

Hazardous to Health

The World Bank and IMF in Africa

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Health is a fundamental human right, recognized in the Universal Declaration of Human Rights (1948), and the Constitution of the World Health Organization (1946). Health is also an essential component of development, vital to a nation's growth and internal stability.

Over the past two decades, the World Bank and International Monetary Fund (IMF) have undermined Africa's health through the policies they have imposed. The dependence of poor and highly indebted African countries on World Bank and IMF loans has given these institutions leverage to control economic policy-making in these countries. The policies mandated by the World Bank and IMF have forced African governments to orient their economies towards greater integration in international markets at the expense of social services and long-term development priorities. They have reduced the role of the state and cut back government expenditure.

While many African countries succeeded in improving their health care systems in the first decades after independence, the intervention of the World Bank and IMF reversed this progress. Investments in health care by African governments in the 1970s achieved improvements in key health indicators. In Kenya, for example, child mortality was reduced by almost 50% in the first two decades after independence in 1963 (1). Across sub-Saharan Africa, the first decades after independence saw significant increases in life expectancy, from an average of 44 years to more than 50 years (2).

In the 1980s and 1990s, however, African governments had to cede control over their economic decision-making in order to qualify for World Bank and IMF loans. The conditions attached to these loans undid much of the progress achieved in public health. The policies dictated by the World Bank and IMF exacerbated poverty, providing fertile ground for the spread of HIV/AIDS and other infectious diseases. Cutbacks in health budgets and privatization of health services eroded previous advances in health care and weakened the capacity of African governments to cope with the growing health crisis. Consequently, during the past two decades the life expectancy of Africans has dropped by 15 years (3).

Africa Action calls for an end to World Bank and IMF policies that undermine health. This requires canceling the debts that prevent African governments from making their full contribution to addressing the health crisis. It also requires ending the imposition of harmful economic policies as conditions for future loans or grants.

This position paper provides a brief background overview of World Bank and IMF policies. It focuses particularly on their impact on health.



1. The World Bank and IMF in Africa

The World Bank and IMF were created at the Bretton Woods Conference in New Hampshire, U.S.A., in 1944. They were designed as pillars of the post-war global economic order. The World Bank's focus is the provision of long-term loans to support development projects and programs. The IMF concentrates on providing loans to stabilize countries with short-term financial crises.

The World Bank and IMF became increasingly powerful in Africa with the economic crisis of the early 1980s. In the late 1970s, rising oil prices, rising interest rates, and falling prices for other primary commodities left many poor African countries unable to repay mounting foreign debts. In the early 1980s, Africa's debt crisis worsened. The ratio of its foreign debt to its export income grew to 500% (4). African countries needed increasing amounts of "hard currency" to repay their external debts (i.e. convertible foreign currencies such as dollars and deutschmarks). But their share of world trade was decreasing and their export earnings dropped as global prices for primary commodities fell. The reliance of many African countries on imports of manufactured goods, which they themselves did not produce, left them importing more while they exported less. Their balance of payments problems worsened and their foreign debt burdens became unsustainable.

African governments needed new loans to pay their outstanding debts and to meet critical domestic needs. The World Bank and IMF became key providers of loans to countries that were unable to borrow elsewhere. They took over from wealthy governments and private banks as the main source of loans for poor countries. These institutions provided "hard currency" loans to African countries to insure repayment of their external debts and to restore economic stability.

The World Bank and IMF were important instruments of Western powers during the Cold War in both economic and political terms. They performed a political function by subordinating development objectives to geostrategic interests. They also promoted an economic agenda that sought to preserve Western dominance in the global economy.

Not surprisingly, the World Bank and IMF are directed by the governments of the world's richest countries. Combined, the "Group of 7" (U.S., Britain, Canada, France, Germany, Italy and Japan) hold more than 40% of the votes on the Boards of Directors of these institutions. The U.S. alone accounts for almost 20% (5).

It was U.S. policy during the Reagan Administration in the early 1980s, to expand the role of the World Bank and IMF in managing developing economies (6). The dependence of African countries on new loans gave the World Bank and IMF great leverage. The conditions attached to these loans required African countries to submit to economic changes that favored "free markets."



This standard policy package imposed by the World Bank and IMF was termed "structural adjustment." This referred to the purpose of correcting trade imbalances and government deficits. It involved cutting back the role of the state and promoting the role of the private sector. The ideology behind these policies is often labeled "neo-liberalism," "free market fundamentalism," or the "Washington Consensus." From the 1970s on, this orientation became the dominant economic paradigm for rich country governments and for the international financial institutions.

The basic assumption behind structural adjustment was that an increased role for the market would bring benefits to both poor and rich. In the Darwinian world of international markets, the strongest would win out. This would encourage others to follow their example. The development of a market economy with a greater role for the private sector was therefore seen as the key to stimulating economic growth.

The crisis experienced by African countries in the early 1980s did expose the need for economic adjustments. With declining incomes and rising expenses, African economies were becoming badly distorted. Corrective reforms became increasingly necessary. The key issue with adjustments of this kind, however, is whether they build the capacity to recover and whether they promote long-term development. The adjustments dictated by the World Bank and IMF did neither.

African countries require essential investments in health, education and infrastructure before they can compete internationally. The World Bank and IMF instead required countries to reduce state support and protection for social and economic sectors. They insisted on pushing weak African economies into markets where they were unable to compete with the might of the international private sector. These policies further undermined the economic development of African countries.

2. What is Structural Adjustment?

Structural adjustment refers to a package of economic policy changes designed to fix imbalances in trade and government budgets. In trade, the objective is to improve a country's balance of payments, by increasing exports and reducing imports. For budgets, the objective is to increase government income and to reduce expenses. In theory, achieving these goals will enable a country to recover macroeconomic stability in the short-term. It will also set the stage for long-term growth and development.

The structural adjustment programs of the early 1980s were meant to provide temporary financing to borrowing countries to stabilize their economies. These loans were intended to enable governments to repay their debts, reduce deficits in spending, and close the gap between imports and exports. Gradually, these loans evolved into a core set of economic policy changes required by the World Bank and IMF. They were designed to further integrate African countries into the global economy, to strengthen the role of the international private sector, and to encourage growth through trade.

Typical components of adjustment programs included cutbacks in government spending, privatization of government-held enterprises and services, and reduced protection for domestic industry. Other types of



adjustment involved currency devaluation, increased interest rates, and the elimination of food subsidies. The underlying intention was to minimize the role of the state.

World Bank and IMF adjustment programs differ according to the role of each institution. In general, IMF loan conditions focus on monetary and fiscal issues. They emphasize programs to address inflation and balance of payments problems, often requiring specific levels of cutbacks in total government spending. The adjustment programs of the World Bank are wider in scope, with a more long-term development focus. They highlight market liberalization and public sector reforms, seen as promoting growth through expanding exports, particularly of cash crops.

Despite these differences, World Bank and IMF adjustment programs reinforce each other. One way is called "cross-conditionality." This means that a government generally must first be approved by the IMF, before qualifying for an adjustment loan from the World Bank. Their agendas also overlap in the financial sector in particular. Both work to impose fiscal austerity and to eliminate subsidies for workers, for example. The market-oriented perspective of both institutions makes their policy prescriptions complementary.

Adjustment lending constitutes 100% of IMF loans. In 2001, approximately 27% of World Bank lending to African countries was for "adjustment." In the World Bank's total loan portfolio, adjustment lending generally accounts for between one-third and one-half (7). The remainder of World Bank loans are disbursed for development projects and programs. The project portfolio of the Bank covers such areas as infrastructure, agricultural and environmental development, and human resource development. In some cases, the projects supported by World Bank loans do make useful contributions to development. But these occasional successes must be weighed against the negative effects of increasing debt, imposed economic policies and their consequences.

The past two decades of World Bank and IMF structural adjustment in Africa have led to greater social and economic deprivation, and an increased dependence of African countries on external loans. The failure of structural adjustment has been so dramatic that some critics of the World Bank and IMF argue that the policies imposed on African countries were never intended to promote development. On the contrary, they claim that their intention was to keep these countries economically weak and dependent.

The most industrialized countries in the world have actually developed under conditions opposite to those imposed by the World Bank and IMF on African governments. The U.S. and the countries of Western Europe accorded a central role to the state in economic activity, and practiced strong protectionism, with subsidies for domestic industries. Under World Bank and IMF programs, African countries have been forced to cut back or abandon the very provisions which helped rich countries to grow and prosper in the past.

Even more significantly, the policies of the World Bank and IMF have impeded Africa's development by undermining Africa's health. Their free market perspective has failed to consider health an integral component of an economic growth and human development strategy. Instead, the policies of these institutions have caused a deterioration in health and in health care services across the African continent.



3. Poverty and Health Care Cuts

Health status is influenced by socioeconomic factors as well as by the state of health care delivery systems. The policies prescribed by the World Bank and IMF have increased poverty in African countries and mandated cutbacks in the health sector. Combined, this has caused a massive deterioration in the continent's health status.

The health care systems inherited by most African states after the colonial era were unevenly weighted toward privileged elites and urban centers. In the 1960s and 1970s, substantial progress was made in improving the reach of health care services in many African countries. Most African governments increased spending on the health sector during this period. They endeavored to extend primary health care and to emphasize the development of a public health system to redress the inequalities of the colonial era. The World Health Organization (WHO) emphasized the importance of primary healthcare at the historic Alma Ata Conference in 1978. The Declaration of Alma Ata focused on a community-based approach to health care and resolved that comprehensive health care was a basic right and a responsibility of government.

These efforts undertaken by African governments after independence were quite successful. There were increases in the numbers of health professionals employed in the public sector, and improvements in health care infrastructure in many countries. There was also some success in extending care to formerly unserved areas and populations. Across the continent, there were improvements in key health care indicators, such as infant mortality rates and life expectancy.

In Zambia, the post-independence government expanded public health care services throughout the country. The number of doctors and nurses was also significantly increased during this time. Infant mortality was reduced from 123 per 1,000 live births in 1965, to 85 in 1984 (8). In Tanzania, during the first two decades of independence, the government succeeded in expanding access to health care nationwide. By 1977, more than three-quarters of Tanzania's population lived within 5 km of a health care facility (9).

While the progress across the African continent was uneven, it was significant, not only because of its positive effects on the health of African populations. It also illustrated a commitment by African leaders to the principle of building and developing their health care systems.

With the economic crisis of the 1980s, much of Africa's economic and social progress over the previous two decades began to come undone. As African governments became clients of the World Bank and IMF, they forfeited control over their domestic spending priorities. The loan conditions of these institutions forced contraction in government spending on health and other social services.

Poverty and Health

The relationship between poverty and ill-health is well established. The economic austerity policies attached to World Bank and IMF loans led to intensified poverty in many African countries in the 1980s and 1990s.



This increased the vulnerability of African populations to the spread of diseases and to other health problems.

The public sector job losses and wage cuts associated with World Bank and IMF programs increased hardship in many African countries. During the 1980s, when most African countries came under World Bank and IMF tutelage, per capita income declined by 25% in most of sub-Saharan Africa (10). The removal of food and agricultural subsidies caused prices to rise and created increased food insecurity. This led to a marked deterioration in nutritional status, especially among women and children. In Zambia, for instance, following the elimination of food subsidies, many poor families had to reduce the number of meals per day from two to one (11). Malnutrition resulted in low birth weights among infants and stunted growth among children in many countries. It is currently estimated that one in every three children in Africa is underweight (12). In general, between one-quarter and one-third of the population of sub-Saharan Africa is chronically malnourished.

The deepening poverty across the continent has created fertile ground for the spread of infectious diseases. Declining living conditions and reduced access to basic services have led to decreased health status. In Africa today, almost half of the population lacks access to safe water and adequate sanitation services (13). As immune systems have become weakened, the susceptibility of Africa's people to infectious diseases has greatly increased. A joint release issued by the WHO and the Joint UN Programme on HIV/AIDS (UNAIDS) in April 2001 reports that the number of cases of tuberculosis in Africa will reach 3.3 million per year by 2005 (14). The WHO reported in 2001 that almost 3,000 Africans die each day of malaria. Each year in Africa, the disease takes the lives of more than 500,000 children below the age of five (15).

Most devastating of all has been the impact of the HIV/AIDS pandemic. The spread of HIV/AIDS in Africa has been facilitated by worsening poverty and by the conditions of inequality intensified by World Bank and IMF policies. Economic insecurity has reinforced migrant labor patterns, which in turn have increased the risk of infection. Reduced access to health care services has increased the spread of sexually transmitted diseases and the vulnerability to HIV infection.

More than 17 million Africans have died of HIV/AIDS. It is currently estimated that more than 28 million of the 40 million people living with the disease worldwide are in sub-Saharan Africa (16). There are more than 12 million African orphans who have lost their mothers or both parents to AIDS (17). The social and economic effects of the AIDS crisis are reversing post-independence progress and exacerbating conditions of underdevelopment. The policies imposed by the World Bank and IMF have fueled the spread of the disease and continue to hinder the response to this health emergency.

Declining Health Care Systems

As poverty has increased Africa's health problems, World Bank and IMF intervention has also led to a breakdown of health care delivery systems. The role of the state in the provision of health care services has been reduced substantially. Cutbacks in the health sector have severely undermined existing services. And



Africa's debt repayment obligations to foreign creditors have diverted money directly from spending on health.

Cutbacks in government spending represent a major component of World Bank and IMF adjustment programs. In the 1980s, real disbursements per person dropped in government expenditure in many African countries. In Madagascar, between 1977 and 1985, government expenditures declined by 24% (18). Cutbacks in government budgets led to major cuts in the health sector. In the 42 poorest countries in Africa, spending on health care fell by 50% during the 1980s (19). In Nigeria, per capita expenditure on health fell by 75% between 1980 and 1987 (20).

The dramatic drop in health expenditure in the 1980s and 1990s resulted in the closure of hundreds of clinics, hospitals and medical facilities across the continent. Those that remained open were generally left under-staffed and lacking in essential medical supplies. Many were unable to afford even basic vaccines. In 14 sub-Saharan African countries between 1990-1992, the level of polio vaccination dropped by more than 10% as a result of cutbacks in health care services (21).

Thousands of health care professionals throughout the continent lost their jobs as a result of public sector cuts. In Ghana, between 1982 and 1992, the number of doctors in the government health care system dropped from 1700 to 665. In Senegal, between 1980 and 1993, the number of people per nurse increased six-fold (22).

Even as government spending on health was cut back, the amounts being paid by African governments to foreign creditors continued to increase. By the 1990s, most African countries were spending more repaying foreign debts than on health or education for their people. Health care services in African countries disintegrated, while desperately needed resources were siphoned off by foreign creditors. It was estimated in 1997 that sub-Saharan African governments were transferring to Northern creditors four times what they were spending on the health of their people (23). In 1998, Senegal spent five times as much repaying foreign debts as on health (24). Across Africa, debt repayments compete directly with spending on Africa's health care services.

The erosion of Africa's health care infrastructure has left many countries unable to cope with the impact of HIV/AIDS and other diseases. Efforts to address the health crisis have been undermined by the lack of available resources and the breakdown in health care delivery systems. The privatization of basic health care has further impeded the response to the health crisis.

4. Privatization and User Fees

Privatization forms a centerpiece of the World Bank and IMF agenda. Reducing the size and scope of government, and privatizing state-owned enterprises and services, is a major element of World Bank and IMF programs. Under World Bank and IMF direction, control of health care services has increasingly been



transferred from African governments to the private sector. The rationale is that health care services are better financed and more efficiently delivered privately.

The World Bank has recommended several forms of privatization in the health sector. These include: the introduction of "user fees" for health services previously provided free of charge; the promotion of health insurance schemes; increased investments in private care in order to attract patients to private facilities. Through these measures, private services are made the primary focus of health care.

Throughout Africa, the privatization of health care has reduced access to necessary services. The introduction of market principles into health care delivery has transformed health care from a public service to a private commodity. The outcome has been the denial of access to the poor, who cannot afford to pay for private care.

For example, the introduction of user fees for health care services has been shown to sharply reduce access for those unable to pay. The World Bank and IMF have promoted "user fees" as a means of generating revenue for the health sector. They argue that these fees will tax the rich and that a system of exemptions will protect the poor from the costs. However, the evidence shows that user fees have actually succeeded in driving the poor away from health care services.

Ghana, Swaziland and the former Zaire were among the first African countries where user fees replaced free, or almost free, services. In each of these, studies showed that the introduction of fees led to reduced utilization of these services (25). Studies in Côte d'Ivoire have shown that those with income above the median make more use of medical services when a user fee is charged. But those with below median incomes reduce their use (26). Across Africa, reports indicate that attendance at hospitals and clinics drops significantly after the introduction of user fees.

Schemes intended to exempt the poor from user fees have been shown to be ineffective. A comprehensive UNICEF study discovered that such schemes are rare (27). The study claims that poor people are generally unaware of such exemptions, and that there are often complex administrative barriers involved. The report concludes that the implementation of exemption schemes is infrequent and is applied in ad hoc ways. It therefore does not appear that user fees have been managed so as to collect revenues only from the rich. Instead, they have had the effect of closing off access to those who cannot pay. As a recent paper concluded, user fees "increase the barriers disproportionately faced by the poor when seeking health care."(28) Their failure to generate revenue has also undermined their economic rationale, as propounded by the World Bank and IMF.

Another form of privatization involves the promotion of insurance schemes as a means to defray the costs of private health care. This is inherently flawed in the African context. Less than 10% of Africa's labor force is employed in the formal job sector (29). Therefore, the vast majority of people are not eligible for insurance through their employer. Income levels in Africa are extremely low, and have been reduced further by wage cuts and lay-offs associated with World Bank and IMF austerity policies. Most Africans cannot afford the



cost of private insurance. In view of such circumstances, insurance schemes cannot resolve the issue of access to private health care in African countries (30).

Beyond the issue of affordability, private health care is also inappropriate in responding to Africa's particular health needs. When infectious diseases constitute the greatest challenge to health in Africa, public health services are essential. Private health care cannot make the necessary interventions at the community level. Private care is less effective at prevention, and is less able to cope with epidemic situations. Successfully responding to the spread of HIV/AIDS and other diseases in Africa requires strong public health care services.

The privatization of health care in Africa has created a two-tier system which reinforces economic and social inequalities. As health care has become an expensive privilege, the poor have been unable to pay for essential services. The result has been reduced access and increased rates of illness and mortality. Despite these devastating consequences, the World Bank and IMF have continued to push for the privatization of public health services.

5. Recent Developments: Reform or Repackaging?

In recent years, there has been growing criticism of the impact of World Bank and IMF programs in developing countries. As a result, these institutions have shifted their public stance in favor of "poverty reduction." They have attempted to re-package structural adjustment to include greater emphasis on social development programs.

The "Poverty Reduction" Spin

Both the World Bank and IMF have proclaimed a greater commitment to "poverty reduction" in recent years. They have made it a requirement for countries to prepare Poverty Reduction Strategy Papers (PRSPs) as a condition for the receipt of new loans or debt relief. These papers are intended to be drawn up by national governments in consultation with civil society "stakeholders" and with World Bank and IMF guidance. They are to outline the priorities and strategies of African governments in their development efforts. In order to reflect their concern with social development, the World Bank and IMF have also renamed structural adjustment lending. The IMF now uses the term "Poverty Reduction and Growth Facility" (PRGF). The World Bank's new term is "Poverty Reduction and Support Credits"(PRSCs).

The World Bank has also increased its funding for health, and for HIV/AIDS programs in particular. While the shift in focus towards prioritizing social development and poverty eradication is welcome, fundamental problems remain. New lending for health and education can achieve little when the debt burden of most African countries is already unsustainable. Debt cancellation should be the first step in enabling African countries to tackle their social development challenges. Additional resources to support health and education programs should be conceived as public investment, not new loans. The new spin on the World Bank and IMF priorities fails to change the basic agenda and operations of these institutions. Indeed, it



appears to be largely an exercise in public relations. The conditions attached to World Bank and IMF loans still reflect the same orientation prescribed over the past two decades. The recent moves towards promoting poverty reduction have actually permitted these institutions to increase the scope of their loan conditions to include social sector reforms and governance aspects. This allows an even greater intrusion into the domestic policies of African countries. It is highly inappropriate that external creditors should have such control over the priorities of African governments. And it is disingenuous for such creditors to proclaim concern with poverty reduction when they continue to drain desperately needed resources from the poorest countries.

Equivocation on User Fees

In 1998, the Bank's Operations Evaluation Department reported that nearly 75% of projects in sub-Saharan Africa included the establishment or expansion of user fees (31). As the negative effects of user fees have begun receive more public attention, the Bank has sought to distance itself from the promotion of these fees.

In a policy statement at the end of 2000, the World Bank announced that it was stepping back from the promotion of user fees for basic social services in the developing world. It stated that it supports the provision of basic health care for free. However, it added that well-designed and well-implemented fees can be useful in mobilizing additional resources for these services in poor countries. It maintains that exemption schemes do work in some countries. Overall, it remains convinced that user fees can improve the quality of health care services being provided.

It is difficult to ascertain whether the World Bank is still pushing user fees in practice. Indeed, it is not easy to monitor the content of the Bank's adjustment programs at all because of the lack of information disclosure on this form of lending. In the U.S., an important victory was achieved in 2000, when Congress passed language against user fees. This language requires the U.S. representatives to the World Bank and IMF to oppose user fees. These representatives must inform Congress within 10 days if any loan requiring the imposition of user fees is approved by the International Financial Institutions.

Despite this victory, challenges remain. It has been documented in at least one case since then that user fees have been included in a loan package, despite this legislative language. This calls into question the commitment of the World Bank and, of its U.S. Directors, to ending user fees as part of World Bank and IMF prescriptions. At the IMF, no move has been made to indicate a new policy on the imposition of user fees in borrower countries.

Water Privatization, a Threat to Future Health

The privatization of public water systems is a strategy being promoted by the World Bank in an increasing number of African countries. This involves the reduction of public subsidies for clean water. It also involves, in some cases, the introduction of cost-recovery measures for access to water supplies.



This development represents a major cause for concern. Access to clean water is a vital public health necessity and a basic human right. The privatization of water can only lead to reduced access to safe water for poor communities. In Ghana, the recent moves towards water privatization are being opposed by civil society groups for this reason. Already, according to the Ghanaian Ministry of Health, half of all clinic visits in Ghana are due to water-borne illnesses. The groups opposing privatization are concerned that this move will further reduce access to safe and affordable water in urban areas (32).

Over two million people in developing countries die each year because of diseases related to lack of clean water. Many of these are children. Increased privatization of water in African countries can only increase the risk of ill-health among the poor.

6. Conclusion

The free market fundamentalism of the World Bank and IMF has had a disastrous impact on Africa's health. The all-out pursuit of market-led growth has undermined health and health care in African countries. It has forced governments to sacrifice social needs to meet macroeconomic goals.

This approach to development is fundamentally flawed. The failure to prioritize public health denies its significance in promoting long-term economic growth. As the WHO Commission on Macroeconomics and Health recently concluded, health is more than an outcome of development, it is a crucial means to achieving development (33). Investments in Africa's health must therefore form a central part of any comprehensive development strategy.

Economic and social progress in Africa cannot succeed in the context of the current health crisis. In order to address this crisis, it is necessary to tackle the structural factors that fuel it. The World Bank and IMF must accept responsibility for the devastating impact that their policies have had on Africa's health. If the U.S. is serious about responding to Africa's health crisis, it must use its power at the World Bank and IMF to end the harmful policies of these institutions.



ENDNOTES

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