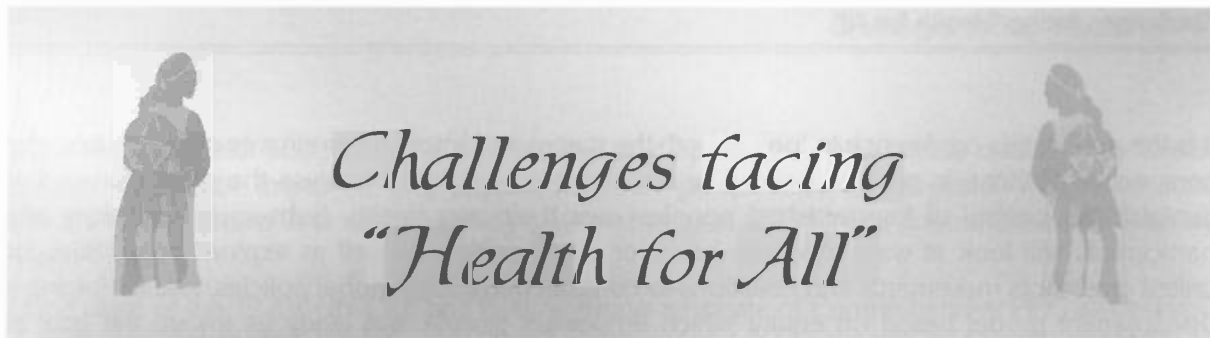




KEYNOTE ADDRESS

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 It has been replaced by a development paradigm based on top-heavy economic growth.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.

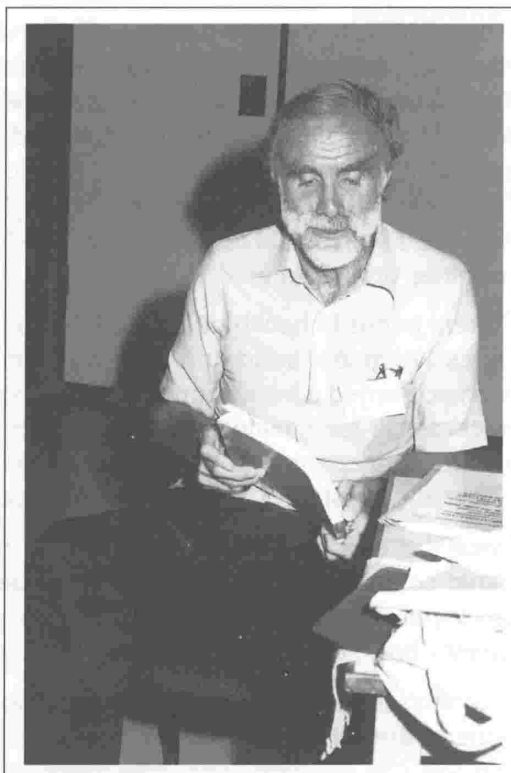
Thus, Primary Health Care was conceived as a comprehensive strategy that would not only include an equitable, consumer-centred approach to health services, but would address the underlying social and political determinants of health. It called for accountability of health workers and health ministries 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.

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



David Werner giving the keynote address

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

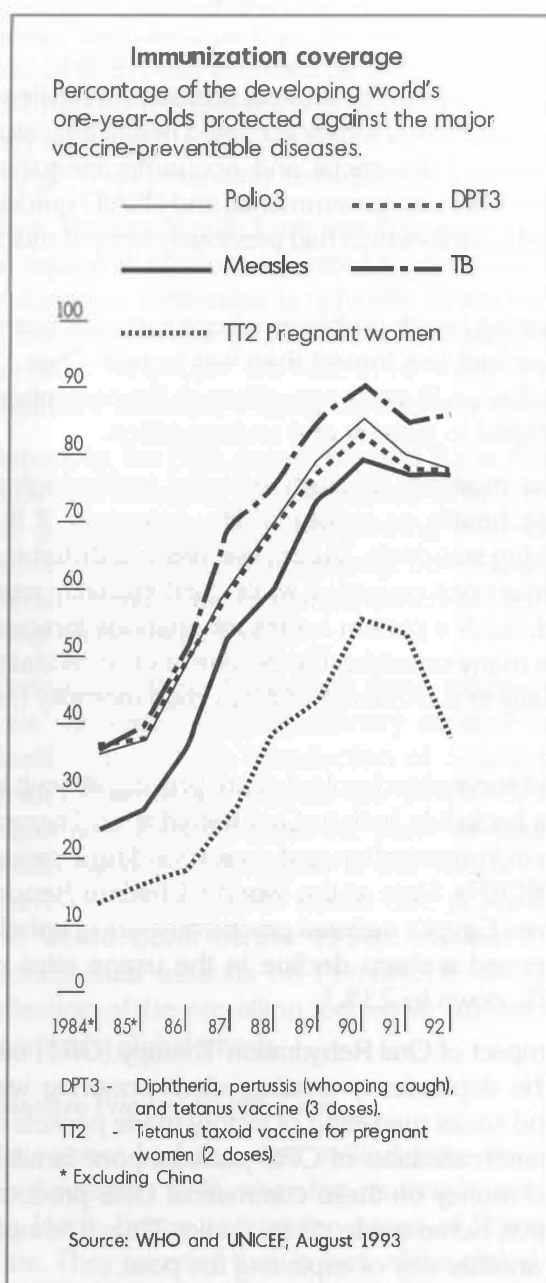
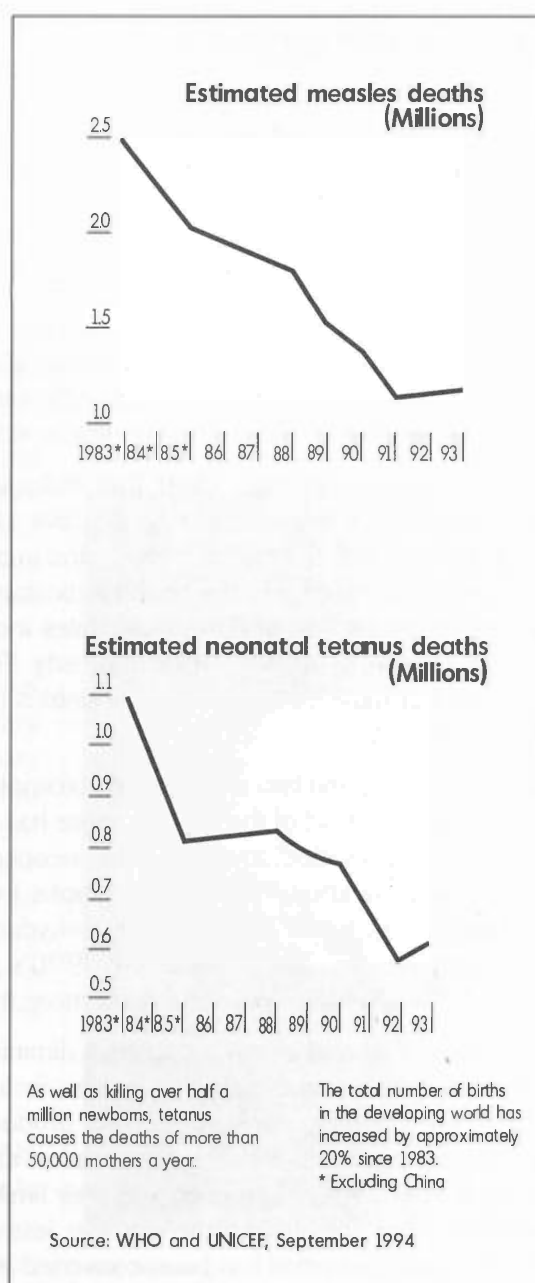


Figure 2: Global deaths: measles & tetanus (millions)



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.

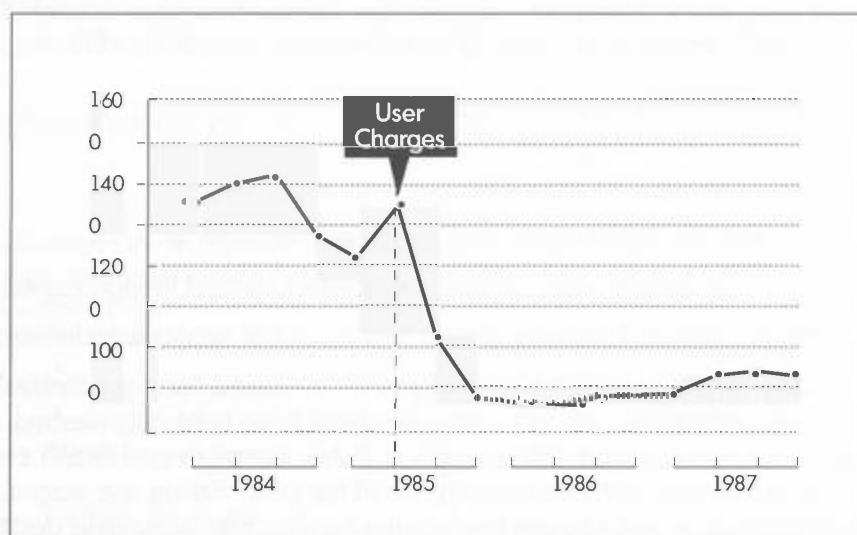
But the evidence is overwhelming that structural adjustment, linked with other conservative trends in recent years, has caused a major set-back to Third World health.⁸ The World Bank defends its strategies with reports and graphs showing that over the past 30 years Third World health has steadily improved. 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 world's 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 DC, 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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