Banking on Disaster

African nations are slashing budgets and shrinking health care. The World Bank and the IMF call it streamlining. Critics say it's killing PWAs.

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Aseffa Okoso was a strong, imposing man with a hearty laugh and a gentleness that defied his stature.

He lived in a small city in Ghana, a West African country hard-hit by AIDS. Okoso had a wife, five children and many friends with whom he shared his repertoire of jokes and songs.

For eight years, Okoso worked in an American-owned gold mine. But in 1996, at age 43, he began to waste and was diagnosed with AIDS. At first, he was able to pay for antidiarrhea medicines, but after his illness forced him to leave his job, medical expenses were beyond his means. When Okoso's family had trouble handling the financial burdens of his illness, his friends helped him pay for care. But knowing that they were poor as well, Okoso eventually stopped accepting their assistance.

Three months after leaving the mines, Okoso -- suffering from both chronic diarrhea and tuberculosis -- gave up on health care altogether. Though a clinic was just a few miles away, he chose to stay home. As Okoso said at the time: "We live day to day on what my wife makes selling vegetables in the market or what my sons bring home from selling things on the streets. If I went to the clinic, they would make me pay a new fee, which my family cannot afford." And any prescription he received for meds would be out of his reach as well. Ultimately, Okoso died of TB -- an easily treatable illness -- just seven months after being diagnosed with AIDS.

Okoso's story is typical of the 90 percent of people with HIV worldwide who live in poor countries -- approximately 28 million, the UN estimates. According to Paul Farmer, MD, an author and infectious disease specialist who divides his doctoring between Harvard Medical School and rural Haiti, "In much of Africa, Asia and Latin America, PWAs die far more quickly than do their counterparts in Western Europe and North America, largely because they lack access to effective care." He notes, for example, that most PWAs in poor countries are, like Okoso, killed by TB, a disease that can be treated for as little as $36 per person. Other common killers, such as diarrhea and fungal or parasitic infections, can be treated for just pennies a day.

But for cash-starved governments with rising AIDS caseloads, those pennies add up fast. That's a particular crisis for sub-Saharan Africa, where the UN estimates that 21 million have HIV, about 17

percent of the sexually active population. As Farmer says, “Most PWAs in Africa can’t afford an aspirin -- let alone $12,000-a-year protease cocktails.” World Bank figures show that the average amount spent by African countries on health care is less than $14 per person per year -- compared to $2,763 in the United States.

Yet spending was not always so low. After independence in the 1950s and 1960s, many new African governments set out to redress the inequities created by European colonial rule by providing expanded and free -- or at least low-cost -- health care to their population. By the 1970s, according to the United Nations, such health indicators as life expectancy and infant mortality had begun to improve significantly in those countries.

But by the 1980s, even before the AIDS crisis established a stranglehold on the continent, much of Africa -- including Okoso’s Ghana -- plunged into a severe and still-ongoing economic crisis. Country after country saw worsening rates of poverty, hunger and disease, including HIV infection. Average incomes fell to that of 1960s levels -- a decline of as much as 50 percent in some cities. But rather than expanding health services to meet growing needs, governments began slashing -- in some cases dismantling -- their health care programs.

Many analysts charge that not only these massive health care cuts, but also the escalating poverty, are largely the result of harsh economic austerity measures. Called “structural adjustment programs” (SAPs), they have been imposed on more than 70 developing nations (40 of them African) since the early 1980s by two powerful international financial institutions: The World Bank (WB) and International Monetary Fund (IMF).

The problem dates back to the 1970s, when commercial banks, heady with deposited oil profits, extended substantial loans throughout the developing world. Within a few short years, as interest rates skyrocketed and commodity export prices collapsed, many countries were about to default. So international lending institutions moved in to protect the commercial banks.

The IMF and WB, largely controlled and funded by governments of the United States, Japan and the wealthiest Western European nations, made SAPs the precondition for new loans to poor countries seeking to escape from their crushing debts. SAPs, which parallel the United States’ “government downsizing” policies of recent years, are characterized by lifting worker protections and environmental regulations, devaluing currencies, granting foreign investors tax breaks, ending food subsidies and slashing public spending through layoffs, pay cuts and privatization. Any indebted government refusing to adopt SAP conditions is threatened with being blacklisted for loans by most Western banks and cut off from U.S. foreign aid.

A 1994 WB report explained the rationale: “SAPs are designed to pave the way for long-term development and prosperity by fundamentally restructuring African economies.” The theory holds that by promoting exports (made cheaper by currency devaluation) and reducing “inefficient” government spending, SAPs will help poor countries earn enough foreign exchange to pay back their debts. This economic growth, the argument goes, will eventually trickle down to reduce poverty and improve public services such as health care.

But by all accounts, the human costs of SAPs -- still in effect in almost every nation where the poorest PWAs live -- have been devastating. Reports from government health ministries, private aid organizations, independent academics, the UN and even the WB itself have found that every country adopting SAPs has suffered significant backslides in health and welfare.

In Africa, SAPs have been particularly disastrous for PWAs: Medicines have become prohibitively expensive; basic drugs and equipment are unavailable to most health facilities; hundreds of clinics are closed or grossly understaffed; malnutrition has increased, contributing to rising disease rates; and water-filtration and sanitation budgets have been slashed, prompting a resurgence of such communicable diseases as cholera, hepatitis and typhoid.

The British Medical Journal has reported that in the early years of SAPs, Ghana -- widely touted by the WB as a "success story" -- had to reduce its health budget by 47 percent (the average cut for sub-Saharan Africa from 1980 to 1985 was 26 percent). SAP-inspired civil service layoffs and salary cuts forced many doctors and nurses to moonlight or even emigrate. According to the WB, the number of doctors in Ghana decreased by almost half between 1985 and 1991. Similar medical brain drains continent-wide have crippled patient care.

Those who have stayed behind are crushed in overwork. The story of Demba Djemay, a highly trained nurse in Senegal -- another WB-touted model -- is typical. Although he works in a small hospital near his hometown, he is largely unable to use his skills to care for patients -- many of them PWAs. His hospital lacks the most basic equipment and medicines. Besides Djemay, only one other nurse and a part-time physician serve a region of more than 250,000 people; Djemay sees up to 70 patients a day. "My work is one frustration after another," he laments. "Under these conditions, I simply can't provide my patients the kind of care they urgently need." Many of them must wait for hours, even days, to see him. And once they do, most cannot afford the few available meds.

Besides such direct reductions in health spending, the SAP measure most often blamed for the breakdown in medical systems is the imposition by some 30 African governments of "user fees." One WB report argued that the pre-'80s policy of many African states "to treat [health care] as a right of citizenry and to attempt to provide free services to everyone ... prevents the government health system from collecting revenues that many patients are both able and willing to pay." Another report added, "When a service costs money, people will think twice about demanding it." Aseffa Okoso, the PWA from Ghana, was living proof of that -- until he died. And in country after country, according to Oxfam, a nonprofit development aid organization, user fees led to a 40 to 65 percent decline in attendance at health facilities, including STD clinics.

"The combination of user fees and highly inflationary currency devaluation has meant that people can no longer get the medicines they need," says Mary C. Smith Fawzi, a Harvard epidemiologist conducting AIDS research in Tanzania. "For PWAs, that often means no antifungals or antibacterials, essential for treating opportunistic infections."

Another SAP measure -- privatization of governmental functions -- is further jeopardizing access to

medications. The WB has strongly urged governments to dismantle such programs as centralized purchasing of pharmaceuticals (which allows for bulk discounts) and drug price controls.

Meanwhile, some researchers maintain that SAPs help increase HIV *transmission*. In 1995, Peter Lurie, MD, a research scientist who spent years studying AIDS in developing countries and is now at the University of Michigan, reported (along with two colleagues) in the journal *AIDS* that SAPs, besides reducing medical care, "may have created conditions favoring the spread of HIV infection" by increasing levels of poverty, driving subsistence farmers off their land, and promoting mass migration to urban centers where HIV is widespread. In a letter to *AIDS*, the WB unsuccessfully attempted to dissuade the editor from publishing the paper, which it labeled "nonsense."

Indeed, the WB -- which has taken the lead in defending SAPs -- has often accused critics of falsely connecting its policies with Africa's recent medical crises. In a 1995 publication, WB officials wrote, "It is time to cease lamenting any possible negative impact of SAPs on the health of the poor in Africa." And A. Edward Elmendorf, the WB's health specialist for Africa, argues, "During the adjusting years, health sector spending was reduced in some countries in Africa, but this decrease was due to economic decline, not SAPs." The WB blames that decline on a range of factors, including government mismanagement, corruption, overpopulation, droughts and even the AIDS epidemic itself. Officials insist that the WB never specifically required cuts in medical spending. And WB research associate Martha Ainsworth says her agency has even taken steps to protect local populations: "As part of its adjustment lending, the Bank has often included programs of social assistance for people who otherwise might be hurt in the short run."

In fact, the WB says it helps fight AIDS in Africa, citing $800 million in easy-repayment loans granted since 1986 to 27 sub-Saharan African nations for AIDS-related projects. But the majority of this funding has gone into prevention efforts or research programs. Only recently has the WB begun to address the problem of treating AIDS, granting African countries several small interest-free loans to purchase drugs for STDs and TB. Last December, the WB, a key participant in the UN's AIDS program, helped launch a pilot project offering loans to four poor nations, two of them African, for the purchase of antiretroviral drugs at greatly reduced prices.

"They give with one hand while taking with another," says the University of Michigan's Lurie. "SAPs and growing external debt undermine governments' capacity to care for PWAs, so the World Bank comes back with nominal efforts to prevent the worst effects. It's too little, way too late."

Silvia Federici, an associate professor of political philosophy at Hofstra University, has researched the IMF and WB extensively and challenges the agencies' assertion that they don't exercise power over national health policies. She says, "IMF reps sit on its central bank board, no major economic project can be launched without their approval, and every few months the government must plead with foreign agencies for debt rescheduling or new loans."

The ultimate defense offered by WB officials is that, as one report put it, SAPs "may take five or more years to bear fruit." But the Bank's chief economist for Africa admitted in 1991, "We did not think that the human costs of these programs could be so great, and the economic gains so slow

in coming."

Neither did many elected officials in some lender nations, until recent years. In a 1995 open letter to the WB and IMF, 130 U.S. representatives, 30 U.S. senators and 1,200 parliamentarians from Western countries wrote that SAPs "have too often been associated with lower incomes for the poor and reductions in basic education and health." The letter called for reforms of SAPs -- including protecting health spending and avoiding medical user fees -- as well as increased loans for health and education.

The WB responded by promising to pressure indebted governments to spend more on social programs and to make more loans to support such efforts. Yet WB figures show that a year later, its lending for health and education programs actually *declined* from $4 billion to $2.25 billion.

The core of the problem remains the crushing debt burden, which, ironically, has *increased* in most of these countries, despite SAPs. The WB says that between 1980 and 1995, sub-Saharan Africa's external debt rose from 92 percent to 242 percent of its annual exports. The Africa Policy Information Center recently reported, "Africa now spends four times as much on debt repayment as on health care." No wonder that when President Clinton toured the continent in April, *The New York Times* reported, "The subject of debt relief had been raised by every African leader he had met."

Lurie and his colleagues wrote in their 1995 *AIDS* article, "The charters of the IMF and the World Bank must be altered to permit the cancellation or rescheduling of debt." They also called for the relaxation of strict SAPs. Such sentiments have echoes around the world, most prominently in the form of three grassroots pressure campaigns.

One is coordinated by the African Women's Economic Policy Network, a coalition of women's organizations working "to halt SAPs in Africa," while educating women to demand more equitable economic policies from both their national governments and the IMF and WB.

The second campaign, based in Washington, was launched in 1994 on the half-century anniversary of the two institutions' founding. The 50 Years Is Enough Network, composed of more than 300 religious, social-justice and development organizations worldwide, seeks, as its position paper states, to "reorient [the IMF and WB] to sustainable and participatory practices that alleviate poverty rather than exacerbating it" and to cancel 100 percent of the debt owed those institutions by the most severely indebted poor countries.

A third international coalition, Jubilee 2000, led by hundreds of religious organizations, calls for "cancelling unpayable debts of the world's poorest countries by the year 2000."

Where would the money for this come from? Advocates argue that the banks themselves could certainly afford those write-offs, since most indebted countries have long since repaid their loan principal.

Lobbying, letter-writing and demonstrations by these advocates and others have finally prompted

the WB and IMF to respond. In a plan labeled “good news for the world’s poor” by the WB’s president, the two agencies have proposed to cancel between 67 percent and 80 percent of a country’s debt -- but only if its government is deemed in full compliance with SAPs and other harsh economic directives. Few nations have so far met that test. Even when they do, the plan will take several years to go into effect.

While words like “structural adjustment programs” and “debt relief” are increasingly being heard at AIDS conferences in developing nations, Western AIDS advocates have been slower to catch on. But the issue of inequitable treatment access for the poor reached center stage in several speeches at the 1996 International AIDS Conference in Vancouver. The official slogan of “One World, One Hope” was mocked by a group of angry African delegates who unfurled a banner that read, “What World? What Hope?” At the World AIDS Conference in Geneva this July, the theme is “Bridging the Gap,” implying a readiness to confront the crisis in developing-world AIDS care.

But turning the rhetoric into reality will require tackling the deeper roots of those inequities. Peter Lurie believes that action is needed. “Until steps are taken to alleviate the crushing burden of African debt, lifesaving and life-extending AIDS therapies will remain out of reach for those who need them most.”

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