THE IMPACT OF ADJUSTMENT ON THE HEALTH STATUS IN SUB-SAHARAN AFRICA (SSA): A CASE STUDY OF KENYA {1980-2000}

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DECLARATION

This project is my original work and has not been submitted for a degree in any other university.

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DEDICATION

TO MY LOVING HUSBAND **RICHARD TIRIMBA**, MY SON **VINCENT TIRIMBA** AND MY PARENTS **RUTH ONDIEKI** AND **ANDREW ONDIEKI** FOR THEIR UNFAILING ENCOURAGEMENT.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunity Deficiency Syndrome
BOP	Balance of Payments
CA	Communal Area {Tribal Trust Land}
DALYs	Disability Adjustment Life Years
DHMBs	District Health Management Boards
DHMTs	District Health Management Teams
DPT	Diphtheria
ECA	Economic Commission of Africa
EDL	Essential Drugs List
ENHR	Essential National Health Research
ESAPs	Economic Structural Adjustment Programmes
GATT	General Agreement of Tariffs and Trade
GNP	Gross National Product
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
HMBs	Hospital Management Boards
IMF	International Monetary Fund
IMR	Infant Mortality Rate
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
KEPI	Kenya Expanded Programme on Immunization
KM	Kilometers
KShs	Kenya Shillings
MOH	Ministry of Health
MUN	Municipal
NACP	National Health Control Programme
NGOs	Non-Governmental Organizations
NHIC	National Hospital Insurance Corporation
NHIF	National Hospital Insurance Fund
NHRDC	National Health Research Development Center
NICs	Newly Industrialized Countries
OAU	Organization of African Unity
OHSS	Occupational Health and Safety Services
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PRV	Private
PSRI	Population Studies Research Institute
PTPP	Part Time Private Practice
SAPs	Structural Adjustment Programmes
SSA	Sub-Saharan Africa
SSCFA	Small Scale Commercial Farming Area {A Native Purchase Area}
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
TBAs	Traditional Birth Attendants
U5MR	Under Five Mortality Rate
UN	United Nations
UNDP	United Nations Development Program
UNICEF	United Nations Children Education Fund
US$	United States Dollars
WHO	World Health Organization

ABSTRACT

Since the introduction of the Structural Adjustment Programmes in Africa, there has been a raging debate on their expected outcome. There has been varying analytical reports on their impact on various sectors of the economy. Their main aim was to lead African economies from crisis to sustainable growth. Some observers have regarded SAPs as a stepping-stone to development while others have seen them as a failed policy approach to the already downcast economies of Africa. This study is yet another contribution to the SAPs debate. It attempts to shed some light on the health situation in Africa and Kenya in particular, with regard to implementation of structural adjustment programmes

The main objective of this study was to establish the impact of Adjustment on the Kenya health sector. Many people blame the health related structural adjustment policies on the poor health status of Kenyans of all walks of life especially the poor.

In Kenya the contention is that even though the Government tried to formulate and implement policies to solve the health problems their implementation was poor. There was inadequate institutional capacity to implement the policies to their full extent resulting to negative impacts. Adjustment policies though well intended, led to marginalization of the vulnerable sections of the population. This is not however, to say all SAPs policies were wrong. Some positive aspects arose from these policies. In general to create a healthy population a nation needs to create an enabling environment right from the structure in place in order to expect the policies to work.

CHAPTER I

1.1 INTRODUCTION

Sub-Saharan Africa is a region of great diversity. There is nonetheless considerable homogeneity within the region. The continent has both open and specialized economies that depend on the exploitation of primary products for their foreign exchange and economic survival. The African economy is predominantly subsistence. The non-subsistence sector is also characterized by the predominance of commercial and trading activities based mainly on imports and exports with domestic production playing a secondary role. The production base in Africa is narrow, both in terms of size and in relation to the range of goods produced and it is also characterized by weak intersectoral linkages.

The other important features of the structure of the African economy include the neglected informal sector, a degraded environment, and lopsided development due to the urban bias of public policies generally and development policies in particular. On the other hand there is the fragmentation of the economy, high index of openness and excessive dependence of the economies including dependence on external factor inputs and weak institutional capacities.

The structure of the African economy defines the essential features of Africa's central problem of underdevelopment. The major problems of mass poverty, food shortage, low productivity, weak production base and backward technology that plague Africa are basic bottlenecks that arise from the structures of production, consumption, technology, employment and social-political organization. As Africa's submission to the special

session of the United Nations General Assembly summed it, the fundamental problem of Africa is that of

> *"A vicious interaction between excruciating poverty and abysmally low levels of productivity in an environment characterized by serious deficiencies in basic and social infrastructure, most especially the physical capital, research capabilities, technological know-how and human resource development that are indispensable to an integrated and dynamic economy" (ECA/OAU, 1980:4).*

In the 1970's African countries experienced a serious development crisis, which became aggravated throughout the 1980's. The crisis soon assumed economic, social, political, health, and environmental dimensions. This crisis arose basically from the structural deficiencies of the African economies. It was nevertheless perceived in terms of external and internal financial imbalances; deteriorating terms of trade, increasing balance of payment deficits, and depletion of external reserves. The crisis provoked international attention, especially from donors and international financial institutions.

Kenya entered the 1970s with a relatively strong economy, exemplifying the impressive macroeconomic performance of the 1960s. This was reflected in the high growth of overall and sectoral Gross Domestic Product (GDP), averaging at more than 5% per annum; balance of payments (BOP) surpluses and a minimal external debt burden; and price stability with the inflation rate averaging less than 4% per annum. The macro-economic performance record of the Kenyan economy during the 1960-1980 period was attributed to several factors including high savings and investment ratios, expansion of smallholder production of cash crops, and a favorable external environment (Gesami, 2000:16).

The country's health sector recorded a tremendous growth especially in its public sub-sector. By 1980 the crude death rate was 12 per 1000 people as compared with 20 per 1000 in 1965. The doctor's population ratio decreased from 1 per 13,450 patients in 1965 to 1 per 7,540 patients in 1980, and life expectancy increased from 40 years in 1965 to 60 years in 1980 (Institute of economic affairs, 1994: 257). This growth was attributed to the high priority accorded to the improvement of the health status of Kenyans in the socioeconomic development of the country. The priority was reflected in the level and growth of resource commitments to health. During these decades, the sector accounted for 5% of GDP, and, on average, about 5% of total central government expenditure and 6% of the government's total recurrent vote. However, the sector was not able to expand as rapidly as the population to ensure adequate coverage, accessibility and acceptable quality of health care for all. This situation was worsened by inadequate finance for health care, inefficient utilization of existing resources, emergence of new diseases and by a rapidly growing demand for modern health care (Gesami, 2000:10). These constraints led to increased pressure to institute remedial measures especially in the form of structural adjustment programmes (SAPs).

The concept of structural adjustment took root, especially after the publication of a World Bank paper entitled " *Accelerated Development in Sub-Saharan Africa: An Agenda for Action"* (popularly known as the Berg Report) (World Bank, 1994). The paper proposed stabilization programmes meant to reverse Africa's economic trend. Kenya was one of the first SSA countries to sign a structural agreement with the World Bank in 1980, but SAPs were adopted in 1986 through Sessional Paper No 1 on *"Economic Management for Renewed Growth."*

1.2 STATEMENT OF THE PROBLEM

Historical and contemporary experiences have shown that there is a definite but complex relationship between economic growth and health status. Apart from being educated and becoming experts in their field of work, a productive population is one that is healthy, in terms of being free from disease and being well kept in terms of food security. Kenya continues to have problems with providing good health care for all, despite the fact that many intervention measures have been implemented.

The impact of SAPs on the Kenyan health situation is still an issue that the Kenyans have to grapple with. A key element brought about by the implementation of SAPs, as a management strategy, is budgetary austerity. While initially, the austerity only affected the economic sectors, it was later extended to cover social sectors including healthcare. This budgetary austerity brought about a shift away from the hitherto general tax revenue and donor-based financing of recurrent and development healthcare expenditures, to one based on greater sectoral recovery of costs via 'user fees'. The cost sharing policies affect individual utilization of health services because price is one of the determinants in the utilization of health facilities.

Structural Adjustment, as advocated by the international financial institutions, seeks to restore growth and stability by recasting relative prices, domestic expenditures and through the reduction of the role of the state in the economy. From the beginning these reforms seemed to lack a clear design. As a result, they have faced a myriad of challenges. Such challenges feature in this study as it attempts to investigate the effects of SAPs on the Kenya health sector. As its research problem, the study seeks to answer

the question: To what extent have SAPs policies improved or impaired the health status of Kenya as an adjusting country?

1.3 OBJECTIVES OF THE STUDY

Broadly, this study aims at investigating the pitfalls and opportunities brought about by the implementation of health related Structural Adjustment Programmes in Sub-Saharan Africa taking Kenya as a case study. It also hopes to propose measures that can inform the policy making process in Kenya's health sector.

The specific objectives of this study include:

a) To determine the impact of SAPs on Kenya's health sector.

b) To establish the accessibility level to health facilities before and after SAPs.

c) To suggest alternative intervention measures that can be utilized by policy makers.

1.4 JUSTIFICATION OF THE STUDY

There is a premise that without 'health for all'; true development will elude us. We may have economic and agricultural success but if the health of the citizens is endangered we cannot claim adequate provision of basic needs. Moreover, poor health negates the attainment of family welfare and therefore of national development goals. A healthy labor force is a necessary condition for sustained socioeconomic development. Good health is both a basic right and a prerequisite for rapid economic development. It is in view of this fact that governments often invest heavily both in health care delivery and the expansion of health infrastructure. The findings of this study are expected to inform policy makers in the formulation of policies that can facilitate the attainment of good health as a basic need.

The economic justification for investment in health rests on the fact that health programmes are to some extent public goods, especially programmes for controlling or eradicating communicable diseases. At the same time the public would under-consume these services if they were provided in the market only. Access to preventive, promotive and curative health services, in this way, access to adequate and quality healthcare services is considered as one of the fundamental rights of every individual. It is in view of these observations that this study hopes to shed light into the effects brought about by the introduction of cost sharing in the Kenya health sector.

There has been a raging debate on the impact of user fees. With a wide range of diverse views, many people have failed to understand the effects and dynamics of the programme. This study hopes to reduce the confusion by providing clear information to the public. This study also hopes to serve as a reference in matters pertaining to the Kenya health sector reforms and policies.

Though many scholars have researched and written on these controversial reforms, many have not given adequate emphasis on a local point of view. At the same time, a more specific sectoral-based study would elaborate things further. Above all, the study hopes to fill the existing literature gap and add to the existing knowledge in the subject area.

1.5 LITERATURE REVIEW.

The literature review in this study is organized under two sub-headings

1) The concept of Structural Adjustment Programmes (SAPs).
2) The links between Structural Adjustment and Health.

1.5.1 The Concept of Structural Adjustment Programmes (SAPs)

A review of recent studies on Africa's development reveals two major findings that prompted interesting policy and theoretical research questions for the 1990s. First, some of these studies unanimously affirmed that Sub-Saharan Africa (SSA) was undergoing a deep development crisis (Commins, 1988; Cheru, 1989; Nyang'oro and Shaw, 1992; Falola and Ityavyar, 1992; Blomstorm and Lundahl, 1993). These studies further show that although the situation in SSA had been deteriorating for a long time, it became worse in the 1980s and chronic, in the 1990s. The crisis has with time, assumed several dimensions, manifested in the economic, social, political, health, and environmental situations of African societies.

Proponents of SAPs ascribe a significant part of Africa's economic crisis to over-intervention of the state in the economy mainly through direct ownership of assets and the protection of the local market from external competition (Logan and Mengisteah, 1995:2). These are also the sentiments of Wanyande who observes that:

> " *Led by the World Bank and the international Monetary Fund (IMF), the international donor community initially attributed the social and economic decay to the faulty domestic economic policies pursued by post colonial African governments. These policies were characterized by excessive government control and regulation of the economy including administrative determination of interest rates, foreign exchange regimes, price control and the establishment of public enterprises, many of which were not only unnecessary but were also not viable" (Purnac and Raj, 2001:1).*

In response to the African economic crisis (which has exacerbated the continent's under-developed situation), the Structural Adjustment Programmes were introduced in Africa in the late 1980s, (Mbatia, 1996:6).

Various researchers and authors have defined the concept of SAPs differently. According to Walton and Ragin SAPs are austerity policies designed and mandated by the international financial institutions (such as the World Bank and the International Monetary Fund), to restore the economic viability and ensure debt repayment (Walton and Ragin, 1990:155).

According to Gibbon, structural adjustment programmes are economic reforms aimed at stabilizing developing countries' external and internal balances and promoting their export growth by devaluation, producer price changes, trade liberalization, privatization and supporting legal reforms (Gibbon, 1993:11).

Lewis argues that the major components of SAPs are state focused and entail, imposition of states financial discipline through, reduction of state intervention, decontrol of prices, exchange rates and interest rates, devaluation, and promotion of exports (Lewis, 1994:48)

Odada and Ayako (1989) define the concept as macroeconomic responses that are primarily economic in nature, aimed at correcting certain economic imbalances. They describe SAPs as medium term measures and associate them with the works of the World Bank and the International Monetary Fund. They further argue that SAPs are divided into two categories:

a) Demand management policies, which are aimed at achieving internal and external balance together with the stabilization of the price level. This include cuts in public expenditure, devaluation, wage freeze, cuts in subsidies and transfer payments,

restriction on credit expansion, reduction of net domestic assets of the Central Bank and reduction of net borrowing by the government from the Central Bank.

b) Supply management policies which include institutional reforms, in particular, increasing private sector participation in economic activity, devaluation, reforms in interest rate structure, decontrolling prices especially producer prices, export promotion, and trade liberalization.

According to the proponents of these policies, a typical adjustment package contains one or more of the following policy instruments: devaluation, liberalization of trade both domestic and external, monetary and fiscal policies, market reforms, and a wide range of cost sharing programmes and other expenditure rationalization reforms.

The IMF and World Bank introduced Structural Adjustment Programmes in order to correct macro-economic imbalances, particularly the distortion of prices, and thereby restore incentives for production, revive economic activity and economic growth. However, after two decades of adjustment in Africa, results have been generally mixed and claims of success and failure counterbalance each other in the literature on economic development. Since their introduction, an academic debate and political controversies have ensued over their appropriateness and efficiency in reforming the already devastated African social sectors like health and education (Logan & Mengisteab, 1995; Simon et al., 1995; Lewis, 1994; Nyang'oro & Shaw, 1992; Zongde, 1991).

The debate has generated antagonism between two schools of thought: the orthodox and the heterodox (Tibaijuka and Cormack, 1998). The orthodox view best expressed by

the World Bank and its supporters, argue that reforms have paid-off and that seriously adjusting countries have experienced a turn-round in their growth rates and other performance indicators including, in some cases, a reduction in poverty (Global Coalition, 1993).

According to the World Bank, macroeconomic adjustment policies have improved economic performance, and that in general, the greater the degree of implementation, the better the results (World Bank, 1994). Three main arguments are often presented in support of this claim.

1) Failure to adjust will, ultimately, impose huge costs on the poor, with unsustainable budgets and trade deficits leading to hyperinflation, currency instability, and economic collapse (Watkins, 1995).
2) Where properly implemented, SAPs have not only created conditions for growth, but growth that benefit the poor. For example liberalization, together with labor market deregulation, has led to the creation of jobs (World Bank, 1993; Watkins, 1995:78).
3) SAPs incorporate "social conditionality" and provisions that aim at protecting welfare service delivery to the poor (World Bank, 1993; Watkins, 1995).

Serageldin is of the opinion that countries with sustained adjustment programmes achieved 0.8 % annual real growth rates of GDP *per capita* over 1984-1986, while those that had not adopted such programmes registered a negative 2.5 % a year. Both groups registered declines in GDP *per capita* averaging close to negative 4 % a year over 1980-1984. But growth, it can be argued, is hostage to climate and external shocks (Serageldin, 1989:2). He however notes that in spite of some successes in many SSA

countries, the debt situation remains critical. Twenty-two SSA countries were expected (in the absence of debt rescheduling) to face debt service ratios of 30% of GDP or more in the period 1988-1990. All but 2 of these countries were in the low-income group, with a sub-group of 17 countries accounting for about 43% of total African indebtedness.

The World Bank (1994) defends itself by arguing that the developing economies lacked the capacity to manage market distortions. However, in a brief account, the Bank accepts that SAPs had their shortfalls. It states thus:

> *"We are learning from experience in adjustment programs, just as we have been learning in our project lending. We must be careful not to overestimate what can be achieved in a short period. Restoring sustainable growth will take time. Perseverance is essential. Just as essential however, is to ensure that the poor participate in and benefit from the restored growth" (Serageldin, 1989:v).*

The heterodox approach, best articulated by UNICEF in its work 'Adjustment with a human face' (Cornia, et al., 1987), the Economic Commission for Africa (1989), many African scholars and some Governments, dispute such claims (Campbell & Stein, 1992).

William Van Der Geest (1994) argues that overall assessments of the programmes of the 1980s indicate that they have, in most cases, not ventured beyond the narrow boundaries and objectives of economic stabilization. The intended transformation of the economies has been hampered by external imbalance and limited domestic resources. The programmes notwithstanding, their commitment to efficiency and growth seem to have been confined to a reduction of public deficits and a reorientation towards 'minimal' government.

Cornia, Jolly and Stewart (1987: 2-5) argue that adjustment cannot be expected to work without a 'human face'. The 'human face' implies the need to consider the socio-economic implications of adjustment policies in the formulation and implementation stages. As de Larosie're, Managing Director of IMF put it:

> " *The extent to which adjustment is compatible with growth and with an improvement in living standards depends in large part on what form that adjustment takes. Adjustment that takes the form of increase in exports, savings, investment and economic efficiency will clearly be more supportive of growth than that which relies on cuts in investment and in imports. Similarly, adjustment that pays attention to the health, nutrition and educational requirements of the most vulnerable groups is going to protect the human conditions better than adjustment, which ignores them. This means that the authorities will have to be concerned, not only if they close the fiscical deficit but also with how they do so".*

Cornia et al further agree with the United Nations International Children's Educational Fund (UNICEF) that the primary cause of downward economic pressures on the human situation in most of the countries affected is the overall economic situation, globally and nationally, not adjustment policy as such. Indeed, without some form of adjustment, the situation would often be worse. They however warn against accepting that all adjustment policies are or have been equally adequate for ensuring adjustment to a more growth-oriented pattern of development in which the human needs of the vulnerable are protected in the short, as well as the medium to long term.

Kawewe and Dibie (2000) are of the opinion that the Economic Structural Adjustment Programmes (ESAPs), introduced by the World Bank and the International Monetary Fund, have been inappropriate public policies for Zimbabwe.

> *"These economic reforms inflate poverty, decrease the county's capability to develop a strong diversified domestic economy, increase the exploitation of workers through deregulation accompanied by environmental degradation"(Kawewe and Dibie, 2000:6).*

Despite the fact that Zimbabwe and Ghana were economic success stories of the 1980s and early 1990s (Boafo-Arthur, 1991), they have both plunged into economic crises with the Zimbabwe GDP recording far much lower than before the adoption of SAPs (French, 1998).

Given the mechanisms by which the World Bank and IMF used in the introduction of ESAPs in many African countries prior to the seal of approval to get loans for economic liberalization and globalization, and given the underpinnings of democracy, some policy analysts argue that the two processes do not ensure policy ownership or implementation (Jeong, 1998; Jamal, 1994).

Authors like Azzam Mahjoud are pessimistic about SAPs because of their capitalistic nature. Azzam is of the opinion that world capitalist expansion has always had and still has a polarizing effect. That is, from the very beginning it produced and perpetuated a contrast between center and periphery, with the North as the center and the South as the periphery. In this sense then, the development of the periphery has always entailed a never-ending 'adjustment' to the demands and constraints of the dominant center. This is to say that the centers are 'restructured', while the peripheries are 'adjusted' to this restructuring (Azzam, 1993:167).

According to Ravenhill (1986), African countries paid back more- (a total of $1.5 billion) to the IMF from 1986 to 1989 than they gained in new borrowing. The Structural Adjustment Programmes to him, is a project of the Bank and Fund that has transformed the actualities if not yet the analysis of Africa's political economy. This transformations-

from devaluation and privatization to deregulation and user pay- has taken place not only at the level of policies but also in terms of politics and economics.

Since 1983, Ghana has implemented the World Bank and IMF sponsored SAPs. It is claimed by Kwadwo, that the implementation of SAPs has salvaged Ghana's economy from complete collapse, resulted in consistent growth in GDP averaging 6% over the past decade, reduced inflation levels, created budget surpluses, and increased budget earnings. Compared to the 1970s, these are the best of times indeed. Describing the turbulent times that characterized the setting of his book *'A Tale of Two Cities'*, Charles Dickens wrote, "it was the best of times and the worst of times." This time-honored phrase according to Kwadwo, to a large extent, describe the current bittersweet social-economic conditions and spatial inequalities in Ghana, Zimbabwe, Kenya, Malawi, and several other African countries, with regard to mixed blessing that have flowed from the World Bank and IMF sponsored SAPs. While many African economies undergoing SAPs may experience unprecedented social-economic growth, they may also experience uneven development, decreasing standards of living, increasing poverty, and reduced access to basic needs (Kwadwo, 1988:469).

According to the critics of the World Bank, the character of most national packages tend to be quite homogenous, leading to defaults or backsliding on some conditionalities as political opposition or other unforeseen consequences arise (Mosley, Harrigan & Toye, 1991).

The impact of adjustment remains unpredictable (Shaw, 1993:68). Observers (see for example Odada and Ayako (1989), argue against the "trickle down" hypothesis, which associates economic growth with automatic benefits to the vulnerable groups. In their view, economic growth is necessary for the improvement of the welfare of the vulnerable groups, but is not a sufficient condition. That is, there is no automatic assurance that these groups will be beneficiaries of any growth that takes place. They further argue that the theoretical justification for these policies comes from a comparative static analysis performed under conditions that assume the existence of a developed world economy.

Structural adjustment packages directed to the reduction of government expenditure have drawn their own share of criticism. Drawing from the experience of the East Asian Newly Industrialized Countries (NICs), Lall argues that the interventionist role of the state in economic development is indispensable. According to him, the great success of many of these countries was due in large measure to heavy and consistent public sector involvement in their economies (Lall, 1992; Ernst, et al., 1994).

Mlambo (1995) concurs with Lall and Ernst. According to him, one of the most illogical measures imposed through SAPs is that which requires governments to reduce their 'presence' in the economy. In the poor countries of SSA where capital is scarce, only the government, by virtue of its comparatively abundant resources accumulated over years, is the major catalyst for economic growth.

Even debates about the same issues of SAPs seem to be parallel. In divergent introductions to a pair of reports representing the same three year period of the mid decade, Edward Jaycox, Bank Vice President for Africa, argues in Africa's adjustment that:

> " *An important feature of the movement towards policy reform and orderly Structural Adjustment is that Africans accepted the principal responsibility for their economic decisions and destiny... data in this report suggest that a strategy of adjustment with growth is viable in Africa" (World Bank & UNDP, 1989:iii).*

Executive secretary Adebayo Adedeji, responds in the economic report that:

> " *Any attempt to portray the economic situation currently prevailing in Africa in rosy terms, to minimize the impact of an adverse external environment and to depict the effect of SAPs as having been always positive, does not only detract from the reality of the situation, but is also cynical in the extreme"(ECA, 1989:iii).*

Some are not categorical on the effects of adjustment. For example, in Ikiara's account, economic reforms undertaken in the 1990s expanded the overall employment in the informal sector from 1,237,500 people in 1992 to 2,240,500 people in 1995 and produced annual growth rates in the informal sector employment of between 18.5% and 25% between 1993 and 1995 (Ikiara, 1995). He however notes that the implementation of SAPs without well-designed safety nets could have negative effects on the poor and other vulnerable groups.

Onjala explains how SAPs have sorted out areas of inefficiency:

> ..."*The government managed to bring down the budget deficit, the deteriorating balance of payments, domestic credit and inflationary pressure. Between 1980 and 1984, the overall budgetary deficit fell from 10% of GDP to under 4%. The rate of domestic credit fell from about 19% to under 9% over the same period. The current account deficit as a percentage of GDP declined from 8.3% in 1981 to about 2% in 1984.*

Overall balance of payment surpluses were recorded in 1983 and 1984. Inflation declined from about 20% in 1981 to about 14% in 1982 and to an average of about 10% in 1983/84" (Onjala, 1995:74).

He however acknowledges the negative impact of SAPs on growth, income distribution, employment and poverty.

There is need to reduce this unnecessary debate and controversies about SAPs, evident in the literature. Largely, the debate according to Ikiara has persisted due to lack of in-depth studies on the relationship between SAPs and socio-economic variables. It is therefore important to design more focused studies to help move away from conclusions based either on purely speculative approaches or inadequate short-term information (Ikiara, 1995:324). This is what this study intends to do.

1.5.2 The links between Structural Adjustment and Health

According to the World Health Organization (WHO), health is a state of complete physical, mental and social well being and not merely absence of disease or infirmity (WHO, 1993).

Health is fundamental to building a humane society (Mandela, 1994). Since good health increases the economic productivity of individuals and enhances economic growth, investing in health is one way of accelerating development. More important, health is a goal in itself (World Bank, 1993). Good health and nutrition are basic requirements for sustainable economic and population growth (World Bank, 1990, 1991c, 1993a). Better health and nutrition raises workers' productivity and prolong their potential working lives, while poor health inhibits human capital development, reduces returns from

learning, impedes entrepreneurial activities, and holds back growth of Gross National Product (GNP) (World Bank, 1995a).

According to Matshalaga, health status is a contextual subject. Good or bad health is determined mainly by what seem to be the major proxies for health to a given society in a particular time and space. What may appear to be major health problems for a developed industrialized nation may not be the major health problems for a developing industrializing nation. Access to health services is defined as the ability of household members to have easy physical access to health institutions such as clinics and hospitals. It also entails the ability to access basic medical services such as drugs and other medication or treatment (Matshalaga, 2000: 769).

Income levels affect general health. The poor are more susceptible to illness than the rich (Amax-Neef, 1992), because income levels determine one's dietary patterns and living conditions, both of which seem to have a bearing on health outcomes. While illness is experienced both by the rural and urban population, slightly higher percentages of low-income groups become ill than the higher income population. Compared to their male counterparts, women are more likely to be ill. A number of factors contribute to this trend. For instance, the reproductive role of females put them at a greater risk of being ill than males (UNDP, 1997; UNDP, 1998).

Although good health is considered as a basic need and a fundamental right for every human being (WHO, 1979; World Bank, 1993), thousands of people in Africa simply do not have access to modern medical facilities. The health status in Africa (as in many

developing countries) is in jeopardy (Ferranti, 1985:2) and good healthcare is only readily available to the elite (Stock & Anyinam, 1992:217). What is more poverty and poor health have led to hunger, homelessness, loss of human dignity and death in SSA (WHO, 1997a)

After political independence most African countries stressed the importance of good health and consequently promised free healthcare services to their people (Geest, 1992; Manundu, Mondi & Rao, 1989). This promise was not possible to fulfill however, largely because the state lacked resources and the functioning infrastructure. As a result, a crisis gradually emerged and has persisted in the health status of many African countries. There is a suggestion that this crisis is a function of the glaring inequality in Africa, inappropriate government policies, mismanagement of public health institutions that serve the poor, the severe economic stagnation that started in 1980s (Aluko, 1990; Mcpake et al 1993), and more recently the debt crisis (Mbatia, 1996:4)

Most developing countries have chosen systems of healthcare that do not meet the health needs of their people (Carrol, 1971; Bader, 1977; Blix, 1979; Hu, 1991; Free, 1992; Perry & Marx, 1992; Serpa-Florez, 1993; Walters and Bunn, 1995). They have emphasized urban health care, particularly in the form of well-equipped hospitals with highly trained medical staff. Such hospital-based systems are favored partly as symbols of modernity (Banta, 1986; Barnum & Kutzin, 1993; Kachienga & Boonzaier, 1999).

The World Development Reports of 1990 and 1993 show that SSA is the only region in the developing World where health and nutrition have worsened in recent years. In

most of SSA life expectancy averages around 50 years, but it is as low as 40 years in Somalia and in some parts of West Africa. Infant mortality ranges from 70 per 1000 births in Kenya to 190 in Guinea and Sierra Leone. In Zambia and Zimbabwe, more than 20% of children suffer from second or third degree malnutrition; in Burundi, Sudan and Tanzania the proportion exceeds 50%. The absence of clean and safe water and sanitation is another factor contributing to poor health in the developing countries. Although rural water programs are encouraged, maintenance of equipment and systems remain a major problem. Urban water and sanitation systems have also generally suffered from poor planing and population pressure (World Bank, 1993a, 1993b).

The literature is devoid of statistics that allocate scores to the various factors that contribute towards poor health status. This study hopes to provide the missing statistics.

In general the various components of SAPs that directly influence the health sector fall under six categories. Devaluation of the currency, cuts in government spending, additional taxation on mass consumption goods, removal of subsidies on basic foodstuffs and other basic needs, removal of price controls, and improvement in public sector planning and execution (Odada & Ayako, 1989:59)

Cornia et al. (1987) argues that adjustment policies frequently involve cutbacks in government expenditure. From 1980 to 1984, real government expenditure *per capita* on health fell in over half the countries of the developing world, with a greater proportion declining among countries with adjustment policies than among the non-adjusting countries. Vulnerable groups are particularly affected by changes in

government expenditure on basic health and education and food subsidies. Services available to the most vulnerable are reduced in both quantity and quality and prevent progress towards extension of services to the whole population. They come to the conclusion that SAPs combined with inflation and population expansion have led to a precipitous and exponential decline in basic human needs, health included.

According to Gibbon, some aspects of healthcare and health status were already showing cause for concern before the economic reforms occurred. In particular, aspects of health status like nutrition, which relate more to general economic conditions rather than to the extent and efficiency of health interventions, seem to have hardly improved since the early 1980s. Adjustment itself has been associated with enforcement of restrictive rules for free access to medical treatment and increased drug charges (Gibbon, 1993:15).

The objective of user fees advocated by SAPs is to increase the government's financial capacity to produce good quality health care in the face of the increased cost of health care (Republic of Kenya, 1989a: 238; Oyugi, 1992:227). In highlighting the positive aspects of user fees, Griffin (1988:iii) contends that user fees are a largely unexploited tool for achieving many financial, efficiency, equity and management goals in the health sector of the developing countries. On the same premise, Vogel (1988) argues that cost-recovery in form of user charges, can be regarded as a means of solving some of the efficiency and equity problems in the health sector, as well as a means for providing additional resources. But can the user fees strategy successfully generate more resources for health and improve the effectiveness of African health systems? And more

importantly, what are the impacts of user fees on users of public health facilities especially at local levels.

Matshalaga notes that the policy of free health for low-income households made it possible for poorer groups to access health facilities more easily. However, the introduction of economic reform programmes popularly known as Economic Structural Adjustment Programmes in Zimbabwe, has witnessed a massive shift in macropolicies. These policy changes have tended to affect the health sector in a negative manner. The introduction of user fees as a cost recovery measure and the roll back on government expenditure on social sectors has reduced accessibility to health facilities (Matshalaga, 2000:769).

In Ghana, a prolonged crisis resulted in cuts in health expenditure *per capita.* By 1982/83, 80% of the 1974 expenditure level was recorded. A project of immunization against yellow fever met only 50% of its target, and all project vehicles were withdrawn because of shortage of fuel. Lack of expenditure on maintenance meant that in the Accra region, in mid 1983, 20 out of 57 refrigerators were not functioning (UNICEF-Ghana 1984).

In Mozambique the drugs and equipment needed to maintain the primary healthcare infrastructure could not be maintained because of shortages of foreign exchange. The negative effects of the financial crisis on basic services were not confined to direct cuts in expenditure in these services. The collapse of the transport system that had occurred in many parts of Africa- following lack of maintenance to roads and vehicles and higher

fuel prices had adversely affected supplies for the rural health system (UNICEF 1981). They further argue that not only SAPS can be blamed as they say

> *"Almost invariably, the worst affected countries in health have been those which have magnified the effects of GDP decline. One fundamental requirement in order to protect the vulnerable is to reverse the decline in GDP per capita".*

The cost sharing policies affect individual utilization of health services because price is one of the determinants of health utilization (Gesami, 2000:38). Some of the literature generally reports a low and statistically insignificant price elasticity of demand for curative health. This implies marginality or neutrality of pricing reform in health care service utilization (Akin, et al, 1986; Schwartz, et al, 1988; Kirigia, et al, 1989; World Bank, 1997; REACH, 1988a, 1988b; Birdsall & Chuban, 1986).

The evidence seems to have rationalized the introduction of user charges to finance health care in many African countries. The findings of this stream of literature have been considered paradoxical considering the very low income and medical insurance coverage levels in developing countries (Deolalikar, 1996).

Evidence from a recent stream of literature reports high and statistically significant price elasticity of demand for curative health care especially at the lower end of income distribution. This implies a significant negative effect of user fees on health service utilization by the poor (Mwabu & Wangombe, 1994, 1997,1998; Mwabu, et al., 1993; Moses, et al., 1992; Huber, 1993; Kraushaar & Akumu, 1993; Quick, et al., 1993; Gertler, et al., 1987; Alderman & Gertler, 1988; Gertler & Van der Graag, 1990; Bekele & Lewis, 1986; Mcpake, et al., 1993; and Collins, et al., 1996). The result of this latter

stream of studies, has been rationalized on several grounds including low levels of existing user fees (on which additional fees are levied), and availability of alternative source of medical care.

Despite the cautionary implication of the findings against user fees, fees were implemented in many developing countries, mainly on the grounds that they would improve efficiency and sometimes equity (Sauerborn et al., 1994). Results of studies from Niger (Diop, et al., 1995; Wouters, 1995) show opposite effects of fees. Here implementation of user charges improved service quality, averting reductions in medical care use.

The implementation of SAPs can have negative repercussions on the performance of health personnel and the services under their responsibility (Coll, 1990). After salaries decreased in Zambia in 1983, many government health workers migrated to the private sector or to other countries (Freund, 1986). In Uganda, after massive wage decreases and price rises (Hansen & Twaddle 1991), health workers supplemented their salaries by working in private clinics and drug shops, thus spending less time on their government jobs (Chew, 1990; Van der Heijden & Jitta 1993). Similar coping strategies have been reported from Nigeria, Ghana and other African countries (Unicef 1990).

There is therefore a relationship between SAPs and health that has not been fully explored. A focus on the Kenyan situation may therefore shed more light on this relationship.

1.6 THE THEORETICAL FRAMEWORK

This study is guided by the **neoclassical paradigm**. The paradigm encompasses all those approaches that emphasize the powerful self-collecting forces in an economy. It has its roots in the writings of Adam Smith, J.B. Say, and John Stuart Mill. In particular, the paradigm is thought to have begun with the work of Adam Smith, the author of *'The Nature and Causes of the Wealth of Nations'.* He and those who followed him, particularly David Ricardo and John Stuart Mill believed that the powerhouse behind quickening the pace of the economy was capital investment and tight controls of a nation-state were not the best way to ensure efficient capital accumulation (Samuelson, 1995; Whitehead, 1970).

According to neoclassical economic theory, socio-economic and spatial inequalities are merely short-term aberrations that arise from structural factors; in an otherwise well functioning system. Consequently it is assumed that the inequalities created between the rich and the poor and between prosperous and depressed areas melt away as countries undertake development programs, especially those that are driven by market forces (see Kuznets, 1955; Theil, 1979; Browett, 1984).

This policy is the rationale for Structural Adjustment in Sub-Saharan Africa. Thus underlying the adjustment prescriptions in the neoclassical assumption is that markets work; markets are generally competitive; and market signals are good guides to resource allocation. Structural Adjustment thus means the introduction of more market oriented policies- liberalization of markets, more efficient use of prices, greater openness to trade and a bigger role for the private sector. It demands the reduction of budget and

balance of payments deficits through fiscal and monetary measures and advocates for a public service that is efficient and reliable, with transparent accounting for public monies. Why? 1) Adjusting the pricing system in government health facilities would generate more revenue. 2) It would improve access of the poor to health services. 3) It would make government health services more effective. 4) It would also make consumers more reasonable in their utilization of the healthcare services. (Akin et al., 1987:26).

A complete reform package, derived from the neoclassical paradigm contains five components: 1) freeing markets to determine prices; 2) adjusting controlled prices to market values; 3) shifting resources from government into private hands; 4) rationalizing the government's remaining role in development; and 5) reforming institutions to carry out government's new role.

1.7 HYPOTHESES OF THE STUDY

As a guide to the achievement of the stated objectives, three hypotheses guide this study:

1) The implementation of Structural Adjustment Programmes health policies increases the demand for modern healthcare services.
2) Structural Adjustment Programmes policies are necessary but not sufficient intervention strategies in improving health care delivery especially among the vulnerable groups.
3) User fees improve the quality of health services.

1.8 METHODOLOGY

This study drew from both primary and secondary sources of information.

Primary data was derived from interactive interviews with the personnel at the Ministry of Health, Kenyatta National Hospital, National Hospital Insurance Fund, The Kenya Red Cross and ST Johns Ambulance. By voluntary work at Kivuli Center Dispensary I acted as a participating observer of the personnel and the patients at the same time and got first hand information and data from a health center. The instruments of data collection included interviews, which consisted of open-ended questions that were used in interactive interviews.

The secondary data was sourced from the collection and review of published and unpublished books. These included journals such as the *Journal of Econometrics*, the *Social Science and Medicine Journal* and the *Journal of sociology and social welfare*. Periodicals, academic papers, government documents such as *the National Development Plans*, electronic and print media. This was taken through intensive and critical analysis. The analysis carried out was mainly descriptive with emphasis being laid upon the dependent variable {the Health status}. This was geared towards showing how the independent variable {Adjustment} had affected the {Health Status} of SSA with Kenya's health sector as the case study.

CHAPTER II

2.0. AN OVERVIEW OF HEALTH ISSUES IN SUB-SAHARAN AFRICA.

2.1 INTRODUCTION

Good health is basic to human welfare and a fundamental objective of social and economic development. Yet according to the World Bank, most of Africa's forty-five countries lag far behind other developing countries in the vital task of improving health. In an analysis carried out by the Bank, Africa is host to a number of major disease vectors. A warm, tropical climate and variable rainy seasons aids their transmission. The mean number of infective malaria bites per person is ten times higher in the forest or Savannah areas than in the Sahel or more mountainous areas. In agricultural communities, exposure to various infections, especially diarrhoea, malaria and guinea worm, tends to be greatest during the wet season, when food is in short supply and high prices prevail (World Bank, 1995a: 12).

High rates of disease and premature mortality in Sub-Saharan Africa are costing the continent dearly. Poor health causes pain and suffering, reduces human energies, and makes millions of Africans less able to cope with life, let alone enjoy it. The economic consequences are immense. Poor health shackles human capital, reduces returns to learning, impends entrepreneurial activities, and holds back growth of Gross National Product (GNP) (World Bank, 1995a: 13).

Ferranti argues that throughout the developing world, the health sector is in trouble noting:

> *"Beset by conflicting pressures rooted in financial difficulties and resource allocation problems. Governmental budgetary support for health has been*

falling and in some cases declined in actual terms as countries struggle to exercise fiscal restraint in the face of poor economic development performance and burgeoning debt. Worse still, escalating costs threaten to erode past health gains" (Ferranti, 1985: x).

African leaders attending the world summit for children at the United Nations in September 1990 reminded us of the facts of life in Africa. President Chissano of Mozambique cited his country's infant mortality rate of 159 per thousand life births, one of the highest in the world. Uganda's president Museveni noted that, of the 30 countries with highest death rates for children under five years of age, 21 were African. He argued that:

> *"These children die of diseases preventable by immunization, basic sanitation and simple community-based primary care- dehydration due to diarrhoea, measles, whooping cough, tetanus, and pneumonia. Malaria kills many more and has increased in the 1980s. Blindness, war related and post-polio disabilities are widespread. Women suffer increasingly high rates of death in childbirth. Meningitis stalks Africa's dry, dusty zones, while guinea worm cripples tens of thousands in its moister areas. Chronic undernutrition and lack of long term food security makes all of this worse" (Seldman & Anang 1992: 149).*

Senegal's president Diouf called for bilateral cancellation of all foreign debt, noting that

> *"A solution cannot be found to these (children's) problems without a solution to the debt crisis" (Seldman & Anang 1992: 149).*

No discussion of health in Africa can neglect the variety of ways public indebtedness has been translated into higher food prices, poorer medical services, and worsening health. Green notes that in Ghana, for instance, infant mortality had fallen from 132 per thousand live births in 1960 to 107 per thousand live births in 1970 to 86 per 1000 live births in the late 1970s only to climb back up to 107-120 range in the 1980s. Access to safe domestic water decreased in both rural and urban Ghana. As a percentage of

requirement average caloric availability declined from 97% in 1970 to 88% in the late 1970s to an alarming 68% in the 1980s (Green, 1989:38).

Hence in the end of it all when we look at Africa the conventional image we get is one of a continent torn by wars, ravaged by drought, and haunted by the fear of AIDS. People at greater risk tend to be members of vulnerable groups, including newborns, infants, toddlers, and women of reproductive age.

A cursory inspection of the world's health picture suggests that the single most important factor positively influencing health outcomes is income. However, the World Bank is of the opinion that even within the existing levels of per capita income, health in SSA can be dramatically improved by strategies that create an enabling environment for health (World Bank, 1995a: 29). Other inputs, which together with income can create this enabling environment for health, include safe drinking water and improved sanitation, food and nutrition, education (particularly for females) and culture among others. However, even if the triad of these factors is got right, unless the use of the available health resources is got right, the possibility of inefficient resource use in the health sector prevents the attainment of the anticipated health improvements.

Since basic needs are indivisible, it is not surprising that health cannot improve in an environment where shelter, water, food, clothing, education or even personal security is in doubt.

2.2 KEY FEATURES OF AFRICA'S HEALTH STATUS

Africa's struggle to overcome illness and disease has had mixed results. On the positive side, the World Bank notes that by taking advantage of the innovations in the industrialized world (vaccines, microbiologic techniques, and antibiotics, for example) Africa has achieved much faster rates of improvement in health status. The infant mortality rate has been cut by more than one-third, and average life expectancy has increased by more than ten years (World Bank, 1995a: 12). At the beginning of the period of adjustment, only one in seven Africans was supplied with safe water, whereas 25 years later about 40% of the African population is obtaining drinking water from a safe source. By the end of the 1980s, around half of all Africans were able to travel to a health care facility within one hour. The population growth rate in most low-income African countries is still increasing, and in most of them exceeds 2.5% a year, largely a result of improvements in health and education conditions that are both reducing mortality and increasing fertility (Unicef, 1992b).

On the negative side, however, the World Bank notes that there are signs that this rate of progress is not being sustained. Life expectancy in the less-developed regions of the world, which had been rising by 0.64 year annually between 1950-1960, slowed to 0.40 year annually 15 years later. Infant mortality was 55% higher and average life expectancy was 11 years less in SSA than in the World's low-income developing countries. In 1991, life expectancy in Africa was only 51 years, compared with 62 years for low-income countries and 77 years for the industrial countries. Maternal mortality, at 700 women per 100,000 live births, was almost double that of other low and middle income developing countries and more than 40 times greater than in the industrial

nations. Tens of millions of Africans suffered from malaria each year, an estimated 170 million were afflicted by tuberculosis, and the AIDS epidemic seriously threatened several of the continent's countries (World Bank, 1995a).

Table 2.1: Key Health Indicators: Sub-Saharan Africa and Other Countries

	COUNTRY GROUP			
Indicator	High income	Middle income	Low income	SSA
Life expectancy at birth (years)	77	68	62	51
Infant mortality (per 1,000 life births)	8	38	71	104
Maternal mortality (per 1,000 live births)	Not available	107	308	686

Source: World Bank, 1993.

Feachem observed that mortality differentials among African countries were no less striking. The mortality of children under five ranged from more than 200 deaths per 1,000 live births in Mali, Angola, and Mozambique to fewer than 100 in Botswana and Zimbabwe. Maternal deaths per 100,000 live births were estimated to range from 83 in Zimbabwe to more than 2,000 in Mali. Adult mortality- the risk of dying between ages fifteen and sixty- was estimated to range from 18% in Northern Sudan to as high as 58% in Sierra Leone. In many countries, more than 30% of females and 40% of males of working age died before age sixty (Feachem et al, 1992).

Substantial intercountry differences in health were accompanied by equally notable variations within countries. These differences were pronounced between urban and rural areas. The United Nations estimated the crude death rate for 1980 in the rural areas of the developing world as 21.7 per 1,000, compared with 15.4 for urban areas. Data on infant mortality was especially pertinent as it referred to the population most vulnerable

to health hazards. Absolute levels of infant mortality were probably grossly underreported in developing countries; the degree of underreporting was probably much greater for rural than for urban areas. These differentials were the consequence of the marked contrast in socioeconomic conditions between rural and urban areas. Compared with rural people, the health status of urban dwellers in the developing countries was better; this is because they enjoyed higher incomes, better sanitation and water supply, higher school enrollment ratios, and superior environmental and personal health services.

Gwatkin observes that in Zimbabwe, childhood mortality in urban areas was 45% less than the rate in rural areas and was up to 20% less among urban dwellers in Sudan, Togo, and Uganda. The children of married women with a secondary education were 25 to 50% less likely to die before age five than were the children of women with no education. Differentials between residential areas with higher and lower incomes gave rise to the so called "ten to twenty" rule of thumb, meaning that in most settings the life expectancy of the richest ten to twenty percent of the population was somewhere on the order of ten to twenty years higher than that of the poorest 10 to 20% (Gwatkin, 1991). In 1994, only about 11% of the rural population in Cote D'ivore, 15% in Somalia, 30% in Liberia, Niger and Nigeria had access to personal care facilities within less than one hour from their locations. However, in countries that had emphasized the delivery of primary health care in rural areas, the WHO reported that some 99% of the rural residents of Mauritius had access to such services within an hour, as did 85% on Botswana, 73% in Tanzania, and 70% in Congo (World Bank 1994).

Other discrepancies manifest themselves in the unequal access across districts in African countries to a number of important health sector parameters. The World Bank notes that among 30 states in Nigeria, the number of health facilities ranges from one per 200 people in Lagos to one per 129,000 in Benue. Three quarters of the country's public and private health facilities are located in urban areas, which contain only 30% of the population. In Angola, the supply of beds ranges from 4 per 10,000 people in Malage, to 42 per 10,000 in Luanda Norte (World Bank, 1994). Nganda concurs with the Bank as he argues that in Kenya, in 1991-92, the population per (public sector) medical doctor ranged from under 5,000 people in Nairobi to over 883,000 in Nyanza (Nganda, 1994) although the Bank observes that the picture changes somewhat when both public and private sector resources are considered. For example, there is one doctor per 500 people in Nairobi, compared with one per 160,000 in Turkana (World Bank, 1994).

Ethnicity also ranks as a powerful correlate of infant and child mortality differentials, even after education and occupation are taken into account (Akoto &Tabutin, 1989). In the Cameroon, for example, the mortality of children less than 2 years of age between 1978-1988 ranged from 116 per 1,000 live births in one ethnic group to 251 in another. In Kenya, child death rates ranged from 74 for one ethnic group to 194 for another, while in Ghana they ranged from 74 to 158 and in Senegal from 261 to 452 (Akoto & Tabutin, 1989). These ethnic differentials may be attributable in part to different attitudes concerning illness and nutritional practices, access to and use of modern services, and dependence of modern versus traditional healers. But they are also due to schisms among ethnic groups that produce unequal access to social and economic opportunities.

Besides the imbalances in the distribution of physical and human health resources, there were also great imbalances in the public spending on public health care. Major urban (tertiary care) hospitals often received half or more of the public funds spent on health and commonly 50 to 80% of the recurrent health expenditures by the government. In the mid 1980s for example the major hospitals recurrent budget expenditure share was 74, 70, 66, 54 and 49% respectively in Lesotho, Somalia, Burundi, Zimbabwe and Botswana (World Bank, 1994). In Kenya in 1989-90 the per capita recurrent public health expenditure ranged from KSh 90 in Nairobi to KSh 20 in the North Eastern province (Nganda, 1994) although, Nairobi is better served by the private sector.

Table 2.2: Health Expenditure as a Social Indicator of African Health Status

	Public expenditure as % of GDP. 1990-98	Private expenditure as % of GDP 1990-98	Total expenditure 1990-1998		
			As % of GDP	Per capita, US$	Per capita International $
Sub-Saharan Africa	--	--	--	--	--
Excluding South Africa	1.3	--	--	--	--
Angola	4.0	--	--	--	--
Benin	1.7	--	--	--	--
Botswana	1.9	1.4	3.1	109	171
Burkina Faso	2.3	3.2	5.5	22	43
Burundi	0.9	--	--	--	--
Cameroon	1.0	0.4	1.4	7	33
Chad	3.4	0.1	3.5	6	26
Comoros	1.0	0.2	1.2	8	18
Republic of Congo	1.8	3.2	6.3	102	170
Cote d'Ivoire	1.4	2.0	3.4	22	71
Equatorial Guinea	5.8	1.3	7.2	42	--
Eritrea	1.1	0.9	2.0	--	--
Ghana	1.3	0.1	1.4	4	30
Kenya	1.9	1.0	2.5	13	34
Lesotho	3.5	--	--	--	--
Mali	2.0	1.3	2.9	11	15
Mauritania	1.8	4.1	5.2	35	75
Mauritius	2.2	1.7	3.4	109	408
Namibia	3.7	3.7	7.6	153	303
Nigeria	0.3	1.0	1.4	5	18
Sierra Leone	1.6	2.0	3.6	18	22
South Africa	3.6	4.3	7.9	257	396
Sudan	--	2.7	0.3	29	--
Togo	1.7	2.2	3.4	20	40
Uganda	1.6	2.2	3.9	10	61
Zambia	2.4	0.7	3.3	362	31
Zimbabwe	2.0	4.2	6.5	86	122

Source: World Bank, 1998: 335.

In Seldman and Anang's observation the World Bank, Unicef and WHO agree that the major African health challenges are: chronic malnutrition; diarrhoeal diseases and associated domestic water supply and sanitation; malaria and other vector born and communicable diseases; HIV infection; and health care financing (Seldman & Anang, 1992: 151)

2.2.1 Hunger and Food Security.

Green (1989:36-37) lists seven groups of people who are highly vulnerable to food insecurity.

1) Victims of sustained drought and/or ecological degradation whose previous sources of income (herds, seed stock, land improvements) have been wiped out.
2) Land hungry migrants- often poor, women-headed households- who move into marginal land (in terms of soil, weather, ecological fragility).
3) Isolated or peripheral rural people at the end of marketing, administrative and supply lines.
4) Small producers who are self-provisioning, but also sell food for cash income
5) Victims of war
6) Members of the urban informal sector who cannot match high urban prices with low income and live in crowded, poorly serviced slum or ex-urban areas
7) Urban wage earners whose purchasing power has fallen dramatically in the last decade

The World Bank (1989:72) notes that one quarter of the population of Sub-Saharan Africa eats on average, across good and bad crop years, less than 80% of their energy

requirements. In addition to emphasizing the core area of food insecurity in the drought prone Sahel and Southern Africa, the World Bank goes on to point out other conditions that undermine food security. Kenya is a case

> *"In which income distribution is particularly skewed and a part of the population is very poor even though the agricultural base and national income levels are strong"* (World Bank, 1989: 73).

The Bank also mentions war- in Angola, Ethiopia, and Mozambique as a cause of food insecurity, as well as countries with poor infrastructure- Uganda, Zaire- and those with large urban population- Zambia, and Sudan.

It was estimated that during the period 1973-1983 Africa had an annual average of 22 million cases of malnutrition of children aged 0-4 (Chandler, 1985:11). Unicef (1985a) estimated that between 1975 and 1981, 60% of Ethiopia's children suffered from mild to moderate malnutrition. For Sudan, the figure was 50%, for Tanzania 43%, for Kenya 30%. Severe malnutrition affected 40% of under fives in Burkina Faso, 28% of those in cote d'voire and 16% in Nigeria (Timberlake, 1988:37). Thirteen African countries had a total of more than 12 million underweight children (¾ of all the underweight children on the continent). These countries include Nigeria, Ethiopia, Sudan, Zaire, Kenya, Tanzania and Uganda.

By far the greatest number of malnourished children (3.5 million) is found in Nigeria, Africa's most populous country, where, the distortions caused by oil wealth have severely undermined agriculture and aggravated socioeconomic stratification (Watts, 1986; Nafziger, 1988: 123-124). Access to health services is highly inequitable because of pronounced urban/rural disparity and the predominance of a private health sector,

which many cannot afford (Stock, 1985a). In 1981 the average rural household in Northern Nigeria consumed 11% calories more than the required level suggested by FAO. Households in the first decile however suffered a calorie deficit of 25%. The poorest 30-40% of households were seriously impoverished and needed to borrow grain from high-income households during the pre-harvest hungry season (Nafziger, 1988:123-4).

Studies in Kenya show that 28% of children aged 1-4 are below their expected height-for-age (stunting) and a similar proportion below the expected weight for age (wasting) (Unicef 1988). Wisner argues that Kenya has a very highly skewed income distribution and great pressure on available land. 80% of the country is classified arid and semi-arid. The remaining 20% constitute the well-watered and highly fertile volcanic soils once monopolized by the colonial settlers. Since independence a small elite of African farmers, linked to the government and the dominant political party, have largely replaced the whites. The landless and the land poor have migrated to the cities and into the margin of the arid and semi-arid zone where they face the risk of drought (Wisner, 1988:167-198). According to Mwabu and Mwangi contrasts by class and geographical region are evident in nutritional data. In 1982, rates of stunting of children in Kenya provinces of Coast and Nyanza were 36.2% and 29.9%, more than one third higher than in the provinces of Central and Rift-valley (respectively 20.4% and 19.8% (Mwangi & Mwabu, 1986:776).

In Zimbabwe 118 nutritional surveys conducted between 1980-1982 showed that between 21-23% of the under five population remained below 75% of their expected

weight for age. Another large-scale study of nearly 2,000 Zimbabwean children in 1982 found low weight-for age in 22% of the age group 0-3 years (Unicef, 1985b: 40). The Southern part of the country is more prone to drought and less well provided with health care facilities. In part this reflects the colonial geographical division of the country along racial lines depending on agricultural potential, with patterns of urbanization, roads and social infrastructure falling in line. In part, it results from postcolonial tensions between the Northern Shona and Southern Matabale leadership, which slowed investment in the south during the critical period 1983-1988.

(CA) a Communal Area formerly termed as 'tribal trust land' reserved for Africans and (SSCFA) a Small Scale Commercial Farming Area 'a native purchase area' where Africans were allowed to buy on the edges of white commercial farming areas are adjacent areas that share a common rainfall, soil etc. but the statistics on health and nutrition reflect differences.

Table 2.3: CHILD WELFARE: DIFFRENCES BETWEEN CA & ZIMBABWE, 1983-1988

	Poorly served	Well served
Under nutrition	Very high	high
80% weight for age	24%	14%
90% height for age	28%	17%
85% weight for height	11%	6%
% frequency of diarrhoea reporting episode in last month for under 5s	43%	35%
Food intake	low	higher
No oil or beans in past 24 hours consumed by under fives	81%	77%
Fruit, vegetables consumed 1-2 times by under 5s	71%	82%
No protein consumed in past 24 hours by under 5s	82%	53%
Peanuts consumed weekly	10%	20%
Oil, margarine consumed daily	34%	50%

Source: Campbell et al, 1989:61-72

2.2.2 Childhood Diarrhoea, Sanitation and Communicable Diseases

Preventable childhood diseases, like measles, whooping cough, diphtheria and diarrhoea, caused by a variety of water and fly born pathogens, and tuberculosis tend to exacerbate malnutrition, often interfering with the ability of the child to absorb nutrients. In turn, malnourishment makes these diseases impact on the child more severe (Van Ginneken & Muller, 1984; Duggan etal, 1986).

Unicef's standard immunization package protects against measles, whooping cough, diphtheria, tuberculosis, tetanus (especially important to protect pregnant women and their babies), and polio (Unicef, 1985c). The success of mass immunization campaigns in Africa has been mixed. In small densely populated countries like Rwanda, Burundi, Guinea-Bissau and Lesotho coverage has been good. Some larger countries with difficult logistical conditions have achieved high levels of coverage through popular mobilization and maximum use of some of the best-developed rural primary healthcare services on the continent. For instance, Zimbabwe, Tanzania, Burkinafaso, Congo, Cote d'voire, Senegal and Kenya. Higher rates of coverage have been obtained against tuberculosis and measles. Polio and DPT immunization requires several attendances.

Unevenness of coverage may reflect the history of public health priorities before the recent campaigns. For instance, Zambia, Zimbabwe and Botswana all have a long history of tuberculosis brought home by migrant workers returning from the mines in South Africa. For years health authorities have been concerned with T.B, as reflected by high rates of immunization. Unicef noted that:

"For poorer countries---especially those hard hit by the economic crisis, assistance (with immunization) will have to continue well beyond 1990, and it may have to cover some recurrent expenses normally assumed by governments" (Unicef, 1987:28).

International and bilateral donors place a lot of emphasis on control of diarrhoea, or more precisely, on low cost, simple means of replacement of water and electrolytes in children suffering from diarrhoea. The use of such oral rehydration therapy (ORT) has constituted a major success in child health in Africa (Unicef, 1989a: 8).

The best way of dealing with diarrhoea, of course, is to avoid it. The U.N water supply and sanitation decade (1981-1990) had that goal. By the year 1990 all people in the world were to have "reasonable access to safe water" (Agarwal etal, 1981). Average African domestic water consumption is a mere 10 litters per capita per day compared with something like 300-600 litters in industrialized countries (White etal, 1972; Lindskog & Lundquist, 1989:9-10). In Europe 95 out of 100 people have access to piped water. In Africa 90% do not (Timberlake, 1988:38).

What has the U.N through UNDP managed to accomplish in Africa? Because of the very high rate of urbanization in Africa, a decade's heavy investment has produced only a 5% net increase in urban dwellers' access to piped water. Improvements in urban sanitation are similar. Rural access to a protected water source and improved sanitation (usually in the form of a pit latrine) has not grown as rapidly (Wisner, 1988:87-111; UNDP/WHO, 1990). Although there has been a net and percentage increase in rural access to sanitation facilities during the decade, the absolute number of rural dwellers in need has grown by 30 million (equivalent to the population of Sudan, Zaire or South Africa).

Leaving 303 million people still without access to improved sanitation (Agarwal etal, 1981). Similarly, rural access to protected water supplies increased by a small margin (3%), but the number in need increased by 49 million (nearly equivalent to the population in Ethiopia), leaving 229 million people still in need of service (UNDP/WHO, 1990:17).

Not surprising, the incidence of water borne, water vectored and water related diseases continued to increase during the 1980s. Africa was seriously affected during the great cholera pandemics of earlier decades (Stock, 1976), but in the 1970s and 1980s the disease became endemic. There has been a number of recent outbreaks, including one in 1984 involving Burkinafaso, Mali, Niger, Nigeria, Cameroon, Ghana, Kenya and Tanzania in which, out of 6,500 reported cases, 600 people died. In 1985 some 2000 people died of cholera in refugee camps in Sudan (Timberlake, 1988:39). In 1991, Zimbabwe was seriously affected.

2.2.3 Malaria and Other Diseases

Despite efforts to control malaria, it has been increasing in many parts of the world, especially in Africa. 80% of all reported cases of malaria occur in Africa, where more than 90% of the population lives in malarious areas and where the prevalence of the disease in the general population is 50%. Among young African children prevalence approaches 100% (Clyde, 1987:219; Breman & Campbell, 1988:611; WHO, 1986; World Resource Institute, 1990:56). An estimated 100,000 African children under one year of age and 575,000 between one and four years die each year from malaria (Breman & Campbell, 1988:56). Placental malaria- a condition associated with low birth- weight

babies may occur in 20-34 % of African women living in malarious zones (Mc Gregor, 1984).

Malaria parasites have become increasingly resistant to most common drugs. In 1990 Kenya suffered nearly 500 deaths in an epidemic of chloroquine-resistant falciparum malaria in highland centers like Eldoret and Western Kenya. During the 1980s, economic hardships have forced many people to migrate from the highlands (where they do not gain partial immunity from frequent childhood exposure to malaria) into the lowlands where malaria is hiolo-endemic. In secondary towns like Nakuru and Eldoret in Kenya, overburdened by the very high rate of urban growth, the government's structural adjustment measures have deferred maintenance of urban drainage and sewage systems. This has led to an increase in mosquito breeding sites.

Among the casualties of economic decline in the 1980s are massive national and multi-national projects to control such diseases as river blindness, sleeping sickness and bilharzia (World Bank, 1989:65). Wars have also contributed to the abandonment of zones where tse-tse fly habitat can regrow, leading to an eventual resurgence of sleeping sickness. Likewise desert locust control has been complicated by war, adding another threat to regional food security.

Tuberculosis is endemic in most of Africa despite vaccination campaigns. This is partly due to the presence of an older, unvaccinated population and partly due to the problems with the vaccine. TB is a particular problem in South Africa and Southern Africa (Packard, 1989b). Of great concern is evidence that HIV infected persons are more at

risk of developing clinical T.B and eventually spreading it. Simpler diagnostic tests are needed as well as a longer lasting vaccine and shorter acting drugs for treating active cases (Commission on Health Research for Development, 1990:22).

2.2.4 HIV Infection

By June 1988, out of a worldwide total of 100,410 cases; roughly 11,500 cases of clinical AIDS – 11.5% were reported in African countries (Panos institute, 1989:156-7). Considerably controversy about the reliability of tests for seropositivity (presence of antibodies against HIV in the blood) includes the suspicion that frequent exposure to malaria can produce antibodies that read as false HIV positive (Chirimuuta & Chirimuuta, 1989). Nevertheless, more and more evidence suggests that the virus has infected a large number of Africans- including children, women and men- although they may not show symptoms of the disease. Estimates range as high as 3.5 million infected Africans out of a worldwide total of 6.5 million people infected (Makenzie, 1990:6)

The countries with the highest numbers of reported AIDS cases per million of population (in June 1988) were Congo (595), Burundi (231), Uganda (149), Rwanda (133), Zambia (106), Central African Republic (94), Malawi (79), Tanzania (68) and Kenya (67). The largest absolute numbers of reported cases (June 1988) were found in Uganda (2,369), Tanzania (1,608), Kenya (1,497), Congo (1,250), Burundi (1,156), Rwanda (901), Zambia (754), Malawi ((583) and Zaire (335) (Panos Institute, 1989:156-7).

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), the region most affected has been SSA. At the end of 1998, 22.5 million people including one million children were living with HIV/AIDS in SSA, two thirds of the worldwide total. At least 4 million Africans were newly infected with the virus in 1998. In Botswana, Namibia, Zambia, and Zimbabwe, between 20 and 26% of people aged 15 to 49 were infected. In 12 other SSA countries, including Ethiopia, Kenya, Mozambique, South Africa, and Tanzania, 9 to 20% of adults were infected (UNAIDS, 1998a).

It was likely that life in rural areas was already being disrupted by AIDS mortality. The number of orphaned children was increasing rapidly in Uganda and probably elsewhere (Blackie, 1990). Unicef estimated that by the year 2000 there would be as many as 110 million orphans in Africa due to AIDS. Anon observed that the burden of treating AIDS patients weighed heavily on limited health facilities and personnel already strained by financial crisis and budget cuts (Anon, 1988:48).

Table 2.4: Rank and share of malaria, AIDS, and other diseases in the total burden of disease and injury, Africa 1990.

FEMALE		MALE	
Occurrence by rank order	Share %	Occurrence by rank order	Share %
Malaria	11	Injuries	13
Respiratory infections	11	Respiratory infection	11
Diarrheal diseases	10	Malaria	11
Childhood cluster (a)	9	Diarrheal diseases	10
HIV/AIDS	6	Childhood cluster (a)	10
Perinatal	6	Perinatal	9
Maternal	6	HIV/AIDS	6
injuries	6	Tuberculosis	5
Tuberculosis	4	Other STDs	2
Other STDs	3	Other causes	23
Other causes	28		
Total	100	Total	100

(a) Pertussis, polio, diphtheria, measles, and tetanus.
Source: World Bank, 1993e.

Any discussion of health policy must start with a sense of the scale of health problems. These problems are assessed in terms of mortality (and/or the closely related concept of life expectancy). However, mortality alone is not an adequate indicator of the health situation. It fails to account for the losses that occur because of the handicap, pain or other disability occasioned by illness that are not fatal such as chronic depression and paralysis by polio, among other conditions that are common, often lasting a long time and frequently leading to significant demands on the health system, and also affect the productivity and the quality of life (of the affected and the other individuals).

In order to account for both direct and indirect losses occasioned by premature deaths and disability due to illness, the World Bank (1993) adopts a measure of the burden of disease termed the Disability Adjustment Life Year (DALY).

In terms of DALYs lost for every 1000 population among various regions in the world, SSA's performance is equally poor. Whereas the world average in the 1990 was 259, SSA performance lost 575 DALYs for every 1000 population, more than twice the global average and the averages recorded for most other regions. The main cause of loss in DALYs in SSA in 1990 was communicable diseases, accounting for about 71% of the disease burden per 1,000 population. Besides, emerging health challenges particularly AIDS, are afflicting Africa worse than elsewhere.

Table 2.5: Distribution of DALYs Loss by Cause and Demographic Region 1990

Cause	World	SSA	India	China	Other Asia & islands	Latin America and the Caribbean	Middle eastern crescent	Former socialist economy of Europe	Established market economies
Population	5267	510	850	1134	683	444	503	346	798
Communicable diseases	45.8	71.3	50.5	25.3	48.5	42.2	51	8.6	9.7
Tuberculosis	3.4	4.7	3.7	2.9	5.1	2.5	2.8	0.6	0.2
AIDS & HIV	3.8	8.8	2.7	1.7	1.5	6.6	0.7	1.2	3.4
Diarrhoea	7.3	10.4	9.6	2.1	8.3	5.7	10.7	0.4	0.3
Vaccine preventable childhood diseases	5	9.6	6.7	0.9	4.5	1.6	6	0.1	0.1
Malaria	2.6	10.8	0.3	*	1.4	0.4	0.2	*	*
Worm infection	1.8	1.8	0.9	3.4	3.4	2.5	0.4	*	*
Respiratory infection	9	10.8	10.9	6.4	11.1	6.2	4.5	2.6	2.6
Maternal causes	2.2	2.7	2.7	1.2	2.5	1.7	2.9	0.8	0.6
Prenatal cause	7.3	7.1	9.1	5.2	7.4	9.1	10.9	2.4	2.2
Other diseases	3.5	4.6	4	1.4	3.3	5.8	4.9	0.6	0.5
Noncommunicable diseases	42.2	19.4	40.4	58	40.1	42.8	36	74.8	78.4
Injuries	11.9	9.3	9.1	16.7	11.3	15	13	16.6	11.9
Total	100	100	100	100	100	100	100	100	100
Millions of DALYs	1362	293	292	201	177	103	144	58	94
Equivalent infant deaths (million)	42	9	9	6.2	5.1	3.2	4.4	1.8	2.9
DALYs per 1000 population	259	575	344	178	260	233	286	168	117

* Less than 0.05 percent
Source: World Bank, 1993.

2.3 THE SOURCES OF HEALTH SECTOR PROBLEMS AND OBSTACLES TO BETTER HEALTH IN AFRICAN HEALTH CARE SYSTEMS

The World Bank observes that although African countries made numerous promises to adopt one of the prime elements of an enabling environment- namely, better primary and preventive health care- they have not implemented the institutional and financial changes necessary to bring it about. In most countries governments give most of their attention and funding for health to high-priced curative care and relatively cost-ineffective services provided through hospitals. Such services not only consume a large share of ministry of health resources but also benefit a small share of the population. The better off in most countries have better access both to non-government services, because they can afford them, and to government services, because they live in urban areas and know how to use the system. The rural poor benefit little from tax-funded subsidies to urban hospitals, yet often pay high prices for drugs and traditional care in the non-government sector. Health facilities and personnel are concentrated in urban areas, and within the urban population the services are oriented to the middle income and upper income groups, neglecting the peri-urban poor (World Bank, 1995a: 2).

The Bank further agues that there has been a general disinclination to appropriate a larger share of government funds to health purposes. They are of the opinion that poor economic conditions played some role, but they do not totally explain the often-observed tendency to give health services short shrift in funding. As a result, publicly owned and operated infrastructure and equipment were visibly aging in many countries. Stock-outs of drugs were frequent, especially at publicly run urban health centers and village health posts. Inefficiency and waste in the procurement, storage, prescribing and

use of drugs were so extensive that consumers in some countries got the benefits of only $12 worth of drugs for each $100 spent on drugs by the public sector. Neither providers nor patients were encouraged to behave in ways that minimized waste; and pervasive waste, through both misallocation and internal inefficiencies (e.g. weak management), was a serious problem in the health sectors of many developing countries. Also the operating policies hindered efficiency more broadly because distortionary tax policies were used to raise the public revenue that paid for health services.

To some extent, donor funding compensated for low funding of health in national budgets. And, in some countries donor funded projects did not address the country's dominant health problems. An unwelcome side effect has been the fragmentation of systems of healthcare and lack of government leadership. The government spending alone, even if it were better allocated, would not be sufficient to fully finance for everyone, a minimum package of cost-effective health activities, including both the truly "public" health programmes and basic curative care and referral services. Although non-government spending on health was substantial, not enough of it went to basic cost-effective health services. As a result, the growth of important health activities was slowed despite the great needs of fast growing populations. With this in mind the World Bank recommended the use of structural health related cost sharing policies to try and resolve the problem.

On the other hand Akin argues that nonsalary recurrent expenditure for drugs, fuel and maintenance were chronically underfunded, a situation that often reduced dramatically the effectiveness of health staff. He says:

> *"Many physicians could not accommodate their patients' loads, yet other trained staff were not productively employed. Lower-level facilities were underused while central outpatient clinics and hospitals were overcrowded. Logistical problems were pervasive in the distribution of services, equipment, and drugs. The quality of government health services was often poor; clients faced unconcerned or harried personnel, shortages of drugs and deteriorating buildings and equipment" (Akin, 1987: 2).*

Another deep-seated obstacle was the hierarchical and centralized structure of Ministry of Health programs and policies. Several African countries made notable progress towards developing responsibilities for program development and implementation, but an entrenched opposition to the decentralization of authority often prevailed. A chief argument was that better health in Africa depended on an overall decentralization that encouraged African households and communities to become more responsible for their own health and more capable of achieving it. Although many countries sited equity as the reason for strong government controls, public sector- controlled policies had no good track record on equity. Van Der Gaag noted that in Tanzania the richest fifth of the population used more than twice as many government beds and more than four times as many outpatient services as the poorest fifth. In Cote d'Ivoire less than one quarter of the rural poor who were sick received any form of medical care, as compared with half of the urban rich. In general, when government expenditures were concentrated on urban areas and on hospitals other than basic services, the results were highly inequitable, governments were essentially subsidizing the rich (Van Der Gaag, 1995:18).

Nganda concurs with Van Der Gaag arguing:

"The sources of most African health sector problems can be traced in large to the continued hierarchical organization of healthcare, particularly in terms of resource distribution to various types of healthcare institutions. The dominance of personal healthcare institutions reflects most countries administrative hierarchy, which operates from top to bottom. The lower level institutions- village posts, dispensaries, health centers and small hospitals are intended to provide the primary care needed by people living in rural and peri-urban areas. This is where the bulk of African populations live, where demand is highest, and where preventive and primary health care would have the greatest positive impact on national health. But in most health systems in Africa and other developing countries, these levels of the health care delivery hierarchy not only experience the weakest bureaucratic control, but also receive the lowest budgetary allocation. For example, in 1991-92, rural health services and preventive and promotive medicine in Kenya received about 70% of the total recurrent budget" (Nganda, 1994).

Hence the World Bank recommended the decentralization adjustment policy to resolve this issue.

Another issue was the shortage of skilled health personnel, particularly in the poor countries. As John Evans and others argued:

"National averages for physician: population ratios are reported to be 1:17000 in the least developed countries. The nurse: population ratios are 1:6500. These national averages disguise the fact that in some rural areas there may be only one doctor serving 40,000 to 200,000 people. The pyramid of health manpower is inverted, particularly in the least developed countries. Instead of a broad base of inexpensively trained, less skilled personnel working at the community level, priority has been given to expensive training programs for 'conventional' doctors, who expect sophisticated facilities and equipment, gravitate to practice in the cities, and have a propensity to migrate" (John Evans et al., 1981).

The World Bank argues that the consequences of all these obstacles were frequently compounded by other encumbrances that were no less significant- rapid population growth, gender inequalities, and pervasive poverty. In combination with poor economic performance, rapid population growth had contributed to negligible rates of growth in Gross National Product per capita in more than half of the African countries over the past two decades. As better health in Africa cannot be divorced from the implications of

rapid population growth, the benefit of spacing and limiting of births for the healthy mother and child were stressed. Money alone did not ensure good health. However, in the opinion of most development specialists, the overriding constraint to improving health status in the least developed countries was the extreme poverty of most of the population and the low level of the gross national product per capita (below $400). Health had to compete with other pressing developmental needs for extremely limited resources (World Bank, 1995a: 3).

The World Bank (1980) noted that it was evident that the most persistent problems in improving health did not result from the complexity of medical technology, and only partially from the scarcity of financial resources. Rather they derived principally from problems in the design and implementation of policy, management, and logistics (World Bank, 1980: 6). Commitments to creating an enabling environment for health in Africa had therefore to be integral to a successful health strategy. Such a strategy had to provide those services efficiently and equitably. This is the necessity and base with which structural adjustment health related policies were implemented.

2.4 REFORMS AND ADJUSTMENT PROGRAMMES

According to Nganda (1994:378) changes in resource allocation procedures, system organizational structures (achieved through decentralization), introduction of competition (privatization), and regulation are among the leading mechanisms favored by healthcare sector reformers as possible vehicles for enhancing incentive compatibility (among participants) in order to achieve efficiency and equity in the health sector.

The World Bank is of the opinion that much health improvement is achieved by reforming health care systems to use available human and financial resources more efficiently. Correcting the many sources of waste and inefficiency takes top priority. The Bank notes that inefficiencies in the procurement, storage, prescribing, and use of drugs were so extensive in African countries that consumers got the benefit of only $12 worth of drugs for each $100 spent on drugs in the public sector. Inequalities prevailed to the extent that poor households had no access to quality care at times of serious illness or injury (World Bank, 1995a: xiii).

Critically, important to health system reforms was better management of pharmaceuticals, health sector personnel, and health infrastructure and equipment. The Bank agreed that African ministries of health were working on this in a number of countries. By giving more attention to the formulation and implementation of national policies and devolving responsibilities for health care provision to decentralized entities and the non-government sector, they spurred reform (World Bank, 1995a: 3). In many countries private voluntary organizations already assumed a large share of the responsibility for providing health care. Legal and regulatory environments became increasingly conducive to the provision of health services by the private sector.

Cost effective packages of basic health services- delivered through networks of local health centers and small hospitals in rural and peri-urban areas- went a long way to respond to the needs of households and reduce the burden of disease in Africa. According to the Bank's experience a package of such services was provided in a typical low-income African country for as little as $13 *per capita per year*. This compares with

average per capita expenditures on health from all sources in Sub- Saharan Africa of $14, ranging from $10 or less *per capita* in countries like Nigeria and Zaire to more than $100 *per capita* in Botswana and Gabon (World Bank, 1994).

2.4.1 Health Financing Adjustment Policy Reforms

One of the main obstacles to good health in Africa is financing and expenditure. Public expenditures on the social sectors, especially education and health, have an important bearing on human development and the prospects of participation by the poor in the long run growth of an economy. Overall cuts in spending was not a favored feature of adjustment programmes in Sub-Saharan Africa, but still there were spending cuts in social services that had previously benefited the poor to some degree.

Table 2.6: Changes in Real Health Expenditures in Selected Countries 1980-83 to 1987-89 (percent)

COUNTRY	HEALTH	COUNTRY	HEALTH
Burkina Faso	11.7	Malawi	3.4
Cameroon	18.5	Niger	36.7
The Gambia	-	Nigeria	-50.5
Ghana	-	Sierra Leone	-
Kenya	1.5	Togo	-
Madagascar	6.2	Uganda	-24.1
Zambia	-3.4	Zimbabwe	37.6
Mean 3.8			
Median 4.8			

- Not Available

Source: Sahn (1992)

For these countries, median real health spending increased by about 5% between 1980-83 and 1987-89. Real spending per capita, by contrast, increased only slightly in health and declined even more in education, as governments could not keep up with rapid population growth.

Table 2.7: Social Spending in Selected Countries

COUNTRY	HEALTH EXPENDITURE AS A % OF GDP	
	1981-1986	1987-1990
LARGE IMPROVEMENT IN MICROECONOMIC POLICIES		
Ghana	0.8	1.3
Tanzania	1.3	0.6
Gambia	2.3	1.5
Burkina Faso	0.7	0.6
Zimbabwe	2.3	2.9
MEAN	1.5	1.4
MEDIAN	1.3	1.3
SMALL IMPROVEMENT		
Madagascar	1.0	1.2
Malawi	2.0	2.0
Kenya	1.8	1.6
Mali	0.8	0.7
Niger	0.8	1.3
Uganda	0.4	0.4
MEAN	1.1	1.2
MEDIAN	0.9	1.2
DETERIORATION		
Sierra Leone	1.1	0.4
Togo	1.7	1.3
Zambia	2.3	1.7
Cameroon	0.9	0.8
MEAN	1.5	1.2
MEDIAN	1.4	1.1
ALL COUNTRIES		
MEAN	1.3	1.2
MEDIAN	1.1	1.3
Source: Nashashibi & Bazzoni (1994)		

From the table above we see that shares of GDP, median health spending increased slightly between the first and second halves of the decade. Countries that improved macroeconomic policies allocated a marginally higher share of expenditure to health and education but the difference among groups is not large.

On analyzing the situation in the 1970s the World Bank (1980:19) noted that health care expenditures in developing countries were substantial; governments reported annual public spending of about $1 to $8 per capita, excluding outlays by local authorities,

voluntary agencies, and individuals. Payments by households to private providers of traditional and modern health care, and for purchase of drugs generally exceeded government health expenditures. In addition to paying for health services and drugs, households frequently paid for transportation and sacrificed substantial earnings while seeking healthcare. Fragmentary evidence suggests that about 6% to 10% of the GDP was spent on healthcare; additional sums were devoted to water supply, waste disposal, nutrition, and family planning, in part, to improve health. Total expenditures for healthcare in developing countries were at the order of $75 billion a year; this contrasted with an estimated annual expenditure on education of $40 billion to $45 billion.

The era of structural adjustment led to a severe decrease in public financing hence a decrease in healthcare in Africa. All over the continent, governments reduced their total budgets. In addition, some cut the share of shrinking public revenue allocated to health (Pinstrup-Anderson etal, 1987:73-83). Hence Pinstrup argues that considering the low per capita expenditure on health in the first place (something like US$ 2 per person per year on average), the impact of cuts had an even more devastating impact. The remaining funds were spent on urban-based clinical services for a small elite. Despite the rhetoric in favor of primary healthcare, expenditures on rural and preventive services continued to lag.

In the face of crisis, the World Bank encouraged a fee-for-service approach. They emphasized that safeguards had to be built into any such cost-sharing approach. Services with high public health significance such as antenatal care and immunization

were exempted; those who could not pay had recourse to clear simple procedures for forgiveness of fees; the fees collected was spent on the improvement of services provided (Ellis, 1987; Kanji, 1989). Mwabu and Mwangi argue that the majority of Kenya's rural poor were expected to benefit from selective application of user fees if some of the US$ 442 million budgeted by the government for urban hospitals (67% of the health budget) were freed to improve rural coverage and quality of care. They say:

> *"Not only could the poor be excused fees in an organized manner or fees be waived for people referred up the government hospital hierarchy, but whose geographical regions could be exempted on the basis of poor health indicators in a procedure referred to as health zoning (Mwabu & Mwangi, 1986: 767; Wood, 1990)".*

Akin argues that the more common approach to healthcare in developing countries was to treat it as a right of the citizenry and to attempt to provide free services to everyone. Thus the entire cost of healthcare was financed through frequently overburdened tax systems. It encouraged clients to use high-cost hospital services when their needs could be addressed at lower levels of the system. It deprived health workers at government facilities of feedback on their success in satisfying consumers' needs. It made it impossible to reduce subsidies to the rich by charging for certain services, or to improve subsidies for the poor by expanding other services (Akin, 1987: 3).

User fees and contributions in kind from the individual or the community have been important means of supplementing financing from government. John Evans et al (1981) notes that many governments resisted any form of user charges, for fear of excluding the poor or in the belief that users would not understand the value of the services. In support of user charges they further argued:

"Paradoxically, imposition of user charges can have a positive impact on utilization of health services, by increasing the perceived value of services and therefore the demand for them over alternative "free" care. Traditional healers and birth attendants practice on a fee for service basis and enjoy a high level of community acceptance; with appropriate training, they could serve as an extension of the health system financed by user fees" (John Evans et al., 1981:18).

The World Bank agrees with John Evans and others as they argue:

"Cost sharing can make an important contribution to health equity and the sustainability of health services. It can also stimulate the provision of quality services in rural and urban areas. User fees and health insurance are now a reality in many countries and merit increasing roles. User fees and other types of cost recovery are important to ensure the financial sustainability of publicly provided health services. Revenue generated may be modest at first, but it can be expected to increase when quality of services are improved, and households perceive the benefits of paying. Even low-income African households are prepared to pay what is necessary to obtain basic curative services, especially if the quality of the services is good. The retention of fees at the point of collection, moreover, is an incentive to hospital and health center managers to strengthen revenue collection and service quality. Moreover, and purely on equity grounds patients from African households with higher incomes (some of which have health insurance) should be required to pay for the healthcare they receive. In particular, charging better off patients at publicly financed or operated hospitals affords ministries of health the opportunity of freeing up scarce resources for reallocation to primary and preventive care (World Bank, 1981).

Hecht et al (1992) noted that as the countries of SSA strived to generate adequate resources to support their financially strapped health systems and to improve the quality, efficiency and equity of health services, their governments were increasingly focusing on the option of having patients pay part of all of their healthcare costs. They ague thus:

"A number of countries are moving to increase user charges for government health services (e.g. Lesotho), or to establish nationwide fee systems to replace free care (e.g. Uganda, Kenya). Other countries are promoting the creation and or strengthening of community financing schemes for health services (e.g. Guinea, Rwanda, and Nigeria)" (Hecht et al, 1992).

Skeptics like creese (1991) argued that fees affordable to most Africans did not generate significant revenues and that the administrative costs offset revenues. Further, they argued that user charges seriously reduced access to healthcare, especially for the poor, with important negative effects on health status.

According to an analysis done by the United Nations International Children's Education Fund utilization rates of health services remained low overall. Cost recovery did not prove to be an effective means to fund preventive services or individual disease interventions (Unicef, 1998). The implementation of cost-sharing schemes did not attain the proposed goals of protection of equity and basic needs. In Ghana, for instance, the fee-for-service system reportedly denied service to the poorest citizens (Waddington & Enyimayew, 1989). In Zimbabwe when the municipal councils raised the fees charged for obstetric services, fewer women used them (Loewensen etal, 1990) in Kenya doubts were expressed early on about the impact of cost-sharing without substantial safeguards (Mwabu & Mwangi, 1986:766).

Another approach to healthcare financing recommended by the World Bank was privatization. In many countries including Zimbabwe, Kenya and Nigeria the private sector health care providers have grown rapidly. But according to Bunugire, these private practitioners were even more urban biased than the government medical services. In addition, doubts were expressed about the quality of services available in circumstances where the urban poor had few alternatives. He argues that in Uganda, government health workers put in short hours at government facilities in order to make ends meet by working outside in the private sector. He estimated that effective labor

time spent in public health clinics declined from six or seven hours a day to only one. Meanwhile in Uganda the ratio of population to doctor increased from 11,100:1 in 1965 to 24,500:1 in 1981. Private clinics were opened up in rural trading centers as well as Uganda's major cities and towns. Subsequently, rising prices excluded more and more people. Even those who could afford these private services found a low level of professionalism (Banugire, 1987:102).

2.4.2 The Role of the Government in Health Sector Adjustment

Throughout most of recorded history people went to private doctors and hospitals when they were ill. Traditional birth attendants, bonesetters, herbalists and spiritual doctors were active in their contribution to the health of the community (this are today referred to as traditional health care attendants). Only in the 20th century did governments become important providers of social services, in extreme cases excluding the private sector all together.

Though traditional health care attendants still remain important, governments strive to achieve the most productive balance of the private and public sector in social services provision. Van Der Gaag (1995: 3) is of the opinion that it is unfortunate that too often the officials who made these decisions were well informed about public sector options (through innumerable reports, conferences, and their own experience) but knew relatively little about what the private sector had to offer. Most were unaware that over the ages and around the world, private providers had developed a rich variety of strategies for delivering education, nutrition, health and population services.

Van Der Gaag further argues that in the developing world, health systems generally reflect the organizational approach favored by the relevant colonial power. When government provision did not keep pace with public need the private health sector- both non-profit and for profit- expanded. In South Africa 59% of all physicians were in private practice, in Zimbabwe that figure is 66%. Even in countries with completely public health systems, it was not uncommon for patients to pay significant fees or "gratuities" either to public physicians who were legally moonlighting in private practices or as under the table payments. An estimated 50% of all-global spending for healthcare came from the private sector, although the amount varied considerably across countries and regions. Hence we see that the governments encouraged privatization as an option to providing health care (Van Der Gaag, 1995:13).

Table 2.8: HEALTH EXPENDITURE IN VARIOUS REGIONS, 1995

REGION	PERCENTAGE OF TOTAL HEALTH EXPENDITURES	
	PUBLIC	PRIVATE
Established market economies	61	39
Middle East	57	43
Formerly Soviet economies	71	29
India	22	78
China	59	41
Other Asia and the Pacific Islands	39	61
Latin America and the Caribbean	61	39
Sub-Saharan Africa	53	47

Source: Van Der Gaag, 1995:13

The global view of the World Bank (1995a: 9) is that the government's primary role is leadership. That is, Identifying and promoting cost-effective approaches to health and facilitating the activities of public and non-government providers. This is not to say that governments were the main providers of healthcare. Rather, priorities for action by African governments in adjustment included the following: Establishing appropriate programs of public health services, and financing them before supporting other health services. Determining which package of health services, if adequately used, was the

most cost effective, reducing direct government engagement in provision of healthcare where non-government providers showed potential for an increasing role, and reallocating public financial support for healthcare for relatively cost-effective curative care interventions to the basic package (this was done with the adjustment policy reform of rationalization of Government expenditure in mind). Subsidizing the package of services for the poor and in the absence of non-government willingness they provided services to the poor. Subsidizing those components of the package that resulted in the largest number of direct and indirect benefits for the largest number of people (e.g. immunizations). And providing information to the public that stimulated demand for the basic package, empower citizens to choose wisely among providers, and assist households to make sound use of the package.

2.4.3 The Role of the World Bank in African Health Sector Adjustment

Akin acknowledges that by 1983 the World Bank had become one of the largest funders of health programs in developing countries. The Bank's lending operations in more than thirty countries was focused on the development of basic healthcare programs, including expansion of primary healthcare, provision of drugs, and support for training and technical assistance. Lending operations were generally preceded by systematic studies of the health sector as a whole. These studies enabled the Bank to carry on a policy dialogue regarding systemwide health issues with government officials (Akin 1987: 8).

There has been mounting concern in the Bank and in member countries about the resource problem in health, and a conviction that the Bank, itself a financial institution, was able to make a useful contribution to improving health in developing countries by

encouraging innovative health financing policies. With this in mind the Bank made renewed efforts to do so. A strengthened program of country sector work included attention to the health financing issue. General reviews of overall government expenditures increasingly included special attention to the health sector. Innovative lending programs included assistance to countries in the development and implementation of new health financing approaches. Dialogue with other lending agencies was more active, and a program of research and operational evaluation on the effects of new approaches was planned (Akin, 1987: 10).

The World Bank has become a major lender in the health sector under its health, population, education, and nutrition policies even though it has not directly funded health projects. As the implementation of adjustment health related policies took root in Africa, the Bank financed basic health care and vector control activities with total project costs of about $160 million; and water supply and sanitation activities costing an additional $3.9 billion. Akin further observes that the Bank developed close working relationships with WHO and other organizations promoting health in developing countries, and was carrying out a small program of operational research on health services.

2.5 CONCLUSION

The World Bank is of the opinion that to achieve better health, African households and communities need the knowledge and resources to recognize and respond effectively to health problems. Publicly sponsored programs that inform households and communities about threats to health and the services that respond to them are essential. Formal and

non-formal education plays a major role, providing information and practical guidance on self-care, cleanliness, food preparation, and nutrition. The central position of women in household management and reproductive health must be emphasized. Intersectoral interventions to complete and sustain health improvements, such as the provision of safe water, are important. So too is local and community participation in the management of health services. These factors make crucial contribution to an "enabling environment for health"(World Bank, 1995a: xii).

Seldman and Anang are of the opinion that through the encouragement of privatization on African health systems there were successful pilot schemes in primary healthcare with participation from community members. These programs produced lessons on how to generate local priorities through village health communities and community assessment (Seldman & Anang, 1992).

Adjustment programmes enabled the provision of educational and social support network for projects to combat major diseases in Africa like malaria (Spenser etal, 1987) promote the use of ORT and child feeding, and monitor growth and the rural water supply. Questions remain about the role and training of and compensation for village health workers, but the potential for community mobilization has been demonstrated (Warner, 1977; Vaughan, 1980; Rifkin & Walt, 1988). Unicef notes that one of the most successful projects in 168 villages in Iringa, Tanzania, reduced severe malnutrition by 60% and young child deaths by 30%. The program centered on community- supported day care centers and has now been expanded to include all 620 villages in Iringa region (Unicef, 1989a: 66).

Minimal preconditions for creation of a healthy future is needed. African women, men, workers, farmers, healers, teachers and children, must participate in creating the conditions for a healthier future. In the words of one of our leaders " tomorrow is built today" (Nyathi, 1990). However, they need the space within which they can experiment and create their future. As the UN secretary General for Africa has put it " *let the people put themselves first. Let them seize the initiative"* (Adedeji, 1990:45). Such political and economic 'space' for popular action requires some minimal conditions:

1) Adjustment with much more than a human face fiscal policy must put the needs of the people first
2) Donor care
3) Donor encouragement of projects and programs that take an intersectoral view of health.

These minimal conditions could open up a space in the economic crisis within which Africans could more freely experiment with democratic forms of defining health priorities and controlling the determinant of their health.

A policy, according to the Webster dictionary, is a principle upon which any measure or course of action is based. Most African countries during the crisis years realized the problems in their health sectors and tried to change this trend by implementing the health related structural adjustment policies. Kenya as a Sub-Saharan African country is the country I use in this study to show how African countries implemented these policies in the next chapter.

CHAPTER III

3.0 A REVIEW OF KENYA HEALTH SECTOR REFORMS AND POLICIES

3.1 INTRODUCTION

3.1.1 Health Care System in Kenya

In Kenya the health system is organized in three tier systems. The Ministry of Health organizes the activities of health on a central basis with four lower levels according to the political and administrative set up. The four levels are National; Provincial; District and Divisional levels. At the top, also known, as the central level is the headquarters Ministry of Health (MOH) where all policy matters are decided co-ordinated and directed. A politically appointed minister heads the ministry. The Permanent Secretary who heads all administrative activities of the ministry assists the Minister administratively. There are also other professional heads in the administration i.e. Director of Medical Services.

The central government through the Ministry of Health is responsible for organizing and managing government hospitals. The hospitals are based on an integrated system of sub-district and district hospitals. Provincial hospitals act as referrals in the province and have better facilities than the district hospitals. The central consultative hospital in Kenya is Kenyatta National Hospital. It is the central health care facility and it is well endowed with a wide range of modern facilities such as, cardiology clinics; kidney transplant unit; cancer research center; dental and medical training school which trains doctors, nurses, and clinicians for the public and private sectors. Besides these, there are other specialist institutions including the main mental hospital at mathare and an infectious disease hospital with a respiratory wing at Mbangathi District Hospital.

The expertise at the Kenyatta National Hospital in Nairobi serves as far as the Eastern and Central Africa Region. The Kenyatta National Hospital receives complicated cases from these regions, as well as from provincial hospitals. In the provinces there are health managers known as the Provincial Medical Officers (PMO). They oversee the general administration of medical activities at the provincial headquarters, district and sub-district levels. At the district levels, there are District Medical Officers (DMO) of Health who are in charge of the overall management of the district hospital and also oversee health issues at the sub-district levels, though most of the sub-district facilities are managed by the Clinical Officers (COs).

Apart from the (MOH) controlled care systems, local authorities especially the Nairobi City Council (NCC) and several other municipal councils operate facilities that are equivalent to the (MOH) owned facilities. Therefore, we find that Kenya's referral systems are a pyramid-like structure. The system permits movements of patients from the base referral system to the top.

3.1.2 Health Care Facilities

Since independence in 1963, Kenya has continued to promote access to modern health care. The Government subscribed early and readily to the aim of *Health for All by the Year 2000* which sought to enhance access to health care services while also catering for a rapidly growing population (GOK/MOH, 1997). An early aim was to provide health care free of charge and to locate a health facility within 10 kilometers (KM) of each citizen.

Currently 42% of the population is within 4 kilometers of a rural health facility; and more than 75% are within 8 kilometers. These are considerable achievements within a regional context. The public sector provides about 70% of the total hospital beds; a similar percentage of the health centers and dispensaries. Table 3.1 shows that the growth in health care facilities especially those likely to benefit the rural poor, have more than kept pace with population growth. The rate of increase in the number of hospitals did not, between 1978 and 1987, keep pace with population growth but then moved ahead of population by almost 10% in the five years until 1992, and rose to achieve an almost 16% net increase by 1996 (GOK, 1999: 46).

The growth in the number of health centers, sub-centers and dispensaries, serving rural people mainly, was ahead of population growth from 1978 onwards, and in the four years before 1996 achieved almost a 42% net increase. This increase in the number of facilities directly serving the rural population has been a major achievement in social provision. Even so, rural people with limited incomes continue to have difficulty in accessing primary health care services, either because of the nearest facility's distance from their homes, its lack of drugs and other essential supplies, or because they cannot pay the user charges (see table 3.2).

Table 3.1: Health Care Facilities and Population Growth, 1967-2000

Year	1967	1978	1987	1992	1996	2000
Estimated population (millions)	10.9	14.8	20.8	23.4	26.4	30.3
Hospitals	199	226	254	301	387	481
% Growth in facilities +/- rate of population growth	-	-	-28.2	9.2	15.8	-
Health centers	162	233	282	477	548	601
Health sub-centers/ dispensaries	500	1088	1535	1859	3058	3273
Total centers/ dispensaries	662	1221	1817	2336	3606	3874
% Growth in facilities +/- rate of population growth	-	-	8.3	16.1	41.6	-

Source: Ministry of Health, 1997,2001

Table 3.2: Rural – Urban Disparities in Health

Indicator	Rural	Urban
Mean monthly household income	Kshs 5000	Kshs 13000
Disease incidence %	13.7	17.7
Infant Mortality Rate (IMR)	74	55
Under Five Mortality (U5M)	109	88
Total Fertility Rate (TFR)	5.16	3.12
HIV/AIDS prevalence (%)	12.2	17.5
Food poverty (%)	50.7	38.3
Female headed households (%)	30.5	21.4
Taking 60 minutes + to reach a qualified doctor (%)	63.3	2.3

Sources: Republic of Kenya 1998), 2000b, 2001a

The emphasis on health is based on the recognition that good health satisfies one of the basic human needs and contributes significantly towards maintaining and enhancing the productive potential of the people. Improving health forms an investment in human capital and has positive impacts on development (World Bank, 1993:17). In recognizing these benefits, the Kenyan Government has, since independence in 1963, continued to design and implement policies aimed at improving the country's health status. Such policies have attempted to increase coverage of and access to health care services; reduce morbidity, mortality and control fertility; promote primary health care; and encourage participation of the private sector and non-governmental organizations (NGOs) to enhance their role in the delivery and financing of healthcare services.

The government policy as relates to the health of Kenyans, is clearly stipulated in the Kenya Health Policy Framework (1994). Health policy in Kenya revolves around two critical issues, namely, how to deliver the basic package of quality health services to a growing population, and how to finance and manage those services in a way that guarantees their availability, accessibility and affordability to those most in need of them.

The Government recognized the following policy issues, which were explored before programmes were designed around them:

a) The need to use the non-governmental resources more effectively to achieve health sector objectives. The government recognized the role of the non-governmental sector in health programmes in view of its potential.

b) The need to examine the possibilities of restructuring and/or reorganizing the health sector as a whole and, especially, the public health sub-sector: decentralization of governmental health services was considered one of the more attractive policy options.

c) Sessional paper No.6 of 1986 recognized that it was necessary for those benefiting from public services to be involved in cost sharing in order to generate more revenue for financing the services. In this respect, the Government liked the policy option of charging the users of government health facilities to be explored with all its implications.

d) Health insurance and risk sharing were underdeveloped programmes in the Kenya health sector. There was thus need to explore all possibilities of providing insurance and other forms of risk sharing since they had the potential of becoming sustainable sources of healthcare finance.

3.2 THE SITUATION BEFORE ADJUSTMENT

Before and during the colonial times modern health care for the African population was rare, they relied mostly on traditional health care attendants. Hence historically, most independent African governments had an aim of providing free medical services. In 1978 the Health for All movement was launched giving this "free" policy aim more support.

This led to a situation where the public sector led by the state remained dominant in the provision and financing of health care while the growth of the private sector was suppressed. Gesami (2000:48) notes that in a number of successive policy documents, especially development plans, the Kenyan government repeatedly expressed its commitment towards providing health care services as a basic need for all Kenyans. In support of the policy objective, budgetary allocations to health increased in absolute terms over the years. The Ministry of Health's recurrent budget for 1979-80 fiscal year rose from Kenyan pounds 43.0 million to 351 million in 1996/97 (GOK/MOH, 1997). Gesami further observes that during and throughout this period of public sector dominance and expansion of health services, the non-government sector was less exploited due to the weak institutional links between them and the government sector. This led to a situation where their opinion was not solicited and incorporated in policy formulation.

The 1980s and 1990s witnessed a shift, driven by fiscal and ideological concerns from state dominance to multiple and diverse forms of provision, delivery and financing of health services. This was a period when most African economies were faced with a harsh economic climate coinciding with a critical phase of demographic transition that gave rise to an imbalance between the demand for and supply of health services. Gesami argues that rapid population growth, new emerging diseases (like AIDS), resurgence of epidemics, natural and man-made disasters, confronted the Kenya health system with challenges for which it was not prepared, thus calling for health care reforms.

3.3 THE ERA OF ADJUSTMENT

3.3.1 Decentralization

Before adjustment the state represented by the Ministry of Health played a dominant role in all matters pertaining to health issues. In the era of adjustment there was a shift from heavy public sector dominance in the provision of health care. As set out in the Kenya Policy Framework (1994), the creation of a forum for periodic review and revision of comprehensive health sector policy was achieved by amending the Public Health Act to give the Central Board for Health greater responsibility in guiding National Health Policy, and the Ministry of Health greater responsibility in its implementation. This led to the operationalization of a high level Health Sector Policy Review and implementation committee at Ministry of Health Headquarters.

The Ministry of Health took the lead in ensuring that health sector policies were elaborated and implemented, and where necessary, suitable legislation was either enacted or amended. The government continued to regulate the health sector and the provision of services through enforcement of regulatory legislation as stipulated in the following Laws of Kenya: Cap. 242 Public Health Act, Cap. 243 Radiation Protection Act, Cap. 244 Pharmacy and Poisons Act, Cap. 245 Dangerous Drugs Act, Cap. 246 Malaria Prevention Act, Cap. 248 Mental Health Act (1989), Cap. 253 Medical Practitioners and Dentists Act, Cap. 257 Nurses Act, Cap. 260 Clinical Officers (Training, Registration and Licensing) Act, Cap. 255 National Hospital Insurance Act, Cap. 254 Food, Drugs and Chemical Substances Act, Cap. 364 Animal Diseases Act.

Through the strengthening of the public policy making role of the central Ministry of Health the Government continued to promote the expansion of health care services in underserved areas and provided care to the majority poor staying in the rural and urban areas. This was achieved through regulatory measures, which encouraged the proliferation of the private, Mission and NGO sectors by providing material and financial incentives to health care providers operating or establishing clinics in underserved areas. The government enhanced the regular quality control and quality assurance of care through statutory and management inspections with the aim of maximizing efficiency in man and machines commensurate with the investments made.

After thorough examination of issues, a National Policy concerning decentralization in the health sector was prepared, adopted and implemented. Consideration was given to fully decentralizing decisions regarding at least the non-salary-operating budget for health.

Before adjustment districts and provinces had little opportunity for making contributions to policy development (GOK, 1994). Although policy development must be centrally coordinated, a more structured participatory process for reviewing policy options was established with the root of adjustment. Regular meetings involving senior officers from central, provincial and district levels to discuss specific policy issues were followed up by working groups involving different levels of the system who analyzed policy options for consideration by the MOH senior management.

Apart from decentralization planning systems, most other management systems had remained centralized. However, the manpower management information systems which was under development was fully decentralized to the districts to give them far greater responsibility for the day to day management of personnel and for planning and budgeting.

In the process of decentralization the needs-based approach to district planning and budgeting shifted to a resource-based model. A key aspect of resource–based planning was the production of budgets, which conveyed a sense of realism and provided sensible and convincing justifications and explanations about trade-offs between competing priorities. These budgets reflected strategies set out in a national framework for health development, which defined those essential curative and preventive services to be provided, but which were adjusted to local conditions and requirements.

District health management boards were created by legal notice in 1992. At the root of adjustment through cost sharing the World Bank was of the opinion that cost sharing could be more effective if the money collected was retained to improve health services at the respective health facilities. The role of the *District Health Management Boards (DHMBs*) was to oversee the management of cost sharing monies. This was extended to permit them to oversee all health sector activities within their districts. This was coupled with the formation of Hospital Management Boards (HMBs) to manage Ministry of Health hospitals. To reinforce this important innovation, DHMBs, DHMTs and HMBs received training and material support to promote more effective operations. These changes called for amendment of appropriate legislation in order to enable the Boards to assume

much broader roles. At the lower level, health center and dispensary committees were established to enhance the functioning of these facilities and promote community ownership.

To effectively implement present and future health policies the DHMBs needed greater support from the District Health Management Teams (DHMTs) which were expanded and trained in modern management and planning methods to permit them to better fulfil their operational responsibilities and functions. The proposed strengthening of district level planning and management combined with effective leadership from the DHMBs made health management more effective and responsive to local needs, thereby improving accountability and reducing inefficiencies which were common in the pre-adjustment era.

Medical diagnostic facilities (laboratory and radiological) at the Health Center level was strengthened so as to elevate the standard of clinical care at that level. This promoted more cost-effective clinical services. The critical clinical staff (doctors, nurses and clinical officers) at the Health Center level was strengthened so as to improve the clinical performance of the health centers. This improved the referral system of patients. Outreach and Mobile Clinical Services were intensified in the remote areas with nomadic and semi nomadic populations, as well as in other under-served areas, particularly in urban slums.

3.3.2 Privatization

Odada and Odhiambo (1989) observes that the Non-Governmental Organizations (NGOs) and the private sector provide about 40% of the health services, and 33% of in-patient care (this came up with adjustment when state protectionism was replaced with competitive provision of health care by various providers). Most of the NGOs charged user-fees at a much lower rate than the private health providers. In addition, some of the NGOs also trained their health workers in their health training institutions. This improved the skills of their health personnel.

A health policy guideline was developed for all the NGOs and private providers of healthcare. A planning committee was established which coordinated and oversaw the activities of the NGOs and the private sector in order to avoid the duplication of efforts. This was achieved by providing an enabling environment for their expansion to take on incremental health services over and above those which the Government undertook to provide. This included subsidizing or contracting these services in areas where the Ministry of Health was not able to cater for the population specifically.

It was necessary to ensure that the quality of care and standards of medical practice and professional ethics met what was stipulated in the regulatory health legislation in the Laws of Kenya. To better respond to the needs of patients and health care professionals alike, the main legislation was amended to provide for an inspectorate and for the institution of proper regulatory mechanisms. This entailed regulating private practice to ensure compliance with the relevant laws and regulations concerning standards of care and maintenance of good medical practice, as well as the regulation of

part time private practice (PTPP) by consultants employed by the Government to ensure that they provide the services for which they were paid.

The legal framework for the practice of the medical professions was revised so that private practice became easier to initiate, but was regulated in such a manner that the quality and costs of care delivered were maintained at levels acceptable to both providers and beneficiaries. At the same time, those who choose to remain in practice in Government health care institutions were offered the necessary financial and professional incentives to do so. The legislation governing private practice of the medical professions and the rules governing part-time private practice (PTPP) by consultants employed by the Government was revised. Before part-time private practice was not addressed by the Medical Practitioners and Dentists Act, but was covered by an administrative arrangement allowing doctors in Government service to engage in PTPP due to demand for specialized services outside Ministry of Health Institutions. In the interest of the public PTPP was regulated by the Ministry of Health and by the respective Professional Boards. Consultants were well informed that abuses of this practice could lead to withdrawals of privileges and discipline for professional misconduct.

Also, in the interest of the general public the respective Boards defined what constituted professional misconduct and such definitions were made available to all the professionals concerned. The training curricula gave more emphasis to professional ethics than was the case then.

Shifting a proportionally greater burden of curative care to private, mission and other non-governmental sources the government reduced imposed costs and constraints, strengthened the financial viability of mission health services, and expanded insurance coverage and benefits. The government provided incentives to those practitioners who wished to establish private practice in underserved areas.

3.3.3 Alternative Health Financing Policy Initiatives

3.3.3.1 Cost Sharing

Since independence in 1963 the Kenyan communities have largely relied on Government financing for their health care as well as other social needs. By the time adjustment policies took root in Kenya it had become a matter of grave concern to the Government that most of the allocations to the MOH were consumed mainly by recurrent expenditure with no savings at all to generate growth. For instance Odada and Odhiambo notes that curative care consistently took the dominant share of the recurrent expenditure of the MOH-68.4% in 1980/81, 72.3% in 1983/84, and 67.3% in 1884/85.

Within the public health sector, it was evident that quite a large proportion of the budgetary resources was used in the curative services rather than the relatively low-cost preventive and promotive health services. In addition to the above, it was also evident that about 70% of the public health recurrent budget, maintained the personnel expenses and the balance went to operation and maintenance of health services (odada & odhiambo, 1989:10). As a result the Government was unable to cope with the financing of all the health needs of its entire population and the quality of care had declined.

Table 3.3: Financing of Health Services 1983/84 (KSh Million).

	Govt.	Mun.	Mission	Other NGOs	Pvt. Hos.	Pvt. Care	Pvt. H/h
Government	163.2	-	34.1	5.6	-	7.5	25.5
Municipality	-	152.6	-	-	-	-	-
NHIF	12.0	0.6	23.0	-	7.5	65.9	-
Missions	-	-	29.3	-	-	-	-
NGOs	-	-	-	13.4	-	-	-
Prv companies	-	-	-	-	3.9	50.0	-
Prv inst.direct	17.8	7.4	80.5	-	-	141.4	963.8
International Donors	51.2	-	2.0	17.8	-	-	-
Total	1244.2	160.6	168.9	36.8	11.4	264.8	989.3
Grand total- 2876.0							

Source: MOH/World Bank Report (1986) Expenditure and Financing of Health Services in Kenya

Table 3.4: Allocation of Each Health Programme as a Percentage of the Gross Recurrent Expenditure 1980/81-1984/85

Programme	Actual 80/81	Actual 81/82	Actual 82/83	Approved 83/84	Estimate 84/85
General administration	5.5	6.0	6.6	6.0	5.3
Curative care	68.4	72.3	69.0	66.9	67.3
Preventive & promotive	6.6	4.6	5.2	5.2	5.3
Rural health services	9.2	8.2	11.2	10.9	9.8
Health training	6.0	6.0	6.0	7.2	7.1
National insurance	0.3	0.2	0.5	0.6	0.7
Medical supplies	2.4	2.7	0.7	1.0	0.9
Medical research	1.8	-	-	2.4	3.2
Total	100.2	100.0	100.0	100.0	100.2

Source: MOH/World Bank Report (1986) Expenditure and Financing of Health Services in Kenya February

Policy weaknesses in health financing practices included: a growing gap between the financial resource requirement for projects and resource availability from public budgetary sources; underfunding of existing health facilities resulting in lowered effectiveness and maintenance standards; non-reconcilability of the need for public investment in growth sectors of the economy with the demand for health programme expenditure. At the same time, the mechanisms of allocating resources were inadequate, making it impossible to have cost-effective public sector health programmes. Huge disparities also existed in the distribution of resources from budget

sources between regions, and between urban and rural areas. Finally, emphasis on hospitals and tertiary level institutions did not promote equity, which was a major policy goal.

In the situation of economic decline, increased demand for public health services made it increasingly difficult for the large majority of African governments to afford costs of basic inputs required in the health sector (Mwabu, et al, 1993). Due to this, in 1989, the Kenyan government introduced user fees in hospitals and health centers leaving the services in the dispensaries free. It was modified in 1992 to convert user charges from a consultation fee to a treatment fee. A user charge scheme included levying fees for a registration card and then providing free services; charging a uniform fee for each episode of illness; or charging for drugs only. At all times the schemes being planned took account of the poor and the vulnerable. And there are large numbers of these in Kenya.

The Government's policy proposal was that cost sharing was one of the options for containing public spending on consumer services. It was to facilitate cost recovery, generate additional revenue, improve equity, and discourage frivolous demand. Cost sharing was a new policy measure being adopted to create alternative financing and/or supplemental sources of financial demand for social services. The broad objective of cost sharing measures in the health sector was to restructure the financing system for health services. A number of public health services still remained free of charge; this included the sexually transmitted diseases, preventive and the promotive health services. Patients between the ages of 0-15 years were also exempted from paying for health services. It

was proposed that 75% of the revenues collected be retained by the institutions providing the service to encourage them to improve the quality of care, while 25% was used to enhance preventive and promotive health services in the respective districts.

Longer-term options, which were considered, included the provision of block grants from the Government to the districts. Under these arrangements district level planners and managers had the option of restructuring health services in a manner that best suited both local circumstances and the levels of resources they were allocated and those local funds they could raise from cost sharing and other local initiatives.

3.3.3.2 Insurance Schemes

Introduction or development of health insurance schemes is one of the health care financing reform options that was explored in Kenya in an effort to cope with the problem of severe budgetary constraints in health services delivery in the public sector. Strengthening of health insurance in the country was expected to encourage expansion of the private sector, in addition to enhancing financial resources for the public sector.

Mwabu et al (1993:6) argue that health insurance is an institutional and financial mechanism that helps households and private individuals to set aside financial resources to meet costs of medical care in the event of illness. They further argue that it is an important mechanism for supplementing the health finance available from public sources. The attractiveness of health insurance lies in risk sharing. An individual, a household or an organization, needs health insurance to cover itself against two basic types of risks, namely:

1) Losses due to expenses on normal but expensive illnesses: households and other agents typically like to cover themselves against expenses which are likely to occur due to some illness in the future. If the sum of premiums these agents have to pay to join a risk sharing scheme is smaller than the expected cost of illness, then the risk-sharing scheme is worthwhile and they are likely to join it.
2) Costs of catastrophic and unexpected illnesses: certain illnesses will occur within a population, which will involve the affected household in major financial outlays on medical care. Individual households, however face a very small probability of experiencing such catastrophic illnesses. For an affordable premium, each household would like to be covered against such expenses. Both the poor and the rich need insurance to cover themselves against these risks.

Insurance in Kenya became important with the root of adjustment when the providers of health services started charging for their services. This is one of the conditions that must prevail in order for a private market insurance to thrive.

The National Hospital Insurance Fund (NHIF) was established in 1966 under the National Health Insurance Fund Act. The NHIF reimbursement mechanisms of the Government of Kenya (GOK) health institutions were streamlined to enable them to benefit from the fund's benefits. With the onset of cost sharing in health facilities an aggressive recruitment campaign was undertaken to increase the population with health insurance coverage from 33% to 40% of the population. The NHIF scheme was expanded to cover contributors whose monthly earnings fell below Shs. 1,000 and the monthly premium was increased.

Under the then health reform measures, the NHIF was reorganized into a National Health Insurance Corporation (NHIC). This was to coordinate and administrate a health insurance scheme, which enabled the members to enjoy more benefits. In the public sector, the health of the employees was covered under the National Health Insurance Fund, which catered for particular hospitalization costs. The scheme for civil servants was reviewed. The role the employer played in insuring his employees was reviewed with the intention of having the employer meet half of the health insurance premium of the employees.

Through policy leadership, legislation, regulation and education the Ministry strengthened the role of NHIF, increased the population covered by health insurance (both NHIF and private), broadened insurance benefits, and increased community-financing efforts. The expansion of existing private and community insurance schemes were promoted through the forging of links with these financing institutions.

The NHIF was encouraged to develop and expand its benefits package to cover more than reimbursement for board and lodging in hospitals and nursing homes. In this manner, it became a National Health Insurance Fund. Likewise, the creation of an enabling environment for the expansion of private practices into underserved areas was examined, with a view towards NHIF offering loans for the establishment of these practices at preferential rates.

The health insurance sector was reformed through the development of innovative financing mechanisms that guaranteed the accessibility of basic packages of health

services to all, based on need and not ability to pay. In particular, legislation was enacted to transform the National Hospital Insurance Fund (NHIF) into an effective, pay-as- you-go health insurance fund with mandatory coverage for all formal sector workers.

3.4 AN OVERVIEW OF OTHER HEALTH CARE POLICIES

It is not only the adjustment policies that prevailed in the Kenya health sector, other health care policies were also being undertaken simultaneously.

3.4.1 Civil Service Health Manpower Reform.

In a developing country like Kenya, where the level of technology is low, healthcare is labor intensive. In order to fully utilize the available health staff the Government endeavored to train and properly manage the health staff. In this regard, Manpower Planning Unit was established to:

- Develop a computerized Personnel Information System;
- Formulate the staffing norms for the MOH cadres, and
- Draw a long-term health manpower needs and training programme for the health sector. These measures coupled with appropriate deployment of staff ensured that health institutions had the correct mix of staff required to manage their workloads. The majority of the qualified health personnel in the public health sector are in the urban areas. The Government examined ways in which it could encourage the medical personnel to work and establish health clinics in the rural areas.

Personnel and supplies were directed to the peripheral dispensaries and health centers. If effectively managed, this reduced the workload at hospitals. Clear staffing norms were developed to form the basis for future personnel policy geared towards making smaller

facilities functional and adequately staffed so as to enhance their outpatient services. Similar norms for manpower allocations and postings to the districts were set.

Using staffing norms, policies were directed towards ensuring that there existed a proper ratio among the various cadres. These ratios were used to control either increases or reduction in the number of certain cadres trained at public expenses. At the same time, training of essential clinical specialists was closely controlled and monitored to ensure the availability of the most critical cadres.

It was necessary to redeploy some staff from in-patient services in favor of outpatient and community based services. Priority was given to the deployment of newly trained staff to underserved provinces and rural health facilities. Ceilings were imposed upon the number of Ministry of Health personnel deployed to hospitals and large urban facilities, and this meant the establishment of targets for the number of Ministry of Health hospital beds, which received support.

Basic Education of Health Professionals was reformed to ensure they had a high level of skill to deal with the problems of curative care and in preventive strategies. It was necessary to meet projections of future demand given current attrition rates from the existing supply of health personnel. This included curricula reform, substantial training of trainers and administrative staff and the establishment of a full time professional trainers scheme of service and benefits.

There was a number of changes for strengthening personnel management, increasing their effectiveness and efficiency personnel retraining and attracting qualified staff, zero growth budgeting for staff and the creation of a balance between urban and rural staff deployment through the following measures:

- Harmonization of policies among cadres who wished to leave the public sector and enter into private practice
- Health professionals' terms and conditions of service were improved to assure basic individual needs.
- It was critical to deploy and retain staff at facilities in the rural areas where more than 85% of the population lives. A system to encourage rural staff retention was established. The classification of hardship areas was reviewed to improve the incentive and benefits structure.
- The Ministry of Health drastically reduced the number of Surbodinate staff on its payroll. Districts were empowered to recruit Surbodinate staff in accordance with the needs of their facilities and they were expected to meet their costs from new and innovative sources. Civil service reform in general seeks to trim the size of the civil service, and as part of this reform program, in 1993 the Ministry of Health began implementation of a voluntary early retirement scheme for those in lower job groups.
- Similarly, the Ministry of Health set targets for other health personnel to be paid in each district using a weighted capitation formula. Additional staff were hired and paid directly at the district level.

3.4.2 Aids Policy

HIV/AIDS was declared a national disaster in 1997 (Republic of Kenya, 1997). GOK, (2002-2008:18) observes that Kenya ranks among the highly affected countries in Africa with over 2.2 million cases. This is about 16% of the adult population. Of the AIDS cases reported, about 76% fell in the 20-44 years age bracket (20-29 for females and 30-44 for males). On the economic front, AIDS thus claimed productive members of the country's labor force, many of whom were highly trained. Many of these people left young orphans, many of whom went without basic needs including food, shelter, clothing, and education. The cost of treating AIDS related ailments including tuberculosis which had proved difficult to handle meant shifting resource from preventive and Promotive to curative health, in addition to engaging a big proportion of hospital beds.

If the spread of the virus was not controlled, the economic impact of the disease would be monumental. It was estimated that the cumulative economic impact could be as high as 15% of the GDP by the year 2000, up from 2% in 1994 (GOK, 1994). From a gender perspective, women are doubly at risk, firstly as potential victims and secondly as traditional health care providers.

Other expected consequences of the pandemic are an increase in families headed by children, declining educational enrolments as children were forced out of school to care for sick parents and increased child labor sector as children attempted to supplement the income earning activities of sick parents. From a fiscal standpoint, the pandemic threatened to tie up the entire MOH recurrent budget by the end of the century.

Since AIDS can only be prevented and not cured, the following control measures were implemented:

- The National AIDS Control Programme (NACP) was launched by the government in 1986 to respond to the AIDS epidemic, provide information and education on AIDS to the public, ensure that blood and blood products were routinely screened in all hospitals, improve clinical management of AIDS-related complications, come up with interventions appropriate to prevention of AIDS transmission, and to counsel victims and their families;
- A multi-sectoral National AIDS Control Council was established to formulate policies on AIDS and provide guidelines for development and implementation of control programmes; and
- The Government placed more emphasis on community based management of AIDS, in accordance with the Bamako Initiative and pallative treatment of AIDS-related conditions were made available through community pharmacies and community health workers.

Prevention of transmission of HIV to women was by far the best strategy for preventing transmission from mother to child. Because most women were unaware of their infection status, efforts were made to avail facilities for voluntary testing of pregnant women. Secondly prevention of perinatal transmission depended on the avoidance of child bearing by HIV positive women. Voluntary counseling, contraception and other fertility regulation services were made available to women everywhere as part of health services and supportive environment needed for prevention of Perinatal transmission. Research was used to evaluate the impact of counseling methods for couples and

women of childbearing age, and to determine how to improve this impact through alternative methods, for example using religious leaders and traditional health practitioners. Over the longer term, biomedical research was to pursue the development of 'perinatal vaccines' and other such drugs for preventing HIV infection in the unborn and newborn babies of HIV positive women.

Proper care and support of HIV positive persons was stressed so that they were useful and productive. The Government strived to ensure that humane care of a quality at least equal to that provided for other diseases was available for HIV positive infected adults and children. Services were appropriate, accessible and continuous, at the minimum, clinical care included pain relief and treatment for common opportunistic infections. With regard to social security and health insurance schemes, the coverage afforded to people with HIV/AIDS was made equal to that provided for people with other diseases. Community Based Home Care for AIDS sufferers was emphasized and developed. Community based foster care homes, day-care centers, and a bigger parenting role for schools supplemented traditional approaches to care of orphans. Other options included village associations or cooperatives, which parents joined in preparation for the orphanhood of their children, the use of religious and other charitable institutions to protect orphans' property, and the creation of a protective climate for widows, and orphans.

3.4.3 Adoption and Implementation of A National Drug Policy

This ensured that available resources were used to develop pharmaceutical services to meet the requirements of all Kenyans in the prevention, diagnosis and treatment of

diseases using efficacious, high quality, safe and cost effective pharmaceutical products. The National Drugs Policy served as the guiding document for legislative reforms, staff development, and management improvements.

Drug availability was increased at government health facilities through improvements in the selection, financing, procurement, distribution, and use of pharmaceuticals. The first critical step in making drug selections more cost-effective was taken in September 1993 with the launching of the revised National Essential Drugs List (EDL). With assistance from the World Health Organization, the list was made available to all health institutions in the country, both governmental and non-governmental. Availability of drugs at ministry health institutions was also improved through financing arrangements based on actual per capita drug requirements and on re-establishment of a well managed revolving drug fund. Good pharmaceutical procurement practices were implemented: procurement by generic name, concentration on the EDL, rational needs assessment, pre-qualification of suppliers, competitive tendering among pre-qualified suppliers, improved quality assurance, and systematic monitoring of supplier performance. Efforts to improve distribution also continued. The ministry obtained a commitment from WHO to provide financial and technical support for a senior level committee to re-structure the supply process. Drug availability in the private, mission, and NGO sectors was improved through a strengthened registration system, a more systematic approach to determining where particular types of drugs were sold ("scheduling") and streamlining of the importation process.

The high cost of drugs in the public sector was addressed primarily through the improved financing and procurement procedures. Affordability of drugs in pharmacies and at private health institutions was addressed by several measures in the National Drug Policy. First, a major emphasis was placed on promoting generic labeling, prescription, and substitution. Educational programs for medical practitioners, pharmacists, other health professionals, and the general public emphasized the cost-effectiveness of generic products. Proper registration and quality assurance procedures ensured that generic products were safe and effective. Second, registration of drugs in Kenya was limited to products, which had proven quality, safety, and efficacy and which met a specific medical need. Products whose proposed wholesale and retail prices were excessive compared to those already on the market were not accepted. Third, efforts were made to extend NHIF and other insurance coverage to include pharmaceuticals, thus easing the burden on individuals. Fourth, alternatives to the system of compensating pharmacists/ pharmaceutical technologists were explored. Fifth, traditional medicine was encouraged, but supervised through the new policy. Finally, though there was no formal price control mechanism, the ministry ensured that established wholesale prices were regularly published and that a mechanism was established to exchange price information with other countries.

Rational drug use improves health and reduces costs. Better prescribing, dispensing, and patient use of drugs was addressed by regularly updating and widely disseminating standard treatment guidelines for hospitals and rural health facilities, standardizing levels of authorized prescribing, integrating the Essential Drugs Concept into all health – related training, introducing Pharmacy and Therapeutics Committees into all major

health institutions, establishing a national drug information system, and controlling drug advertising and promotion.

The quality of drugs imported into Kenya and manufactured in Kenya was controlled by making the National Quality Control Laboratory fully operational, by enforcing international- standard good manufacturing practices among all manufacturers, and by actively participating in the WHO Certification Scheme on the Quality of pharmaceutical products.

Kenya has an active pharmaceutical industry, which contributes to the economy, security and health of the country. Continued growth of this industry was encouraged through promotion of genetic products, local production incentives, a local preference margin in Ministry pharmaceutical tenders, review of applicable patent laws, and harnessing of potential research and development funds to expand local technical know-how.

The availability, affordability, rational use, and quality of drugs for veterinary services was improved by applying the same Essential Drugs Concepts to the selection, procurement, distribution, and use of veterinary drugs as were applied to drugs for human consumption. This included preparation of a Veterinary Essential Drugs List, promotion of general prescribing and related activities.

The implementation of the National Drug Policy did not occur over-night. Some policy elements required legislative adjustments, while still others required changes in day to day Ministry operations. Implementation of certain aspects of the NDP rested solely with

the Ministry of Health, while the implementation of other aspects required collaboration among several Ministries. Enabling legislation already existed in the following Acts of parliament, in some of which specific sections required subsidiary legislation in support of the National Drug Policy:

> *The Public Health Act Cap 242, the pharmacy and poisons Act Cap. 244, the Dangerous Drugs Act Cap 245, the Medical Practitioners and dentists Act Cap 253, the Clinical Officers (Training, Registration and Licensing) Act, Cap. 260, the Nurses Act Cap. 257, the Malaria Prevention Act Cap. 246, the National Hospital Insurance Act Cap. 255, the Food, Drugs and Chemical Substances Act Cap 254, the Animal Diseases Act Cap. 36 and the Price Control Act Cap. 504.*

3.4.4 National Policy on Development of Physical Facilities and Major Equipment

To guide and improve public investments in health facilities and equipment, a national policy on the development of physical facilities and equipment was prepared and implemented. This national policy governed the choice of type and location of physical facilities and equipment by all providers, and limited new construction only to those facilities considered necessary to provide equitable access to essential curative and preventive services. Guidelines were developed for the provinces and districts, which permitted them to decide where additional facilities or services were located in their area of jurisdiction. At the same time, the policy defined the requirements for the rehabilitation of existing facilities and equipment and for their continued maintenance and repair.

The development of appropriate policy guidelines contributed to the preparation of a long-term public investment plan for the health sector by the Ministry of Health which

channeled future investments towards a more equitable and sustainable provision of health care services in Kenya.

3.4.5 Policies on Health Research

Essential National Health Research focuses on priority health problems, is cost-effective and its recommendations are easily implemented. Its objective is to accelerate the people's, socio-economic development through better health. The Essential National Health Research (ENHR) activities started in 1990, when the situational analysis on the ENHR was done and showed that there was no agenda for the ENHR in the country and ENHR was allocated relatively less resources than those of the other health related activities; the research activities undertaken were not coordinated and therefore the results were disseminated. Therefore ENHR was to focus on the following:

- The Biomedical Science Research Center was to develop new techniques for diagnosis and management, including identification of animal models for such diseases as leishmaniasis, bilharzia and filariasis;
- The Viruses Research Center was to research on the various viruses which affect man, in addition to the on-going work on Hepatitis B, Measles and Aids;
- The traditional medicines and drugs research center was to continue collaborating with traditional doctors and provide scientific basis for drugs;
- The formation of the professional associations for traditional medicine practitioners was encouraged by the Government;
- The Alupe Leprosy and Skin Disease Center was to research better and cheaper tools for the diagnosis, control and management of leprosy and other skin diseases; and

- A National Health Research Information and Documentation Center was established. This set up a health research inventory database.

The Government recognized that health research supports the activities of all agencies operating within the health sector, and that research into priority diseases and conditions and the means to combat them must be better coordinated.

The Government, through the Ministry of Health established the Division of Research, Health Standards and Inspectorate. This Division, together with the National Health Research Development Center (NHRDC), coordinated all health research services in the country including the creation and implementation of health standards to ensure compliance with the health laws. This involved: -

- Coordination of health systems as well as clinical and biomedical research
- Setting health standards as a priority for patient care and management of disease.
- Reinforcing the set health standards
- Collaborating with all health research institutions (e.g. NHRDC, KEMRI, ICIPE)
- Collaborating with the relevant Boards/ Councils on matters of health standards (e.g. Medical practitioners and Dentists Board, Nursing Council, Clinical Officers Council).

3.5 CONCLUSION

The policies that the government has pursued over the years have had a direct impact in improving the health status of Kenyans. Despite a decline in economic performance, cumulative gains have been made in the health sector as evidenced by the improvement in basic health indicators. Considerable progress was made in improving the health

status of the population. (GOK, 1989). It is however important to note that although the national health indicators looked impressive, there were significant geographic disparities which needed to be addressed in order to achieve some equity. (GOK, 1994).

However, not all policies formulated over the period were translated into actions or realized their desired outcomes. The decline in resource availability and to some extent the mismanagement of resources limited the implementation of policy and expected benefits were not fully realized. This is to say that the Kenyan Government realized the problems in the health sector and tried to formulate and implement some policies in a bid to rectify the situation. The question is did this policies turn round the situation? This is the discussion in the next chapter in particular those policies brought about by the Structural Adjustment Programmes in the health sector.

CHAPTER IV

4.0 THE PERFORMANCE OF THE KENYA HEALTH SECTOR UNDER STRUCTURAL ADJUSTMENT

4.1 INTRODUCTION

A sound health care delivery system, good nutritional status, food security and the absence of epidemic diseases, are necessary conditions for a country to have healthy people capable of participating in a country's economic, social and political development.

Life expectancy, infant, child and maternal mortality and morbidity rates are basic indicators of a country's health and socio-economic situation and quality of life. Rates of childhood mortality will vary over-time in relation to changes in epidemiological risks (exposure to diseases), nutritional deficiencies (susceptibility to diseases and death), and the extent to which a country's health and social services sectors prevent and mitigate these threats to health and survival.

Kenya started the 1980s with many more favorable economic features than other Sub-Saharan countries. Ishrat and Rashid (1994) observe that the structure and dynamism of the economy in the late 1970s evolved out of the favorable policy environment of the past. But economic management deteriorated in the late 1970s, which resulted in the intensification or emergence of a number of most distortions. During the 1980s progress was measurable and significant in only a few areas, and the economy's momentum of the first two decades of independence slowed considerably. As one commentator observed,

> *"Few country lending experiences have given the [World] Bank so much cause for frustration" (Mosley, 1991).*

The stated policies-which were broadly in line with the World Bank's recommendations-were undermined by implementation that was often lethargic and sometimes contrary to the stated policies. Swamy (1994) notes that the first adjustment attempt (1980-1984) was marked by a total lack of compliance, partly because of design and timing problems, but also because the commitment to the stated policy changes was limited to a small group of top civil servants. In the second period of adjustment (1985-91), when much more effort went into building a consensus, the pace was incremental, and the commitment of top officials shifted.

A complication in Kenya's implementation of structural adjustment in the 1990s was the high speed with which the reform programme was implemented at a time when donor aid had been suspended. The IMF and the World Bank had become impatient with the slow rate of implementation of the reform programmes in the previous decade (Swamy, 1994). Hence, in order to appease the donor community the government made a number of reform measures almost simultaneously, leading to painful adjustments. Donor financing which should have accompanied the reform to avert a decline in public expenditures was not available due to the suspension of aid by donors. The situation was compounded by the governments' determination to mop up excess liquidity arising from money, which had been pumped, into the system by irresponsible spending during the election campaign in 1992. The result of this was a deterioration in the provision of public services such as health, at a time when the government was reluctant or not able to adjust wages to compensate workers for the erosion of their real earnings (Ikiara & Tostensen, 1995).

According to a 1988 UNICEF workshop report, structural adjustment posed a serious threat to the country's health care, with serious implications on the access of the poor and other vulnerable groups to adequate and good quality health care, without the necessary measures by the government to protect these groups from the adverse effects on health manpower training programmes by reducing both the numbers and quality of people trained for health care provisioning in the country. The breakdown in many aspects of the country's infrastructure and services had also been distributed to structural adjustment programmes (Ochoro & Omoro, 1989:37).

> *" In the course of structural adjustment in Kenya in this decade some of the most starkly visible deteriorations are found in supplies due to expenditure reductions. Due to these expenditure cuts on the maintenance of the fuel for government vehicles, access to the rural areas health facilities is greatly reduced which means reductions in the extension services" (Ochoro and Omoro, 1989).*

4.2 KENYA HEALTH STATUS SITUATIONAL ANALYSIS: PROGRESS IN MEETING HEALTH TARGETS IN THE ERA OF ADJUSTMENT

4.2.1 Life Expectancy at Birth

Life expectancy at birth for males increased from 46.9 years in 1969 to 52 years in 1969-79 decade and to 57.5 years during 1979-89. Expectation of life at birth for females increased from 51.2 years in 1969 to 55.1 years during 1969-79 decade and to 61.4 years during 1979-89. The national average (for men and women) life expectation was 59.5 years in 1989 and it fell to 48 years in the 2000 World population analysis. The underlying factors leading to increased life expectation included improvements in the health care system, reduced rates of mortality, increased earnings and higher levels of education (see table 4.1, 4.3 & 4.4). A significant variation in life expectancy across districts was evident. All districts in Coast (except Taita Taveta), North Eastern, Nyanza and Western (except Bungoma) provinces had life expectancies below the national

average. The highest life expectancy recorded during 1989 was 69.8 years in Nyandarua District while Turkana district recorded the lowest life expectancy of 44.7 years. However there has been a rapid rise in the rate of adults deaths, especially young and middle aged Kenyans since AIDS became one of the major causes of death. This may significantly reduce life expectancy in the coming years. In fact, the crude death rate, which declined from 17 per 1,000 population in 1960 to 10 in 1992, had begun to rise reaching 12 per 1,000 population in 1995 and 14 per 1,000 in 2000(see table 4.1).

Table 4.1: Mortality Rates in Kenya, 1960-2003

Indicator	1960	1979	1991	1992	1993	1995	1998	2000	2003
Infant mortality rate (per 1000 live births)	119	104	52	51	60	61	74	74	66
Under 5 mortality rate (per 1000 live births)	202	112	75	74	90	90	112	114	115
Maternal mortality rate (per 10,000 live births)	-	-	-	150-300	150-300	365-498	-	-	-
Crude death rate (per 1,000 population)	17	14	11	10	10	12	13	14	15

Source: 1989 Census Analytical Report, Vol. V- Baseline Survey Report, and 1998 KDHS Report.
Sources: World Population Data Sheet, 2000), 2003
(-) Data not available
(Note: Maternal Mortality is shown per 10,000 live births)

4.2.2 Infant, Child and Maternal Mortality

Data on infant, child and maternal mortality and crude death rates are presented in the table 4.1. The infant mortality rate (IMR) dropped from 119 per 1,000 live births in 1960 to 51 in 1992, while under-five mortality rate (U5MR) declined from 202 per 1,000 births in 1960 to 74 in 1992. However, both rates increased significantly thereafter reaching 74 and 112 deaths per 1000 live births for IMR and U5MR respectively. At the regional level, infant mortality was found to be highest in Nyanza Province. In 1989, for example Siaya and South Nyanza districts had IMR of 135 and 137 per 1,000 live births respectively. The IMR was lowest in Central Province, where Nyeri and Nyandarua

districts had IMR of 21 and 25 per 1,000 live births respectively. This translates into a ratio of one death in Nyeri to about six in Siaya and South Nyanza. Children in rural areas experienced a 21% higher risk of dying before age five than their urban counterparts. This is attributed to greater concentration of health facilities (70%) in urban centers as compared to rural areas and higher education among mothers in urban areas. Mothers with primary education only had higher infant and child mortality rates compared to those with secondary education and above (see table 4.2).

Table 4.2: Regional Inequalities in Health

Indicator	Nairobi	Central	Coast	Rift valley	Nyanza	North Eastern	Western	Eastern	Kenya
Population as at 1999 (000)	2,143	3,724	2,487	6,987	4,392	962	3,359	4,632	28,687
Life expectancy at birth	61.6	63.7	51.5	58.5	45.7	52.4	52.4	62.3	54.7
Infant Mortality Rate (IMR)	41.1	27.3	69.8	50.3	135.3	-	63.9	53.1	71.0
Under Five Mortality (U5M)	66.1	33.5	95.8	67.8	198.8	-	122.5	77.8	105.0
Total Fertility Rate (TFR)	2.6	3.7	5.1	5.3	5.0	-	5.6	4.7	4.7
Female-headed households (%)	19.6	36.4	31.7	27.6	34.5	-	35.4	35.1	31.7
Foster/ Orphaned Children (%)	5.7	9.5	15.2	16.8	19.0	-	24.9	13.4	15.3
Children Underweight (%)	16.3	15.7	27.3	27.4	29.1	35.8	25.4	27.8	26.4
Health Facilities (% of total)	12.0	13.0	11.0	25.0	8.0	2.0	8.0	21.0	4,355

Source: Republic of Kenya 1998, 2001a, 2001d

Maternal mortality posed a major threat to women of reproductive age in Kenya. Data on maternal mortality are scanty. It was established to range between 150 and 300 deaths per 100,000 births in 1992. The 1994 Baseline Survey by the Population Studies and Research Institute (PSRI) of the University of Nairobi estimated the maternal mortality rate at between 365 and 498 deaths per 100,000 births. This is a significant increase within a very short period. It was also found that there were geographical variations, which showed that Kwale had 2,221, South Nyanza 1,072 and Busia 1,002

deaths per 100,000 births; which contrasts sharply with the exceptionally low rates of 18 deaths in Nyeri and 137 in Embu. The Baseline survey also indicated that 47% of maternal deaths occur in hospitals. The percentage distribution of maternal deaths by cause were: abortion and related complications 4%, direct obstetric deaths 47%, indirect obstetric 25%, and others 24%.

The results from the 1993 Kenya Demographic and Health Survey (KDHS) indicated that Kenya had achieved remarkable progress in the delivery of key child survival interventions. The rates of use of antenatal care and tetanus toxoid coverage among pregnant women were both high. Almost half of the women were able to deliver their babies with the assistance of medical professionals, even though some had to travel farther than 5 kilometers to do so. Maternal mortality was found to be 365 in 100,000. The level of utilization of curative services for diarrhoea was relatively high; one-third of all children were given oral rehydration salts. Childhood immunization coverage, achieved through the Kenya Expanded Programme on Immunization (KEPI) and in partnership with UNICEF and NGOs, was also high (GOK, 1999:48).

Despite these achievements there was still a major challenge ahead to meet basic health care targets, especially to focus on the specific health needs of poor households and to lower maternal and infant mortality. One in ten Kenyan children still died before reaching their 5th birthday. The rate in the five years before the KDHS was 96 per 1,000 live births. Infant mortality was 62 per 1,000 live births. Mortality among children under five was especially high in Nyanza province. The infant mortality rate there (128) was almost twice that of the second highest rate (Coast province at 68). Previous gains in

the fight against childhood mortality were threatened as the rate of decline had stagnated. Poor nutrition may have played a role in this. One third of the children under five were stunted, reflecting chronic under-nutrition. This proportion is 14 times the level expected in a healthy well-nourished population. 12% of the population in the KDHS were severely stunted.

In general, earlier reductions in mortality rates were due in part to health policies and programmes which focused on improvements of rural health services and adoption of primary health care (PHC) as a strategy of health for all. Secondly, reduction in IMR and U5MR was attributed to increase in child immunization coverage. For the latter, various national programmes targeting children and mothers backed community efforts. These included the Kenya Expanded Programme on Immunization (KEPI), Control of Diarrhoea Diseases, Traditional Birth Attendants (TBAs) training programme, Maternal and Child Health/Family planning services and improved nutrition.

The positive achievements in reducing mortality rates between 1960 and 1992 appear to have been reversed thereafter (see table 4.3 & 4.4). This is confirmed by the 1998 Kenya Demographic Health Survey (KDHS) report, which showed that the IMR went up from 51 in 1992 to 74 in 1998 per 1,000 live births. The U5MR shot up from 74 in 1992 to 90 in 1995 and 112 in 1998. This is alarming as a significant portion of the gains made during the first 25 years of independence was rapidly eroded in just six years. The underlying factors include a deterioration in the quality and quantity of health services and their reduced access to the poor following the introduction of fees, an overall decline in food availability and nutrition, decrease in immunization coverage, increased

incidence of HIV/AIDS and increasing poverty. Immunization coverage had declined from 79% in 1993 to 60% in 1998 and increased to 82% in 2000. Nyanza Province with the highest IMR also had the lowest immunization coverage of 40% as compared to Central Province with 65-70% coverage. These issues required urgent attention and concerted efforts to reverse these negative trends (UNDP, 1999:48).

Table 4.3: Trends in Kenya's Vital Health Status Indicators, 1965-2003

Health indicator	1965	1980	1993	1997	2000	2003
Crude death rate	20/1000	12/1000	12/1000	12/1000	14/1000	15/1000
Crude birth rate	50/1000	49/1000	46/1000	46/1000	35/1000	35/1000
Immunization coverage	*	74/100	76/100	80/100	82/100	84/100
Infant mortality rate	120/1000	74/1000	67/1000	66/1000	74/1000	66/1000
Life expectancy	40 years	60 years	60 years	55 years	48 years	46 years
Adult literacy rate	46/100	69/100	69/100	69/100	71/100	72/100
Doctors/population ratio	1/13,450	1/7,540	1/7,004	1/7092	15.4/100,000	*
Nurses/ population ratio	1/1,860	1/990	1/983	1/755	95.2/100,000	*
Clinical officers/ population ratio	1/12,944	1/10,889	1/9,834	1/9009	4,492/30.3 million	*
Health facilities/ population ratio	*	1/12,580	1/12,580	14.2/10000	4,355/30.3 million	*
Beds and cots/ population ratio	*	1/153	1/153	1/1176	19/100,000	*
GNP per capita	US$ 280	US$ 370	US$ 340	US$ 330	US$ 350	US$370

Source: Institute of Economic Affairs, Agenda '94: People Economic Affairs and Politics, Nairobi, Institute of Economics Affairs p.257.
2000&2003 Data was sourced from: World Population Data Sheet 2000, 2003

Table 4.4: Demographic Indicators, 1963-2003

Indicator	1963	1979	1984	1990	1993	1995	2000	2003
Estimated population	8.9	15.3	18.4	21.4	24.5	27.5	30.3	31.6
Total fertility rate	6.8	7.9	7.7	6.7	5.4	5.0	4.7	4.4
Crude death rate/1000	20	14	13	12	12	12	14	15
Crude birth rate/1000	50	52	50	49	46	43	35	35
Infant mortality rate/1000	120	104	87	74	67	67	74	66
Life expectancy at birth	44	54	56	58	60	58	48	46
Contraceptive prevalence rate	*	7	17	27	33	36	39	40
Population growth rate	3.0	3.8	3.3	3.3	3.4	3.0	2.1	2.0

Sources: Central Bureau of Statistics, Office of the Vice President and Ministry of Planning and National Development; World Population Data Sheet 2000, 2003

One then comes to the conclusion that in rhyme with the phenomenal growth in health care institutions, programmes and personnel during the country's first two decades of independence, was a significant improvement in the health status of Kenyans. Available

data on trends in vital health status indicators, summarized in tables 4.3 and 4.4 generally confirm this. However, the remarkable performance of the country's health sector could not be sustained into the subsequent decades of the country's independence, as is reflected in the stagnation in both health care institutions and health status in the 1990s. This has been attributed to the prevailing harsh macroeconomic climate, inappropriate policy responses to this climate, and a host of health care delivery system problems including inefficiencies, inequalities, resource scarcities and new epidemiological pressures.

4.3 COST RECOVERY ADJUSTMENT STRATEGIES: COST SHARING AND USER CHARGES

Cuts in government expenditure were reforms brought about in line with the policy requirement of rationalization of government expenditure. According to the critics of SAPs (see UNICEF, 1998) they were a major impediment to the achievement of one of the government's key objectives in the post-independence era, i.e. improvement of the welfare levels of the people through alleviation of hunger, ignorance, disease and poverty (GOK, 1965). In practical terms this objective was originally to be achieved through subsidized or free provision of essential public services, especially education, health and housing for marginal groups in the pre- SAPs era.

Since the initial period of independence, the government operated a system "free" medical service alongside subsidized church and private services. In reality, however, not all services were entirely free. Visits to government centers and dispensaries, and to hospital outpatient departments, were free of any charges. In-patient services were free

to patients aged 16 years and below, but adult in-patients paid a fee of Kshs 60 (US$ 1.00) at the time of discharge irrespective of duration of stay. Other assorted charges existed, such as Kshs 180 for amenity, some x-rays and for prosthetic devices. Additionally government hospitals ran amenity wards with a few beds for which Kshs 90 was charged per day.

The collection of fees was poorly enforced, however, because this would have been a contradiction of the governments stated objective, upon attaining independence, of providing free medical services. However, as constraints on social spending became more evident, the government became increasingly interested in implementing its cost-sharing policies with the root of adjustment. The most forceful policy statements regarding charging of user fees as a means of cost recovery were contained in both the Ndegwa committee report 1982 and the Ministry of health (GOK, 1984: 19-20).

The National Development plan 1984-88 adopted the proposals by the Ministry of Health and labeled the provisions as alternative financing mechanisms. The plan argued for cost sharing as a response to the rising cost of providing good quality medical care and the difficulties faced by the government in paying the costs from general revenues. It proposed the establishment and improvement of amenity wards and selective charges for hospital outpatient and inpatient services. Both the Ndegwa committee report and the Development plan argued for increased consumer cost sharing for medical services. They were merely suggesting implementation of a principle that had existed since independence. These policy statements were echoed in sessional paper No. 1 of 1986

on Economic Management for Renewed Growth, (GOK, 1986) and the Ministry of Health concept paper of 1989 on cost sharing.

This series of policy statements, began in 1982, and finally resulted in the decision to implement fees through the government of Kenya Cabinet Paper of August 1989, recommending that the ministry introduce user fees in all its facilities, except at the lowest dispensary level. Fees were introduced on December 1, 1989.

The paper emphasized that the primary goal of the reform was not to disengage the government from the health sector but to raise additional revenues for health service delivery and to allow the government to reallocate its spending in the service of improving the efficiency and equity of tax-financed services. User fees was also to be a tool to target public subsidies for curative services more carefully to patients who needed them most. Those who could contribute were to contribute, but those who could not, were not to be denied access to public medical services. Ensuring continued access by the poor was also considered important to the political acceptability of implementing cost sharing. Another stated aim of the reform was to improve the quality of services. Given that one of the demands prompting the cost sharing initiative was a perceived need for higher quality services, some portion of the revenues from cost sharing was to be returned to the originating facility.

Gesami (2000) notes that in August 1990, nine months later, the above health care pricing reform was abruptly reversed, implying suspension of all fees for outpatient and in-patient health care services. The reversal of the reform was based on strong

suspicions that it had negative effects on the poor, as well as its failure to bring about the anticipated improvements in the quality of services provided by the facilities. It was also claimed that the reform had significantly reduced access by the poor to health care services and that complaint about shortages of drugs and stationary in government health facilities continued even after implementing of the reform.

During the period the suspension was in effect, the government's fiscal situation continued to deteriorate, leading to its inability to compensate the facilities for the fee revenue they had lost (Dahlgren, 1990). Consequently in April 1992 the government announced a phase reinstatement of a slightly modified health service pricing reform. This was publicly accepted and led to some improvement in the quality of services. It was preceded by public information campaigns and it was accompanied by several managerial reforms. One of the managerial reform was the creation of a central unit within the MOH to implement the new user fees, which could set fees, initiate changes in national insurance regulations and train health personnel in the new system of financial management. The other financial innovations of the new reform related to timing of payment of charges, authorization of expenditure of retained funds, and groups of population exempted from charges. It provided for payment of charges after treatment, decentralized management of 75% of the fee revenue retained in facilities by District Health Management Boards (DHMBs) with representation of the community, and expansion of the groups of population exempt from the fees including civil servants, the military and the unemployed.

The existing cost sharing mechanism was found to cause hardship and to restrict access to modern health care by the vulnerable, and to endanger primary and preventive health care activities (see tables below).

Table 4.5: Availability of Health Facilities in Kenya, 1967-2000

Year	**1967**	**1978**	**1987**	**1992**	**1996**	**2000**
Estimated population (millions)	10.9	14.8	20.8	23.4	26.4	30.3
Hospitals	**199**	**226**	**254**	**301**	**387**	**481**
Health centers	162	233	282	477	548	601
Health sub-centers/ dispensaries	500	1088	1535	1859	3058	3273
Total centers/ dispensaries	**662**	**1221**	**1817**	**2336**	**3606**	**3874**

Source: Ministry of Health, 1997,2001

Table 4.6: Distribution of Population by Action Taken while Sick (%), 2000

Region	Private doctor/ Dispensary	Public Dispensary	Community Health Center	Private Hospital	Provincial District hospital	Missionary Hospital/ Dispensary	Pharmacy/ Chemist	Traditional/ Faith healer
Poor								
Central Rural	19.5	43.2	10.2	0.5	10.4	8.6	7.6	0.0
Coast Rural	21.9	33.3	5.4	0.0	13.2	2.3	23.8	0.0
Eastern Rural	15.7	28.8	6.5	3.5	9.0	13.2	23.2	0.0
Nyanza Rural	16.9	27.0	12.4	3.5	8.6	6.2	25.4	0.0
Rift Valley Rural	30.5	22.3	10.4	3.6	8.5	7.6	17.1	0.0
Western Rural	21.6	18.1	11.2	1.5	6.6	3.9	37.1	0.0
Total Rural	**20.3**	**26.7**	**9.6**	**2.7**	**8.9**	**7.8**	**24.1**	**0.0**
Total Urban	**23.7**	**23.0**	**0.5**	**8.7**	**19.5**	**4.0**	**18.4**	**2.2**
Nairobi	26.3	30.2	0.0	12.5	5.3	5.0	20.6	0.0
Mombasa	19.5	39.4	1.6	5.4	19.5	5.2	6.1	3.2
Kisumu	21.8	11.6	4.3	8.2	27.2	1.7	10.9	14.3
Nakuru	2.6	31.6	0.0	0.0	39.7	0.0	26.1	0.0
Other Urban	24.8	10.7	0.0	5.4	34.2	3.7	19.3	1.9
Nation	**20.8**	**26.1**	**8.1**	**3.7**	**10.6**	**7.1**	**23.2**	**0.4**
Non Poor								
Central Rural	31.6	17.7	8.0	8.2	15.9	7.8	10.6	0.2
Coast Rural	32.9	22.0	7.1	5.8	12.9	0.8	18.1	0.5
Eastern Rural	31.1	20.1	4.3	5.0	5.9	14.8	17.4	1.3
Nyanza Rural	16.8	21.8	9.8	7.4	6.5	6.3	24.6	6.9
Rift Valley Rural	23.6	22.8	9.0	6.8	12.9	12.6	10.3	1.9
Western Rural	14.7	14.2	10.3	1.8	10.8	6.0	41.8	0.5
Total Rural	**24.6**	**19.9**	**8.0**	**6.0**	**10.3**	**9.5**	**19.5**	**2.2**
Total Urban	**19.6**	**14.6**	**1.9**	**24.4**	**21.0**	**2.0**	**15.1**	**1.4**
Nairobi	22.1	23.3	0.8	27.0	4.9	2.5	18.8	0.7
Mombasa	24.6	5.1	6.9	46.4	13.2	1.3	1.1	1.5
Kisumu	27.4	3.7	2.4	20.0	33.6	0.0	11.0	1.9
Nakuru	14.5	17.6	0.0	6.8	39.3	0.9	20.9	0.0
Other Urban	13.5	8.6	0.9	13.4	41.8	2.4	16.9	2.5
Nation	**23.6**	**18.9**	**6.9**	**9.4**	**12.3**	**8.1**	**18.7**	**2.0**

Source: Republic of Kenya, 2000b: 28

Table 4.7: Time Taken to Reach Various Health Facilities, 2000

A: Distribution of Time Taken to Reach Nearest Qualified Doctor's Office								
Region	**Poor**				**Non-poor**			
	<10 minutes	10-29 minutes	30-59 minutes	60+ minutes	<10 minutes	10-30 minutes	30-60 minutes	60+ minutes
Central Rural	0.1	25.5	19.1	55.2	0.5	24.4	24.0	51.1
Coast Rural	0.5	14.2	19.4	65.9	2.1	23.4	16.5	58.0
Eastern Rural	0.0	9.8	9.4	80.8	0.0	20.2	10.3	69.5
Nyanza Rural	0.1	14.2	16.5	69.1	0.0	12.2	18.3	69.6
Rift Valley Rural	0.3	19.7	18.5	61.4	1.5	21.7	17.2	59.5
Western Rural	0.1	20.3	16.5	63.1	0.7	26.1	18.8	54.4
Total Rural	**0.2**	**16.8**	**16.1**	**66.8**	**0.7**	**21.2**	**18.3**	**59.7**
Total Urban	**5.7**	**81.9**	**9.8**	**3.5**	**9.0**	**78.5**	**11.4**	**1.1**
Nairobi	6.8	82.4	5.7	5.1	11.5	74.9	12.7	0.9
Mombasa	4.3	83.1	11.4	1.2	3.0	80.0	17.0	0.0
Kisumu	2.7	90.9	5.1	1.3	3.5	92.6	3.9	0.0
Nakuru	10.4	86.8	1.4	1.4	10.2	85.9	2.5	1.4
Other Urban	4.1	74.9	18.6	2.4	9.2	79.1	9.8	1.9
Nation	**1.2**	**29.2**	**14.9**	**54.7**	**2.5**	**33.4**	**16.9**	**47.3**
B: Distribution of Time Taken to Reach the Nearest Dispensary (%)								
	<1 minutes	10-30 minutes	30-60 minutes	60+ minutes	<10 minutes	10-30 minutes	30-60 minutes	60+ minutes
Central Rural	2.9	43.7	27.2	26.1	2.2	48.7	28.7	20.4
Coast Rural	1.8	36.8	18.6	42.9	3.5	55.8	16.1	24.7
Eastern Rural	1.3	32.7	17.7	48.4	0.7	40.5	19.8	39.0
Nyanza Rural	0.2	37.7	28.7	33.4	1.8	35.1	29.0	34.0
Rift Valley Rural	0.6	29.7	24.2	45.5	2.3	34.9	25.7	37.1
Western Rural	0.9	32.6	28.4	38.2	1.6	42.4	21.3	34.8
Total Rural	**1.0**	**34.7**	**24.7**	**39.7**	**2.0**	**41.3**	**25.2**	**31.5**
Total Urban	**4.7**	**83.7**	**9.6**	**1.9**	**5.8**	**82.5**	**10.2**	**1.6**
Nairobi	8.0	82.7	8.7	0.6	9.2	74.1	16.2	0.4
Mombasa	0.0	90.6	7.6	1.8	3.2	94.4	2.5	0.0
Kisumu	2.2	95.1	1.8	0.9	4.2	95.8	0.0	0.0
Nakuru	1.6	90.6	7.2	0.7	0.0	92.2	5.6	2.1
Other Urban	2.2	78.9	14.2	4.7	4.0	83.4	8.2	4.3
Nation	**1.7**	**44.1**	**21.8**	**32.4**	**2.8**	**50.1**	**22.0**	**25.2**
B: Distribution of Time Taken to Reach the Nearest Hospital (%)								
	<10 minutes	10-30 minutes	30-60 minutes	60+ minutes	<10 minutes	10-30 minutes	30-60 minutes	60+ minutes
Central Rural	0.0	10.2	17.0	72.8	0.3	13.8	15.7	70.2
Coast Rural	0.5	8.0	17.3	74.2	1.2	10.2	14.6	74.0
Eastern Rural	0.0	5.6	4.1	90.3	0.0	13.2	8.7	78.0
Nyanza Rural	0.0	6.3	12.2	81.5	0.0	6.5	14.0	79.5
Rift Valley Rural	0.1	7.8	12,7	79.4	0.0	8.2	13.3	78.5
Western Rural	0.3	6.9	10.5	82.4	0.0	7.9	15.9	76.2
Total Rural	**0.1**	**7.1**	**11.4**	**81.4**	**0.2**	**10.2**	**13.8**	**75.9**
Total Urban	**0.5**	**47.5**	**28.3**	**23.7**	**1.4**	**50.7**	**28.6**	**19.3**
Nairobi	0.0	36.9	28.0	35.1	0.0	36.2	33.7	30.1
Mombasa	0.0	48.0	35.8	16.3	0.0	57.2	32.0	10.8
Kisumu	0.0	73.0	24.9	2.1	0.0	73.8	21.1	5.1
Nakuru	0.0	48.1	30.8	21.1	0.0	55.5	27.0	17.5
Other Urban	1.9	59.2	26.2	12.7	5.0	64.1	20.6	10.3
Nation	**0.2**	**14.9**	**14.6**	**70.3**	**0.4**	**18.8**	**16.9**	**63.9**

Source: Republic of Kenya, 2000b: 33

Table 4.5 shows that the number of lower facilities (total centers and dispensaries=3874 in the year 2000) as compared to the higher facilities (hospitals=481 in the year 2000) are more. These differentials in availability of health facilities indicate that the lower facilities are more likely to be accessible than higher facilities that are less. When we look at the existing referral system in the Kenya health system which was discussed in the introduction of chapter three the higher you go the better the facilities hence the higher the quality of health delivery services. This then means that most of the population will not access the better quality services.

Table 4.6 shows the distribution of actions taken by people when sick. Nationally, the poor prefer to visit a public dispensary (26.1%), the second most favored option is to buy drugs from the pharmacy (23.2%), the third option is to visit a private doctor/dispensary (20.8%). As for the non-poor population, 23.6 % visited private doctors/ dispensaries, 18.9% visited public dispensaries, and 18.7% bought drugs from pharmacies. Firstly the table tells us that the provision of health care is no longer a domain of the state. The private providers have a critical role in the health provision, which came with the root of adjustment through privatization. The low use government facilities (public dispensary 18.9%) as compared to private facilities (private doctor/dispensary 23.6%) by the non-poor is likely to be explained by their low rates of reliability and efficiency. The cost of using a health care facility especially the non-state facilities is likely to be a barrier to accessibility especially among the poor hence their use (private doctor/dispensary 20.8% as compared to public dispensary 26.1%).

Distance or time taken to reach health facilities is considered to be an important indicator of accessibility. Incurring transport costs reduces accessibility especially to higher health facilities. When a poor man looks at his available income and the best health facility that is near will use that money in transport alone he then prefers to use the nearest which might not be better equipped. Sometimes geographical accessibility is likely to be a more important determinant of utilization of government hospitals than affordability of user fees.

Table 4.7 presents information on the time taken to reach the nearest qualified doctor's office. Nationally, most (54.7%) of the poor take over 60 minutes, very few poor people (1.2%) live close to the nearest qualified doctor's office, while 29.2% take between 10 and 30 minutes, 14.9% between 30 and 60 minutes. A similar pattern is shown among the non-poor and there is an enormous divide in terms of time taken between urban and rural areas. Comparisons between rural and urban areas shows that over 80% of the urban population live within 10-30 minutes of the nearest dispensary compared to 34.7% of the rural poor and 41.3% of the rural non-poor. Hospitals are even further away- the majority of the poor (70.3%) and non-poor (63.9%) live more than half an hour away from the nearest hospital.

Table 4.8 (below) shows the distribution of place of delivery by region and poverty status. The situation at the national level shows that most children from poor households (64.4%) were delivered at home whereas most children from non-poor households (52.3%) were delivered in hospitals or at health facilities. But when we look at rural-urban comparison we see that a high percentage of mothers in urban areas

whether poor (68.9%) or non-poor (87.3%) delivered in hospitals. Hence this means the place of delivery is much a function of location as it is of having money to pay.

Table 4.8: Distribution of Place of Delivery by Poverty (%), 2000

Region	Poor			Non Poor		
	Hospital /Health Facility	At Home	Other	Hospital /Health Facility	At Home	Other
Central Rural	68.2	31,8	0.0	73.6	25.9	0.4
Coast Rural	15.7	84.3	0.0	27.0	72.4	0.5
Eastern Rural	33.4	66.3	0.3	50.9	47.7	1.4
Nyanza Rural	38.9	60.1	1.0	41.1	58.6	0.3
Rift Valley Rural	22.3	77.7	0.0	41.3	58.6	0.1
Western Rural	24.2	75.5	0.3	30.6	69.4	0.0
Total Rural	**30.1**	**69.6**	**0.3**	**46.6**	**53.0**	**0.4**
Total Urban	**68.9**	**31.1**	**0.0**	**87.3**	**12.2**	**0.5**
Nairobi	68.8	31.3	0.0	88.9	11.1	0.0
Mombasa	52.5	47.5	0.0	77.5	20.0	2.5
Kisumu	68.4	31.6	0.0	95.6	4.4	0.0
Nakuru	79.5	20.5	0.0	88.0	12.0	0.0
Other Urban	70.5	29.5	0.0	86.8	12.6	0.5
Nation	**35.4**	**64.4**	**0.2**	**52.3**	**47.3**	**0.4**

Source: Republic of Kenya, 2000b: 34

Table 4.9: Distribution of Assistance during Delivery (%) Poor/Non Poor,2000

Region	Doctor Poor/Nonpoor	Nurse Poor/Nonpoor	Midwife Poor/Nonpoor	T.B.A Poor/Nonpoor	Self Poor/Nonpoor
Central Rural	6.5 / 11.9	35.9 / 35.2	29.4 /28.2	14.7 /13.7	13.5 / 11.0
Coast Rural	2.0 / 4.3	10.0 / 16.3	11.2 /13.0	54.2 /56.0	22.5 / 10.3
Eastern Rural	3.6 / 5.6	13.9 / 18.6	23.1 /28.8	48.8 /36.1	10.5 / 10.9
Nyanza Rural	3.7 / 2.6	27.5 / 25.1	9.7 /14.9	32.5 /41.4	26.7 / 16.0
Rift Valley Rural	2.4 / 3.4	11.5 / 22.0	14.1 /18.9	55.9 /45.6	16.0 / 10.2
Western Rural	4.0 / 3.0	9.4 / 10.3	13.7 /21.4	37.0 /43.2	35.9 /22.2
Total Rural	**3.4 / 5.3**	**16.0 /23.0**	**15.7 /21.1**	**44.4 /38.1**	**20.5 /12.5**
Total Urban	**7.4 / 19.7**	**36.2/ 37.3**	**29.9 /31.1**	**15.1 /8.4**	**11.4 / 3.5**
Nairobi	12.5 / 28.9	12.5 / 15.6	46.9 /44.4	15.6 /4.4	12.5 / 6.7
Mombasa	12.5 / 45.0	37.5 / 32.5	10.0 /2.5	25.0 /15.0	15.0 /5.0
Kisumu	8.8 / 15.6	33.3 / 55.6	29.8 /24.4	24.6 /2.2	3.5 /2.2
Nakuru	5.1 / 28.0	33.3 / 32.0	43.6 /28.0	2.6 /6.0	15.4 / 6.0
Other Towns	5.5 / 41.5	41.5 / 40.5	28.4 /36.3	12.6 /10.0	12.0 / 2.1
Nation	**3.9 / 7.3**	**18.8/ 25.0**	**17.6 /22.5**	**40.4 /33.9**	**19.3 /11.3**

Source: Republic of Kenya, 2000b: 36

Table 4.9 (above) shows that Traditional Birth Attendants (TBAs) are the most common source of assistance amongst the poor (44.4%) and non-poor (38%) in the rural areas. In the urban areas a nurse is the most common type of attendant for both poor (36.2%) and the non-poor (37.3%). The important role that TBAs play in rural area show that accessibility to health facilities is difficult for all, regardless of the availability of money to pay. The high percentage of self-delivery particularly among the rural poor could be due to accessibility and affordability of delivery assistance.

Table 4.10: Immunization Coverage of Under Fives by Antigen (%), 2000

Region	BCG	DPT 1	DPT 2	DPT 3	Polio birth	Polio 1	Polio 2	Polio 3	Measle vaccin
	Poor/Non Poor								
Central Rural	96.4/98.9	94.0/98.9	94.6/98.6	91.0/97.3	91.0/95.9	94.0/98.6	94.6/98.4	91.0/96.6	87.5/90.
Coast Rural	96.3/96.8	96.4/97.3	94.7/96/8	93.2/94.7	63.1/87.6	96.4/97.3	94.7/96.3	93.2/94.7	84.7/88.
Eastern Rural	97.9/99.6	96.1/98.2	94.0/96.9	88.6/92.3	82.2/93.4	96.1/98.6	94.0/97.2	88.6/92.7	82.4/83.
Nyanza Rural	82.6/90.5	78.2/88.5	74.6/87.0	70.8/83.0	69.8/79.6	78.1/88.2	75.1/86.7	70.7/83.0	63.3/77.
Rift Valley Rural	95.5/95.5	93.4/96.4	92.3/95.1	86.9/92.4	82.1/91.5	93.3/96.6	92.3/95.5	86.0/92.5	77.9/86.
Western Rural	93.0/94.2	90.1/92.4	87.6/89.9	82.8/84.6	67.9/73.7	89.8/92.4	87.3/89.9	82.6/84.6	69.6/72.
Total Rural	93.6/95.9	91.2/95.5	89.3/94.4	84.9/91.2	76.5/88.6	91.1/95.5	89.4/94.4	84.5/91.2	76.4/84.
Total Urban	98.8/98.8	96.9/98.6	96.9/98.4	95.2/96.8	92.4/95.5	96.9/98.4	96.9/98.4	95.2/96.8	88.1/88.
Nairobi	100/100	100/100	100/100	100/100	94.4/98.0	100/100	100/100	100/100	88.6/87.
Mombasa	97.4/95.0	92.5/95.0	95.0/95.0	90.0/95.0	84.6/90.0	92.5/95.0	95.0/95.0	90.0/95.0	92.5/90.
Kisumu	100/100	100/100	95.7/100	98.3/93.6	93.1/93.6	100/97.9	100/97.9	98.3/93.6	84.5/83.
Nakuru	97.4/100	95.1/100	100/95.1	95.1/96.2	95.1/98.1	95.1/100	95.1/100	95.1/96.2	87.5/92.
Other Towns	98.8/98.9	96.6/99.4	99.4/96.0	94.4/97.3	92.7/95.7	96.6/98.4	96.0/98.4	94.4/97.3	88.3/88.

Source: Republic of Kenya, 2000b: 37

From table 4.10 (above) we realize that immunization coverage is quite high throughout the country and there are no marked differences in coverage between the poor and the non-poor or between the rural and the urban. According to the second report on poverty in Kenya (November 2000) this high immunization coverage nationwide is because of the intensified immunization campaigns, increased awareness among parents, and above all the fact that the immunization service is provided free of charge in most of the health units in the country.

Ndolo (1998) contended that in what had become a nightmare among the Kenyan population; the term cost sharing had become a household vocabulary! He argues thus:

> *"Any medical attention without money was a foregone story. Hospital drug stores had dried up and syringes had to be bought at the chemistry. With most people earning less than a dollar per day, the marginalised groups could hardly afford medical services" (Ndolo, 1998).*

However, the system was maintained in some form since the government was unable to fully finance or deliver highly subsidized health services to all citizens. More innovative approaches therefore were put in place to overcome the implementation weaknesses. Strategies were adopted to improve efficiency in revenue collection, to balance the revenue generation and access objectives, to ensure quality services, and to direct government financial support or cross-subsidies to poorer facilities. Disincentive against loss, mismanagement and diversion of health care funds to other uses were put in place and strictly enforced.

4.4 CONCLUSION

In general, movement in health indicators was positive at national level but there was need to concentrate new programmes on the poorest districts and poorer households. Improved access to family planning services by poor households is one key priority area for action. The same priority districts- in the Lake Victoria Basin, on the Coast and in Eastern province- for increased family planning service coverage and promotion are also high priority areas for increased attention to child survival.

Private and mission health facilities are more important sources of medical care for high-income earners. This implies that improvements in rural and basic urban public health facilities would benefit the poor proportionately more than the rich. It also implies that

there is further scope for cost recovery through user charges at hospitals, since it is the higher income-earning patients who use them disproportionately. This pattern of use by income category is not, however, reflected in the pattern of public expenditure and cost sharing. Health center users pay nearly 20% towards their treatment, while hospital care consumers pay only 7.6% of the care.

Structural adjustment and economic reforms were stern political and controversial issues in Kenya just like in other countries in Africa. Adjustment policies revealed a two-pronged behavior. In some aspects the poor enjoyed considerable gains (like free immunization through the concentration of the state in providing primary and preventive health care as public goods). In other circumstances they lose (like paying for transport at the same time paying for health care due to distance in health facilities). The problem with this scenario is that losses normally precede the gains. What conclusion does one come to from the discussion above particularly from the Kenyan situation? This is the discussion in the next chapter that gives the summary, conclusion and recommendation.

CHAPTER V

5.0 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 SUMMARY

This study set out with the main objective of investigating the opportunities and pitfalls brought about by the implementation of health related structural adjustment policies in SSA using Kenya as a case study. Looking at the health situation in SSA, several aspects came up. It was established that the region in general seems to be prone with various health problems that are manifested in different ways. This is to the extent that SSA is seen as a region where poor health is a conventional image especially where the 'unfortunate' commonly known as the vulnerable groups are concerned.

The main reason that came up for poor health is the fact that in the world today one's income dictates one's state of health. The GNP in African countries is very low as compared to the other developed and even developing countries hence this results to poor health outcomes. These differential results extend further within the countries between rural and urban areas. We see generally the trend is that curative health measures are given priority as compared to the promotive/ preventive health care strategies which in most cases benefits the vulnerable groups (children and mothers) mostly found in the rural areas.

At the same time the non-improving state of health in SSA goes hand in hand with food insecurity that results to malnutrition especially among the young children. This, with the political non-commitment to implementing health related policies to their full extent ends in poor health in SSA.

The health situation of Kenyans had improved progressively since independence to 1990. The policies and programmes had achieved commendable results. However, there appears to have been a reversal in the direction of change in the health status of the population in the 1990s as reflected by the increases in mortality and morbidity indicators. The health situation of women and children rapidly worsened. Increasing poverty was the major cause and also a consequence of this trend. The factors included a decline in per capita food availability, deteriorating quality of and the poor access (due to introduction of user fees and other factors) to health services, increased incidence of HIV/AIDS, and limited budget allocations.

Kenya depicts an example of a country that does not exist in a policy vacuum. Time and again as seen from chapter III Kenya has realized its health problems and come up with policies hoping they would in turn be solutions. This means the problem is not in the lack of policies but further down the line on how those policies are implemented. The importance of the health status of Kenyans is brought out with the formulation of the Kenya Health Policy Framework of 1994 depicting the commitment put forth towards the health sector. But health policies alone do not solve the problem they need to have a linkage to other policies to avoid contradiction and have an intersectoral commitment in terms of working together towards the same end.

The main objective of this study is realized in chapter IV that brings out the reality of the positive impact of structural policies while at the same time the other side of the coin is examined by bringing up the negative attributes that arose from the same policies.

5.2 CONCLUSION

Macroeconomic policies in Kenya have tended to shape health outcomes. They have also had an impact on trends in household income levels and access to health facilities. In the early years of independence the government's health policy of 'equity in health' led to increased access to health facilities. The policy of free health made it possible for poorer groups to access health services. Throughout the 1980s and 1990s there has been persistent geographical differences in the availability of and access to health facilities. The inhabitants of rural areas have had less access to health facilities as compared to those of urban areas. This all begins with the initial design of the policies, which had the 'developed' countries economic structures in mind. For these policies to have resulted into positive outcomes as they did in 'developed' countries they needed adjusting to suit the structures in place in adjusting countries like Kenya. Otherwise before this is done, it results to the differentials that come up between developed, developing and underdeveloped while within countries we have urban versus rural areas showing different outcomes.

The introduction of user fees as a cost recovery measure has meant a reduction in the number of people able to access health facilities. This study has come to the conclusion that upstream issues of healthcare, such as water and sanitary conditions, preventive health strategies, household level incomes and a solid national health policy, all contribute to positive health outcomes. Meaning that there is an interlinkage between various sectors that need to work hand in hand to create an enabling environment for good health.

The study comes to the realization that SAPs have had some positive impact in good health outcomes, but to some extent the distribution of the achievements under SAPs may have been quite uneven. The people in the rural areas as well as the poorest of the poor in the urban areas (vulnerable groups) seem to have suffered significantly due to their inability to compete in the market. The benefits have not trickled down to all parts of the country, and to all socio-economic groups. For example while curative services centers (mostly private) compete and try to give the best hence services become more effective and the quality is improved most of these centers will not be extended to areas accessible to these vulnerable groups because they are branded as non-profitable and non-marketable zones. This means that to the poor, access to health services has been severely curtailed under SAPs.

As competition was injected in the health sector with the introduction of 'user fees', one of the positive outcomes was the improved quality of health services. To some extent, the health related macroeconomic policies increased the demand for modern health care as a better alternative to traditional healers especially when it comes to preventive and promotive health services for many came to realize that in the end of it all 'prevention is better than cure'. This is also seen from the increase in health facilities for one did not make what was not needed.

The results confirm a priori expectation of a reduction in utilization of health care services following user fees. The reduction in service utilization was larger in government than in Non-Governmental facilities. The reduction in services utilization however appears to be due also to factors other than the user fees. In particular, there

was a drop in real per capita income during the cost-sharing period, which undoubtedly contributed to the drop in health services utilization.

The results suggest that improvements in quality of services after the introduction of cost sharing increased the use of health services during the period 1989-1995 (the cost-sharing period). Availability of drugs was cited as the main reason for the service improvement. This is consistent with the findings of Collins et al 1996, that the availability of doctors, x-ray machines, theaters, and support staff are all associated with increased utilization of health services. This findings reinforces the need to allow retention and expenditure of cost sharing revenue at the local health facilities.

5.3 RECOMMENDATIONS

The times in which we blamed other people (foreigners and outsiders) for our health problems are long gone and people need to move forward. The wearer of a shoe knows best where it itches so there is a need to try and solve our problems. African economic problems over the last two decades can be traced mainly to a host of international and domestic factors. Many of the international factors and some of the domestic factors such as lack of suitable resource endowment are outside the control of the governments and administrators. However a significant part of the problems can be traced to corruption and other forms of inefficiencies. Instead of blaming the IMF for the dismal performance in Africa, we should focus on the African leaderships and their policies. The level of their commitment and the policies they have adopted and implemented increasingly seem to confirm only their deployable lack of compassion for fellow Africans and a callous detachment from the people's welfare. The status quo must change to

prevent further erosion of the economic base in the continent. If we should borrow a leaf from the 'boosted Asian economies' using the same policies, we come to the realization that everyone matters and we should involve everyone in the policies concerned in their welfare. In the end all will be committed to make the policies work for they are targeted at improving everyone's welfare without discrimination.

There is need to create a self-sustaining economy for any policies to work. Policy makers need to design a macroeconomic programme that could rejuvenate the economy with regard to employment, wealth creation and poverty reduction. This could help to raise household incomes. A feasible alternative is what has been described as the sacrifice approach, which takes into account availability and access to resources and urges officials to become more responsible and accountable to the public. The sacrifice approach will succeed only if there is genuine commitment and willingness to make sacrifices, especially on the part of leaders. A key ingredient in any package of measures is the elimination of corruption and the presence of a strong democratic process. The issue is much more a question of political will than of economic capacity. A political will of sufficient intensity can galvanize authorities and the mass of people into formulating, adopting, and implementing the structural changes that would lead to rapid and self-sustaining economic growth.

There is need to revisit the health policies, which have witnessed dwindling allocations to the health budget. While it is important to reduce the overall budget, a well-planned budget with proper priorities in place could lead to an increased budget allocation for the health sector. The internal and external efficiencies of the health delivery system

need considerable improvements. Public expenditure on health services was only 60% of the requirements. The bulk of public resources were devoted to curative services with rural promotive and preventive services receiving less than 20% of the total expenditure. The non-poor seems to be the major beneficiaries of the system. The resource allocation in the sector needs to shift from the current emphasis on the curative service to promotive and preventive health care, particularly in the rural areas. Introduction of macroeconomic reform measures including user fees in the late 1980s has adversely affected the access and affordability of government health services to the poor. The fee structure seems to be regressive with the poor paying a larger proportion of the cost of service as compared to the non-poor.

Despite the increase in utilization due to possible effect of quality improvements, the net effect of cost sharing implementation was negative, however, since the increase in utilization was not high enough to counteract the effect of higher fees, this findings indicates the need for policy and programme managers to exercise caution when introducing fees since they can lead to a large drop in utilization, especially among poor households, which also tend to have large families.

Research is needed to determine the mechanism for compensating rural populations because they are served by dispersed facilities and therefore do not have the advantage of enjoying better quality services. This will be useful in addressing some of the quality concerns in health care delivery.

The devastating impact of the HIV/AIDS pandemic on the infected, their families and communities and the economy of the country are increasingly recognized. The plight of women and children is of serious concern. Full implementation of the strategies and programmes in 1997 sessional paper on HIV/AIDS should be pursued actively in partnership with all stakeholders including donors.

Food availability and security have direct links with nutrition and health status of the population. Food availability per capita has declined significantly during the past decades and the near term prospects do not seem favorable. The damaging impact on children was reflected by increases in malnutrition, stunting, morbidity and mortality. Improving productivity and production in the small-scale agricultural sector may be one of the most effective ways of reversing this trend.

Finally SAPs were just a beginning point of hope for the adjusting countries meaning they needed to start somewhere to bring change. A scapegoat does not solve matters so as an African adjusting country we have a long way towards creating good health and this can only be done by pulling together. Let everyone do his part and for sure an enabling environment for good health will be created. This is the starting point for any good policy that hopes to change issues.

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