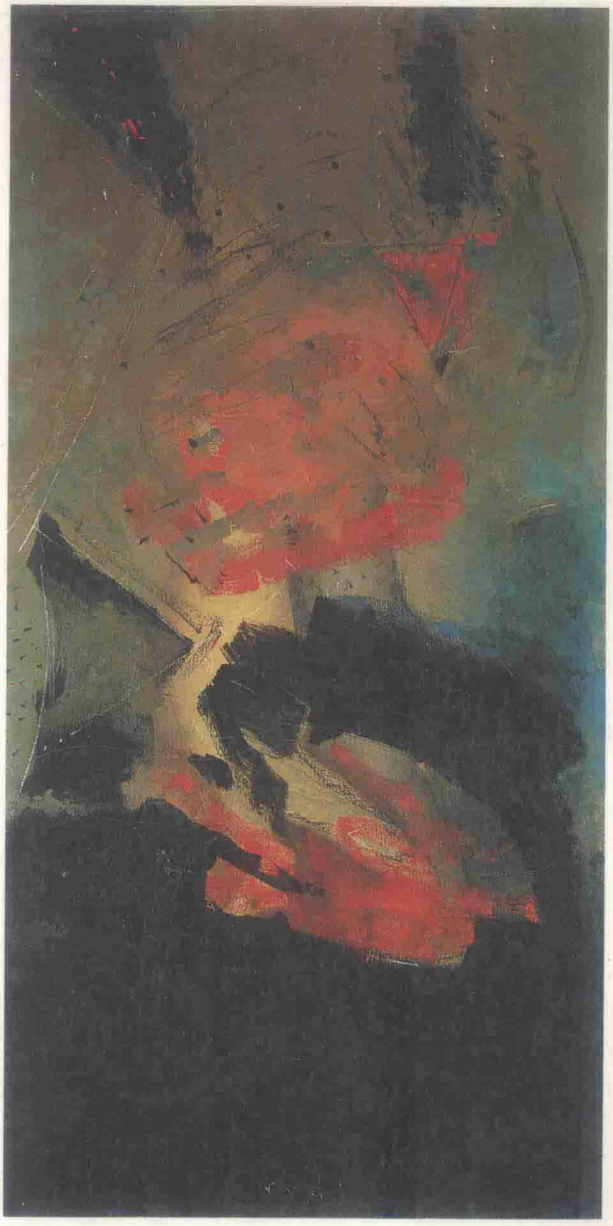
Health Dimensions of Economic Reform



World Health Organization
Geneva

Health Dimensions of Economic Reform

World Health Organization
Geneva
1992

WHO Library Cataloguing in Publication Data

Health dimensions of economic reform

1.Economic development 2.Health status 3.Public health 4.Social conditions

ISBN 92 4 156146 7 (NLM Classification: WA 30)

This text was prepared for the International Forum on Health: a Conditionality for Economic Development, held in Accra, Ghana, on 4 to 6 December 1991, and was originally distributed as an unpublished document. In order not to delay its wider distribution, it is now being issued in published form without editorial revision.

Contributors to the document were: Dr S. Litsios, Dr R. Long, Dr K. Mott, Dr R. Thapa, Mrs D. Cooper Weil, the Steering Committee for the International Forum and the country teams. The work was carried out under the general direction of Dr A. El Bindari Hammad and Mrs C. Mulholland, with Mr G. Gunatilleke as principal editor.

The contributors and editors alone are responsible for the views expressed in this publication.

Designed by WHO Graphics
News clippings, collages and graphs by Marilyn Langfeld

Printed in Switzerland
92/9196 - Impressa - 4000

Excerpts from the Constitution of the World Health Organization

- *The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.*

- *The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.*

- *Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.*

- *Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.*

Source: World Health Organization, *Basic Documents*, 38th Edition, Geneva, WHO, 1990.

Introduction

Health is an essential objective of development. The capacity to develop is itself dependent on health. These two aspects of health and its links with development are now emerging with greater force and clarity. Health status cannot be traded off against economic gain. There is a better understanding of the crucial contribution of health to economic activity, to improvement of the human condition and, through these, to all the processes of development. The achievement of appropriate health objectives is therefore an important measure of the effectiveness of development strategies.

Awareness of the value of health for development was heightened during the economic recession of the 1980s, with the serious adverse consequences this had on the quality of life in developing countries. Policy-makers now pay closer attention to the impact that economic adjustment policies have on health and nutrition and are attempting to bring out more clearly than before the relationships between economic policies and health outcomes.

While there have been these special responses to the impact of adjustment policies, the same cannot be said of development policies in general. Despite the effects of development policies on health, the knowledge has not been systematically integrated into the process of policy-making. The impact that development policies have on health is seldom referred back to the policies themselves. Had this been done, policy-makers could have made adjustments that would have averted adverse health outcomes from the outset. Instead, there has been a continuing tendency to leave the emerging new health situations and problems within the domain of the health services. The main concern has been how the health services can deal with these situations and problems through expansion and improvement of their own capacity.

Development strategies therefore tend to attempt to reconcile the increasing burden of ill-health resulting from an accumulation of new health hazards with the escalating costs of health services and increasing sophistication of health technologies. Such a model of health care is proving impossible, even for the developed countries. It is biased in favour of the affluent and has already generated grave inequalities in access to health and health care. Its adoption by the developing countries would have disastrous consequences for the health of the vast majority of their populations. What is needed is a thorough reorientation of social and economic strategies, incorporating the health dimension at a more fundamental level in relation to selection of the options available for growth and development.

The problems of human health emerging as a result of the prevailing patterns of development are also assuming a global dimension. They are similar and closely linked to those that underlie the environmental crisis. The health issues, however, have an independent identity and must not be subsumed within the issues central to concern regarding the environment.

There has been some complacency with regard to ill-health following on industrialization, greater life expectancy, and the far-reaching changes in lifestyles and values now taking place. The complacency is mainly attributable to the expectation that advances in technology

would be adequate to cope with the problems. Only recently have the global prospects for human health begun to disturb this complacency and attract the attention of the world community. The impact of environmental degradation on human health, the AIDS pandemic, the realization that modern transport and mobility promote the speedy transmission of disease, and some of the consequences of modern lifestyles detrimental to health have contributed to this awareness. The industrialized countries are now becoming aware of the magnitude of the health hazards that industrialization can generate and of how they accumulate and are often detected only after they have caused widespread serious impairment of human health. Many developing countries are confronted with a double health burden: not only must health authorities cope with the continued prevalence of malnutrition, diarrhoeal and respiratory diseases, and others such as AIDS and malaria, they must also face the emerging problems associated with industrialization, urbanization, and changing lifestyles, including occupational hazards, cardiovascular disease, cancer, drug abuse, and accidents. If this situation continues, it will give rise to a health crisis of unmanageable proportions.

The protection of health and the improvement of health status must therefore become essential conditions of socioeconomic policy. The term "conditionality" is used throughout this publication in a wide sense and applies both nationally and internationally. As it is currently used, it denotes the state of being subject to a set of economic conditions related to fiscal and exchange rate policies, the removal of subsidies, reduction in government spending, and other conditions that form part of the macroeconomic "discipline" imposed on borrowing countries by international lending agencies. The term has acquired certain negative connotations, since these policies when implemented have had severe adverse effects in the short term on the welfare of the vulnerable groups, especially in poor countries, even though the long-term effects are intended to benefit the economy and promote social well-being as a whole. Some population groups – the poor, women, and some communities – are especially vulnerable to the impact of these measures on their health status and quality of life.

If conditionality is considered in the specific context of economic adjustment, then "health conditionality" is the counterpart of economic conditionality. Action in response to the adverse social effects of adjustment policies has mostly been remedial in character and aimed at dealing with the effects, consisting of a few compensatory measures to bring some relief to the segments of the population that are adversely affected.

Conditionality has often been applied to lending for conventional projects and, in many cases, this has had social objectives. For example, utility projects often contain loan conditions aimed at extending water or other public services to the poor, often at subsidized rates. Environmental conditions attached to lending operations in a variety of sectors are often of benefit to the poor or disadvantaged, who tend to suffer most from environmental degradation.

Health conditionality is, however, wider in scope and more fundamental in character than remedial or project responses. It implies that the essential health objectives of protection and improvement of health status and quality of life should be defined at the very outset along with the macroeconomic objectives, and that the processes of adjustment should achieve both sets of objectives simultaneously.

For the developing countries, making health part of conditionality represents a more positive response to the basic issues of well-being that arise in the process of adjustment. However, health conditionality should not be restricted to

the developing countries; it should be applied in all countries, since its aim is that the protection and promotion of health should be as much the primary objective of development as economic growth. Thus the objective of economic decision-making should from the beginning include the objective of protecting and promoting the quality of life.

A major issue that emerges at various points of the discussion in this publication is the role of the market. The approach that has been outlined relies essentially on the market for achieving its objectives, direct welfare-oriented state intervention being replaced by processes that increase the capacity of people for responsible decision-making. It therefore falls within the larger context of liberalization and restructuring of economic policy in which most countries are currently engaged. Four elements characterize this reorientation. First, the economic transformation of vulnerable groups involves increasing their self-reliance and enabling them to compete efficiently in the market. Second, households and communities should become increasingly responsible for the improvement of their health status and quality of life through access to health-related resources and as informed health consumers. Better flow of knowledge and information will promote this process. Third, public policy, through emphasis on health conditionality, should create the conditions for a health-promoting environment and provide incentives to that effect that align the market in relation to health objectives. Fourth, independent nongovernmental organizations, the media, and other groups safeguarding the interests of the public should play an important role in social decision-making.

The main themes in this publication are presented in the six chapters that follow. The argument put forward is that in setting general conditions for development any society needs to identify the areas of vulnerability in that society and their acute manifestations in highly vulnerable groups. The book is arranged in the following order:

Chapter 1 is entitled "The outcomes of past development strategies" and briefly reviews the achievements of past strategies as reflected in the performance of developing countries during the 1980s. It provides the backdrop for an examination of some of the critical issues relating to health and development; the health situation of the vulnerable groups throughout the world providing the point of entry to such an examination as their health status is the best reflection of the development process.

Chapter 2 is entitled "The concept of vulnerability". This chapter defines the key elements in high vulnerability and indicates how the health status of vulnerable groups is an integral part of their economic well-being.

Chapter 3 is entitled "The role of functional literacy" and, with ***Chapter 4*** on "Linking economic well-being with health status", examines in greater detail some elements singled out as basic to strategies aimed at the transformation of vulnerable groups. In Chapter 3 the concept of functional literacy and its role are examined and in Chapter 4 the growth of productivity and economic enterprise in the vulnerable groups is discussed.

Chapter 5 entitled "Beyond the welfare-oriented approach" examines the larger issues involved in integrating health in development policy.

Chapter 6 on "Health as conditionality for development" looks at the implications of making health an essential condition of development at both micro and macro levels.

Chapter 7, the final chapter, summarizes the main conclusions.

Contents

Chapter 1
The outcomes of past development strategies

The performance of developing countries

Throughout the 1980s the poorest countries, with per capita incomes below US$ 500 (as defined in the World Development Report of the World Bank), had falling mortality rates and increasing average life span. Adult literacy rose. In aggregate terms the daily calorie supply increased marginally. In terms of food availability, health, and education, therefore, the outcome for this group of countries, taken together, recorded some improvement in well-being. But, as analysts have frequently pointed out, the figures used as aggregates for 42 countries with a population of 2950 million conceal sharp disparities. The population of China and India, for example, comprises two-thirds of this category; therefore, improvements in the health status of these two countries alone more than offset the poor performance of all the other countries put together. This can be seen in the aggregate data in Table 1, presented separately for India and China and the group of other low-income countries. When China is excluded, the average life expectancy drops from 62 to 57 years; when India is also excluded, it drops to 55.

In 1988 16 of the 42 countries in the group had an average life expectancy of below 50 years. This implies low child survival rates with infant mortality rates above 100 per 1000 live births. Twenty-six of the 33 countries for which data were available for 1985 had female illiteracy

Table 1: ***Development in low-income countries – selected indicators 1977-1989***

	Population in mid-1989 (millions)	Life expectancy at birth (years)		Adult literacy (%)		Daily calorie supply per capita		Growth of GDP per capita
		1980	1989	1977	1985	1977	1988	1980-1989
Low-income (a) countries excluding China & India	1002.0	48	55	34	49	2113	2182	0.7
China	1113.9	64	70	66	69	2441	2632	8.3
India	832.5	52	59	36	43	2021	2104	3.2
All low-income countries	2948.4	57	62	50	56	2238	2331	4.2
Mozambique (b)	14.9	47	49		38	1906	1595	-4.1
Bangladesh (b)	108.9	46	51		33		1927	0.9
Haiti (b)	6.3	53	55		38	2100	1902	-2.4

(a) Countries with per capita GNP of US$ 545 or below in 1988 and US$ 410 or below in 1980, as classified in the *World Development Report*, 1990 and 1982.
(b) The country with lowest per capita GNP (1988) has been selected from Africa, Asia, and Latin America.

Source: World Bank, *World Development Reports* 1982, 1990, and 1991.

rates above 50%. In 33 countries the crude birth rate was over 40 (per 1000 population). The marginal improvements therefore occurred in conditions in which the quality of life and the state of human development as reflected in health indicators remain extremely low.

Other developments in the 1980s heightened the risk to the health and well-being of the population in most poor countries. The economic base for protecting and improving health and well-being was seriously eroded as a result of adverse developments in the world economy and the consequent adjustments the poor countries had to make. Here again, there were wide variations in performance among the developing countries. Asian developing countries showed greater resilience in coping with the crisis and continued to maintain relatively satisfactory rates of growth, while many countries in Latin America and Africa suffered a significant decline in real per capita income. The per capita incomes of sub-Saharan Africa are estimated to have fallen by approximately 25% during the 1980s. Structural adjustment took a heavy toll of public expenditure. The resulting austerities and hardships contributed to social and political destabilization. The cuts imposed on health budgets further depleted and constrained services already quite inadequate to have the desired impact on the existing poor health status. The allocation for public expenditure on health in 43 countries with a low human development index (as defined in the UNDP Human Development Report) has remained at 0.7% of the GNP during the past three decades. With the decline in GNP in absolute terms, the real per capita expenditure on the services has fallen. The levels of health expenditure would have been better able to protect and promote health if the development strategies that were adopted had not continuously added new hazards to the burden of ill-health and further distorted priorities in health care.

Survival with low quality of life

Improvements in health status and enhancement of the capacity for survival, even though marginal, have begun in the poorest countries to pose a new set of problems and challenges that have not yet been clearly identified or adequately understood (see box).

The initial outcome of lower mortality has been a rapid increase in population. While the average crude death rate for the poorest countries (excluding China and India) fell by 38% during the period 1965-1989, the crude birth rate dropped by only 13%. The decline in the total fertility rate was only marginal, from

Table 2: Mortality and fertility in low-income countries (1965 and 1989)

	Crude birth rate		Crude death rate		Total fertility rate	
	1965	1989	1965	1989	1965	1989
Low-income countries excluding China & India	46	40	21	13	6.3	5.5
China	38	22	10	7	6.4	2.5
India	45	31	20	11	6.2	4.1
All low-income countries	42	31	16	10	6.3	3.9

Source: World Bank, *World Development Report 1991*, Table 27.

Living longer but not better

The aging of populations is now a global phenomenon manifest in several parts of the world, incipient in all the rest.

The regional distribution of the population aged 60 and over reflects the growing tendency of the world's elderly to be concentrated in developing countries. The proportion of the world's aging population was evenly distributed between developing and developed countries from 1950 to 1975. By 2025, 72% of the elderly – about 858 million people – will be living in developing countries.

Lumping together the population aged 60 and above conceals two important factors: age and gender. In 1950 there were 13 million very old (defined as 80 years and above) in the world, constituting 7% of the total elderly population. In 1985 the number of very old had more than tripled to 45 million, 10% of the total elderly population, which only doubled during the same period. By 2025 the very old will number about 137 million, 11% of the total elderly. The increase in the 80-plus age group will be more rapid in developing countries. In both developed and developing countries, the 80-plus age group will grow twice as fast as the 60-plus age group.

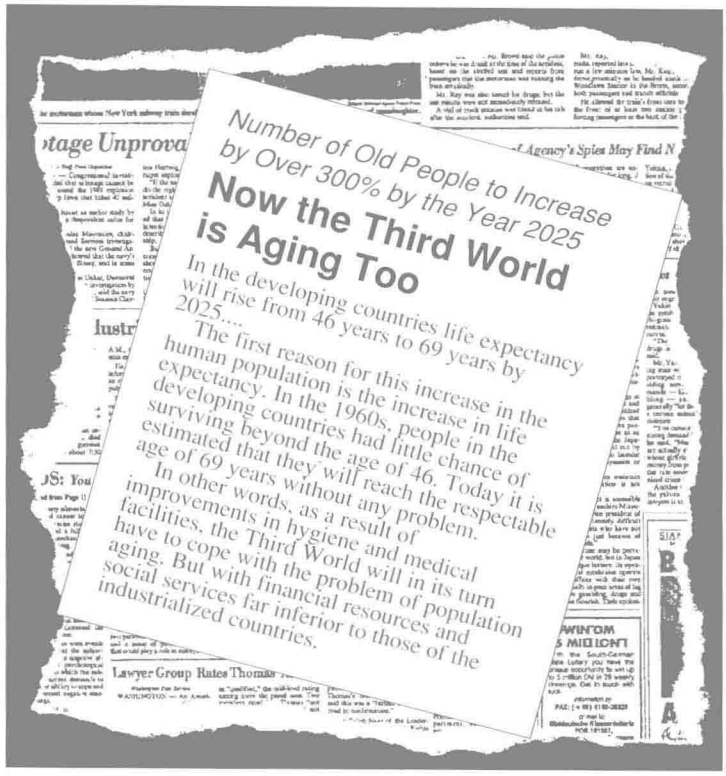
There will also be a greater increase in the number of old women than of old men. Between 1985 and 2025 the projected increases for persons aged 70 and above are 32 million for males and 38 million for females in developed countries and 284 million for males and 317 million for females in the developing countries.

The conclusion is inescapable: the populations of developing countries will age, involve larger numbers, and age more rapidly than the populations of developed countries. Aging is usually regarded as a problem confined to developed countries. It is clear that in the future this will not be so. Aging is now a global problem, affecting developing countries as well as developed countries. The central policy implication, therefore, is that developing countries will have to plan for the increasingly rapid aging of their populations.

Source: United Nations Office at Vienna, Centre for Social Development & Humanitarian Affairs. *The World Aging Situation, 1991.*

6.4 to 5.6 during this period. With poverty and illiteracy persisting, women have had an increasing burden of child care and have had to cope with households of larger size.

More disturbing are the indications that the capacity for survival in the prevailing socioeconomic conditions is accompanied by adaptation to a poorer quality of life and increasing undernourishment, particularly among mothers, infants, and children. The technology and health care available appear to be able to sustain and prolong life in conditions of great deprivation. The proportion of babies with a low birth weight in a poor country with a relatively high life expectancy such as Sri Lanka – 28% of babies with a low birth weight and an average life expectancy of 71 years – is alarming evidence of this phenomenon (see Table 3, page 5).


Number of Old People to Increase by Over 300% by the Year 2025

Now the Third World is Aging Too

In the developing countries life expectancy will rise from 46 years to 69 years by 2025....

The first reason for this increase in the human population is the increase in life expectancy. In the 1960s, people in the developing countries had little chance of surviving beyond the age of 46. Today it is estimated that they will reach the respectable age of 69 years without any problem.

In other words, as a result of improvements in hygiene and medical facilities, the Third World will in its turn have to cope with the problem of population aging. But with financial resources and social services far inferior to those of the industrialized countries.

Such projections call for a new look at development plans. Soon most of the world's elderly will live in developing countries, their lives often prolonged despite great deprivation.

The health dividend from economic growth

For the poorest countries, excluding China and India, average per capita incomes rose by approximately 40% during the period 1965-1989, while infant mortality declined by about 35%. It could be argued that, even within the relatively slow increase in economic well-being, improvement in health status as measured by infant mortality did not keep pace with economic growth. The health dividend of GNP growth (the share of the benefit accruing to health) in countries such as China and Sri Lanka has been much higher, that for India even poorer. The size of the health dividend reflects the differences in the ranking of priorities in the different development strategies and the sectoral mix of the investments undertaken.

Within these aggregates too, the rural-urban differentials remained high. National development strategies were inherently biased in favour of the small organized urban sectors in these countries. They did not adequately cover the poorer rural majority, and within this majority they tended to bypass the more vulnerable deprived groups. This is evident in some of the key indicators relating to the social infrastructure. Data reported at the end of the period show that, in the 44 developing countries that have the lowest indicators of human development according to the UNDP Human Development Report 1990, the share of the rural population having access to health services, safe water, and sanitation was 37%, 38%, and 6%, respectively. The comparable figures for the urban population in these countries were 81%, 74%, and 39%.

Within these rural-urban disparities the vulnerable population in the urban sector itself has continued to increase. The share of the urban population in the total population of the poorest countries, excluding China and India, rose from 14% to 25% during the period 1965-1989. This was not an orderly process in which the superior amenities available in the urban sector became available to the expanding population as a whole. Rapid urban growth has produced pockets of deprivation and subhuman conditions of living which are at times more severe than those to be found in the rural sector.

These development data help to identify the most vulnerable part of humanity. The population of the countries with the lowest socioeconomic indicators is estimated at approximately 1500 million. More than three decades of sustained development efforts have therefore failed to make a significant impact on the quality of life of a large part of the world's population. Neither the national development strategies that have been pursued by the majority of the poorest countries, nor the substantial flow of financial and technical assistance from the world community and international agencies, have yet succeeded in generating processes capable of rapidly transforming the quality of the deprived strata of their population.

Table 3: ***Survival with low quality of life***
Selected indicators for Sri Lanka

Per capita GNP 1990, US Dollars	416
Life expectancy at birth in years, 1989	71
Female as percentage of male	106.1
Crude birth rate per 1000 population, 1989	21.3
Crude death rate per 1000 population, 1989	6.2
Total fertility rate per 1000 population, 1982-1987	2.8
Adult literacy, percent, Total 1988	87.0
Female 1988	83.0
Malnutrition	
Babies with low birth weight, percent, 1988	28.0
Wasting, percent, 1987	13.0
Stunting, percent, 1987	27.5
Anaemia among pregnant mothers, per cent, 1987	60.0
Causes of mortality	
Rate per 100 000 for the three disease groups with highest rates.	
Infants: Diseases of the respiratory system	264
Infectious & parasitic diseases including intestinal infectious diseases	219
Diseases of the nervous system	92
Total Population: Diseases of the circulatory system	37.9
Injury and poisoning	21.1
Infections and parasitic diseases	14.3

Sources: Ministry of Health, Sri Lanka, *Annual Health Bulletin*, 1990.
Department of Census & Statistics, Sri Lanka, *Demographic & Health Survey 1987*.
Central Bank of Sri Lanka, *Annual Report 1990*.

Several international agencies have helped to promote strategies at the global and national level that attempt to reach these groups. WHO, with its goal of Health for All by the Year 2000, has drawn the attention of the world community to the fundamental issues of access to and equity in health and thereby promoted a basic reorientation of health strategies. Similarly, UNESCO with its goal of universal primary education, UNCTAD, UNDP, and other international agencies with their concern for the countries defined as the least developed, IFAD with its focus on the poorest populations in the agricultural sector, ILO with its programmes of employment promotion, FAO with its integrated rural development programmes, the World Bank with its emphasis on the alleviation of poverty, and UNICEF with its concern for the well-being of children, have all contributed to the development of policies and strategies that assign high priority to attacking the problems of the hard core of low income, illiteracy, and undernutrition, which have not yielded to past strategies.

Above all there is the growing realization that development incapable of reaching out to and transforming the disadvantaged and marginalized segments of society is flawed and incomplete from the outset.

Missed opportunities for human development: the case of Brazil

Despite rapid economic growth and substantial meso interventions, Brazil's human development record has been unsatisfactory. The under-five mortality rate was still 85 per 1000 in 1988, almost twice Sri Lanka's and only slightly lower than Myanmar's, countries with per capita incomes amounting respectively to a fifth and a tenth of Brazil's. The life expectancy was 65 years in 1987, and the male and female literacy rates respectively in 1985 were 79% and 76%.

These national averages hide significant regional differences. In the poorer north-east, for example, infant mortality rates in 1986 were more than twice those in the rest of Brazil (116 compared with 52 per 1000), life expectancy at birth in 1978 was 49 years compared with 64, and prevalence of child malnutrition was twice the national average.

There are two important reasons for such poor demographic statistics in Brazil. One is the extreme inequality of income distribution. The other is inefficient targeting of public resources.

Well-structured meso policies can compensate for a poor distribution of income and improve human conditions. This has not happened in Brazil because public resources have not reached the poor or improved basic human development.

In health, preventive programmes such as immunization, prenatal care, and vector-borne disease control are estimated to be some five times more cost-effective than curative programmes in reducing mortality. But an estimated 78% of all public spending on health is allocated to largely curative, high-cost hospital care, mainly in urban areas and especially in the urban south. This is in sharp contrast to the 87% of public expenditure that Brazil allocated to preventive care in 1949, a share that fell steadily to 41% in 1961 and to a low of 15% in 1982 before rising to 22% in 1986. Similarly, more than a quarter of all public spending on education in 1983 went to higher education, only half to primary education.

Brazil thus demonstrates that substantial meso policy interventions, if poorly structured and badly targeted, cannot make up for an unequal distribution of income – even if the overall growth of income is more than adequate.

Source: United Nations Development Programme, *Human Development Report 1990*, pp 56-58.

Basic conditions of vulnerability

How can development strategies be designed to reach the disadvantaged segments of society and transform their conditions? The global data draw attention to a vulnerability structure which in turn indicates a critical path for reaching this objective.

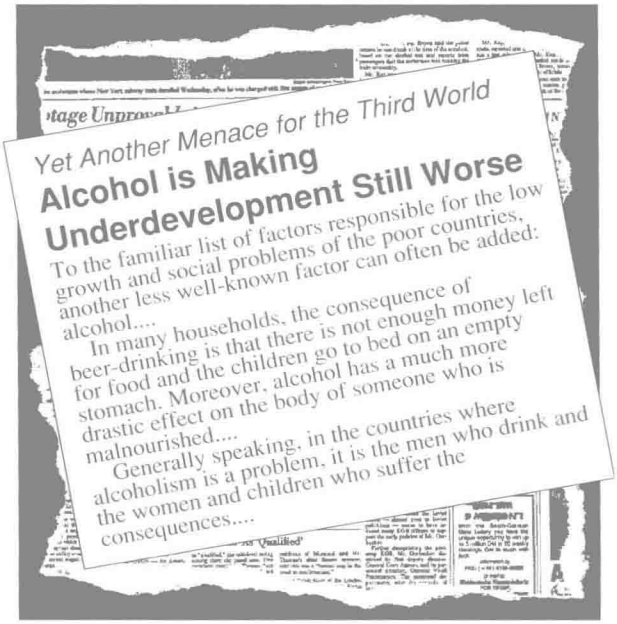
Countries with a low ranking on the scale of human development invariably suffer from several combined forms of vulnerability. ***They are deprived in relation to health, knowledge and education, purchasing power and income-earning capacity.*** These forms of vulnerability exist within a general condition of powerlessness and lack of access to and control of resources. Almost all the poor countries are passing through a health transition stage in which mortality and fertility are high and life expectancy low.

The initial decline in mortality that occurs in this stage leads to a rapid increase in population. The average annual rate of population growth for these countries taken together increased from about 2% in the early 1950s to 2.6% in the period 1965-1980 and 2.8% in 1980-1988. But the avoidance of early mortality has not been accompanied by an increase in the capacity to promote and protect health. This includes the capacity to eliminate such risks as those encountered in repeated and teenage pregnancies, which contribute both to high maternal mortality and to population increase.

The fact that 60% of the population of the poor countries are still illiterate is one of the most important factors perpetuating this situation. The expanding population (population densities of 3900 per 1000 hectares are found in some instances) not only exerts pressure on the limited resources available but also, in the absence of technological progress, restricts the growth of productivity and income-earning capacity. The average per capita income of this group of countries was estimated at US$ 300 for 1987, and the prospects for a quick increase are bleak.

These forms of vulnerability cannot be considered in isolation from each other; they are inseparably linked and continuously reinforce each other in a vicious cycle. In the poorest developing countries, where agriculture is the largest economic sector, low human development exists primarily in the rural sector, in its most acute form in numerous widely dispersed small communities functioning with limited resources.

These forms of vulnerability are not confined to the developing countries. Similar situations are increasingly appearing in the industrialized world, such as teenage pregnancies and parenthood in the United States of America. In a recent study it was shown that teenage mothers are more likely to be unmarried, live in poverty, and remain so throughout their twenties (see box, page 9).


Yet Another Menace for the Third World

Alcohol is Making Underdevelopment Still Worse

To the familiar list of factors responsible for the low growth and social problems of the poor countries, another less well-known factor can often be added: alcohol....

In many households, the consequence of beer-drinking is that there is not enough money left for food and the children go to bed on an empty stomach. Moreover, alcohol has a much more drastic effect on the body of someone who is malnourished....

Generally speaking, in the countries where alcoholism is a problem, it is the men who drink and the women and children who suffer the consequences....

Economic Austerity Throws Latin America Into Recession

Record numbers of Argentines are unemployed. Brazil's economy has shrunk almost 10 percent in a year and millions of Peruvians go hungry. A deep recession is spreading through many of the countries that stretch south from the Caribbean to Tierra del Fuego. The free-market economic "shock" programs adopted in the past several years have conquered hyperinflation, but at the brutal cost of making most Latin Americans desperately poor....

"Every person has limits and we are now approaching ours," Javier Silva Ruete, former economy minister of Peru, said recently. "The people are going to explode." ... Brazilian auto workers rioted in July, burning 50 cars. Union leader Vicente Paulo Da Silva called it "a sign of the violence that could erupt as a result of the workers' despair." Violence probably will continue because governments have little money, and sometimes little political desire, to ease the human costs of the austerity programs they impose....

Juan Jose Vega of the UNICEF office in Lima said the shock has "tremendously and permanently affected" the mental and physical health of an entire generation of Peruvian children. Economic shock programs in other countries have been less severe, but the recessions they provoked also have fallen most heavily on the poor and the middle class....

The vicious cycle of poor health, poor nutrition, low productivity and lack of the knowledge necessary in the context of change cannot be broken by action on any one of those elements independently of the others.

Low productivity derives from conditions in which poor health status has both short-term and long-term adverse effects on the manpower available. Low productivity and poor health status together derive from conditions in which households do not have the skills and information they need for developing the values and attitudes required to adapt successfully to the rapid changes that are taking place. These capacities must rest on an economic base that has the potential for increased productivity and purchasing power.

Vulnerable groups have, nevertheless, been able to evolve strategies for survival in conditions of extreme deprivation. This capacity indicates their potential for greater productivity, given adequate access to resources.

The development strategy that can transform vulnerable communities and lift them to a higher state of development will have to act simultaneously on all the conditions responsible for their vulnerability. The continuing impact that such a strategy has on the well-being of the household and the community will be the measure of its success. In it improvement of health status plays a vital role and becomes a critical indicator for the other inputs required for the process of transformation.

The focus on the most vulnerable groups

The need to identify community problems through the most vulnerable groups has universal application in any development situation and any society. This does not imply that development strategies must concern themselves exclusively or even primarily with raising the standards of such groups. Macroeconomic policies and strategies and national transformation through large-scale projects and investments no doubt provide the major thrust for structural change and economic growth. But

structural problems that inhibit the process of development as a whole are reflected at the micro level because vulnerability is concentrated in the most disadvantaged segments of the population. Understanding the factors of vulnerability enables the necessary adjustments to be made to policies so as to prevent or mitigate vulnerability throughout the community.

Focusing on the most vulnerable groups is necessary as they have become a severe constraint on economic growth and development, the reason being that they tend to become marginalized in a strategy that relies mainly on the impetus imparted by large-scale national investment. Strategies that bypass these groups widen social and economic disparities and enlarge the hard core of vulnerability. This has

Teenage mothers in poverty

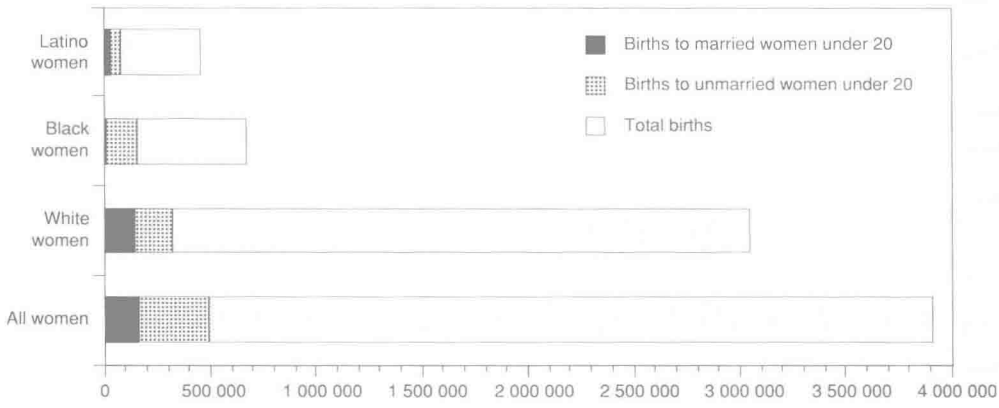
In the United States of America, one in three mothers aged 25-29 years who first gave birth as a teenager was poor in 1986, compared with one in six mothers of the same age who delayed childbearing until after the age of 20.

In 1988 both the number of births to teenagers and the birth rate among teenagers increased. The increase in the birth rate was for the second successive year. The rate increase was greatest for 15-17 year olds, for whom the rate rose from 31.8 births per 1000 to 33.8. These young mothers are even less likely than older teenagers to have finished high school or to be married, and their children confront greater health risks than those born to older teenagers.

Although death rates for babies born to teenagers are lower within the first 28 days after birth than for babies born to women in their twenties, the death rates within the first year of life are higher. Moreover, babies of mothers younger than 15 are at increased risk of low birth weight, which is associated with infant death and conditions such as cerebral palsy, autism, and learning disabilities.

Source: Children's Defense Fund. *The State of America's Children 1991*. Washington, DC, 1991, pp. 93-95.

Births to women younger than 20 in the USA, 1988



Source: National Center for Health Statistics, calculations by Children's Defense Fund.