sector were beginning to speak the same language as that of the health struggle. SAHSSO had to begin to distinguish itself from other organisations that were merely paying lip service to the Comprehensive Primary Health Care approach and the principle of community participation.

Post-Election / The New Economic Era

The year 1994 was historic in the history of South Africa. The first democratic elections were held in April and the ANC within the context of GNU assumed power with an overwhelming majority. The birth of the new democratic era must be seen in the context of the international as well as national political and economic environment.

Through the process of negotiation and the development of the interim constitution, compromises and records of understanding were struck. This has certainly negatively affected the ability of the ANC to translate the phase of policy and legislative development into more effective implementation and enforcement. The struggle between the government, capitalist forces and labour is still prominent today and continues to impact on important matters such as privatisation, labour legislation etc. At an international level through the globalisation of the world economy, South Africa and Southern African Region, like every other region in the world, finds itself at the receiving end of the neo-liberal policies of the G7 countries. This means that almost all aspects of our economic, political and social structures and formations are influenced by and determined by the forces operating in the World economy today. Many developing countries like ourselves are faced with the prospect of the Structural Adjustment Programme (SAP) imposed by the World Bank (WB) and the International Monetary Fund (IMF). These strategies have, in many instances, had significant negative effects on the health of people, with governments being forced to reduce expenditure on health and social services in exchange for the financial assistance on offer.

It is significant that the recent decision to accept the loan from the World Bank is a reversal of ANC policy as espoused in 1993. In addition, the RDP document attacked the Bank and promised that no loans would be taken for development purposes if this loan did not assist in raising the export capacity of South Africa. Advice from the WB has also affected a Bank-designed land redistribution programme which has not got off the ground yet, as well as the present housing delivery problem when advice was taken from the WB contrary to that advocated in the RDP document. The tension and pressure that these decisions have had on the historical relationship within the tripartite alliance have already surfaced and the debates around the central issue of the balance of power between government and organs of civil society has resurfaced. This tension, influenced by the international new economic order, has filtered down into NGOs, community structures and organisations, trade unions and other organisations. These organisations need to take up their "watch-dog" role more effectively in relation to government of the day. The government in turn needs to take on its role which is clearly that of governance of this country. The turmoil between the historical allies within the democratic movement, the organs of civil society and the ANC within government revolves around

addressing this tension.

Therefore within South Africa, even though the apartheid system has been dismantled from a political and legislative perspective, changes in the social and economic environment and sphere of influence have been slow and difficult. The country is currently experiencing an economic crisis and there are major problems with regard to the redistribution of resources within the country. This redistribution is taking place within the overall framework of economic development and advancement for the country as a whole. Simultaneously, there is the requirement to maintain equity in and between provinces, regions and local government as debated and discussed within the RDP document. These problems are being compounded by the compromises that were made to accommodate the New South Africa with the negotiations within the GNU and the leadership crisis within the government. Some of the compromises in the process of negotiations include the strongly federalist flavour to national governance, the role of the Inkatha Freedom Party and National Party in their Provinces, the protection of the "old guard" of civil servants for a period of 5 years and the structure of the GNU.

The problems of the external international environment together with the following issues of national importance make the role of SAHSSO and NGOs in general even more strategic:

- The working class and the organs of civil society are also experiencing problems with organisation, mobilisation and re-definition of their role.
- The country is also facing numerous problems in terms of implementation of the new health plan.
- A significant move towards privatisation of health and other services

Within this context, there is the need to critically examine the manner in which the government is responding to NGOs within the country. It would appear as if there is an attempt on behalf of the government to bring NGOs into line with respect to national policies and practices. Funding for NGOs is to be centrally managed with international donors contributing through this process. The nature of the relationship seems to be moving towards defining the boundaries of the contractual obligations of NGOs towards the state with regard to issues of service delivery. Funding to NGOs will probably revolve around specific contracts and tenders for which NGOs will need to compete in order to survive financially. This will obviously raise the whole issue of the independence of NGOs and the focus on health care programmes and services with or without the development of community capacity.

In the period following the elections, SAHSSO had to face these issues head on. Members of SAHSSO continued to be actively involved in supporting the new government in developing a more equitable and just health plan at national, regional and local levels. Much of this policy development took place in the Strategic Management Teams set up by the Provincial Ministries of Health and members of SAHSSO contributed to these teams principally as individuals. This activity involved building on the work that had already been done prior to the elections. Many of our members were also drawn into government and the civil service to facilitate the democratisation of health and social services. It was our belief at the time that this was where we had to locate ourselves to ensure that the principles for which we had fought in the pre-apartheid era would be adhered to and that the theory would translated into practice.

One of the consequences of this has been that a significant proportion of our membership, especially those who were in key leadership positions, became tied up in the daily work of the Health and other government departments. As with many of the progressive NGOs and trade unions, this shift of members affected their involvement in SAHSSO, which dwindled quite dramatically. The net effect was that SAHSSO as an organisation was significantly affected. Despite this the organisation continued to play an important but limited role in the health arena and contributed significantly to a number of initiatives during this phase.

For those who were and still are actively involved in SAHSSO, one of the critical questions that the

organisation grappled with during this period was the role of the organisation. Some of the regions felt that there was no need for such an organisation to exist. It was felt that SAHSSO had fulfilled its mission and that the new government would implement what SAHSSO had been campaigning for. Some members felt that our energies should be channelled into supporting the democratic changes that were taking place within the health and social service sectors. On the other hand, others argued that at this stage it was critical that organisations such as SAHSSO continue to function, especially in the context of developments at both a national and international level.

Even though the principles upon which we were founded remain valid today, the changes that have occurred at an international and national level in the last 3 years necessitate that we critically re-evaluate our role as an organisation. SAHSSO must examine the appropriateness of its present structure and function, and the need to continue to struggle for the principles we believe in albeit in a different form, in a changing South Africa.

Lessons learnt and the way forward

Lessons Learnt

1. Having an impact on the legislative and policy-making process in the absence of strong organs of civil society - repositioning and developing capacity to respond swiftly to government policies

It is clear that despite the development of progressive policies and legislative frameworks for the health and welfare sector and the contribution that members of SAHSSO and other NGOs made, the implementation of these policies is open to severe influences by the external forces mentioned in this document. This potential influence may be even more severe in the absence of strong and organised organs of civil society. Success stories are based on the balance of power between the forces of governance and those of civil society. SAHSSO is not mass-based, does not possess the power of a wide membership and has not consistently and successfully in the post-election period located its struggle in developing organs of civil society. Trade unions like COSATU with a mass worker base have successfully challenged government and capital on the Labour Relations Act, Privatisation as well as rejecting the advances of the WB. Having policies and principles that are people-driven and with participation and empowerment would still require civil society to be able to respond rapidly. This response is in order to effectively ensure delivery from government.

2. Building organs of civil society and participation in community health committees and other structures either as individuals or as members of SAHSSO

The spirit and high level of anticipation generated by the nature of the historical relationship of the tripartite alliance influenced much of the earlier participation of many organisations in the post-election period. In fact this participation was very state-driven with a sense of co-option from NGOs and civics giving health policy makers the necessary and required political credibility to meet the challenges before them. The nature of the tripartite alliance and the history of apartheid struggles also paralysed SAHSSO and other organisations in taking up and challenging government. Engaging and challenging government in areas of policy development and non-delivery are crucial. SAHSSO needs to be critically supportive of government against the background of reactionary right-wing forces. The clear enemy that existed in the apartheid era is no longer. It is therefore crucial for the organs of civil society to be strong and for the role of government in governing to be separated and be independent from the role of civil society. These roles need to ensure that policy of government is implemented and delivered where appropriate. The importance of the NGO sector in health needs to be seen from this perspective.

3. Addressing the issue of progressive members who are holding positions in government

The agenda of SAHSSO as an organisation independent from government is a serious issue that needs attention. This is in the light of Senior cadres of SAHSSO occupying high-level and high-ranking status in the Provincial and National Departments of Health. There needs to be clear delineation of governmental duties and policies and SAHSSO duties and organisational policy although the critical issue remains whether this conflict of interest is reconcilable, practical and functional. SAHSSO, like other NGOs will continue to face this matter and must develop strategies for engaging with political parties /government structures effectively and meaningfully taking into account the capacity, function and potentially conflicting roles of members of SAHSSO. The relationship of progressive members of Health sector NGOs who are now in government and their organisations must be developed in a manner that ensures participation and support with clear lines of accountability.

4. Inability of SAHSSO to sustain model projects

The organisation has through all the phases mentioned established model projects. Problems have arisen with the lack of funding and with reduction of international as well as local funders. In addition, external and internal donors are seeking service delivery projects, introducing the components of competition and contractual obligations with specific time-frames and deadlines in order to meet the requirements of the funding agency. SAHSSO has been unable to meet the challenges of this competition in the context of our organisation based on volunteers with limited support for employed support staff and lack of committed volunteer workers.

The way forward

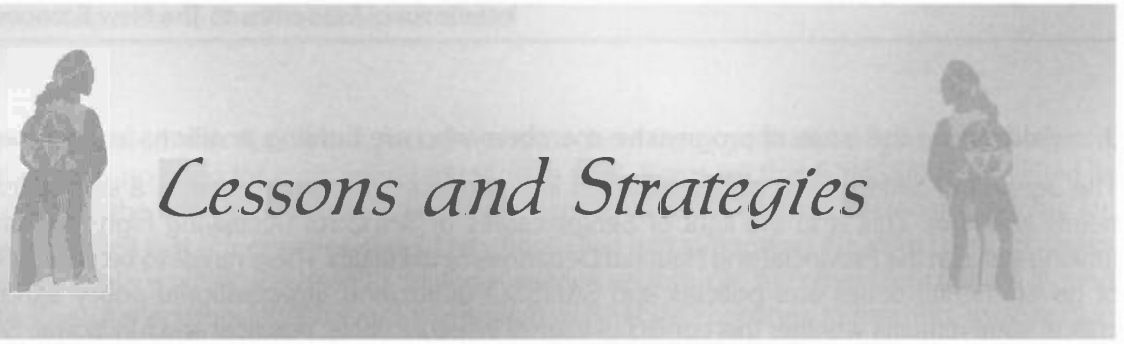
Sustaining health activism through ensuring sustainability of a critical mass of health activist

The critical issue for members of SAHSSO is that the principles, policies and the framework that the organisation followed and struggled for in achieving a better health and social service environment in the context of the political, economic and social struggle are valid today and will be in the future. The future of SAHSSO revolves around the members of this organisation adopting these principles but deciding on the most appropriate vehicle our health activism should take. The external environment both internationally and nationally has changed, as have the internal dynamics of the organisation. The ultimate aim needs to be held high but the vehicle to achieve that aim needs to be appropriate as conditions always determine thought and action.

In sustaining a culture of health activism and developing a groundswell of a mass-based movement for health, the way forward could include the :

- disbanding and closing as a national organisation and operating only regionally
- formation of a new health activist group doing lobbying and advocacy operating within a loose network of national and international contacts.
- disbanding/merging/continuing on regional level with other health sector NGOs
- forming a Public Health Agency and competing for government contracts for policy development and evaluation of Health and Welfare programmes, with full-time members and supporting staff

In conclusion, this conference and the SAHSSO AGM is thus an opportune moment to reassess and re-evaluate our role as a progressive health organisation in the new South Africa and to engage in constructive debates in order to address the multitude of issues facing the organisation.



WHAT ARE THE LESSONS LEARNT FROM OUR PAST EXPERIENCES?

Summary report of workshop group discussions

Setting the Stage

- New threats to health
- Health activism

New threats to health

- The new world order, globalisation of the world economy, structural adjustments are a new threat to health around the world
- Also political threats to health where participatory democracy doesn't exist
- These global issues affect local people and communities around the world and we can learn from each other

The New Economic Order

Lesson: We can see that NEO is damaging to health, but we need more information

- These issues are very complex
- SAP, in particular GEAR, are not well understood
- Lack of representation from World Bank
- Few alternatives to New Economic Order presented
- Need for more facts and less rhetoric

Redistribution of Resources

Lesson: Avoid the Debt Trap

- Equity: redistribution of resources rather than debt
- Live within your means, self-sufficiency

Political Threats to Health

Lesson: Absence of participatory democracy damages health

- Nicaragua, Philippines, Nigeria, and South Africa
- War has devastating effects on health (Rwanda)

Globalisation

Lesson: Global Issues Can Have Serious Local Impacts

- Kerala District in India
- Philippines
- Post-Apartheid South Africa

The Role of Activism

Lesson: Aluta continua: "The struggle continues . . . "

- Not whether activism should continue, but in what form
- We need common understandings of health, health promotion, & development
- We must address some fundamental issues:
  - Sustainability of progressive organisations
  - Defining relationship between government and civil society
  - Relationship between NGOs and the people
  - Creating local and international links
- Value of Social Capital and networks

Community Participation and Empowerment

Lesson: Community Participation and Empowerment are still important.

- Community participation and empowerment must be at heart of any strategy
- Community health workers are still seen as the agents of successful change in many countries
- Mass mobilisation as a community empowerment strategy

Education and Capacity-Building

Lesson: Need for Education and Capacity-Building

- Formal and informal education on political and economic issues
- Networking and progressive alliances
- We must make Government more accountable
- Good Government, Good Communities

Role of Gender

Lesson: NEO Affects Both Genders in Different Ways

- Women suffer under the triple yoke of oppression
- Men's disempowerment: root of community problems

Presenting the lessons learnt and strategies to advance the struggle for Primary Health Care. From left: David Sanders, Sheila Lapinsky and Mohamed Jeebhay

WHAT ARE THE STRATEGIES TO TAKE US FORWARD?

Summary report of workshop group discussions

Meeting the Challenges

- Addressing new threats to health
- Revitalising health activism

Addressing the new threats to health

- The new economic order
- Political threats to health

How to Challenge the New Economic Order

Strategy: Information sharing

- Information sharing on massive scale :
  - SAP, Gear, IMF, World Bank
  - Publish conference proceedings
  - Translate materials so that information is accessible
- Formulate more definite alternatives :
  - Work with progressive economists and legislators
  - Implement people-based budgeting
  - Refocus in SA on RDP and public works programmes

Strategy: Avoid the Debt Trap

- Lobby government to refocus on RDP and public works programmes
- Redistributing resources for equity
- Initiate and support projects to ensure:
  - Skills development
  - Income generation
  - Empowerment
  - Sustainability
- Partnership between NGOs and Communities to set local agenda :
  - "Do what we need and we want"
  - Determining own needs
  - Not driven by funders or government

Limit Political Threats to Health

Strategy: Consolidate Democracy

- "Don't rest on your victories, be vigilant!"
- Conscientise, mobilise and organise to engage Governments
- Build organs of civil society to make government accountable
  - Community structures
  - Civics
- International and national lobbying against the arms trade and weapons of mass destruction

Revitalise Activism

Strategy: "The Struggle Continues"

- Reassert our role as agents for change as :
  - Community Health Workers
  - Community Activists
  - Health Organisations
  - Health Sector NGOs
- Mobilise people around issues that threaten people's health
- Build local structures
  - "Think globally and act locally"
- Create local and international links through networking
- Develop a common understanding of health and health promotion
  - Study groups, focus groups, workshops at local level
  - Develop popular education materials
- Ensure sustainability of progressive organisations
  - Reduce total reliance on external donors
  - Ensure skills development
  - Develop stronger links between community and NGOs
- Negotiate relationship between government and civil society
  - Recognition
  - Funding

Community Participation and Empowerment

Strategy: Empowering communities to participate

- Enable communities to challenge state at all levels
  - Recognition of community structures

  - Enabling environment
- Build capacity to participate in:
  - Decision-making
  - Policy formulation
  - Monitoring policy development and implementation
- CHWs are agents of progressive change
  - Continued training on health prevention and promotion
  - Lobby government for support

Education and Capacity Building

Strategy: Educate and build capacity for liberation

- Formal and informal education on political and economic issues
  - Integrate political and economic issues into curricula
  - Implement continuing education programmes for health workers and communities
  - Training of community health committees, CBOs, and CHWs
- Networking and progressive alliances
- We must make Government more accountable

Address Gender Issues

Strategy: Build Alliances with and among Women's Groups

- Break triple yoke of oppression

  Lobby for:
  - Literacy
  - Economic empowerment
  - Women's rights
  - Support mechanisms
- Sensitise men to gender issues

Appendices

MEDIA STATEMENT

Cape Town. Friday 31st January 1997

"A New World Order : A Challenge to Health For All by the Year 2000"

400 delegates from more than 20 countries gathered at the University of the Western Cape at an International Conference focusing on the impact of The New World Economic Order on health and health care. Participants represented Governments, Trade Unions, Non-Governmental Organisations, Community-Based Organisations, Health Professionals, People with Disabilities, Community Health Workers and Indigenous Peoples. The Conference was hosted by the International People's Health Council (IPHC), the National Progressive Primary Health Care Network (NPPHCN) and the South African Health and Social Services Organisation (SAHSSO).

The Conference investigated the impact of IMF and the World Bank sponsored macro-economic policies on health and development. The evidence from more than 100 countries confirms that these policies, known as Structural Adjustment Programmes (SAPs), have a detrimental effect on the state of the world's health and have led to:

- declining living standards for the majority of the World's population
- widening gaps between rich and poor
- resurgence of known infectious diseases (cholera, yellow fever, TB) and new diseases (Ebola, AIDS)
- deterioration and in many instances a collapse of public health services in both rich and poor countries
- environmental destruction and degradation

Conference delegates reported on the systematic devastation brought about by these policies in their respective countries. Examples given included the introduction of user fees, cuts in public sector spending and the reprioritisation of budgets away from health and education, increased privatisation and downsizing health personnel.

It became evident that in South Africa the Macro-Economic Growth, Employment and Redistribution Policy (GEAR) is a home-grown Structural Adjustment Programme which undermines from the outset the objectives of the Reconstruction and Development Programme. GEAR was formulated by a group of bankers and economists including the participation of two World Bank economists, without public discussion and participation. The fundamental principles of GEAR are in direct opposition to those of the RDP. The conference pointed to the fact that if GEAR were to be implemented fully it would have devastating effects on real earnings, employment and health and educational services in South Africa.

Renewed vigour amongst participants to continue in the pursuit of equitable quality health care was endorsed in the final conference strategies. The Conference concluded on high note with a commitment by all organisations to lobby their Government and financial institutions to review their economic strategies.

"GEARing up for POVERTY!"

Issued by the : International People's Health Council (IPHC)

National Progressive Primary Health Care Network (NPPHCN)

South African Health and Social Services Organisation (SAHSSO)

SITE VISITS TO LOCAL HEALTH PROJECTS SURROUNDING CAPE TOWN

Site Visit No 1 - Brown's Farm Community Health Worker Programme

Brown's Farm is an informal settlement situated 21 kms from central Cape Town, a community of at least 36 000 with major health needs. Health Care Trust started working in Brown's Farm in 1989 following a request from the community. At first, 7 CHWs were elected and trained in 1992 and presently there are 19 trained and working CHWs who cover Brown's Farm as well as the neighbouring Samora Machel settlement. The CHWs were trained at the National Progressive Primary Health Care Network's Community Health Worker Training Centre.

Aims of the project include:

- to improve the health status of the communities of Brown's Farm and Samora Machel;
- to empower the community to participate in health and development and to develop life styles that will lead to good health.

Objectives:

- to do home visits to the shacks so as to identify at-risk families, and to refer persons to relevant services;
- to provide health promotion and preventative services to the communities of Brown's Farm and Samora Machel;
- to offer basic curative care through the CHWs supported by a Primary Health Care Nurse and a voluntary doctor;
- to support the community in identifying health needs and in lobbying for the state to provide appropriate and accessible Primary Health Services;
- to provide health education either on a one-to-one basis while doing home visits or by running community workshops according to the community needs or requests.

Contact person: Phillip (Whitey) Jacobs

Tel No: (021) 313183 /448 2011

Site Visit No 2 - Mitchell's Plain Disability Action Group

Mitchell's Plain Disability Action Group is an organisation formed by disabled people for disabled people, to act on issues that affect their day-to-day existence, operating in Mitchell's Plain, Strandfontein, Colorado Park and Mandalay. It is a non-profit organisation rendering a community service. They provide a free service which may enable disabled people to be as independent as possible in their environment.

Their activities include:

- providing transport to disabled people
- teaching employment skills to the disabled, in order to take responsibility in the role of worker, and encourage initiative, motivation and general personality development;

- workshop for disabled people;
- a sports club for the disabled in Mitchell's Plain;
- fighting for the rights and equality of all disabled people, with all kinds of disabilities, irrespective of race, colour or creed; and
- Mitchell's Plain Workgroup for People with Disabilities

Started by Mitchell's Plain Disability Action Group, UWC Rehabilitation Project and DPSA. Nine people are engaging in business which includes: wheelchair repair, sewing, cane-work and woodwork.

Contact person: *Andre Adams*

Tel No: *(021) 376 42 87*

Site Visit No 3-Philani Nutrition Centres

Philani is a community-based health and nutrition organisation established in 1980. The project operates in three separate but interlinked areas. It runs a Nutrition Rehabilitation Project with an ongoing health and nutrition education programme, an Empowerment Project and an Educare Programme at each of the five centres.

Contact person: *Ingrid le Roux*

Tel No: *(021) 404 3367*

Site Visit No 4-Planned Parenthood Association of South Africa (PPASA)

Community-Based Distribution (CBD) Contraception Project of contraceptive services is an approach to making family planning widely available to people in developing countries, by making use of trained, non-technical people drawn from a community, who provide condoms and oral contraceptives to community residents in a variety of convenient settings outside of clinics. In January 1995, an initial introductory phase began as a collaborative venture between PPASA, SACLA and Zibonele. The aim of this 3-year pilot project is to determine whether a community-based component should be considered as a complement to the existing Family Planning Services, more especially in areas where present services are inadequate, two of these areas being Harare and Makhaza.

CBD agents were selected, through community participation, and were given an intensive 6-week training course. An office and equipment were acquired. Continuous networking with community structures and health personnel occurred, ensuring a workable referral system for clients requesting other methods, and as a back-up for problem cases.

Women's Wellness And Advocacy Project: Improving women's health and status and enhancing their decision-making in the area of sexual and reproductive health is essential for the long-term success of population programmes. Education is one of the most important means of empowering women to participate fully in the development process. They have run the following courses for their members: all aspects of sexual and reproductive health education, including HIV/AIDS prevention; sexual abuse, rape, and breast and cervical cancer; healthy nutrition, good housekeeping and home care. The communal vegetable garden project is thriving where 17 women tend to their own plot growing a variety of vegetables for their own use and selling. The project's skills development component teaches basic sewing, knitting and pattern-making skills. A volunteer, Mrs. Leonie Lasker, teaches them to knit, sew and use the equipment. Staff development is also one of their priorities and various courses have been attended.

Contact persons: *Project Manager - Ms Vivienne Gongota*

Team Leader - Mrs. B Mlungu

Tel No: *(021) 448 7312*

Site Visit No 5 - NNPHCN Media & Training Centre (MTC) and Radio Zibonele

MTC has been in existence for the past four years, developing through participatory methods, adequate and relevant primary health care media targeted to specific communities and health workers. MTC does this in partnership with certain under-resourced communities in the Western Cape and nationally through media projects, jointly identified by the MTC and PPHCN. This is done by facilitating production, use and research of PHC media using participatory methods, to develop self-sustainable media programmes in communities. Radio Zibonele is one of the first community radio stations that broadcasted in South Africa. The station is owned, managed and programmed by community residents. For a period of more than one year Radio Zibonele, a primary health care radio station, broadcasted illegally to the community of Griffith Mxenge. The Community Health Workers of the Zibonele Community Health Centre fill the role of reporters, presenters and role-play actors every Tuesday morning for a period of two hours.

A lot of changes and growth occurred since Radio Zibonele was granted a licence by the Independent Broadcasting Authority in 1995 to broadcast to the whole of Khayelitsha. The station had to transform from a small illegal radio station broadcasting to the community of Griffith Mxenge two hours a week, to a radio station that would reach the whole of the community with a population of more or less 700 000, broadcasting 19 hours a day.

Contact person: *Gabrielle Urgioti*

Tel No: *(021) 47 2482*

CONFERENCE DELEGATE REGISTER

Name	Country of Origin
Aalbersberg, Roel	- Netherlands
Abdullah, Fareed	- South Africa
Abrahams, B	- South Africa
Abrahams, Nomzi	- South Africa
Abucar, Mohamed Hagi	- South Africa
Acayo-Adonga, Janet	- Sudan
Adams, Andre	- South Africa
Ahern, M (Dr)	- South Africa
Alfino, Pat	- South Africa
Alliers, Lynette Des	- South Africa
Alperstein, Garth	- South Africa
Alperstein, Melanie	- South Africa
Ambrose, Sandra	- South Africa
Andawi-Apalla, Jocelyn	- Philippines
Andrews, Gail	- South Africa
Andrews, Mercia	- South Africa
Arendse, A	- South Africa
Arendse, Mercia	- South Africa
Ashley, Brian	- South Africa
Baez, Carmen	- South Africa
Bailey, Darryll	- South Africa
Bakoko, Zoe	- Uganda
Balani, N Y	- South Africa
Banda, Sharon	- South Africa
Baqwa, Dumo	- South Africa
Barry, G C (Ms)	- South Africa
Baum, Fran	- Australia
Beltran, Danilo	- Philippines
Berman, Dr M D	- South Africa
Bester, Abraham	- South Africa
Billings, M	- South Africa
Biruta, Vincent	- Rwanda
Bismilla, R (Dr)	- South Africa
Bloom, J B	- South Africa
Boikanyo, Ruth	- South Africa
Bolofo, C	- South Africa
Boniwe, Triphena	- South Africa
Booi, M	- South Africa
Booi, Remona	- South Africa
Borg, Jan	- Ghana
Buch, E	- South Africa
Bud, Debbie	- South Africa
Budd, John	- South Africa
Butler, Paul	- Australia
Chaane, T	- South Africa
Chossudovsky, Michel	- Canada
Choudhury, Dr Zafrullah	- Bangladesh
Christians, Lilian	- South Africa
Clarke, Marina	- South Africa

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Yasin-Harnekar - South Africa
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Zinkin, Pam - England
Zintathu, Ndzo - South Africa
Zondi, Gugu - South Africa
Zondo, George - South Africa
Zweliyangqina, Nokhatywa - South Africa

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CONTACT:
P.O.Box 43241, Salt River, 7924, Cape Town, South Africa or Call L. Bali at Tel: 27-21-696 8470
Fax: 27-21-696 9308, E-mail Address: pphcwc@wn.apc.org

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