Abstract

Article 25 of the Universal Declaration of Human Rights clearly emphasizes health as a human right. Poverty and social exclusion are the most important drivers of ill–health. The causes of increasing poverty are complex but one significant factor is international debt. This affects mainly sub-Saharan Africa but, with the global economic crisis in South East Asia, may spread. Structural adjustment policies which cut social spending compound the health effects of debt and poverty. Privatization of health care and user charges particularly affect women, children, the disabled, and other marginalized communities. To improve health, governments and international institutions have a duty to examine the determinants of health, including human rights and economic policy.

L'article 25 de la Déclaration Universelle des Droits de l'Homme affirme clairement la santé comme un droit humain. La pauvreté et l'exclusion sociale sont les facteurs les plus importants de mauvaise santé. Les causes de la pauvreté croissante sont complexes mais l'un des facteurs essentiels en est la dette internationale. Elle affecte principalement l'Afrique sub-saharienne, mais pourrait s'étendre en raison de la crise économique générale en Asie du Sud-Est. Les politiques d'ajustement structurel en réduisant les dépenses sociales, aggravent les effets de la dette et de la pauvreté. La privatisation des soins de santé et l'existence de tickets modérateurs affecte particulièrement les marginalisés, les femmes, les enfants, et les handicapés. Pour améliorer la santé, les gouvernements et les institutions internationales ont le devoir d'examiner les déterminants de la santé, y compris les droits humains et les politiques économiques.

El artículo 25 de la Declaración Universal de Derechos Humanos enfatiza de forma clara la salud como un derecho humano. La pobreza y la exclusión social son los principales factores condicionantes de la mala salud. Las causas de la pobreza creciente son complejas pero la deuda internacional es uno de los factores esenciales. Ésta afecta principalmente a África subsahariana, pero podría extenderse como consecuencia de la crisis económica general del sudeste asiático. Las políticas de ajuste estructural que recortan los gastos sociales agravan los efectos de la deuda y de la pobreza. La privatización de la atención en salud y la cotización por uso de esta atención afectas en particular a las mujeres, a los niños y a las niñas, a las personas descapacitadas, y las comunidades marginalizadas. Los gobiernos y las instituciones internacionales tienen el deber de examinar los determinantes de la salud, incluyendo los derechos humanos y las políticas económicas para mejorar la salud.

Poverty and Health: Debt Relief Could Help Achieve Human Rights Objectives

Dorothy Logie and Michael Rowson

UDHR Article 25

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

An emphasis on civil and political rights has dominated the human rights agenda, but Articles 23 through 27 of the visionary Universal Declaration of Human Rights (UDHR) just as firmly emphasized economic, social and cultural rights. Gradually, the indivisibility of all human rights is being recognized. The 1966 International Covenant on Economic Social and Cultural Rights states, in its preamble, that, "in accordance with the UDHR, the ideal of free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social and cultural rights as well as his civil and political rights."[1] The same Covenant specifically outlines a right to health (Article 12). Health and health–related issues are also addressed in the 1979 Convention on the Elimination of All Forms of Discrimination Against Women and the 1989 Convention on the Rights of the Child, as well as in the

Dorothy Logie, MB, ChB, FRCGP, is a primary care physician and General Practitioner Advisor at Scottish Borders Health Board, Scotland. Michael Rowson, BA, MSc, is Coordinator of the Economic Policy and Health Project at MEDACT. Please address correspondence to the authors care of Michael Rowson, 601 Holloway Road, London N19 4DJ, United Kingdom.

programs of action from a series of recent UN–sponsored global conferences including the World Conference on Human Rights (Vienna 1993), the International Conference on Population and Development (Cairo 1994), the World Summit for Social Development (Copenhagen 1995), and the Fourth World Conference on Women (Beijing 1995).

Amongst these documents, however, Article 25 of the UDHR remains particularly important. For Article 25 is not only the precursor to all that followed, but it promotes health as a right while insisting on protecting the determinants of health. The Alma Ata Declaration reaffirms this when it notes that "health, as a state of complete physical, mental, social well–being, and not merely the absence of infirmity, *is a fundamental human right and...the most important social goal whose realization requires action in many other social and economic sectors in addition to the health sector"* (emphasis added).[2]

These are fine words but, on the fiftieth anniversary of the UDHR, human rights activists still confront the bitter reality of widespread hunger, disease and discrimination in the context of a global economy characterized by widening inequality and poverty. Although the preamble to the UDHR reaffirms the worth of each individual person and the equal rights of men and women to progress towards a better standard of living, and although the idea of freedom from poverty has been in human rights law and discourse since the adoption of the UDHR, poverty–related issues have not been given priority in the human rights agenda. This anniversary represents both an opportunity to push poverty to the front of that agenda, and to promote action that might enable its reduction.

Poverty and Ill–Health

Poverty, in both its absolute and relative forms, is the single most important driver of ill–health in the world today.[3] This is hardly surprising. In developing countries, the pathways by which low levels of economic and social well–being affect health are easily found and are the daily reality of hundreds of millions. These pathways include: lack of access to safe water (experienced by 1.2 billion people); lack of adequate sanitation; poor housing; low income (at least 1.3

billion people live on under US$1 per day); and lack of access to health services (faced by 800 million people). Discrimination against women, the elderly, ethnic minorities, refugees, the disabled and other marginalized groups both causes and magnifies these problems. Many other factors, such as conflict and adverse climate changes, for example, can also contribute to poverty and ill–health. Another contributor can be the skewed spending priorities of governments which may have high levels of military expenditure or may devote most of their health budgets to secondary health care for urban citizens, at the expense of primary and preventative health services.[4]

Human Rights Response

Faced by such diverse causes of poverty and ill–health, human rights activists obviously need to work at international, national and community levels, and both within and outside the health sector, to make their anti–poverty agenda effective and credible. It is beyond the scope of this article to fully explore the range of strategies which might be employed as it would encompass action against the various types of discrimination that contribute to poverty, as well as action to alleviate general economic and social problems. Here we will focus our attention at the level of the international economy.

The anniversary of the UDHR is taking place in the midst of a widespread economic crisis, which threatens to lead to a global recession. Countries in East and South East Asia are particularly affected (in Indonesia, for example, a halving of per capita income is predicted, coupled with a three–fold increase in the poverty rate by the year 2000), and there are signs that the crisis could soon spread to Latin America and elsewhere.[5,6] For many countries, a new recession may be only the latest stage in a downward economic record — since 1980, 100 countries have experienced economic decline or stagnation, and 1.6 billion people have seen their incomes reduced.[7] This decline has been most obvious in sub–Saharan Africa.

When crisis (often provoked by an uncontainable rise in private or public sector debt) has beset poor countries, donor governments and multilateral institutions such as the World Bank and the International Monetary Fund (IMF) have, over

the last two decades, made further financial assistance for these countries dependent on their compliance with sets of policy recommendations known as structural adjustment programs. Generally these programs have mandated that the state withdraw from areas of economic and social life which it previously financed and regulated.

This type of policy shift at a time of economic crisis can compromise the broad objectives of Article 25 by making the kind of well–financed, intersectoral action needed for large–scale poverty reduction less possible, and compromise the ability of governments to provide special protection for vulnerable social groups. Here we highlight the ongoing impact of the debt crisis in sub–Saharan Africa and ill–considered policy advice, which represent two important influences on poverty and health in developing countries. We focus specifically on the situation of vulnerable social groups and how their situations might be undermined by both financial constraints and inappropriate economic policies.

Debt and Economic Adjustment

Today a large burden of foreign debt is carried by over 40 of the world's poorest countries. This potentially has multiple effects on their economies and acts as a significant constraint to improvements in international health. First, it undermines prospects for economic growth (and thus poverty reduction) by discouraging public and private investment; private investors, in particular, fear the higher taxes, higher inflation and currency speculation that an unsustainable debt burden can bring. Second, debt repayments siphon away precious foreign exchange needed to buy the imports essential for economic growth and the maintenance of health systems. Third, debt repayments divert money from government budgets which could be used for health, education and poverty reduction initiatives. And fourth, they use up sources of foreign exchange (other than export revenues) such as grants and loans from government and multilateral donors. For poor countries, the accumulation of a large foreign debt can thus be the prelude to a catalogue of economic disasters.

The Scale of Sub–Saharan African Debt

> Many states in Africa lack the financial capital needed to address basic expectations and fundamental needs. This is one of the central crises in Africa today, and one that is due in large measure to the problem of African public sector debt.[8]

In the early 1980s, the developing world as a whole faced foreign debts of around US$800 billion — the results of a decade of irresponsible actions on the part of both creditors and borrowers. Today, total debt stands at over two trillion US dollars, despite large repayments in the intervening years. Sub–Saharan Africa, containing 34 of the 41 most heavily indebted poor countries, is worst affected. Taken together, its US$230 billion debt is small compared to debt in other parts of the world, but compared to its earnings from exports or its total GDP, the debt represents an overwhelming burden. More money is spent on interest payments than on health and education, and many countries are unable to afford even the most basic annual health package, estimated by the World Bank to cost around US$12 per capita. In Uganda, with one of the highest infant and maternal morality rates (and an AIDS epidemic), the government spends annually only US$2.50 per capita on health. Several other heavily–indebted countries are spending equally small amounts on health, leading to an increasing reliance on cost–recovery mechanisms (such as user charges) to cover the widening gap between health needs and budgetary capacity.

Many countries in the region are literally bankrupt, and are in the process of building up huge arrears of debts that can never be repaid. What repayment they do manage is financed by revenues from exports and other money from the domestic budget, new loans (thus incurring further debts), and grants from aid donors. It is sobering to note that in 1996, twenty–three percent of all aid given to sub–Saharan Africa was spent on debt repayments to financial institutions and governments in the North.[9]

Structural Adjustment Policies

In return for either delaying debt repayments or lending more money, international donors such as the World Bank

and IMF have demanded that countries undertake policy reforms, known as structural adjustment programs, aimed at reducing domestic demand by raising interest rates, devaluing currencies and reducing public expenditure. They also recommend that the state's role in public life be reduced by, for example, eliminating subsidies for food and fertilizers, relaxing foreign investment regulations, privatizing state–run industries and services, and cutting government bureaucracy (including in the health sector).[10]

Have these reforms stemmed economic crisis and provided a stable macro–economic framework for poverty reduction? The recent internal review of the Enhanced Structural Adjustment Facility (ESAF), the IMF's policy–linked lending program, contains indications that they have not necessarily done so. The internal review notes that since 1981 the "average level of per capita income in ESAF countries fell further behind other developing countries" and that their external debts almost doubled during the period 1985–1995.[11] Clearly, this is disturbing news from both an economic and a health perspective.

Adjustment programs propose wide–ranging changes to economies which affect incomes, prices and social expenditures and, in turn, people's economic and social behaviors as well as their living and working conditions. These changes are likely to have multiple health impacts on populations, and some will take time to reveal their full effects. Although linkages between adjustment and health are complex, many commentators, including international agencies such as UNICEF and the World Health Organization (WHO), have drawn attention to both possible and actual negative outcomes.[12,13,14] This literature is not reviewed in detail here, but what has been written so far demonstrates the need to set up a health impact assessment process to examine (ex–ante if at all possible) the likely effects of economic policies on individual health.

Economic Crisis, Adjustment and Vulnerable Groups

Article 25 of the UDHR specifically points to mothers and children as social groups needing special attention. Today we might extend this concern to other vulnerable groups such as women, the disabled and people living with HIV/

AIDS. These groups are at greater risk of suffering during economic crises for a range of reasons, most notably related to discrimination. Debt and inappropriate economic adjustment can reduce the state's capacity to intervene to correct discrimination, vulnerability and inequality, thus putting these groups at even greater disadvantage in difficult times.

In certain cases, adjustment programs have exacerbated already–existing structures of discrimination. For example, one aim of adjustment has been to promote increased agricultural production, but this was done while ignoring the situation of women farmers. Women grow 80 percent of Africa's food, but they have limited land rights and have been unable to react to rising prices in the ways predicted by the designers of economic adjustment programs. Partly as a consequence, food production per capita in sub–Saharan Africa is lower today than it was in 1980, and far lower than in Latin America or Asia.[15] This has resulted in widespread nutritional deficiencies which represent serious health problems that affect women and children most severely. For example, it is estimated that two–thirds of women in sub–Saharan Africa suffer iron–deficiency anemia in pregnancy.[16]

Due in part to the lack of funds which can result from the constraints debt and adjustment impose on social sector spending, international and national plans for improving the health of women and children remain to be fully carried out. For example, 40 African countries have prepared National Plans of Action in response to the global Plan of Action emanating from the 1990 World Summit for Children which incorporated priority health goals for children and for women. These plans include raising immunization rates, improving oral hydration, eliminating iodine and Vitamin A deficiencies and encouraging breastfeeding. But implementation has been slow or nonexistent due to lack of both money and political will.

Access to education further illustrates the problem posed by reductions in social spending. Maternal illiteracy casts a long shadow on the future health of children. Research on the determinants of infant mortality shows that the level of the mother's education is the single most important influence on child survival.[17] In response to economic adjustment, user fees for education have been introduced. This has meant

that many families throughout Africa, Asia and Latin America have been forced to choose which of their children to educate. As a result of the pervasive nature of gender–based discrimination, many choose their sons. Girls may also be removed from school to look after younger siblings while their parents, who may be working longer hours because of wage cuts, are absent from home. This has obvious implications for the health of both present and future generations.

It should be noted that Africa is the only part of the world in which the number of children out of school is increasing.[18] In Niger, for example, fewer than one–quarter of children attend primary school, and less than 20 percent of these are girls.[19] Where it exists, school often means a mud hut with a leaking roof, classes of 40 or more students and a chronic lack of teaching materials. In Zambia, expenditure on primary schools is now at less than half its mid–1980s level.[20] This is a denial of the right to education as stated in Article 26 of the UDHR and also of Article 15 of the Convention on the Rights of the Child (which has been ratified by all of the governments of Africa except Somalia).[21]

Reproductive Health

Article 25 throws the spotlight on motherhood as a condition during which women require 'special care.' However, in what has been described as "the health scandal of our time," 585,000 women still die each year from pregnancy–related causes and many times that number are incapacitated as a result of child–bearing.[22] In parts of sub–Saharan Africa maternal mortality is still rising and, a decade after the introduction of the 1987 Safe Motherhood Initiative, its implementation remains frustrated not only by lack of funds and political will but also by continuing discrimination against women.

Again, the absence of a supportive macro–economic framework is of great importance. This merits particular attention because it bears significantly on the quality and accessibility of health services. Low levels of spending on health can result in inadequate medical and physical infrastructure, maternal malnutrition, user charges, poor–quality staff training and motivation, unreliable blood supplies and lack of drugs. It should be noted that the use of maternity services is

especially vulnerable when patients must bear the burden of payment. Several countries have reported that implementing charges for antenatal care has increased the number of deliveries requiring unbooked emergency care.[23] The negative effect of user charges in these countries should be expected, as the cost of health services is often very high in relation to income. For example, the cost of an uncomplicated cesarean section in Nigeria is US$274, or nine months of the average annual income.[24]

Failure to address the substantial unmet need for contraception also contributes to unnecessary loss of life. Under Article 16 of the Women's Convention the right to decide the number and spacing of children and to have the information and means to implement that decision are guaranteed.[25] Although developing countries pay for three–quarters of their family planning and reproductive health services, donor contributions have not changed since 1995, and in some cases have even declined.[26] The United Nations predicts a sharp rise in unwanted pregnancies, abortion and infant and maternal mortality unless the stagnation affecting aid programs is halted and health and education spending within countries is increased.[27]

HIV/AIDS

AIDS has become a marker for injustice, discrimination and lack of realization of human rights. The virus thrives on poverty, social disruption, ignorance and accelerated urbanization: its spread is encouraged by lack of resources, lack of clean water, commercial sex, and rapidly declining health services. Each of these factors is potentially exacerbated when adjustment policies lead to budget cuts, unemployment, and migration.

Ninety–three percent of global HIV occurs in developing countries, with Africa currently bearing the brunt.[28] Recent statistics show that almost half the adult population of some cities in Zambia, Malawi and Botswana are HIV–infected.[29] Forty million children in the developing world will lose one or both parents to AIDS by 2010.[30] In many African hospitals, over half the patients are infected with HIV.[31] Africa's explosive epidemics may soon be followed by large epidemics in India, Myanmar, Thailand and Cambodia.[32] This

is especially worrisome because of the already high prevalence of tuberculosis in these countries.

Pediatric AIDS is now threatening much of the progress that has been made in child survival. With HIV increasing among women, more and more children are infected in utero, during delivery or via breastfeeding. In high prevalence areas, transmission rates from mother to child range from 13 to 52 percent.[33] In countries where antenatal courses of the drug zidovudine are affordable (at a cost of $150 per delivery) the decrease in perinatal transmission is 66 percent.[34] However, a few tablets of this drug cost the equivalent of the annual per capita health budget of many countries and few countries can afford it.

North America and Western Europe, with nine percent of the world's HIV infection, absorb 82 percent of the global HIV/AIDS expenditure.[35] In many parts of the world HIV–infected people are denied access to regimes of treatment and care which exist and are available to others. In nearly all highly indebted poor countries, the lack of access is absolute. In the North, the epidemic is being controlled through such factors as health education, free condoms, needle exchanges, safe blood and treatment of STDs. There is every reason to believe that the course of the pandemic could also be altered profoundly in the South. However, debt and economic adjustment have often resulted in user fees for STD clinics and for maternity care, a lack of adequate and cheap antibiotics, shortages of condoms and few attempts to treat partner contacts. Even in Zambia, which has a high–profile STD control program, the country has slashed its health budget in the face of an overwhelming debt burden and care is far from optimal.[36]

Using Debt Relief to Promote Gains in Health

After a decade of vociferous pressure from NGOs and others, both creditor governments and the international financial institutions have moved to a point where they have agreed to put a mechanism into place (the Highly Indebted Poor Countries Initiative) which will cancel some low–income country debts. It is believed that by relieving a proportion of foreign debt, economic growth will be encouraged and, if the relief is deep enough, this should free resources that

governments could then use to tackle some of the enormous health problems outlined above. However, the process is slow, the relief is offered to too few countries and, even where provided, the relief is often not extensive enough to make a significant impact on human development problems. Oxfam has put forward a scheme which would require countries, in return for faster and deeper debt cancellation, to use the gains from debt relief to implement national development priorities agreed to by governments, civil society, and donors. They have also shown that for some highly–indebted poor countries, debt cancellation could provide a significant portion of the external finance needed to implement the National Plans of Action agreed to after the World Summit for Children.[37]

In the long–term, debt relief could reduce the need for countries to undertake economic adjustment — with its technical–fix approach to health as a commodity and the resulting emphasis on introducing user charges, competition, and other market mechanisms into the delivery of health care. Countries could then be free to reorient their vision of health towards universal primary health care (as contained in the Alma Ata Declaration) and to emphasize a preventative public health agenda.

The Problem of Conditionality

The experience of having policy conditions imposed on aid or on loans has not necessarily been a happy one for developing countries. Negotiating detailed conditions takes up a great deal of governmental time and resources and, as in the case with ESAF programs, there is great concern that when implemented, many of the policies will be ineffective or counterproductive.[38]

Making debt relief conditional on improvements in health and conditions of poverty could be equally controversial. Our concern focuses on three areas:

- First, that countries might be forced to devote all money gained from debt relief to sectors such as health and education. Some countries, especially those emerging from conflicts, might wish to spend some of the gains from debt relief in other socially–important sectors such as infrastructure development.

- Second, debt cancellation might become dependent on countries reforming their health systems to reflect the current ideology of cost–sharing and privatization mandated by the World Bank and IMF. For example, the agreement to cancel Mozambique's debt in April 1998 was accompanied by recommendations that urged the government to raise the amount of revenue gained through charging patients for health services.[39]
- Third, there is some evidence to indicate that programs which have a great number of conditions attached to them are prone to failure, and a growing awareness that reform programs must be truly owned by the country if they are to succeed. There is also the possibility that forcing countries to comply with a large number of conditions could lead to delays in the actual application of debt relief.

Nevertheless, human rights activists and health professionals might link up to ensure that debt relief does help to reduce poverty and promote health, and that it does so in a fair way. For example they might:

- work to ensure that the debt relief process is open and accountable and not dominated by the interests and agendas of creditors, but also includes the concerns of governments and civil society representatives;
- help to highlight and build upon schemes proposed by developing countries themselves — schemes that use debt relief to achieve human rights objectives. In fact, several poor countries (such as Uganda) already have human–development–oriented schemes waiting in the wings to be financed by the proceeds from debt relief;
- make sure that debt relief is not conditional on health or economic system reforms that are potentially harmful to health outcomes; and
- press for governments that have ratified human rights instruments (such as the Convention on the Rights of the Child) and the World Bank and IMF (which are components of the UN system) to modify their policies in accordance with these international obligations.

Conclusions

Debt relief is not a solution on its own, but if channeled in the right direction, and with the active involvement of civil society, it can achieve progress in reaching human development targets. There is a responsibility, and a legal obligation, for governments and international financial institutions to address the determinants of health (including income, education, safe water and food, and all human rights) in order to achieve lasting health improvement.

Human rights activists and health professionals should work toward addressing these issues by pressing for swift and generous debt relief. They should also look critically at economic policies that have effects both inside and outside the health sector. For example, policies that cause unemployment or raise the price of food (through cutting food subsidies, for example) should be scrutinized thoroughly for their health impact on different population groups, and effective safety–nets should be ensured. A large dose of skepticism should be directed within the health sector towards the intrusion of market–led polices such as the promotion of private finance, insurance companies or user charges. The more health is seen as a commodity, the more it loses its universal public health perspective. In particular the World Bank, which currently dominates global health financing and policy, must reexamine its role in setting the health sector agenda and take considerations of equity and fairness into account.

The fiftieth anniversary of the UDHR is a time to call again for poverty reduction and health equality to be at the center of development strategies. In the meantime, the UDHR remains a living document, a standard by which we can measure the world's imperfections and work towards righting wrongs — past, present and future. The more people — health professionals, nongovernmental organizations and activists — understand what human rights instruments have to say about poverty and health, the more these instruments can be used to lever change.

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