Structural adjustment: source of structural adversity. Socio-economic stress, health and child nutritional status in Zimbabwe
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Summary

From the late 1970s onwards, most low-income countries have been engaged in structural adjustment programmes for shorter or longer periods. These programmes were promoted and supported by lending institutions, such as the World Bank and the International Monetary Fund, as well as by international and bilateral donor agencies, and were aimed at creating a suitable policy environment for sustainable macro-economic growth. Critics started voicing concern about the negative social implications of structural adjustment in the course of the 1980s. In the international debate, policy makers and scholars were basically divided into two camps - proponents and opponents of adjustment - a phenomenon that had its roots in ideological differences and that could not be resolved immediately because of methodological difficulties in assessing the effects of adjustment. Several cross-country studies have tried to demonstrate the health and welfare effects of adjustment, mainly by comparing adjusting and non-adjusting countries. These studies have certain limitations and the results are ambiguous.

This thesis takes the case of Zimbabwe, a country that was late in adopting its first structural adjustment programme, towards the end of 1991. Our study looks at both the short-term and long-term effects of structural adjustment on health and welfare, with a strong focus on effects on the delivery of health services and on changes at the household level. It recognises that the effects of unsustainable economic policies prior to adjustment and that of adjustment measures cannot be disentangled. It also takes into account that environmental determinants other than adjustment and macro-economic changes - such as health policy changes, the spread of HIV/AIDS and drought - influence health and welfare as well. The central hypothesis tested is that structural adjustment in Zimbabwe and the accompanying measures to cushion the possible negative short-term effects of adjustment, drought and HIV/AIDS on vulnerable groups - or the absence of such measures - have failed to avert a further aggravation of the scope and intensity of poverty. We use a pragmatic conceptual framework to analyse changes that occurred during the 1990s in indicators of process (at the level of health services and households), output (in terms of health seeking behaviour) and outcome (in terms of nutritional status, morbidity and mortality).

Chapter 2 provides a profile of Zimbabwe, including a historical background of
political, economic and socio-demographic patterns that originate from the time before the country gained political independence (in 1980). During its first decade of independence, Zimbabwe’s economic performance was reasonable, with significant investments and achievements in the social sectors—education and health. Little progress was made, though, in the redistribution of land ownership, which was highly skewed for historical reasons, and which has remained, throughout the 1990s and into the new millennium, a major area of political contention, both domestically and internationally. In the 1990s, Zimbabwe’s economic performance deteriorated strongly and almost persistently, indicating that the strategies forming part of the structural adjustment programme have been inappropriate. The emergence of HIV/AIDS, which did not trigger a timely response from the government and its partners in development cooperation, and two severe drought episodes (in 1991-92 and 1994-95) further constrained social and economic development.

Chapter 3 provides a profile of the health sector and its performance by describing and analysing in detail the national health policy and the way it was implemented by the government and supported by aid agencies. It shows how a reversal occurred in many of the observed positive achievements of the 1980s, as reflected by stagnating and deteriorating indicators of health service utilisation (output) and health status (outcome). These changes are associated with declines in the allocation of resources to the health sector (input) and a general regression in the quality of services (process). In spite of the fact that equity in health was the official mainstay of Zimbabwe’s national health policy, the government’s response to the macro-economic changes in the early 1990s and the HIV/AIDS pandemic has been inadequate in three ways: a strong focus on the equitable distribution of resources to the detriment of attention for quality of services; insufficient attention for variations in health status between different population strata, in particular between various socio-economic groups; and insufficient attention for the deterioration in people’s living conditions predisposing to poor health outcomes.

Chapter 4 then provides background information about the two areas in Zimbabwe—one urban and one rural—from which most of the empirical data presented in this thesis originate. We argue that the study findings for the urban area are representative for large parts of other urban centres, in particular the so-called high-density suburbs. The rural area was suitable for studying the implications of changes in the economic and health policy environment on health and welfare in communal farming areas, because it is a relatively well-endowed area, which was not disproportionately affected by drought in the early 1990s.

Chapter 5 examines changes in the process of health service delivery in the public sector and in people’s appreciation of those services. It demonstrates that a serious erosion of the health services has occurred during the period of structural adjustment. The government has not been able to avert this, despite its intention to protect the social sector and guarantee continued access to quality services to all Zimbabweans, irrespective of their capacity to pay for the services obtained.

Chapters 6, 7 and 8 present the findings from a longitudinal study of two cohorts of households, one urban and one rural. Chapter 6 demonstrates that households in both
areas experienced a general deterioration of their socio-economic situation over a five-year period (1993-1998), with a growing disparity between higher and lower income groups and manifest impoverishment. The emergence of a large proportion of nutritionally wasted children in 1996 and 1998, which is described in Chapter 7, is an indication of acute malnutrition and points at an increase in episodes of food deprivation and or illness. Contrary to our expectation, we did not find an overall increase in chronic child malnutrition as measured by the prevalence of stunting in our two study areas. We suggest, though, that a longer timeframe might have allowed us to demonstrate an effect of the poor weight-for-height scores observed in the latter part of the study period, especially among school-age children, on child stunting in subsequent years.

Chapter 8 relates the observed changes in child nutritional status over the five-years period to individual household characteristics. In both the urban and the rural area we found strong geographical differentials in acute malnutrition from 1995 onwards and children with many siblings were more at risk of growth retardation than those belonging to small families. While low household income was not among the discriminative risk factors for child malnutrition, several economic household attributes started having a differential impact on child nutritional status from 1995 onwards in the urban area. During the first half of the decade, people appeared able to overcome episodes of adversity by a variety of mechanisms, such as diversifying their sources of income, economising on household expenditure, using reserves, taking loans and falling back on social networks. This flexibility to absorb exogenous shocks has not been sustained in the second half of the decade, especially in specific parts of the city and among large households that had nobody with formal employment. In the rural area the turning point came in 1996, when the general economic malaise and the lag effect of repeated drought episodes had depleted the reserves of most households.

The concluding chapter 9 reverts to the central hypothesis of this thesis, which we accept. Structural adjustment in Zimbabwe has failed indeed to avert the deepening of the poverty crisis. The measures taken by the Government of Zimbabwe in conjunction with the international lending institutions and the multilateral and bilateral aid agencies have generally been inadequate to cushion the negative effects of adjustment, drought and HIV/AIDS on vulnerable groups. The lessons learned from experiences in other low-income countries that started their structural adjustment programmes much earlier were not sufficiently taken into account in the case of Zimbabwe. It was not until the late 1990s that some officials of the World Bank acknowledged that adjustment was not a blueprint for poor countries to grow out of poverty and that it had increased economic disparities and social exclusion of the poorest layers in society. Zimbabwe is a tragic example of a country where the standard recipe of structural adjustment has not merely failed to create the conditions that would improve people’s health and welfare, but rather had a significant contribution to the demise of the public health system and the depletion of the reserves of large groups of poor people in society. The current social unrest and political instability (since 2000) can in part be attributed to the general emergence of ill-feeling that resulted from the structural adjustment era. It may still take more time before other long-term effects of poverty and ill-health will be discerned.