

Uneven Health Outcomes and Neoliberalism in Africa

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1. Introduction

In the wake of the devastation wrought in Africa by two decades of ‘neoliberalism’--i.e., state policies that are market-oriented, export-led, subject to fiscal austerity and characterized by the commercialization/privatization of public sector functions--this question repeatedly arises: have matters improved now that the Bretton Woods Institutions (the World Bank and International Monetary Fund) and major donor governments are permitting countries to improve their state health systems and increase spending? And what are civil society watchdog groups and debt advocacy movements such as the Jubilee network saying about recent modifications to neoliberalism, especially the Poverty Reduction Strategy Papers and Highly Indebted Poor Countries debt relief initiative?

There are several issues associated with the direct impact of structural adjustment programs--and neoliberalism more generally--on health and health services in Africa. Effects included disincentives to health-seeking behavior, witnessed by lower utilization rates and declines in the perceived cost and quality of services. Household expenditures on health care and ability to meet major health care expenses dwindled, as did nutritional status. Health services price inflation and additional costs put often unbearable burdens on household disposable incomes and on food consumption. A dramatic decline in employment status had a negative effect on disposable income, time utilization and food purchasing. Other symptoms of neoliberal policies such as urban drift and migration contributed to the HIV/AIDS pandemic.

Effects on health workers were also mainly negative, including cuts in the size of the civil service, wage and salary decay, declining morale, and the brain drain of doctors and researchers. Likewise, the effects on health system integrity included declining fiscal support; difficulties in gaining access to equipment, drugs and transport (often due to foreign exchange shortages accompanying excessive debt repayment); and the diminished ability of health systems to deal with AIDS-related illnesses. Finally, other aspects of SAPs and neoliberalism introduced adverse health implications, such as the increasing commodification of basic health-related goods and services (such as food, water and energy) that made many unaffordable.

The broader context was one of contraction of the economies of sub-Saharan Africa and a decline in the most critical health indicators, alongside growing criticisms of the Bretton Woods Institutions’ role. With respect to governance, ‘IMF Riots’--urban uprisings catalyzed by the

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reduction or elimination of subsidies (on food, transport or other necessities)--occurred increasingly across Africa during the 1980s, culminating in the sweep from state power of no fewer than 35 ruling parties between 1990-94, mainly through elections.

Meanwhile, the HIV/AIDS pandemic was putting enormous pressure on the continent's health services. According to a World Bank discussion document, HIV/AIDS patients occupy between 30 and 80% of hospital beds in countries in the Southern African region (1). The beds needed for HIV/AIDS patients will exceed all available beds in 2002 in Botswana, in 2004 in Swaziland and in 2005 in Namibia. On the assumption that health staff have similar prevalence rates as the population as a whole, there will need to be an increase in training of 25 to 40% just to keep staff numbers constant. Assuming a cost of US\$1,100 per patient per year, providing triple therapy to cover 10% of those who need treatment amounts to 0.2% of Botswana's GDP and 2.4% of that of Malawi, these figures rise to 0.5% and 4.0% respectively in 2010.

Such statistics call for a massive rethink on the allocation of resources to the health sector. Yet one World Bank researcher concludes that aside from the 'possible exception' of Botswana and South Africa, 'none of the countries in the region will be able to offer general access to highly active anti-retroviral therapies through the public health service... Given the serious shortages in personnel and infrastructure the health sector is facing, the scope for alleviating the impact of HIV/AIDS on the health sector through financial aid is limited' (1).

Meanwhile from 2002 into the foreseeable future, a food crisis has affected an estimated 20 million people across the southern African region, including Malawi, Zimbabwe, Zambia, Mozambique, Angola, Lesotho, and Swaziland. Oxfam (2) has documented the role of neoliberalism in the famine:

The food crisis has many causes, which vary in magnitude from country to country. Climate, bad governance, HIV/AIDS, unsustainable debt, and collapsing public services have all contributed. However, one major cause of the food crisis is the failure of agricultural policies. This paper asks why, after years of World Bank and IMF designed agricultural sector reforms, do Malawi, Zambia, and Mozambique, face chronic food insecurity. The simple answer is that the international financial institutions designed agricultural reforms for these countries without first carrying out a serious assessment of their likely impact on poverty and food security. Far from improving food security, World Bank and IMF inspired policies have left poor farmers more vulnerable than ever.

In addition, as we consider in more detail below, the commodification of Africa's water also provides evidence of persistent neoliberalism. In March 2000, the Bank's Orwellian-inspired *Sourcebook on Community Driven Development in the Africa Region* (3) laid out the policy on pricing water: 'Work is still needed with political leaders in some national governments to move away from the concept of free water for all... Promote increased capital cost recovery from users. An upfront cash contribution based on their willingness-to-pay is required from users to demonstrate demand and develop community capacity to administer funds and tariffs. Ensure 100% recovery of operation and maintenance costs'. One implication of the enforcement of this policy in 2000 was disconnection of water to low-income South Africans that was the most direct cause of the country's worst-ever cholera epidemic (4).

In short, doubts remain about whether the Bretton Woods Institutions were, indeed, ever serious about reforming the core neoliberal philosophy that had been dogmatically pursued over the preceding two decades: user fees based upon full cost-recovery, fiscal cutbacks and privatization. Nevertheless, several features of modified neoliberalism deserve discussion. The Bretton Woods Institutions' response to the worsening economic and health crises in Africa and many other Third World settings included the late 1990s introduction of limited debt relief and Poverty Reduction Strategy Papers.

As we will see, however, these have been criticized as a whitewashing technique by civil society, and as inadequate by the World Health Organization (WHO). Contested claims about implications for health spending reveal the inadequacy of official attempts to modify neoliberalism. At this stage, a broader rejection of the Bretton Woods Institutions' modified neoliberal poverty and debt relief strategy is necessary to roll back conditionalities, free up resources and assure the associated decommodification of essential health-related services (such as water and energy) that are crucial for improving Africa's health. These topics are discussed in turn.

2. Neoliberal modification through Poverty Reduction Strategy Papers

Facing criticisms of neoliberal overreach, the Bank and IMF adopted the Highly Indebted Poor Countries (HIPC) initiative in 1996 and Poverty Reduction Strategy Papers in 1999. According to the IMF External Relations Department (5):

The World Bank Group and the IMF approved an approach that recognized that nationally-owned participatory poverty reduction strategies were the most promising means of securing more effective policymaking and better partnerships between countries and donors. To ensure that assistance is well used for poverty reduction, Poverty Reduction Strategy Papers would henceforth be the basis of all their concessional lending, and for debt relief under the enhanced Heavily Indebted Poor Country Initiative.

There has been widespread acceptance of the PRSP approach. Today, these processes are taking hold in some 60 low-income countries, and are helping promote a more open and inclusive national dialogue on the most effective policies and public actions for poverty reduction. And the approach has increasingly been embraced by countries' external development partners. Because it is based on the two pillars of country self-help and support from the international community, the PRSP approach promises to make development assistance more effective. Nevertheless, the process is continually being refined, including through a 2001/2002 review that identified good practices in the PRSP approach, for countries and their partners alike.

The review showed that there is room for improvement. Further actions are required to make participation processes more open and to develop and promptly implement policies that accelerate economic growth. And donors must better align their assistance with PRSPs, simplify and harmonize their procedures, and work for more predictable aid flows.

There has indeed been a significant response to the World Bank and IMF decision on PRSPs, even if the Bretton Woods Institutions do not acknowledge the intense criticism of most civil society groups. In southern Africa, for example, social movements, NGOs, labor and environmentalists have organized in various ways to become involved in the PRSP process. In Zambia, a network--Civil Society for Poverty Reduction--was established specifically to engage with the process. The Malawi Economic Justice Network arose out of meetings of civil society organizations to develop a common approach to PRSPs. In Tanzania and Mozambique, civil society is also organizing around PRSPs. Jubilee 2000 Angola drew representatives of civil society together from across the war-torn country to participate in a conference on PRSPs.

In most instances, expectations of the PRSP process have been dashed and experiences are at odds with claims made by the IMF and World Bank. Concerns have been raised around the commitment of governments and the international institutions to the participatory process, the issues that have been opened for participation and those that have not, the degree to which the voices of civil society have been incorporated into the poverty reduction strategy papers and the role of the World Bank and IMF as final authorities on the content of the papers.

Jubilee South organized conferences in Latin America, Asia and Africa to assess the PRSPs in these regions. The African conference took place in Kampala, Uganda, in May 2001 and included national Jubilee campaigns, debt and development organizations, NGOs, women's

organizations and church representation. A mix of organizations had been participating in PRSP processes in their countries, while others had decided not to take part. The conference thus allowed for the full sweep of debate on the implementation of the PRSPs on the continent. It concluded with a declaration entitled 'Poverty Reduction Strategy Papers: Structural Adjustment Programs in Disguise', which included the following points (6):

- The experiences of the functioning of PRSPs in our countries raise a number of additional concerns with regard to the involvement of organizations of civil society:
 - The PRSPs are not based on real people's participation and ownership, or decision-making. To the contrary, there is no intention of taking civil society perspectives seriously, but to keep participation to mere public relations legitimization;
- The lack of genuine commitment to participation is further manifested in the failure to provide full and timely access to all necessary information, limiting the capacity of civil society to make meaningful contributions.
 - The PRSPs have been introduced according to pre-set external schedules which in most countries has resulted in an altogether inadequate time period for an effective participatory process.
 - In addition to all the constraints placed on governments and civil society organizations in formulating PRSPs, the World Bank and IMF retain the right to veto the final programs. This reflects the ultimate mockery of the threadbare claim that the PRSPs are based on 'national ownership'.
 - An additional serious concern is the way in which PRSPs are being used by the World Bank and IMF, both directly and indirectly, to co-opt NGOs to 'monitor' their own governments on behalf of these institutions.

What are the implications of a residual--but modified, 'participatory'--neoliberalism for the health sector in Africa?

3. PRSPs and health spending

It is still too early to get a clear sense of the degree to which PRSPs are likely to impact on health, but certain trends are already evident. Most importantly, the disparity between resources being released for health care under the PRSP initiative and the resources required to provide decent health services, together with the seemingly unconcerned approach to the health crises facing the region, together suggest that the PRSPs under the direction of the World Bank and IMF do not represent an appropriate solution to the health needs of the region.

As regards health expenditure, the early projections suggest instances in which there may be significant increases in percentage terms, even if overall figures of actual expenditures reveal no or very little change. Indeed, where there are increases, these are off an extremely low base and are not likely to make any significant impact on the health of the poor. Nevertheless, the Bretton Woods Institutions make impressive claims. The IMF and World Bank conducted a study of the 24 HIPC countries that reached their decision points by November 2001. According to their report (7):

- The average debt service due in 2001-03 is roughly 30% less than the amount paid before HIPC relief in 1998-99;
- During 2001-03, the World Bank and IMF will reduce debt service payments by 65 and 55%, respectively, by providing interim relief;
- Debt service drops sharply in relation to exports or fiscal revenues over this period. On average these ratios fall by one-half;
- In all cases, social expenditures are expected to increase in 2001-02 from the levels in 1999. Average social spending in 2001-02 is expected to be more than 45% higher than in 1999, with HIPC savings accounting for a sizable proportion of this increase;

- Average debt service during 2001-02 will be US\$2 billion;
- Average social expenditure, at about US\$6.5 billion, will be more than three times higher than average debt service; and
- Average net resource flows (loans + grants--debt service payable) to this group of countries will increase from US\$3.8 billion in 1998-99 (1.2 times debt service) to US\$7.2 billion (3.7 times debt service) in 2001-2003.

The World Health Organization conducted a study of PRSPs in ten countries, including Mozambique and Tanzania (8). The study revealed variable changes and projected changes in government health budgets and health expenditure per capita. The figures for Mozambique and Tanzania are provided in Table 1.

Table 1: Mozambique and Tanzania health spending, 1999-2003

	1999	2000	2001	2002	2003
<i>Government budget as a percentage of GDP</i>					
Mozambique	22.9	27.7	35.4	29.6	27.1
Tanzania	16.9	16.5	17.3	16.8	n.a.
<i>Health as a percentage of government expenditure</i>					
Mozambique	12.5	11.6	9.3	12.7	9.8
Tanzania	2.1	6.0	6.0	6.6	n.a.
<i>Government health expenditure per capita in real terms, 1999 US\$ million</i>					
Mozambique	5.05	6.41	7.13	9.31	9.83
Tanzania	0.85	2.41	2.49	2.90	n.a.

The wild fluctuations in the government budget as a percentage of GDP figures for Mozambique, the variations in health as a percentage of government expenditure, in particular the steep jump in the Tanzanian figure from 1999 to 2000, and the poor correlation between health as a percentage of government expenditure and health expenditure per capita for Mozambique together raise questions about the accuracy of the statistical information available from the countries.

Nevertheless, the figures for Mozambique suggest an increase in government health expenditure per capita of 53% from 1999 to 2003, those for Tanzania an increase of 242% from 1999 to 2002. The increase in the case of Tanzania is largely accounted for by the large step between 1999 and 2000, before the implementation of the PRSPs. These figures, even taking the likely statistical inaccuracies into account, appear to suggest impressive improvement. However, they need to be put into a broader context. They mask the lack of data on actual spending, due to a combination of the recent introduction of the PRSPs and the poor tracking of PRSP program spending.

The WHO takes issue with the quality of PRSPs because of the lack of information on health sector financing in the papers. It says this is 'particularly striking as all ten countries reviewed have health-related financial analyses in Public Expenditure Reviews, and/or National Health Accounts.' The WHO expresses concern about the lack of clarity around financial resources available for health care, including whether governments are now allocating funds over and above those identified in medium term plans, whether stated increases reflect existing government spending plans or refer to PRSP-related debt relief and whether debt relief funds will partly replace or be fully additive to government funds for the health sector. In Burkina Faso, it appears from information available that the HIPC debt relief allocation for health partly replaces government funds that would otherwise have been available to the health sector.

The WHO also questions whether the projected increases will be realized, given the seemingly overoptimistic estimates for economic growth in the PRSPs. It also notes that the

PRSPs are largely silent on questions of the distribution of health expenditure, thus making it difficult to assess whether resources will be increasingly allocated to benefit the poor.

Uganda provides an illustration of health expenditure becoming the subject of divergent interpretations. According to the IMF's Timothy Geithner, health expenditures in Uganda have increased from 0.7% of GDP in 1997/98 to 1.5% of GDP in 2001/2 and are projected to increase to 1.8% of GDP by 2004/05 (9). It is not clear as to whether these figures include both public and private expenditure and what the changing composition of this expenditure is over the years in question, but Geithner adds that public expenditure on primary health care has shown an even larger increase over this period.

The Uganda National NGO Forum argues that these increases have failed to translate into improved health for the population. According to the forum, price rises in the health sector have exceeded inflation and thus offset the budgetary increases. It suggests numerous other reasons, including the poor standard of service provision in the health sector and shortcomings in other sectors impacting on health, for example the failure of rural policy to reach the majority of the poor and the lack of gender sensitivity in budgetary allocations and programs (10).

Daniel Giusti of the Health Office of the Catholic Bishops Conference in Kampala suggests that the expectation of a growth in the Ugandan health budget has been dashed. There is only US\$9 available per capita for public sector spending. This figure incorporates all resources assigned to health, including the government budget allocation, donor funding via the budget, donor funding outside the budget and user fees. Giusti argues that this inadequate amount is due to macroeconomic policy constraint, not resource constraint. Seven levels of budgetary decision-making must be hurdled, including macroeconomic stability targets, resource envelope determinants, a Medium Term Expenditure Framework expenditure ceiling and sectoral budget ceilings. The Bretton Woods Institutions dictate the fiscal decisions at the higher levels of decision-making and the social service ministries are involved only at the lower levels. In other words, the Ministry of Health is forced to compete with other social service ministries for resources within a given ceiling set by the World Bank and IMF, and has to allocate expenditure within a restrictive budget (11).

By March 2002, the Bank and IMF had only received data on PRSP-defined poverty reduction spending for 2000 from four countries, namely Burkina Faso, Honduras, Mozambique and Uganda. This initial data appears to endorse the perspective that health budgets have remained largely unchanged under the PRSPs. According to a paper released by these institutions, spending on education in these four countries increased from the pre-PRSP year to 2000. But the picture for health was different. Spending on health in these four countries amounted to an overall figure of 2.2% of GDP in the pre-PRSP year and only 2.1% in 2000. Health accounted for 8.5% of total government spending in the pre-PRSP year and 8.7% in 2000. In other words, health spending as a percentage of GDP declined after the introduction of PRSPs and health spending as a percentage of total government spending increased only fractionally.

A further look at projected spending for health in these four countries and Bolivia, Mauritania and Tanzania reveals similarly disconcerting figures. Spending on health across these countries amounted to 2.4% of GDP and 9.9% of total government spending in the pre-PRSP year. The projected figures for 2001-02 are 2.6% and 10.0%, in both instances: the most marginal of increases (12).

There is every chance that the implementation of PRSP programs in those countries outside of the four that collect data will be even poorer. According to the Malawi Economic Justice Network (13),

Reports from the ministry of Finance and related line ministries indicate that not a single Kwacha has

been used from the much-publicized HIPC debt relief. Several explanations are given for this unfortunate behavior realizing how 'scarce' resources are to our national programs.

First it's the procedure. It is said that the World Bank/IMF have got very vertical procedures for the government to access the funds, so much so that the time required to move around the special HIPC forms is not worthy the amount.

Secondly, the Ministry of Finance itself is said not to have put in writing yet the instructions to line ministries how to access these funds.

Other people feel that the line ministries themselves are not taking initiatives to get the funds. Surely no 'unclean hands' would wish to take on these highly watched funds.

The occurrences are of great concern to Malawians. The budget being implemented now contains Priority Poverty Expenditures (PPEs). The question arising now is: how will the PPEs be delivered without this additional funding from HIPC?

The figures represent negligible change coming off a very low base. According to the WHO, only 11% of the global health budget is spent in the low- and middle-income countries, which account for 84% of the global population (14). The World Bank concedes that the median per capita health budget for sub-Saharan Africa is US\$6 and that the mean for the lowest income African countries is US\$3 (15). WHO and World Bank data show total health expenditure in southern Africa ranging from a low of US\$9 per capita in Malawi to a high of US\$203 in South Africa (1).

According to the WHO, US\$60 is required per person per annum to deliver a basic level of health care. The director-general of the WHO, Gro Harlem Brundtland (16), argues,

It is clear that health systems which spend less than \$60 or so per capita are not able to even deliver a reasonable minimum of services, even through extensive internal reform. It does not matter how good the structure is--as long as you can't afford to pay your doctor and nurses proper salaries and fill the shelves with essential medicines and vaccines, a health system will not be performing at a reasonable level.

Sometimes, the WHO is reported as suggesting lower figures. The WHO Commission on Macroeconomics and Health, chaired by Jeffrey Sachs, calculates a per capita spending of US\$34 for a minimum package of health services. The WHO Submission to World Bank/IMF Review of PRSPs refers to 'the minimum of \$30-40 per capita needed to provide decent health care' (8).

For most countries in the southern African region, health expenditure is well below all the WHO estimates of the spending per capita required to provide a minimum level of health care. The figures for Malawi and South Africa translate respectively into 0.2% and 4.1% of the per capita expenditure in the United States. Even when converted to reflect purchasing power parity, the figures of \$45 for Malawi and \$552 for South Africa amount to, respectively, 0.9 and 11.1% of per capita spending in the US (1).

This low base is itself a reflection of years of structural adjustment policies that entailed the slashing of government expenditures, notably on health and education. As can be seen in the table above, the low figures for government budget as a percentage of GDP for Tanzania reflect the end result of such cuts. The budget to GDP figures remain constant for the period 1999 to 2002, indicating that the Tanzanian PRSP process is not translating into a redress of this situation. These low levels of expenditure correlate with extremely low levels of service. For example, in Malawi and Mozambique, there are only three physicians per 100,000 people, i.e., a mere one percent of the number of physicians in the United States and other northern countries.

In the context of largely unchanged allocations for health expenditure, health ministries are only left with the option of reallocating existing budgets to reflect the health sector priorities raised in the PRSPs. The Kenyan PRSP sets itself an objective to 'enhance equity, quality, accessibility and affordability of health care'. It then identifies the means by which it aims to meet this objective, namely 'An application of rational, transparent and poverty focused resource allocation criteria and

weights for the Government of Kenya Ministry of Health budget for districts; criteria and weights to be gradually phased in beginning with FY 2001/2002 budget.' The first three commitments it makes in this regard are as follows:

- reduction of the budget allocation for the Kenyatta National Hospital, as a share of the total Ministry of Health recurrent budget, from approximately 15% in FY 1999/2000 to 10% by FY2004;
- establish an acceptable maximum recurrent budget allocation for provincial hospitals; and
- establish maximum recurrent ceilings for district hospitals as a percentage of total district health recurrent budget.

In other words, the first notable impact of the PRSP on the health sector is a financial squeeze on the hospital sector. South Africa underwent a similar experience in the latter half of the 1990s, with devastating consequences. The World Bank was centrally involved in developing Pretoria's macroeconomic policy, the *Growth, Employment and Redistribution Strategy*, which included extreme fiscal constraint. In contrast, the *Reconstruction and Development Program*, developed by anti-apartheid civil society organizations and adopted by the African National Congress (ANC) government as its mandate to govern, stressed the need to expand primary care so as to make health care accessible to all. Within the constraint of shrinking budgets, the new government slashed hospital budgets so as to release some funds to meet the *RDP* objectives. The outcome included the disintegration of the public hospital sector as well as the erosion of the capacity of the health sector to establish, provide training for and sustain a comprehensive primary health care sector.

4. A narrow versus broad approach to health

The World Health Organization has identified numerous other concerns in its critique of the impact of PRSPs on health. PRSPs in each of the 10 countries reviewed were led by a small team in a finance, economic, planning or related ministry, and excluded the ministries of health and other line ministries. In some countries, inter-ministerial committees were established to get input from health and other ministries. In others, health ministries were approached on a one to one basis. In either case, health ministries were limited in the contributions they could make to the PRSPs.

In Uganda and Rwanda, there was not enough time for consultation with line ministries, particularly on budgeting and program planning. In Vietnam, the Ministry of Planning and Investment took the lead on the Interim PRSP despite the Ministry of Labor, Information and Social Affairs having previously prepared the Hunger Eradication and Poverty Reduction Strategy. The Vietnamese Ministry of Health has not been active in the development of the PRSP.

The WHO review also points to concerns raised that the World Bank and IMF are playing a dominant role, both in terms of their control over the process and their involvement in the development of the PRSPs. It cites a health-related example from Cambodia, namely that the Ministry of Health was not consulted on the health component of the PRSP until after a World Bank consultant had prepared an initial draft.

The WHO insists that the degree to which ill-health results in poverty and the role that improved health can play in reducing poverty are not adequately reflected in the PRSPs, and do not find expression in the programs of action (8):

Ill health is typically described as a consequence of poverty, rather than a cause. Thus many PRSPs provide data on health status by income quintile, showing that the poor are more likely to suffer from ill health, but very few calculate the impoverishing effects of ill health such as out-of-pocket medical

costs, lost income, or the consequences of ill-health/disability of the breadwinner. The gap in analysis is particularly striking as many PRSPs contain the results of a participatory poverty assessment (PPA) in which poor people themselves identify ill health as a cause of poverty.

As a result of this analysis, PRSPs characterize health as an outcome of development, rather than a means of achieving it. Most PRSPs contain several strands, one or more on increasing the rate of economic growth and/or maintaining macroeconomic stability, and one strand on improving human capabilities. The 'growth' strand covers sectors traditionally considered 'productive' (business, tourism, manufacturing, etc.) while the 'human capabilities' strand covers the provision of basic services, including health.

This division creates obstacles to improving health status, and limits the potential of improved health to positively benefit other sectors. For example, improved health is key to worker productivity, to creating and sustaining rural livelihoods, and to educational achievement. Similarly, employment, agriculture, the environment and other sectors all have an impact on health status. Most PRSPs fail to make these links.

PRSPs reflect traditional definitions of health as a social sector, and health spending as consumption rather than investment. This suggests that within the PRSP framework health will remain under-resourced and marginalized as it has been in the past, and that opportunities to reduce poverty through improving health will be missed.

In preparation for the 2000/1 World Development Report, the World Bank conducted an extensive study of people's perspectives and experiences of poverty, entitled *Voices of the Poor*. This included interviews and group discussions with 60,000 people in 60 countries and a review of 81 participatory poverty assessments. Thereafter, the WHO and the World Bank collaborated on a report on the health issues raised in the study, released under the title *Dying for Change* in 2002. According to the co-authored foreword to the report (17),

It aims to illuminate... how poverty creates ill-health and how ill-health leads to poverty. It also highlights the link between good health and economic survival. Poor people everywhere say how much they value good health. A fit, strong body is an asset that allows poor adults to work and poor children to learn... The poor have long recognized the link between good health and development. But until recently, this link has been neglected in mainstream development thinking.

The Bank's track record in the health sector reflects this neglect. In addition to its role in slashing public health services by means of structural adjustment programs, World Bank health projects have also in the main performed poorly. The Bank's Operations Evaluation Department conducted an evaluation of its Health, Nutrition and Population (HNP) projects between 1970 and 1997 and found that less than half the projects were sustainable after completion. Running costs were underestimated and governments' ability to repay the loans was overestimated. Only 21% of projects contributed to institutional development and policy change in the health sector.

In a further internal review of the 17 projects started in 1999, 59% of projects were found to have failed to address the constraints the poor faced in using HNP services, such as the distance to the projects, lack of drugs and payment for services. Researchers at the Dutch health NGO Wemos comment, 'None of the projects had explicit mechanisms to protect the poor from possible adverse impacts of reforms in the health sector. Not a single project addressed the impact on the poor of shocks or reforms outside the health sector such as structural adjustment, economic shocks, and disasters' (14).

The amounts of money involved in the program are substantial. The HNP portfolio amounts to almost US\$16 billion across 92 countries. Average annual commitments come to US\$1.3 billion. This vastly outweighs the WHO's total annual budget of US\$90 million (18). Shortcomings are admitted in the evaluation and review, but the World Bank fails to take financial responsibility for its mistakes. The net result in all too many instances is governments saddled with debts for projects that don't add to the capacity to deliver health care.

The combination of the problems encountered by civil society in participating in the PRSPs, the limitations placed on the ministries of health and related line ministries in making their contributions and the failure to listen to the voices of the poor or heed the participatory poverty assessments has resulted in PRSPs which are unlikely to address the health needs of the poor. Moreover, according to the WHO PRSP review, many PRSPs simply incorporate existing health policy. They focus on improving average indicators and do not include strategies specifically targeted to improve the health status of the poor. The WHO thus questions whether stated interventions will actually reach the poor across the respective countries and highlights the lack of monitoring plans to ascertain the impact of the PRSPs on the poor.

Researchers at Wemos characterize the PRSPs reviewed by the organization as being rooted in a narrow approach to health. They are selective in that they identify a few communicable diseases, they focus on technical solutions to these diseases and they divert attention and resources away from the need to strengthen health systems. They encourage public private partnerships for limited interventions and continue to downsize government's role in service provision. The World Bank actively promotes the privatization of health care, as evidenced by its 2002 Private Sector Development Strategy and the drive by its private sector development wing, the International Finance Corporation, to increase investments in private health care.

Oscar Lanza of Accion Internacional para la Salud describes the process in Bolivia. The money from the HIPC program for health was earmarked to contract more doctors to work in rural areas and to purchase drugs, thus medicalising the problem of ill-health. The pressing need for health facilities, clean water and sanitation remains unaddressed (19).

5. User fees and healthcare commodification

The issue of user charges for health services remains a critical area of concern. The WHO and World Bank publication, *Dying for Change?*, repeatedly refers to the voices of the poor on the financial burden of illness (17):

Sickness of the family breadwinner is something that poor people particularly fear. It means food and income suddenly stop. Paying for treatment brings more impoverishment--assets may have to be sold and debts incurred. A downward spiral of poverty begins: food becomes scarce, causing malnutrition, and children are withdrawn from school and sent to work. If a working adult dies, then the ratio of dependents to adults increases. If he or she is permanently disabled, then another dependant is created.

Illness as a cause of destitution was cited often throughout the study. Of the 15 causes of a downward slide into poverty mentioned by interviewees, this was the most frequently mentioned--ahead of losing a job, which took second place.

In Nicaragua, one civil society response to the PRSP was to conduct a social audit to generate their own information as a basis for informed discussion. The results of the first audit indicate that 45% felt that their family was worse off than a year before. As to the reason for this deterioration, 73% pointed to the economic situation, of which 39% raised the negative impact of paying for illness. The audit identified the cost of illness as being a major drain on household budgets, revealing that this accounted for 21% of monthly income (20).

Yet, PRSPs continue to include user fees for health care. To cite a few examples, Uganda intends to recover 50% of the cost of the total health budget with the help of 'pro-poor implementation of cost recovery'. Kenya is continuing to charge user fees but is amending its 'cost-sharing guidelines' to include 'waivers and exemptions for vulnerable groups'. Ghana is implementing user fees with exemptions and safety nets. Notwithstanding the stated commitment to exemptions, the insistence on continuing to rely on user fees as a key source of finance for the

health system can only lead to a further deepening of poverty given the extent of poverty, marginalization and vulnerability in the PRSP countries.

In November 2000, the United States Government enacted legislation that compels the United States Executive Directors at the IFIs to oppose any loan agreement or debt reduction arrangement that imposes user fees or service charges for primary education and basic health care. But, according to leaked minutes of the IMF and World Bank Board Meeting of December 2000, there was no opposition from the United States on the inclusion of user fees for basic services in the Tanzanian PRSP (21).

It must be remembered that the World Bank and IMF introduced PRSPs with much fanfare about prioritizing education and health care. This can only lead to a further deprioritization of services outside the health care sector that also have a fundamental bearing on people's health, such as water (water-borne diseases kill 2.7 million people each year) (22). Here at the microdevelopmental level, neoliberalism has become more acceptable, notwithstanding enormous damage. Even the WHO's Sachs Commission background report favourably cited the 1993 World Bank *World Development Report* on health, to the effect that earlier state investments in water systems were wasted (22):

Not only is improved water and sanitation not particularly cost effective as a health measure, it is also high in total costs... Between 1981 and 1990, more than US\$134 billion was invested in efforts to expand water supply and sanitation services, approximately 34% of the sum coming from donors. Although some regions were able to make progress in improving access, few attained any of the goals set.

But inexplicably, the WHO report failed to recognise that at the same time, the Bretton Woods Institutions were forcing dramatic cuts in operating subsidies on debtor countries, a practice that, as noted at the outset, continues today (3). When impoverished water consumers could no longer maintain the systems--e.g., refilling diesel tanks to run boreholes, or replacing broken piping--naturally the capital investment was lost.

Yet from this experience, which should have encouraged advocacy on behalf of higher state operating subsidies, the Sachs team drew the opposite lesson, namely that 'improved water and sanitation [are] not particularly cost effective as a health measure' (22). Moreover, the researchers endorsed regulated water privatisation as 'an important tool to ensure the delivery of expanded [privatised] services to the poor.' One tautological rationale--again, without conceding that Washington financial bureaucrats ordered cuts in social and infrastructural spending--was that 'In many places it is the poor themselves, rather than their governments, who are acting to improve their lives by investing in water and sanitation.'

The Mozambique PRSP illustrates the problems that lie ahead. In the wake of HIPC conditionality that included a 1998 requirement (described in a letter from Bank president James Wolfensohn to Mozambican president Joachim Chissano) of a five-fold increase in health clinic cost recovery and the retreat of the state from both urban and rural water systems, the country's health system was devastated, especially in the rural areas (23). Yet while the 2001 PRSP's section on agriculture and land promotes small farmers, public institutions, rural service delivery and infrastructure, state funding for rural development are projected to decrease (10).

Rachel Marcus and John Wilkinson of the Childhood Poverty Research and Policy Centre assessed 20 PRSPs to evaluate their approach to social protection, that is, policies and practices to protect and promote the livelihoods and welfare of those people most vulnerable to economic and social change, shocks and disasters. Their analysis backs up the WHO perspective that the PRSPs are not explicitly pro-poor and thus unlikely to address the needs of the poorest.

Social protection issues are discussed in about two thirds of the papers reviewed, but they

focus on alleviating the worst effects of poverty and fail to identify strategies to help people out of poverty. Gender analysis is largely missing from the PRSPs and childhood poverty is on the whole not prioritized. Social protection measures most commonly referred to include cash for work programs, direct cash transfers and bursaries for poor children to attend school. Food subsidies, nutritional supplementation schemes and water and energy subsidies are the least common. They appear to be at best weakly distributive. The responsibility for social protection is placed with the state and communities and there are no expectations of the private sector. Marcus and Wilkinson conclude (24), ‘In general, we believe this is a missed opportunity for making the most of social protection—ensuring that it can both contain the effects of poverty and help people escape. On the whole, changing international policy discourse in this area seems to have had little impact.’

6. Nepad’s homegrown neoliberalism

As a final confusing element within the modified neoliberal project, several key African rulers led by South African president Thabo Mbeki launched the New Partnership for Africa’s Development (Nepad) (25, for a set of critiques see 26). In 2002, Nepad was the most discussed initiative in Africa. It won endorsement at a UN heads-of-state summit in September 2002, a few weeks being one of the main agenda items at the World Summit on Sustainable Development in Johannesburg. Weeks earlier, Nepad won crucial official state and business endorsements at the June summit of the G8 leaders (the Group of Eight main industrial powers) in Alberta, Canada, immediately followed by the southern African gathering of the World Economic Forum in Durban, and the July launch of the African Union (replacement for the Organization of African Unity), also in Durban. Nepad’s evolution had occurred under conditions of secrecy, in close contact with the G8 in Okinawa in 2000 and Genoa in 2001, the Bretton Woods Institutions and international capital through the World Economic Forum at Davos in 2001 and New York in 2002. Nepad has gone by various names, including the African Renaissance (1996-2000), the Millennium Africa Recovery Plan (2000-July 2001) and the New African Initiative (July-October 2001).

The document’s core premise is that poverty in Africa can be cured, if only the world elite gives the continent a chance. Nepad suggests that ‘The continued marginalization of Africa from the globalization process and the social exclusion of the vast majority of its peoples constitute a serious threat to global stability.’ The argument depends upon a depoliticized view of globalization: ‘We readily admit that globalization is a product of scientific and technological advances, many of which have been market-driven.’

Likewise in areas of such as debt and structural adjustment, Nepad offers only the *status quo*. Instead of promoting debt cancellation, as do virtually all serious reformers, the Nepad strategy is to ‘support existing poverty reduction initiatives at the multilateral level, such as the Comprehensive Development Framework of the World Bank and the Poverty Reduction Strategy approach linked to the Highly Indebted Poor Country debt relief initiative’. Only after trying these discredited strategies, replete with neoliberal conditions such as further privatization, would African leaders ‘seek recourse’ through Nepad. Malawi’s 2002 famine, because the country’s grain stocks were sold following IMF advice to first repay commercial bankers, is telling.

The same approach is apparent in the health sector, where Nepad offers just six paragraphs’ worth of analysis. It is worth considering each in turn:

126. Objectives

- To strengthen programs for containing communicable diseases, so that they do not fall short of the scale required in order to reduce the burden of disease;
- To have a secure health system that meets needs and supports disease control effectively;

- To ensure the necessary support capacity for the sustainable development of an effective health care delivery system;
- To empower the people of Africa to act to improve their own health and to achieve health literacy;
- To successfully reduce the burden of disease on the poorest people in Africa;
- To encourage cooperation between medical doctors and traditional practitioners.

These objectives are laudable. But the last two decades have witnessed the systematic weakening of African health systems due to underfunding and the imposition of cost-recovery provisions, as discussed in the next chapter. The result has been particularly onerous for women and girls, for whom the decline in health care utilization rates is most damaging in both personal and social terms. Nepad does nothing to suggest these trends will be reversed.

Especially worrisome is that the continent's richest and medically most advanced country, South Africa (sponsor of Nepad), has performed very poorly in these regard since 1994, and the difficulty in getting even simple essential medicines at rural clinics is evidence of the state's lack of commitment to its poorest citizens. To target the poorest would require a radical reorientation of the public-private combination of health services, as well as dramatic increases in water, electricity, nutritional and transport services (amongst others) to the poorest people. Nepad contains no information to suggest that this is a genuine objective, and indeed its orientation to public-private partnerships in the provision of infrastructure suggests that the poorest will actually be ignored, as we argue in the next chapter. The Actions proposed are incapable of solving the problems.

127. Actions

- Strengthen Africa's participation in processes aimed at procuring affordable drugs, including those involving the international pharmaceutical companies and the international civil society, and explore the use of alternative delivery systems for essential drugs and supplies;
- Mobilize the resources required to build effective disease interventions and secure health systems;
- Lead the campaign for increased international financial support for the struggle against HIV/AIDS and other communicable diseases;
- Join forces with other international agencies such as the WHO and donors to ensure support for the continent is increased by at least US \$10 billion per annum;
- Encourage African countries to give higher priority to health in their own budgets and to phase such increases in expenditure to a level to be mutually determined;
- Jointly mobilize resources for capacity-building in order to enable all African countries to improve their health infrastructures and management.

Judicious use of drugs — 'treatment' — is one of the most crucial ways to address disease, and it is important to highlight drugs at the outset, alongside disease prevention. The single greatest advance in acquiring medicines at an affordable cost was the withdrawal (due to international public outrage) in April 2001 of 39 pharmaceutical companies, from a lawsuit against the South African government. The lawsuit, had it been successful, would have prevented Pretoria from implementing the 1997 Medicines Act provisions allowing for parallel import, compulsory licensing and generic production of lifesaving drugs. But in the year following that opportunity, Pretoria failed to take advantage of the withdrawal and made no efforts to activate the Medicines Act clauses.

If this is the leadership that Nepad offers Africans in the vital area of medicines access, then progress will be nonexistent. Nepad does not mention the options available through the Medicines Act, or the provisions in the World Trade Organization's Trade in Intellectual Property (Trips) provisions which allow for patent violation in the event of a medical emergency.

As for 'resources required,' they are infinite, of course. But Nepad could attempt to specify ways in which the UN Global Fund (targeting Aids, malaria and TB) would be utilized in Africa. But Nepad doesn't specifically mention this fund, nor the long-standing debate over the Fund's need to prioritize the financing of treatment. Pretoria's leadership on HIV/Aids will likely be as

great a disaster for Africa as it is for South Africa.

The \$10 billion reference apparently refers to the UN's attempt to raise money for the Global Fund to address health crisis in *all* parts of the world (not just Africa). The more funding received, the better--but Nepad does not engage in the heated debates about where such funds should be prioritized, and who should control them.

The 'mutual determination' of health budgets harks back to the structural adjustment era (1980s-present) in which budgets are determined in Washington. There is no indication in Nepad as to what sustainable health budgets are and should be, and in view of the systematic destruction of public health system capacity and the rise of private healthcare options for African ruling classes, the lack of detail and vague references to external funds is worrisome.

Still in the category of 'Action,' Nepad continues,

128. Africa is home to major endemic diseases. Bacteria and parasites carried by insects, the movement of people and other carriers thrive, favored as they are by weak environmental policies and poor living conditions. One of the major impediments facing African development efforts is the widespread incidence of communicable diseases, in particular HIV/AIDS, tuberculosis and malaria. Unless these epidemics are brought under control, real gains in human development will remain a pipe dream.

The only 'action' implied here is bringing the diseases under control. But Pretoria's failure to address HIV/AIDS, in part by promoting dissident analysis in South Africa's Presidential Commission on Aids, and the ongoing cholera and diarrhoea epidemics caused mainly by lack of clean water, suggest that Nepad's own authors are not serious about these problems.

129. In the health sector, Africa compares very poorly with the rest of the world. In 1997, child and juvenile death rates were 105 and 169 per 1000, as against 6 and 7 per 1000 respectively in developed countries. Life expectancy is 48.9 years, as against 77.7 years in developed countries. Only 16 doctors are available per 100 000 inhabitants against 253 in industrialized countries. Poverty, reflected in very low per capita incomes, is one of the major factors limiting the populations' capacity to address their health problems.

This is an obvious point, but contains no information about 'actions' to be taken. Moreover, the phraseology here implies that individuals are responsible for their health status, which takes the burden off the state. Given that individuals' incomes are so low in most of Africa and that health status indicators have fallen so quickly during the era of structural adjustment, the logical conclusion is that market-failure requires massive state intervention, but Nepad notably fails to promote this conclusion.

130. Nutrition is an important ingredient of good health. The average daily intake of calories varies from 2384 in low-income countries to 2846 in middle-income countries to 3390 in the Organization for Economic Co-operation and Development (OECD) countries.

Again, this point cannot be contested, but Nepad contains no information about actions to be taken. If nutrition was taken seriously as a component in Nepad, some additional state interventions in basic food markets and in food-related subsidization would be on the agenda. But it is not.

131. Health, defined by the World Health Organization (WHO) as a state of complete physical and mental well-being, contributes to increase in productivity and consequently to economic growth. The most obvious effects of health improvement on the working population are the reduction in lost working days due to sick leave, the increase in productivity, and the chance to get better paid jobs. Eventually, improvement in health and nutrition directly contributes to improved well-being as the spread of diseases is controlled, infant mortality rates are reduced, and life expectancy is higher. The link with poverty reduction is clearly established.

This information is correct, but again contains no suggestions about actions to be taken. For example, if externalities associated with healthcare, water, sanitation and electricity were incorporated into national and local economic strategies, then increased subsidies would be a logical way to translate those externalities into real economic gains, but Nepad is silent about such implications. Likewise, were the system of national accounts in African countries to be recalculated to take into account the health-poverty linkage, and especially to calculate the importance of women's (unpaid) labor in maintaining the health of the society, it might make it easier to better compensate healthworkers and women, and to improve their status. Again, Nepad shies away from any such conclusion, and the document's lip service to gender equity is unveiled as mere rhetoric, when opportunities to improve women's wellbeing, such as this example, are ignored.

Finally, Nepad is at its most self-contradictory when appealing 'to all the peoples of Africa, in all their diversity, to become aware of the seriousness of the situation and the need to mobilize themselves in order to put an end to further marginalization of the continent and ensure its development by bridging the gap with the developed countries'. The hypocrisy is breathtaking. Africans falling further into poverty as a result of leadership *compradorism* and globalization, particularly women, do not need to 'become aware of the seriousness of the situation', as much as do the elite rulers who generally live in luxury, at great distance from the masses. And when Africans in progressive civil society organizations express 'the need to mobilize themselves', they are nearly invariably met with repression.

7. Conclusion: Beyond WHO, to African social movements

The WHO review of PRSPs (8) recommends the following:

- A conceptual change in the understanding of health's contribution to development: from 'a basic service' that helps to mitigate the impact of poverty, to a prerequisite of growth and poverty reduction.
- That health outcomes are distinguished from the provision of health services. The latter are important, but not sufficient to ensure the health of the poor. Explicit health objectives need to be incorporated into sectors which influence--and are influenced by--health.
- That Ministries of Health take a more active role in the development of PRSPs and other poverty reduction strategies. This will require improved capacity within health ministries, and greater openness within those leading the PRSP process.
- That health and health-related programs are adequately and equitably financed. This means greater resources for health, and a shift of resources within the health sector to favor the poor.

The contrast between the PRSPs being developed under the dominant hand of the World Bank and IMF, and the approach to health embodied in the WHO critique is instructive. The approach of the Bretton Woods Institutions remains fundamentally unchanged from the narrow and selective strategy for health that took increasing hold over countries in the South under the imposition of their structural adjustment programs.

The WHO critique, on the other hand, incorporates elements of the somewhat more comprehensive approach to health identified at Alma Ata in 1978, in terms of its conceptualization of both the interrelationship between health and poverty and the need for a coordinated approach to health across social and economic sectors. At this early stage in the history of PRSPs, the indications are that the approach to health embodied therein and the financial resources being committed to the identified programs fall short of what is required. To be sure, as discussed above, the WHO Commission on Macroeconomics and Health conceded crucial microdevelopmental ground to neoliberalism, especially in relation to water (22).

Most of the civil society advocacy networks now working on these issues are offering

critiques (26). The challenge will be to turn what is being termed the 'African Social Forum' into a vehicle that can transcend the terribly weak homegrown-neoliberal Nepad strategy and PRSPs, and introduce a more genuine African People's Consensus that will give African activists more confidence for future struggles. In January 2002, dozens of African social movements met in Bamako, Mali as the African Social Forum, in preparation for the Porto Alegre World Social Forum. It was one of the first substantial conferences since the era of liberation to combine progressive NGOs and social movements from all parts of the continent, and was followed by African Social Forum sessions in Johannesburg (August 2002) and Addis Ababa (January 2003). The Bamako Declaration included the following paragraphs:

A strong consensus emerged at the Bamako Forum that the values, practices, structures and institutions of the currently dominant neoliberal order are inimical to and incompatible with the realization of Africa's dignity, values and aspirations.

The Forum rejected neoliberal globalization and further integration of Africa into an unjust system as a basis for its growth and development. In this context, there was a strong consensus that initiatives such as Nepad that are inspired by the IMF-WB strategies of Structural Adjustment Programs, tradel liberalization that continues to subject Africa to an unequal exchange, and strictures on governance borrowed from the practices of Western countries and not rooted in the culture and history of the peoples of Africa.

It is that spirit--and an emerging African People's Consensus that can act as an alternative pole for advocacy--that provides hope for genuine social and health progress in Africa, not the minor modifications of neoliberalism apparent in PRSPs and Nepad.

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