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STRUCTURAL ADJUSTMENT, HEALTH, NUTRITION AND FOOD AID IN THE AFRICAN REGION

by

World Health Organization (WHO)
and
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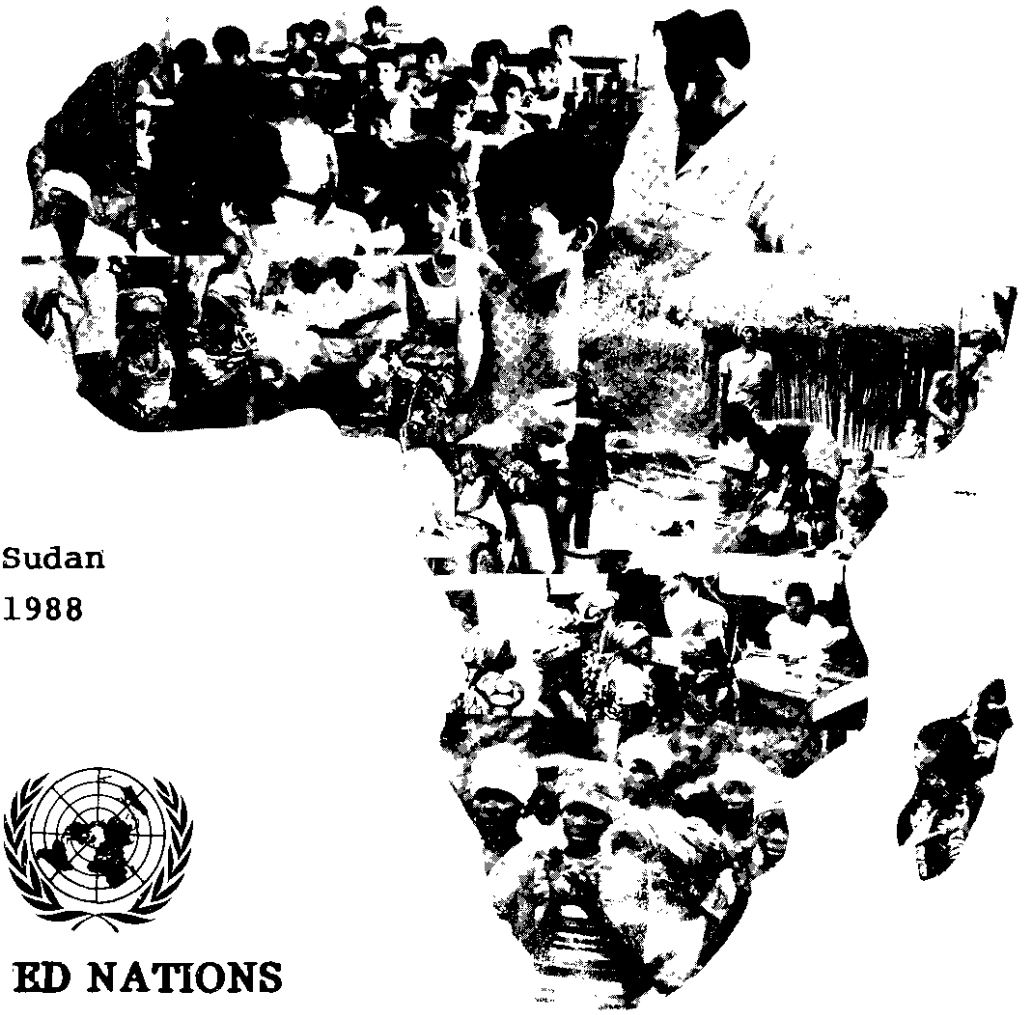

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UNITED NATIONS ECONOMIC COMMISSION FOR AFRICA, ADDIS ABABA, ETHIOPIA

EXECUTIVE SUMMARY

This paper addresses the problems arising from economic adjustment measures which nearly all countries in the region are having to make, in response to internal or external economic pressures. They stem from the fact that domestic production, especially of food and other primary products, is often declining due to drought, instability and other factors, while world prices and demand for most of these products are either stagnating or declining.

A major premise of the paper is that without "health for all", real development is not achieved, and ill health is a serious obstacle to socio-economic development at all levels from the individual to the national. It is considered that better nutrition has a major impact on people's overall health and well-being. Nutrition programmes which are carefully designed and implemented within a broader comprehensive programme for health and nutrition can, in the end, contribute to achieving long-lasting development objectives. Food aid can contribute effectively to such programmes.

The effects of structural adjustment on health include declining government expenditure for health (this is particularly true in the African region), consequent decline in quality of and access to health services, resurgence of endemic and epidemic diseases. This is aggravated by the outflow of skilled health manpower, unemployment, poor work output because of hunger, and malnutrition due to low availability and high prices of food, especially for periurban populations.

There is a need for close monitoring of the adequacy of health service, especially in remote areas, and of the health and nutritional state of the most vulnerable periurban populations. Low-cost methodologies for such monitoring need to be worked out. Also there is a need for more rational and economical use of limited resources.

Member States of WHO have all adopted national strategies for health for all by the year 2000. In that context, current efforts are concentrated, by universal consensus, on district-focus health development characterized by improved management (intersectoral planning, implementation, monitoring and evaluation) by district development committees. Other members of the United Nations family are also adopting this decentralized approach to district development. Intensified and concerted international support for this approach is called for.

Food aid is an important resource which can assist countries undergoing structural and sector adjustment, especially in the field of health and nutrition. The usual types of food aid are discussed, and those bearing on health deserve to be intensified in this context. In addition, the paper makes an appeal for consideration of a new dimension of food aid, as a support for health-sector reform characterized by district-level development. Food aid inputs could be deployed as a major support for intensified district health programme development.

Although its role can be significant, food aid is only a part of measures envisaged to soften the effects of structural adjustment. Examples are given of other measures such as better use of available resources, concentration on essential drugs, use of low-cost technologies and the importance of more systematic search for external resources in support of district health development is stressed.

WHO is already actively collaborating with member States, and with the World Food Programme along the above lines. There is need for a more intensive monitoring of the health and nutritional effects of structural adjustment, particularly on vulnerable groups and implementation of measures to alleviate them particularly at the district level.

A. INTRODUCTION

1. This paper deals with the inter-relationships between:

(a) Structural adjustment processes at the national level (mainly economic measures designed for instance to increase exports, decrease imports and/or attract foreign exchange, reduce public spending and increase state earnings). These may be changes which are adopted voluntarily by countries as a measure of economic survival, or agreed to with an external agency as a condition for extending loans;

(b) Effects of such measures on the health situation and programmes in the country;

(c) The potential role of food aid in support of health and nutrition in such circumstances of structural adjustment;

(d) Other ways of alleviating the health problems associated with structural adjustment measures.

The five main areas of policy that form part of conventional or orthodox adjustment packages are monetary, fiscal-exchange rate, foreign trade and wage-price policy. If concern for nutrition and basic needs is to be part of the adjustment process (which it should be) adjustment policy will need a sixth instrument, focused on nutrition and basic needs and/or on maintaining the incomes and productivity of the poor.

Overview of current economic problems in Africa

2. About 24 countries of the African region are in the United Nations list of "least developed" and FAO's list of "food-deficit, low-income" countries. Most of these are severely affected by drought. Of the rest, seven are significantly dependent on oil production and as such are also currently suffering from serious contraction of their economies. Many others depend heavily for export earnings and foreign exchange on mineral exports which have also mostly declined in value (iron, copper, phosphate, uranium, etc.). The remainder have suffered from decline in the world prices of their primary products like cotton, rubber, groundnuts, palm oil, coconut oil, sisal, coffee, cocoa. The result is that almost all countries have substantial foreign debts and the servicing of these debts consumes a large part of domestic earnings. Finally, several countries are engaged in protracted civil strife or internal warfare at a level which negates any possibility of progress or even stability. Consequently we are in the grips of a continent-wide recession which spares practically no country. While some factors are exogenous, it is also recognized that in most countries their effects are aggravated by economic and socio-political mismanagement - in some cases misguided macro-economic policies and widespread inefficiency. In the marginal conditions prevailing in Africa today, new constraints like drought or drastic changes on world markets, can have catastrophic effects on these economies at national, district and household level.

3. This paper is built on the premise, elaborated more extensively in another paper (2), that without "health for all", true development will elude us. We may have economic and agricultural success but if the health of each family member is fragile, we cannot claim that adequate welfare has been attained. Moreover, poor health negates the attainment of family welfare and therefore of national development goals. A healthy labour force is a necessary condition for sustained socio-economic development.

4. Let us examine for a moment what happens when a family rural housewife falls sick:

(a) She cannot till the fields, so the harvest later on will be reduced;

(b) Her strength will be insufficient to feed the family well - if at all; other persons may however be available (because of widespread unemployment) to fulfil that function;

(c) Something is likely to have to be spent for pharmaceuticals, and probably a journey to the nearest town to get it paid for; and/or a clinic fee paid;

(d) Other family members (especially children) may fall sick if it is a case of infection (e.g., diarrhoea).

In short, poor health is a serious economic and social burden for any family, and the same goes for the village, the district and the nation.

5. There is a need therefore to strengthen preventive and promotive health action at all levels. WHO member States have all adopted national strategies for primary health care and "health for all by the year 2000" (HFA/2000) and recently it was decided to focus WHO's support to primary health care at local level, i.e., in the districts, and the communities of which make up the districts. This approach to attain HFA/2000 through district-level support is outlined in a document (3) which has been unanimously adopted by member States and is serving as a guideline for accelerated efforts for health, not only within the health sector itself, but also involving other sectors whose contribution is essential such as agriculture, education, information, local government, etc. This approach has also been widely appreciated by UNDP, the United Nations Economic Commission for Africa, and the Organization of African Unity.

B. HEALTH EFFECTS OF STRUCTURAL READJUSTMENT MEASURES

6. Although the evidence is incomplete, the following may be cited as examples of health effects associated with structural adjustment measures (keeping in mind that it cannot be deduced that they are directly caused by them):

(a) Declining government revenue requires governments to reduce health expenditures. Analyses have shown that in the African continent (as distinct from other regions), when governments have been obliged to make economies, the health sector has been the first to suffer - in more than half the cases.

Under such constraints, the first economies are made in the provision of equipment and supplies (especially pharmaceuticals), and in maintenance. Nearly all countries are experiencing severe decline in the quality of the health infrastructures (both hospitals and clinics) because of these constraints. Supplies of pharmaceuticals are drastically limited or totally cut off. Sometimes a system of fee-for-service or fee-for-drugs is introduced. In the face of such serious difficulties, employment of personnel tends to be maintained, but they often find their way to the towns, leaving peripheral posts unmanned. Not all these changes are necessarily harmful. More stringent financial control, adoption of limited lists of "essential drugs" and cost-sharing with consumers, and sometimes improved distribution of resources in favour of rural areas are some of the potential gains. For instance, in spite of drought and economic recession in 1980-1982, Zimbabwe managed to increase greatly the proportion of its health budget allocated to primary health care;

(b) Restriction of certain services, e.g., mobile (MCH) services have had to be radically curtailed or abandoned, resulting in reduced coverage of rural areas in many countries. They have not been adequately replaced by equivalent village-based activities;

(c) Breakdown of certain disease-control services: Due to lack of resources there has sometimes been contraction of control measures such as for trypanosomiasis and schistosomiasis. Even priority measures such as immunization for children have sometimes been severely restricted because of financial constraints, and malaria control is severely hampered by lack of funds for both treatment and prevention;

(d) Impaired nutrition: Structural adjustment has often been associated with increased food prices and reduced food availability. In some cases, this is worsened by natural causes like drought. Sometimes the removal of subsidies on food, especially staple foods, has been part of the adjustment measures. Such changes may be beneficial to farmers but do cause hardship to low-income periurban households. The discontinuation of subsidized food or food ratios for government employees can bring serious consequences (such as malnutrition) to their children, as well as low output because of chronic hunger. The low-income periurban households are in fact believed to be the most hard hit by such structural adjustment measures;

(e) Health manpower: Because of inadequate remuneration, there is a catastrophic outflow of all levels of health manpower, and also a demoralization or at least some inertia of remaining personnel because of the necessity to struggle for other ways to survive in view of a hopelessly inadequate salary.

Adjustments at household level

7. Experience has shown that in spite of all these formidable adverse tendencies, families often succeed in adjusting, e.g. by:

(a) Farming (by urban dwellers) in surrounding rural areas during weekends;

(b) Increased petty-trading, especially by women;

(c) Participating in supplementary feeding programmes.

There is in fact little hard evidence to show, for instance, that children of periurban households had more decline in their nutritional state than their rural counterparts. In fact, the data available tend to show that changes were associated more with drought (e g., in the far north of Ghana) than with economic fluctuations. On the other hand, in Botswana and Zimbabwe, in spite of several years of severe drought affecting a large part of the country, community-based supplementary feeding programmes were well organized and there were no clear increases in malnutrition rates. But as the drought becomes prolonged, negative effects inevitably appear.

8. From the above analysis two principal conclusions are drawn:

(a) In the face of continuing adverse factors - environmental, agricultural, and socio-economic - there is a need for closer monitoring of the situation particularly as regards:

(i) Adequacy of health services especially in remote rural areas (since these are usually the earliest to suffer);

(ii) Changes in nutritional state, especially in periurban areas, and comparison with rural areas;

(iii) The adequacy and effectiveness of community-based systems for combatting malnutrition including supplementary feeding programmes supported by internal resources or food aid;

(b) Better deployment of existing resources and search for additional ones are both necessary and urgent to forestall or minimize adverse consequences. This problem is crucial, since health service are almost universally undergoing cutbacks.

C. APPROACHES TO HEALTH PROTECTION AND PROMOTION

9. In such a situation, the general policies have already been defined by most member States in the form of "National strategies for HFA/2000". A regional strategy for HFA has also been defined by WHO, and current approaches to it have already been mentioned (2, 3).

10. The approach emphasizes the need to establish at the "local level" (the district) a health subcommittee of the district development committee, chaired by the district commissioner (or equivalent), and a district health management cycle (planning, implementation, monitoring/evaluation) in support of community health activities in villages, communes, locations, suburbs, etc., that make up a district. At the same time, the system would provide information to intermediate and central levels and would require technical and strategic (respectively) from those levels. Community involvement, intersectoral collaboration and appropriate technologies are the essential features of

this primary health care system. Principally, WHO is endeavouring to face this challenge by mobilizing resources for support to district health development, through its own programmes and by appealing to the international community: sister United Nations agencies (like UNDP, UNICEF, UNFPA, UNECA) and bilateral agencies. The sad fact is that in spite of tremendous efforts to date, the resources are pitifully small. Almost all agencies are faced with declining resources and escalating costs. What is heartening, however, is that many of the United Nations family agencies are following the call for a district-development focus in their inputs, and the need for intersectoral action at all levels (national, intermediate and local) is agreed by all. What remains is to work out international partnership mechanisms so that we may give more effective joint interagency support, to such intersectoral action.

D. FOOD AID, HEALTH AND NUTRITION IN ADJUSTMENT PROGRAMMES

11. As more and more developing countries (especially in Africa) move to adjust their economies to current internal and international circumstances, concern has inevitably grown that food aid - a significant external resource in many developing countries - should also be used more purposefully on a larger scale, to support the adjustment process. This concern becomes even more heightened by the deteriorating health and nutritional status of vulnerable groups which is very often associated with periods of recession and adjustment.

12. The nutritional situation, bad enough in 1980, has significantly deteriorated in subsequent years in very many countries of Africa and Latin America. The clearest indicators are often sustained declines in real per capita income and substantial cutbacks in health and education expenditures. When government resources are reduced, provision of basic services and maintenance of infrastructure are cut back. They are usually cut back from the periphery. When health services face resource crisis, rural health posts and clinics are usually hit first and large central reference hospitals last.

13. One major purpose of this paper is to examine more closely the role of food aid in the adjustment process especially as it impinges on the health sector. Four main types of food aid in structural and sector adjustment have been identified:

Type I	:	General support
Type II	:	Sector reform
Type III	:	Specific development investments
Type IV	:	Compensatory measures

(a) Type I: General support

14. Food aid as a general support for adjustment most commonly takes the form of programme aid in which the food is provided to a government, all of which is then sold or monetized in the country concerned, and the proceeds from the sale are made available to the national treasury. This form of food aid generally provides substantial balance-of-payments savings, as it releases foreign exchange that would otherwise have been used to import food

commercially. Normally it would be part of a total agreement in which the foreign assistance package would be provided conditional upon undertaking agreed, specific adjustment measures. In this form, the food aid provides support through foreign exchange savings and through budgetary income.

(b) Type II: Sector reform

15. A second role for food aid in support of policy reform and economic adjustment programmes is its use within a particular sector or sectors. In these cases, food aid is directly tied to reform measures within a particular sector, may involve partial or full monetization of the food, and often involves a commitment extending over a relatively long period of adjustment measures, such as five years. In most cases, agriculture has been the focus of such sector adjustment schemes although this emphasis need not be exclusive of all other sectors. In fact, food aid used in this manner could contribute effectively in a health sector reform programme by providing the classical nutrition support to health institutions, by aiding in a general shift of resources to locally oriented community-based health programmes and activities through the generation of funds from food sales and by supporting long-term reforms in health policy with reinforcing budgetary resources.

(c) Type III: Specific development investments

16. Food aid has been deployed in support of a wide range of investment activities which, in the context of adjustment, can become especially effective. Examples include:

(a) Labour-intensive food-for-work schemes;

(b) Agricultural settlement schemes;

(c) Training programmes for the enhancement of skills to increase labour productivity and versatility;

(d) Assistance to women in development;

(e) Investments that address the problems of the urban poor through support for activities that contribute, for example, to urban employment;

(f) Support for agricultural research, credit and extension programmes.

(d) Type IV: Compensatory measures

17. Adjustment, by virtue of the wide-ranging retrenchment it often dictates, inevitably produces "losers". Where the poor are the losers, the ensuing combination of high food prices, widespread shortages (sometimes aggravated by drought), malnutrition and seriously deficient health services makes the margin between life and death precariously thinner. In order to arrest the decline in the health and nutritional status of the poor, some form of targeted compensatory programme may be feasible. Such programmes may consist of compensatory employment or nutrition-oriented schemes. Food aid has a special comparative advantage in supporting such programmes. However, it is worth noting that such schemes are best conducted in countries that have a sound administrative structure and can use ongoing food-aided projects as vehicles to expand outreach to those requiring compensation.

18. Two groups that tend to be hurt by adjustment measures and that may be appropriate beneficiaries of compensatory programmes supported by food aid are those who lose their jobs and those who cannot afford price increases in basic food commodities. For each of these two groups, the most appropriate compensatory measures would be to provide income-earning, productive employment, whether in urban or rural areas. In the short run, however, it may be necessary in some cases to provide food directly to those most adversely affected by the adjustment process.

19. Both WHO and WFP recognize that there is wide scope (under the four types outlined above) for the use of food aid in support of health sector rehabilitation and development during periods of adjustment. Regrettably, up to now, efforts to harness food aid in support of health development have not been as extensive and effective as they could be. Resources have traditionally been concentrated on the classical types of food-aided health projects such as institution feeding and the support to health infrastructure construction. Other issues which open up broader avenues for co-operation would include the monitoring of health hazards in other development projects. It is known, for example, that irrigation projects can increase the risk of such parasitic diseases as schistosomiasis and malaria if adequate precautionary measures are not taken. WHO and WFP have, in many cases, collaborated in addressing such issues. At the moment, 99 ongoing projects of various kinds in the African region are being jointly assisted by both agencies. There are broadly four kinds of such projects with a health dimension or components. These are:

(a) Support for rural water and sanitation works at village level, in the context of rural development programmes: i.e., food-for-work for community development;

(b) Vulnerable group feeding projects mainly targeted at mothers and children;

(c) Institutional feeding including hospitals; health training institutions; secondary, vocational and primary schools;

(d) Emergency relief, especially during drought.

20. Classical food-aided health activities of this sort certainly merit more attention especially when budgetary retrenchment puts pressure on health services and facilities as countries undergo adjustment. But, in addition to these, greater attention needs to be paid to the potential for using food aid in support of health sector reform along the lines described under Type II above (para. 15). Reform in favour of greater allocation to rural areas of health resources would be a key component of such programmes and would complement the initiatives taken by countries and WHO to implement district-focus health development activities. Sub-components of such sector reform programmes which could receive food aid either directly or indirectly through monetization would include:

(a) Training programmes for district health and other personnel on the concept of health-for-all and the modalities of intersectoral action for health at district level;

(b) Training programmes for village leaders and development committees, village health workers, traditional birth attendants and healers, water-pump maintainers, etc.;

(c) Support for labour-intensive activities such as village health post construction and, especially, improvement of community water supplies (protection of springs; hand-dug wells, cisterns, etc.) and sanitation (community, school and household latrines; markets).

21. Activities listed in category (c) above usually require considerable inputs in terms of supplies and sometimes equipment, e.g., cement and pumps for shallow wells. These components may be expensive and beyond the means of village communities. However, other donors are sometimes able to support such costs. There are many overall costs in developing an effective district health programme (e.g., baseline health situation analysis; costs of supervisory visits, and monitoring/evaluation, as well as initial training in health planning and management as applied to PHC at district level).

22. In addition to direct distribution to beneficiaries, an appropriate degree of monetization could be introduced in such projects to generate cash resources for meeting at least some of these costs. Most countries have already selected a number of districts for intensified district health activity. This process can be further bolstered if governments gave serious consideration to developing comprehensive sector reform programmes (eventually covering all districts) which could be supported with external assistance. In addition, it would be more advantageous if the district-focus health development programmes, now undergoing intensification, could be launched in those districts where WFP and other agencies are already providing substantial assistance and more general support to rural development. In such cases, the health project(s) could constitute a component within a broader multipurpose programme. Guidance along these lines has already been provided to WHO country representatives in the region for further discussion with government and WFP.

E. OTHER MEASURES FOR ALLEVIATING THE HEALTH AND NUTRITIONAL EFFECTS OF ADJUSTMENT

23. While food aid provides enormous opportunities for both mitigating the effects of adjustment and promoting long-term recovery, it does not in any way provide a total solution. In fact, food aid activities are most successful when they are combined with other reinforcing technical, financial, managerial and policy measures. Governments are already taking some far-reaching steps to adopt policies and implement programmes designed to mitigate the effects of adjustment and to promote the achievement of its objectives. Among them:

(a) Policies favouring a more rational use of resources, less expenditure for high-cost facilities and equipment and more for basic essentials in health services;

(b) More vigilant and imaginative financial management;

(c) Concentration on essential drugs (by adopting a national list of essential drugs) so as to keep drug expenditures to minimum adequate levels; and improvement of systems of procurement and distribution;

(d) Fee for services, drugs, etc.;

(e) Search for low-cost technologies and cost-recovering approaches wherever feasible;

(f) Strengthening the health awareness and role in health development of provincial, district and village development committees;

(g) More systematic search for external resources, particularly in support of such district-level programmes.

F. CONCLUSION

24. Most African countries are facing economic crisis and may have adopted economic recovery programmes including vigorous adjustment measures. The experience so far indicates that in the general atmosphere of cutbacks on public expenditure dictated by economic adjustment, health budgets are often seriously affected. This obviously carries major implications for the quality and delivery capacity of existing health services already stretched to extreme fragility by long-term inadequacy of resources and manpower as well as the over-concentration of resources on larger overly sophisticated urban hospital facilities.

25. Health impairment is in itself a negation of one of the primary goals of national development. To waste much of Africa's basic economic factors of production - the work of its women and men - by allowing them to remain locked in vulnerability to disease, hunger and poverty is not just a human and social failure; it also spells gross economic inefficiency. The human condition of individual people, of families, of communities and of societies is the only ultimate objective, justification and validation of development. To regard nutrition, health services and education as the fruits of development to be deferred until high production and growth is achieved is self-defeating. Only the well-nourished, healthy and literate can consistently and increasingly be efficient and productive workers.

26. With effective design and management, food aid projects and programmes can bring real benefits to the poor - especially the vulnerable groups negatively affected by structural adjustment programmes. In addition to avoiding disincentive effects by building on the income transfer potential of food aid and participatory planning of projects, there is scope for using food aid directly and constructively to provide incentives for desirable economic and social action. In the health sector, attention should increasingly turn to the provision of manageable rural health facilities. In addition, food aid projects should be tailored towards new initiatives such as support for health policy reform and for accelerated programmes in immunization in rural areas. There is a need to broaden the basis of raising incomes of the poor from the simple and traditional 'only nutrition' (food) input into more comprehensive 'health entitlement' and 'improved living environment' approaches.

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