



From the Director's Desk

As we take stock this year of our achievements towards the Millennium Development Goals, the debate surrounding Africa's economic and social development intensifies. For the team of economic and other social scientists working at the ECA's Economic and Social Policy Division (ESPD), the challenge is to produce viable policy recommendations, making sense of the continuous ream of research, policy and strategy papers emanating both from within and outside Africa.

We work in four major interdisciplinary areas: macroeconomic policy development and analysis, poverty and social policy, statistical development, and the flagship Economic Report on Africa (ERA). At the top of our agenda is the issue of how to tackle the devastating impact on Africa's economy of the world's three most deadly diseases: HIV/AIDS, tuberculosis and malaria. Not far below is the need to collect and analyse statistical data to equip policy makers with rigorous and timely information for decision-making.

This newsletter is the first of a series. Its aim is to circumvent "development fatigue," by highlighting economic and social issues that are bound to remain on the development agenda for the next few years. We look forward to your feedback.

Augustin K. Fosu

Articles

HIV/AIDS: A new variant famine?¹

By Shewit Emmanuel

As the HIV/AIDS pandemic grows, the capacity of the African extended family to cope with the disease decreases. Given that the disease affects heads of household and adults, it is up to the children and the elderly to sustain the livelihood of families.

The primary consequence of this new role undertaken by children and the elderly is a steep decline in food security. The backdrop is the increasing "lack of capacity of a household to procure a stable and sustainable basket of adequate food."²

The effect of HIV/AIDS on food security was the theme of a joint study on the impact of HIV/AIDS on food security in Ethiopia, undertaken by ECA, and its UN sister agencies the United Nations Development Programme (UNDP) and the World Food Programme (WFP).

¹ The idea of HIV/AIDS as a 'new variant famine' in Africa was coined by the development writer/editor, Alex de Waal, during a conference on the subject held in South Africa.

² United Nations International Fund for Agricultural Development, 2004, www.ifad.org/pub

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The study confirms similar reports of its kind on Uganda, Cote d'Ivoire, Burkina Faso, Tanzania, Kenya, Malawi, Zambia, Zimbabwe and other African countries.

HIV/AIDS is a rural phenomenon

HIV/AIDS is attacking the rural areas of Africa. In the 25 countries on the continent most affected by the disease, over two thirds of the population live in rural areas, where access to information and health services are most scarce.

Even so, most HIV-infected urban dwellers of rural origin return to their communities when they fall ill.

The impact of AIDS on farming communities differs from village to village and country to country. However, there are many shared consequences.

For example, in nearly all cases, there occurs considerable intra-household relocation of labour, including removal of children, and especially girls, from school. Forced to cope with the responsibilities of caring for relatives who are ill, as well as aging relatives and younger siblings, many children leave school for good.

As children and orphans are relocated to wider social networks, which share the burden of care, the capacity of the 'extended family' to cope decreases. In effect, with more mouths to feed, families witness a reduction in household quantity, quality, and variety of food. This leads to greater levels of malnutrition among both adults and children.

With less labour time available, many households abandon farming altogether, said the joint UN study.

There is also a direct impact on trade levels, as the composition of crops shifts from cash to subsistence, and from vegetables and relishes to less labour-intensive calorie-rich survival foodstuffs such as cassava, sweet potato, and maize. In this line, the production of marketable goods such as honey or crafts declines.

In addition, lack of capacity or need for cash generates the loss of livestock. This compromises not only the economic stability of rural families – animal stocks are the primary form of reserve capital – but also nutrition, as protein consumption falls.

It also poses a serious threat to the environment. Besides off-season planting, usually late in the season, and its consequent increased vulnerability to pests and diseases, critical land-conservation and soil-protection activities such as mulching, terracing and

fallowing are replaced with bush burning, and abandonment of weed and pest control.

Household and death expenditures

The study shows that HIV/AIDS-affected households spent more on health and funeral/mourning-related costs than the general population. With fewer reserves households have resorted to the sale of assets, borrowing, and reduced consumption and investment on the farm.

About one third of the households surveyed with a family member suffering from an AIDS-related illness indicated that they sold livestock (mostly cattle) to cover health-related expenditures. Additionally, a small but significant proportion of households relied on borrowing and assistance from close and distant relatives to cover such costs.

In turn, access to credit became increasingly more difficult due to concerns over the ability of the HIV/AIDS-affected household to repay debts.

Declining institutional capacity

HIV/AIDS directly affects food security by eroding institutions whose function is crucial to urban households. In Kenya, for example, the Ministry of Agriculture has so far lost 58 per cent of its staff to the disease, including many rural extension workers.

The figure is also high in Malawi, where 16 per cent of the staff belonging to the Ministry of Agriculture and Irrigation are HIV positive. In Sub-Saharan Africa, some 50 per cent of agricultural extension staff tested positive to HIV/AIDS in the past five years.

The next meal

The HIV/AIDS pandemic had a direct effect on the productivity of communities throughout the continent. In Zimbabwe, one of the countries most affected by the disease, household marketed maize production declined by 61 per cent, over the period from 1995 to 2000, according to government figures.³

In Ethiopia, from 2000 to present, time spent on agriculture was reduced from 3⁴ hours per week to between 12 and 16 hours.

More pointedly, at least seven million agricultural workers died of HIV/AIDS since 1985 in the 25 hardest-hit countries in Africa. This figure is expected to reach more than 16 million by 2020, and as much as 25 per cent of the agricultural labour force could be lost by 2020.

³ African Development Forum, 2000.

⁴ African Development Forum, 2000 and UNAIDS 2004.

Where more than a third of the gross national product of the most-affected countries comes from agriculture, it makes one wonder where our next meal will come from.

Policies for health financing that work for the Poor

By Maite Irurzun-Lopez

This article is a brief summary of the paper *Financing of Pro-Poor Health Policies* presented at the Ad Hoc Expert Group Meeting on Pro-Poor Growth Strategies in Africa, Kampala, 23 - 24 June 2003, jointly organized by the Economic Commission for Africa (ECA) and the Economic Policy Research Centre, Uganda.

The contribution of health to human and economic development has been widely evidenced. The Millennium Development Goals (MDGs) and the Poverty Reduction Strategy Papers (PRSPs) underscored the links between poverty, health status, and economic development.

Yet health systems in most African countries remain unfavourable to the health of the poor and the very poor. To fulfill health needs in Africa, especially those of the poor, it is crucial to orient health budgets towards ensuring access to services by low-income individuals and communities, combining financing and allocation mechanisms.

The article discusses two basic ways in which pro-poor strategies can finance health policies: increasing financial resources, and maximizing the use of these resources. In raising extra resources both domestic and external sources have much to contribute.

National health policies must focus first on ways of raising funds domestically, rather than waiting for external and conditional funds to arrive. Only by achieving more efficient ways of financing and allocating the budget can health care be expanded in a sustainable manner.

There are five principal financing mechanisms in low-income countries, namely, tax-based; user fees; social insurance; private insurance; and community based insurance. The low tax base and the size of the health burden in Africa make general taxation a limited source of financing. Even so, presently 65 per cent of current health spending is tax funded (CMH 2001).

Hospitals absorb 50-60 per cent of government recurrent expenditure, to the detriment of strategies more conducive to improving the health of the poor, such as community care. An attempt to increase this

expenditure was adopted through user fees, introduced continent-wide in the 1980s. By 1995, 28 out of 37 African state hospital systems had adopted out-of-pocket payments or user fees. In Ghana, for example, hospital fees were introduced with the target of raising 15 per cent of the recurrent budget. But only 1-12 percent cost recovery ratios were sustained. And, in most rural areas, user fees have implied a declining use of health facilities.⁵ (Arhin-Tenkorang 2001).

Different kinds of insurance mechanisms are on the rise in Africa. Insurance schemes are based on contributions, either directly from wage-earner payrolls or voluntary contributions. These exclude the poorest members of a given society. All are based on the concept of cross-subsidies and risk pooling of healthy members and sick members. In Zimbabwe and South Africa large companies have promoted private insurance for high-income earners.

Community-based insurance is a largely unexplored area in Africa with regard to pro-poor health financing. In theory, even those outside the formal sector would be able to participate in insurance schemes, if resources were pooled to cross subsidize and reduce risk at the community level. However, its pro-poor nature can be deterred by cases of special concessions. This is especially the case of costly antiretroviral drugs (ARV). Public intervention may be required in order to ensure their use in the treatment of HIV/AIDS, particularly to guarantee that community based insurance does not omit high-risk clients.

Such is the case in South Africa, where the government through the Medical Schemes Act 2000 defined health packages by insurance companies that must have lifetime coverage, spreading risk, community rating, and prescribed minimum benefits.

The type of allocation for public health budgets must also be part of a pro-poor package. Health allocations in Africa show a huge imbalance between needs and resources. Most communicable diseases - malaria, measles, and others - but are relatively cheap to treat are not given priority they deserve in health budgets.

A system based on maximizing health outcomes for the majority of the population, weighting for cost-effectiveness, and ensuring access are the pillars of needs-based approach that leads to a more pro-poor assessment. A best practice case is given by the study undertaken in some districts of Tanzania.

⁵ Arhin-Tenkorang (2001) 'Health Insurance for the Informal Sector in Africa; Design Features, Risk Protection, and Resource Mobilization', Health, Nutrition and Population (HNP) Discussion Paper, Washington.

In the Tanzania Essential Health Intervention (TEHIP) in Morogoro and Rufiji, two rural districts, surveys were reportedly held to compute a “burden of disease.” In an article in the 15 August 2002 edition of the Economist magazine, it was reported that the amount spent by local authorities bore no relation to the prevalence of diseases.⁶

Malaria accounted for 30 per cent of life lost in Morogoro but only 5 per cent of the health budget, said the Economist. Based on these findings, health workers were given policy instruments with which to treat disease burden and calculate costs. The results were immediate, with infant mortality rates falling by 28 per cent between 1999 and 2000 and under-five mortality rates dropping by 14 per cent in Rufiji.

Through some form of benefit incidence efficiency was achieved both in the allocation of resources and in improved health outcomes. Short and medium-term expenditure trends, if they are to be more cost-effective, must be allocated to the overall general improvement of living standards of citizens, through participatory processes that are also needs-based. It is crucial to correlate the disease burden to expenditure allocations, while taking care of the specific challenges of rising epidemics, with full regard to the need to protect the poor.

Book Review: By Cristina Müller Keeping the Promise!

A report published by the African Union and UN organisations says African governments are devising effective programmes to counter HIV/AIDS, tuberculosis (TB) and malaria but that major challenges still remain.

Launched during a summit of African Heads of State, held in Abuja in January, *Scoring Leadership for Better Health* says good progress has been made in setting up frameworks and institutions to address the diseases. But it says less has been achieved in monitoring the effectiveness of such initiatives, or in passing much needed legislation.

The report is the result of a collaborative assessment by the African Union and three UN partners: the Joint Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO) and the Economic Commission for Africa (ECA) on the progress, best practice, constraints, and lessons learned by African governments in the battle against HIV/AIDS, TB and malaria.

⁶ *Better Health for not much money*, The Economist, 15 August 2002.

⁷ ECA (2004) *Scoring African Leadership for Better Health*, Nairobi.

Africa’s heads of state signed a number of commitments to try and reverse the worsening health trends witnessed by the continent since 1990, and to make greater progress against the three diseases.

In the Abuja Declaration they declared their determination to rollback malaria in the “Africa Plan of Action” in 2000. TB was addressed in the “Amsterdam Declaration to Stop TB” (2000), and in the “Abuja Declaration and Framework for Action on HIV/AIDS, TB and other Related Infectious Diseases” (2001).

In 2001, during the African Summit on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases, held in the Nigerian capital, Abuja, Africa’s leaders asked the African Union, and its partners in the UN system to monitor progress towards meeting commitments, which include measurable and time-bound targets.

On HIV/AIDS, *Scoring African Leadership for Better Health* says that countries across the continent are working to increase awareness of the disease by working with communities, and within education programmes. But more could be done to ensure that legislation is passed to prevent victims of HIV/AIDS from suffering less social ostracism.

The report says that 75 per cent of Africa’s governments have adopted Directly Observed Treatment Short-course (DOTS), for treating TB, leading to a treatment success rate of over 70 per cent. On the down side, it says drug procurement mechanisms as well as partnership with the private sector have yet to improve, in order to ensure uninterrupted supplies in treatment.

There has also been only limited progress in combating malaria. Still tenuous are lasting partnerships with the private sector, programmes for strengthening community based care, and improvements in basic sanitation in urban centers to curb the breeding of mosquitos, which carry and transmit the disease.

Scoring African Leadership for Better Health says the key to success will be doing business differently – scaling up interventions, reinforcing existing health systems, shifting government strategies, strengthening partnerships, mainstreaming health into policymaking, mobilizing financial resources, increasing public awareness of the diseases, and increasing access to biomedical research and development (R&D).

Point of View

Africa: Turning brain drain around

By Adrian Gauci

The exodus of thousands of African intellectuals and skilled workers leaving the continent every year for greener pastures, a movement that is better known as brain drain, is considered one of the factors hindering Africa's development.

The numbers are staggering. In 2003 alone, ten thousand African citizens emigrated to Europe and North America. The cost of this migration is estimated at US\$4 billion per year. Here's why:⁸

To train a new medical doctor in South Africa, for example, it can cost the state an average of \$152,000 dollars a year. The real problem occurs when this same doctor chooses to deploy elsewhere. In effect, the government will have no return on its investment. Ethiopia, for example, ranks first among African nations, ahead of Nigeria and Ghana, in supplying professional and technical personnel to the USA, forming nearly 50 per cent of all immigrants from Africa.

The loss of highly and medium skilled personnel from Africa is a clarion call for help. Investment in human resource development is lost, skills dispersed, and the impact of education on development rendered negligible.

There is a complex blend of push and pull factors motivating skilled personnel to either go or remain abroad. On the push side, domestic politics and economics might be unfavourable. Most African institutions perpetually face an arduous task of ensuring a healthy work environment domestically and keeping abreast with developments both on the continent and in the developed world.

On the pull side, industrialized nations rely on skilled labour from abroad in many sectors. Nearly half of all new registered nurses in the UK come from abroad, many from Africa and the Caribbean.

Notwithstanding the grim numbers and facts, this skill or intellectual exodus can also be considered as brain "circulation:" a movement of skilled labour in an interdependent globalized world. Physical distance is quickly being replaced by virtual 'attendance,' where expertise can be used without physical presence.

⁸ P. Bennel & S. Al-Samarrai (2003) Where has all the education gone in Africa? Employment Outcomes among Secondary School and University leavers, Institute of Development Studies, U.K.

⁹ D. Shinn (2002) *Reversing the Brain Drain in Ethiopia*, Addis Ababa.

Human capital circulation theories have been reformulated to include virtual as well as physical movement. This opens up opportunities for mitigating the negative impact of brain circulation.

So far policy instruments in use in Africa have focused on stemming the flow through incentives for return migration, temporary or otherwise. Yet there are examples of the possible paradigm shift from brain drain to brain "circulation".

Outside Africa, Thailand for example has "The Reverse Brain Drain Project" emphasizing immigrant nationals as part of the nation-building process, without uprooting their physical location. Colombia also has a similar project: experts living abroad can contribute to technical know how in their home country.

Considering the lesser impact in Africa of the information and communication technology (ICT) revolution, its potential for Africa cannot be overstated. It presents enormous opportunity for integrating the continent into the global village. Targeting Africans living at home and abroad could have an enormous impact on Africa's development.

The areas for ICT application in African economies vary from government services to distance learning, and to agricultural production. Expert Africans living abroad can still transfer knowledge, make technical contributions to research institutions, and participate in nation building through the use of ICT.

African governments should first of all re-focus on brain drain not as a win-lose situation, but as a phenomenon that can be tapped for economic growth. Knowledge transmission by African experts from the industrialized nations to the developing world that can have the largest impact on economic and social development.

A database on available expertise/skills of Africans living abroad should be set up, operating at national, subregional and regional levels. The database should be made available to all national economic actors for selection, identification and usage of such knowledge among Africans based abroad.

In this context, bilateral and multilateral agencies, and non-governmental organizations (NGOs) alike have a role to play in facilitating the transfer of knowledge for national development. Both the developing and the industrialized world could benefit from a more cooperative approach to "brain mobility".

News from the Teams

Statistics helps Africa develop

ECA's Statistics unit in April participated in the fourth Committee on Development Information (CODI IV). The role of the Commission in Africa's statistical development was discussed, as well as the need to increase the profile of the discipline in the development agenda on the continent.

Pursuant to last year's 18 November annual Africa Statistics Day, "Managing for Development Results: The Role of Statistical Information," continues to be a priority. "If you can't count it, you can't manage it," said a leading South African statistician during CODI IV.

In the Pipeline

The overarching theme of this year's Economic Report on Africa - ERA 2005 - is unemployment and poverty. Entitled "Meeting the Challenges of Unemployment and Poverty in Africa," the report analyses the issue of labour, employment and poverty on the continent.

In seven chapters, ERA 2005 examines the nature, structure, and determinants of unemployment and poverty in Africa.

Books published

- Economic Report on Africa 2004
- Scoring African Leadership for Better Health
A joint publication of ECA, AU and UNAIDS

ESPD Update is produced by staff of the Economic and Social Policy Division, Economic Commission for Africa.

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ESPD Staff Publications

Article by **Augustin Fosu** on "Mapping Growth into Economic Development: Has Elite Political Instability Mattered in sub-Saharan Africa?", published in the *American Journal of Economics and Sociology*, November 2004, 63(5), 1173-92

A book by **Augustin Fosu** with **Paul Collier** of Oxford University, *Post-Conflict Economies in Africa* (Palgrave/Macmillan, 2005), published recently.

ESPD Staff Presentations in External Conferences and Seminars

Project LINK Fall Meeting, New York, 22-24 November 2004

Shamika Sirimanne made a powerpoint presentation on **Regional Outlook for Africa** on 24 November. She was also part of the panel that discussed **Non-oil Commodity Markets Development and Implication for Developing Countries** on 23 November.

Annual Bank Conference on Development Economics (ABCDE), Dakar, January 2005
Augustin Fosu presented a paper with **Stephen O'Connell** of Swarthmore College, USA, "Explaining African Economic Growth: The Role of Anti-growth Syndromes"; also led presentations on other sessions organized by the World Bank on "Key Issues of African Growth" and "Managing Shocks on African Growth".

Workshop on Macroeconomic Policies and Poverty Reduction in Sudan, 15-16 February 2005, Sudan, Khartoum

Adam Elhiraika and **Kabu Ismail** presented a paper on **Issues on Financial Sector Policy and Poverty Reduction in Sudan**.

Workshop on Environmental Statistics for the Countries in the ECOWAS Region, 28 February - 4 March 2005, IDEP, Dakar Senegal

Bakary Dosso made a presentation on the **Use of the Internet as a tool for Statistics Dissemination in the Economic Community of West African States (ECOWAS) Countries**.

Conference of African Ministers of Finance, Planning and Economic Development, 11 - 13 May 2005, Abuja, Nigeria

Augustin Fosu made presentation on:

- (i) **Achieving the Millennium Development Goals (MDGs) in Africa** and
- (ii) **Survey of Economic and Social Conditions in Africa 2004-2005**.

Internal Presentations

"**Inequality and the Growth-poverty Nexus: Evidence from sub-Saharan Africa**" by Augustin Fosu on 10 February 2005.

"**Will SMEs be the key to Africa's industrial revival?**" by Janvier Nkurunziza on 3 March 2005.

Augustin Fosu presented "**Meeting the MDGs in Africa**" to the African ambassadors based in Addis Ababa on 7 April 2005.