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General discussion and conclusions

The basic aim of our research was to document the changes that have occurred in health service provision, household welfare, people's health and child nutritional status, during the implementation of structural adjustment in Zimbabwe. In the first chapter we have argued that the main methodological difficulty in measuring the social effects of adjustment is the attribution of any causal relationship. The attribution problem could not be resolved because of the fact that other factors, especially drought and HIV/AIDS, have an influence on household welfare and people's health as well. In addition, it was difficult to disentangle the effects of adjustment measures and that of unsustainable economic policies *prior* to adjustment and to appraise how the situation would have looked like *without* adjustment.

The hypothesis that we wanted to test in this thesis was therefore 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 had failed to avert a further aggravation of the scope and intensity of poverty. Central questions to this hypothesis were:

- a. Have the socio-economic position and general welfare of the poorest layers of society been protected? Can any changes in welfare be attributed to specific policy measures or to a lack of adequate policy measures during the period of structural adjustment?
- b. Has the government been able to ensure adequate health service delivery during the adjustment period?
- c. Are there any changes in people's health status, and, more specifically in child nutritional status? Can they be attributed to specific adverse conditions or policy measures?
- d. Where did it go wrong? What would have been a more appropriate response?

We will first recall our conclusions from the previous chapters so as to answer the first three questions. Thereafter we will address the last question and then revert to the central hypothesis of this thesis.

(a) Have the socio-economic position and general welfare of the poorest layers of society been protected? Can any changes in welfare be attributed to specific policy measures or to the lack of adequate policy measures during the period of structural adjustment?

We have demonstrated (in Chapter 6) that households in both the urban and the rural area where we conducted our longitudinal study between 1993 and 1998 experienced a general deterioration of their socio-economic situation, with a growing disparity between higher and lower income groups and with manifest impoverishment. Structural adjustment, drought and HIV/AIDS all contributed to the general economic malaise during the nineties. While the majority of households saw their real incomes decline, adjustment-related policy measures such as the abolition of subsidies on maize and increases in user fees for health services increased the pinch on these same households. We found some evidence of social welfare assistance, such as assistance in paying school fees, exemption from paying clinic fees and allocation of food money to poor families, but more structural protective measures, such as employment creation and training, which the government had announced in the early phase of structural adjustment under the Social Dimensions of Adjustment programme, were not discernable.

Drought could only very partially explain the observed impoverishment in the urban area. It was clear that in the rural area there would have been a much stronger recovery from drought had there been no other negative influences. A differentiation between the influence of adjustment measures and HIV/AIDS was not possible with our data set. We illustrated this with the role of remittances in household income. Remittances and other (non-monetary) forms of social support are signs of the existence of resource sharing networks in both study areas and of strong rural-urban links. The impoverishment of households, particularly in the communal farming area of Murehwa district, was for a large part due to a decline in remittances, without a significant concurrent increase in assistance in kind. While divorce and death took their toll, partly as a result of AIDS, husbands or descendants working elsewhere were often no longer able or willing to continue using part of their earnings to support their relatives, since wages stagnated and the cost of their own living increased. These trends suggested a rise in the risk of falling into extreme poverty, because the decline in remittances could not be compensated by an increase in agricultural activity or a further diversification in other income generating activities. Neither was it compensated by a stronger collective public response in the form of creation of employment opportunities or social welfare assistance.

We observed several distinctive trends in relation to household mobility and composition, sources and levels of household income, agricultural activity, food sufficiency, household expenditure, savings and debts. Household mobility seemed strongly related to poverty, illness and death, much more than to better employment opportunities elsewhere. While urban households were more likely to migrate during the

period under consideration than rural households, an important part of urban households that migrated and were hence lost to follow-up in the study went to a rural part of the country. It was not possible to quantify the relative influence of structural adjustment and that of HIV/AIDS.

The patterns in economic activity and household income and expenditure in the urban and the rural area were not quite the same. In the cohort of *urban* households we observed a growing differentiation of informal sector activities and sources of income over the six-year study period. We attributed this partly to the increased need for cash to meet the soaring cost of living, and partly to the ageing cohort, with young adults joining the work force. The proportion of households depending exclusively on the informal sector increased from about a quarter in 1994-95 to over a third in 1996-98, reflecting an overall loss of formal sector employment. At the same time, assurance of remittances declined among female-headed households and generally among households without any formal source of employment. Those who did report remittances gradually saw these financial contributions become less regular. This suggests a toughening of financial solidarity within the larger family circle. Real household incomes in the urban area fell substantially, especially between 1996 and 1998. The income differential between poor and rich households increased, with the poorest households experiencing larger declines than the richest. *De jure* female-headed households were significantly worse off than male-headed households, although the gap narrowed between 1995 and 1998, mainly because the former category succeeded in diversifying their sources of income. We further observed a rise in urban cultivation which we interpreted as a survival strategy used by households to cope with the increased cost of living. Household expenditure patterns became more diverse over the years, showing an increase in expenditure for funerals and medical care. The increase in expenditure for funerals was undoubtedly AIDS related, and adds to the impoverishment of households that had already started economising on food expenditure in the early 1990s and had experienced food shortages. Given the prevailing stringent economic conditions, it was somewhat surprising that a large proportion of households were able to save money from their incomes. We interpreted the motivation to accumulate savings, mainly for emergency situations such as family illness and funerals, as a sign of growing insecurity. Obviously, in an environment of strong inflation people should be investing rather than saving, but they seemed not to be. Our observation was further underscored by the pattern of financial indebtedness of households – more debts, but smaller amounts – suggesting a growing need for cash loans and possibly a growing reluctance among both lenders and borrowers to lend or borrow large sums. Investment in cattle, as the sole measure of investment that consistently outperforms inflation, seemed beyond the reach of the majority of households.

Changes in economic activity and household income in the *rural* area were more subject to the quality of the rainy season. The cohort of households in Murehwa district started diversifying their informal sector activities and sources of income a little earlier compared to the urban area, following a good rainy season in 1993-94. But one year later,

after the 1994-95 drought, this trend had levelled off and we did not detect any further diversification of incomes, with even a slight regression in 1998 following mediocre maize harvests. Since 1995, remittances exceeded agricultural production as the primary source of income, indicating a declining importance of agriculture as a profitable activity in the rural area. At the same time however, remittances became less important as the *sole* source of income, suggesting that they were no longer sufficient for households to rely on. The proportion of households purely relying on informal sector activities and not receiving any remittances from relatives employed elsewhere increased between 1996 and 1998. These households were likely to experience increasing poverty.

The increase in income differential between poor and rich households in the rural cohort was sharper than in the urban cohort. Despite a modest recovery between 1995 and 1996, associated with the better harvest, the poor suffered disproportionately, losing almost a third of their real income between 1995 and 1998. *De jure* female-headed households were significantly worse off than *de facto* female-headed households, because of the latter category's reliance on remittances. While the category of households that were relying exclusively on remittances decreased, their income situation deteriorated most, suggesting strong impoverishment. The household food security situation in the rural area worsened from year to year. The widespread food shortage and shortage of maize meal at the household level in 1995 could be attributed to a large extent to the poor harvest following the 1994-95 drought, but the further deterioration in 1996 and 1998 was *not* associated with drought and should be attributed to the general economic malaise and the increase in the cost of living. Household expenditure patterns shifted and became more diverse, showing the emergence of funerals as an important type of expenditure. Like in the urban area, an increased ability to save money from incomes, although less prominent in 1995 and 1998, went together with an increase in financial indebtedness and smaller amounts of money that were being borrowed. Like in town, this suggested growing insecurity, and a shortage of cash money.

(b) Has the government of Zimbabwe been able to ensure adequate health service delivery during the period of structural adjustment?

The answer is irrefutably negative. Our main conclusion is that the responsiveness to needs and hence the performance of the health system as a whole has eroded because of poor quality of services, especially at the level of the primary health care institutions, i.e. the urban clinics and the rural health centres. We have provided detailed evidence from two areas in Zimbabwe - Chitungwiza and Murehwa district - that total service utilisation levels did not keep up with population growth during the 1990s, although they did not fall dramatically, except for inpatient care. In the context of a structural adjustment, which required that scarce resources be used more rationally, it was a justifiable policy of the Ministry of Health and Child Welfare to apply user fees, not so much in seeking (partial) cost recovery - as some World Bank representatives advocated - but rather as an instrument to bring about a shift of emphasis from hospitals to clinics in the provision of first-level care. Our data confirm that the desired changes have taken place indeed. For

the rural district of Murehwa we found that a pronounced shift took place during the 1990s in the distribution of outpatient clinic attendance, much more pronounced than in Chitungwiza. The rural health centres have clearly taken over the role of the two hospitals as the main provider of both curative outpatient care and antenatal care. However, with the observed deterioration in the quality of care at all levels of the health system, including the primary care level, and people's understandable dissatisfaction with this universal trend – both from the side of the users of health services and the providers; in the urban as well as in the rural area – we have demonstrated that a serious erosion of the health services occurred during the period of structural adjustment. The government of Zimbabwe, along with the various international agencies that supported the health sector, failed to avert this negative development.

(c) Are there any changes in people's health status? Can they be attributed to specific adverse conditions or policy measures?

We have shown (in Chapter 3) that after a significant improvement in all major health indicators during the 1980s, a reversal occurred around 1990 when several indicators of health service utilisation and coverage (service output) and health status (outcome) stagnated or started deteriorating. These changes were associated with declines in national resource allocation for health, a general regression in the quality of services, the overall deterioration in people's living conditions and the rapid spread of HIV/AIDS. Some of the changes are directly AIDS related, such as the increases in maternal mortality, child mortality and the incidence of TB and the decrease in life expectancy. Others are more likely the result of socio-economic stress – although they cannot be attributed to specific policy measures – or of a combination of poor socio-economic conditions and inadequate health services.

In Chapter 7 we presented the changes in nutritional status among children from urban and rural households – the same from which we obtained longitudinal data on more general aspects of their welfare – between 1993 and 1998. The emergence of a large proportion of nutritionally wasted children pointed at an increase in spells of acute food deprivation and/or illness. Although HIV/AIDS was probably responsible for some of the deterioration in weight-for-height observed among young children (1-2 years of age) in 1998, we consider its influence very limited, if not negligible, in the cohort of children that was followed up throughout the study period. Food deprivation occurred in particular among children of school going age in 1996 and 1998, as indicated by low weight-for-height scores and high rates of wasting of around 10% in certain age groups in both the urban and the rural area. While school-age children thus appeared especially vulnerable to wasting in the latter half of the decade, this had not affected height-for-age scores in a detectable manner. A longer study period might have brought this to light. Overall we found an improvement in the height-for-age indicators (less stunting) in both areas, which can be partly explained by the ageing study population. This is surprising given the overall deterioration in Zimbabwe's economy and general welfare during the 1990s. It suggests that the population has generally been able to absorb serious adverse circum-

stances to the extent that for several years children did not suffer any overall long-term effect in the form of stunting. Since this capacity has not persisted, chronic malnutrition is likely to have increased towards the turn of the century.

For the urban area of Chitungwiza we have demonstrated (in Chapter 8) that economic household attributes started having a differential impact on child nutritional status from 1995 onwards, with the long-term effects of economic malaise on specific categories of children becoming fully apparent in 1998. During the first half of the decade people were able to overcome episodes of adversity by a variety of mechanisms, such as diversifying their sources of income, economising on household expenditure, using their own reserves, taking loans or falling back on their social network. It appears that this flexibility to absorb exogenous shocks has not been sustained, especially in specific parts of the city among households that have many children and nobody with formal employment. Since the long-term effects of an extended period of body thinness (or recurring body thinness) took several years to emerge, we may assume that the observed increase in child nutritional wasting in 1996 and 1998 will have led to increased levels of stunting a few years later. Our study period was not long enough to detect this. We further found that until 1995, engaging in urban agriculture was a successful strategy for households that sold their agricultural produce, in contrast to those who grew maize for their own consumption. Gradually, however, the effectiveness of urban agriculture as a strategy to avert food deprivation declined, despite the fact that its popularity kept growing.

In several respects the picture for the rural area was similar to that of the urban area. There were strong geographical variations in malnutrition from 1995 onwards and children with many siblings were relatively more at risk of growth retardation. We found strong evidence of a differential effect of the 1994/95 drought on child nutritional status: certain parts of the district were much more affected than others, causing disparities in both nutritional wasting and stunting, and the long-term effects were still very much tangible in 1998. Similarly, we were able to detect the effects of the earlier drought of 1991-92 in 1995, when children from parents who participated in one of the large-scale drought relief operations had significantly shorter statures than children from households that did not participate. It seems therefore that the Food-for-Work programme in the early 1990s reached the right people but that it was not entirely successful in preventing malnutrition.

Like in the urban area, failure to diversify household income, especially after the 1994-95 drought emerged as a risk factor for child stunting. Here the drought reinforced the impact of the general economic malaise that had already limited the opportunities for people to generate income through informal activities. The lag effect of repeated drought episodes along with the general economic malaise are both responsible for the deterioration in weight-for-height indicators observed in 1996, which signified a turning point. An increased proportion of rural households had apparently used up their reserves and overstretched their capacity to absorb any further exogenous shocks. While for several years the majority of households thus seemed able to absorb the continuous stress due to repeated drought episodes and general economic adversity, this no longer appeared

to be the case from 1996 onwards. Children from households owning land lost their relative advantage from 1995 onwards and households relying mainly on agriculture for their livelihood became especially vulnerable. We may safely say that a large-scale public effort to avert food deprivation in Murehwa district, comparable to the interventions in the early 1990s and in line with actions undertaken elsewhere in the country after the 1994/95 drought, would have been appropriate.

(d) Where did it go wrong? What would have been a more appropriate response?

Despite several warnings in the early 1990s and even earlier, it has taken time before the worsening of morbidity and mortality indicators was generally acknowledged. While some of the negative trends became apparent from 1992 onwards, it was only in 1999 that the Government admitted that these trends reflected a major decline in socio-economic conditions among the population. We have argued (in Chapter 3) that despite its advocacy of 'equity in health' the Government's policy response to the macro-economic changes has been inadequate in three ways: (1) health policy makers were preoccupied with the equitable distribution of resources and achieving high service coverage rates, but disregarded the importance of quality of care, which was ultimately responsible for the loss of confidence, both among the general public and health care providers themselves; (2) they paid insufficient attention to intra-country variations in changes in health outcomes and neglected the development of any regulatory mechanisms for the private for-profit sector, causing damage to the state-provided health services in the process; and (3) they ignored the deteriorating conditions in society that predispose to poor health outcomes – such as falling incomes and a general regression in various aspects of care – and failed to bring these to the attention of policy makers outside the health sector who may have been better placed to influence these conditions.

More fundamentally, and largely within the sphere of influence of policymakers and analysts that are not necessarily specialised in health, it is clear that the social implications of adjustment have been ignored. Despite a great deal of rhetoric about cushioning negative effects and protecting vulnerable groups during the early phase of ESAP, very few concrete measures were implemented and those that were implemented reached a small minority of people and had little effect. The sole exception was the abolition of user fees for services provided by rural health centres, although this policy measure should have been accompanied by improvements in the quality of care. Yet, when a second package of structural adjustment measures was adopted in 1996 under the new name ZIMPREST, there was still no provision for the effective protection of the poorest groups in society, despite all the evidence accumulated by that time, that poverty was spreading and intensifying fast. We have shown in our two study areas that social welfare assistance declined between 1996 and 1998, and that this was compensated only very partially by an increase in social support from relatives or friends. It would be unrealistic to expect stronger or more widespread solidarity through informal circuits, since there was hardly any family in our two study areas that managed to accumulate wealth over the study period.

Under those circumstances and in view of the fact that the erosion of health services had already become tangible, it was inappropriate to further restrain the allocation of public resources for health care delivery. At the same time, several opportunities were missed to strengthen the Zimbabwean health system because of a general failure to capitalise on insight and experiences gained domestically or elsewhere. Decentralisation of decision-making authority and of resources from the central level to districts has been very slow, much slower than for instance in neighbouring Zambia or in Ghana or Uganda, because of a strong reluctance in the centre to relinquish some of their powers to the periphery. This has contributed to the observed decline in the motivation of staff, who themselves felt the pinch of adverse socio-economic circumstances, and to the health system's general lack of responsiveness to people's needs. In the absence of any firm regulatory mechanism, private practice was allowed to develop itself in an uncontrolled manner and to a large extent at the expense of public services, rather than as a complementary way of rendering services. Mission health institutions, although privately owned, traditionally played a strong public role in Zimbabwe, but except for a few cases of hospitals that earned themselves the status of a designated district hospital – with some attached privileges from the government – the majority of mission institutions, including St Paul's hospital at Musami in Murehwa district, saw their roles marginalized. This was due to the combined effects of dwindling government support, reduced external support from overseas – related to a change in the climate of development cooperation in western countries – and the reduced capacity among clients to pay for services received. Under the prevailing macro-economic conditions of the 1990s, Zimbabwe in fact could not afford to miss the opportunities for strengthening decentralised health management and private enterprise (including mission hospitals). But it did miss them, resulting in unintentional damage to the health system as a whole and affecting the country's good international image that it had earned itself during the 1980s. It is clear that the collective response from the Government of Zimbabwe, including the Ministry of Health and Child Welfare, and the international organisations present in the country – donor agencies and lending institutions, including the World Bank and the IMF – has failed to avert the erosion of the health system and society's general decay.

We thus should accept the hypothesis that was central to this book. Structural adjustment in Zimbabwe has clearly failed to avert the deepening of the poverty crisis. The measures that were taken to cushion the negative effects of adjustment, drought and HIV AIDS on vulnerable groups have generally been inadequate.

At the international scene, several World Bank officials came to realise in the late 1990s that adjustment was not a blueprint for poor countries to grow out of poverty. The World Bank president, James Wolfensohn, spoke of "*the tragedy of exclusion*" referring to the huge disparities in income and opportunities that prevented the poor from participating in economic growth. His pledge to work towards increasing the share of wealth captured by the poor, came under attack when David Dollar and Aart Kraay of the World Bank's Development Research Group published their report *Growth is good for the poor* (Dollar and Kraay, 2001). Some saw this as a conscious attempt to shift the policy debate away

from a concern with equity and as a wrong signal to achieve poverty reduction. OXFAM, for instance, reacted with a paper entitled *Growth with equity is good for the poor* (OXFAM, 2000), refuting three basic messages from the Dollar and Kraay report, namely (1) growth is good for the poor; (2) standard pro-growth macroeconomic policies are good for the poor; and (3) globalisation is good for the poor. OXFAM claims that there is substantial evidence that current patterns of growth are reinforcing, rather than reducing existing inequalities in income across a large spectrum of countries. It further criticises the Dollar and Kraay report for considering various standard macroeconomic measures as inherently good, just because there was no evidence of any significant negative impact on incomes of the poor. OXFAM also remarks that the report unjustifiably presented public investment in health and education as being only marginally relevant for growth and income distribution. And finally it asserts that part of the problem with the positive picture portrayed by Dollar and Kraay is that it contrasts so starkly with the experience of poor people themselves in a large range of countries.

Based on our study on the implications of structural adjustment in Zimbabwe we can add two points to OXFAM's criticism:

1. The tendency of certain economists to reduce the reality of people's lives to monetary terms of income and expenditure, and the corresponding tendency of influential lending institutions such as the World Bank and the IMF to measure poverty in terms of economic status, is a serious limitation. We have demonstrated that other dimensions of human well-being can be monitored as well, which are not necessarily associated with money: people's satisfaction with health services and the use of these services, people's health status, the nutritional status of their children.
2. The lag effects of adverse socio-economic circumstances should not be discounted: while some national health indicators in Zimbabwe did respond almost immediately to socio-economic stress, people generally appeared capable of coping with adversity for several years. At the household level a clear negative trend started setting in around 1996, when reserves got depleted. Zimbabwe's more recent social unrest and political instability (since 2000) should in part be attributed to the general emergence of ill-feeling during the 1990s. However, it may still take more time before other long-term effects of poverty and ill-health will be discernable. Although it may not be acknowledged or even recognised by everyone, impaired learning among children, loss of productivity and social exclusion are the dramatic results of a process of man-made structural adversity that started more than a decade ago.