DISEASE MORTALITY INCREASING

Structural Adjustment Program, Roll Back Malaria and Increasing Disease Mortality

Countries in sub-Saharan Africa began to gain independence from colonial rule in late 1950s, and the majority were fully independent by the end of 1960s.(1)

Guissé reported in 2004 that western institutions imposed a USD59 billion in debt to African countries upon gaining independence, through the International Monetary Fund (IMF), and the World Bank. With a usurious interest rate set at 14%, the debt burden increased rapidly, and by late 1970s, African countries accumulated staggering debts owed to the Western institutions.(2)

Widespread public outcry called for the cancellation of the unfair debt, and the International Monetary Fund/World Bank responded by imposing conditionality for obtaining lower interest rates, or getting new loans packaged in the structural adjustment program.(2,3)

According to the IMF in 2002, the structural adjustment program focused on reducing the fiscal imbalances in an indebted country through privatization, deregulation, devaluation of currency, and cutting social expenditure known as austerity.(4) The effect of structural adjustment was massive scale-down in public spending, privatization of state and parastatal agencies, resulting in massive lay offs, effectively sinking millions into abject poverty.(2)

The introduction of the structural adjustment program in the early 1980s coincided with the emergence of widespread infection by the human immunodeficiency virus, and subsequent devastation by HIV/AIDS, which, left untreated, has a 100% case fatality rate.(5) In the same period, tuberculosis and malaria rapidly resurged.(6) Aggressive campaigns against tuberculosis and malaria occasioned widespread rise of multi-drug resistant variants and spread of the disease to new locations, leading to new strains of bacterium and the parasite colonizing the highlands.(6,7)

Poverty indices increased sharply, and by the end of the 1980s, the number of humans living below the poverty line, set at under a USD1 a day, increased 10 fold.(8) The massive failure of structural adjustment resulted in a shift of emphasis toward poverty reduction in the late 1990s, and in 1999, the International Monetary Fund created poverty reduction strategic papers (PRSPs). The International Monetary Fund and the World Bank required the strategic papers from the country government in order for an indebted country to gain considerations for debt relief within a heavily indebted poor coun-

The relationship between poverty and malaria has long been recognized.... Recent studies suggest that causality works both ways, trapping communities in reinforcing cycles of poverty and disease. If malaria is to be controlled or eventually eliminated, the social and economic conditions that fuel malaria transmission need to be addressed. At the same time, malaria control should be seen as a poverty reduction strategy.

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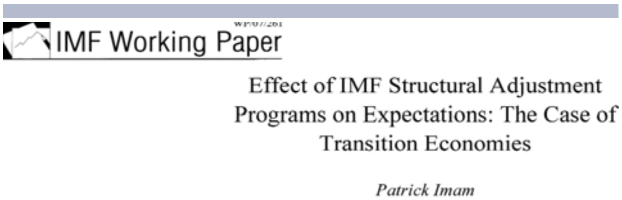
IMF Working Paper

Effect of IMF Structural Adjustment Programs on Expectations: The Case of Transition Economies

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Dr Macharia Waruingi left, at the World Bank; center, meeting with World Bank official and the Director of the North West Chamber of Commerce President; and right, World Bank consultant Mr Melvyn Foote.

DISEASE MORTALITY INCREASING

try program (HIPC).(4)

In spite of these prescriptions, poverty continued to rise, mortality rate increased progressively, and life expectancy at birth progressively diminished.(9) Malaria endemicity rose sharply, and the parasite conquered new geographical zones.(6) Cuts to health spending required by austerity measures opened opportunity for diseases such as the HIV/AIDS to devastate vast economic zones by destroying the workforce.(10)

In 1998, the World Health Organization formed a partnership with the United Nation's Children's Fund (UNICEF), and World Bank to create the Roll Back Malaria program to address the malaria challenge.(11) The goal of Roll Back Malaria was to cause a dramatic turnaround in the malaria epidemic, by cutting down the incidence of malaria by half each 5 years. By 1998, malaria killed on average 350,000 humans each year, but by 2003, the incidence of malaria increased, and mortality due to malaria was estimated at 3 million deaths a year.(12) Although some of this increase was attributable to an increase in the awareness of the disease (because of case finding, case ascertainment, and reporting), the true rise in malaria incidence was remarkable, and the disease reportedly has occurred in distinctively new geographical locations, complicated by emergence of multi-drug resistance strains of the parasite.(6)

In 2000, the United Nations convened an expert group to address the rising poverty, and mortality in the developing world.(13) The expert group released a brand new prescription known as the millennium development goals (MDGs), aimed at reducing incidence of poverty and death by half for every 5 years until 2015.(13) Neither poverty, nor mortality rates decreased: by 2005, poverty and mortality due to malaria, tuberculosis, and the HIV/AIDS increased 10 fold in some regions.(8)

If the World Bank would like to improve its success rate with adjustment lending, then it must become more selective and do a better job of understanding what are promising environments for reform and what are not. This change is likely to lead to fewer adjustment loans unless there is a significant exogenous change in the number of promising reformers. To become more effective at supporting policy reform the agency would have to be willing to accept that this may lead to smaller volumes of lending.

From David Dollar, Jakob Svensson, Macroeconomics and Growth Group, The World Bank in What Explains the Success or Failure of Structural Adjustment Programs? April 1998.

The structural adjustment program, poverty reduction strategic papers, Roll Back Malaria, and millennium development goals, responded to explicit knowledge of human health and development in sub-Saharan Africa.(14) The orientation to capture the explicit knowledge obviates the need to include all stakeholders of global health and human development in formulation of solutions. Since explicit knowledge is easily identifiable, and coded, the orientation towards the explicit evoked the emergence of 2 types of stakeholders of global health and human development: The salient, and the fringe stakeholders.(15)

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