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Editorial: The Health Issue

The depth of the crisis in African countries generated by the current world recession became clear at the conference organised by the *Review* in September 1984.* The crisis is the proper context in which to situate the health issue and we begin our editorial with a summary of its main features.

The Crisis in Africa

Thirty African countries had a gross national product of less than US\$500 per person in 1983, another nine earned under US\$1,000, and three showed incomes between US\$1,000 and US\$1,500, according to the World Bank. Thirty-two countries are experiencing 'double digit' rates of inflation and twelve register negative income growth. Since 1980 real income has fallen 11 per cent per person (Loxley 1984).

The production of primary commodities, including cash crops, animal products, minerals, metals, and in four countries (Angola, Congo, Nigeria, and Gabon) oil, dominates the economies of sub-Saharan Africa. In fifteen countries primary commodities accounted for over 85 per cent of exports in 1981. A few countries depend totally on one export (e.g., Burundi on coffee, Gambia on groundnuts). Prices are falling and, at the same time, total exports declined — by 0.6 per cent per year in the 1970s and by 7.2 per cent in the recent recession.

Most agricultural production is still in the hands of peasant farm households, but agribusiness transnationals are dominant in supplying farm inputs, are owners of plantations and management firms, and control the buying, shipping, selling, processing, and marketing of the major cash crops. In some instances, a few companies control world sales e.g., Cadbury-Schweppes, Nestles, Gill & Duffus, and Rowntree control 60 to 80 per cent of world cocoa sales [Dinham & Hines 1983, 33]. Agricultural exports fell by 1.9 per cent per year in the 1970s.

Transnational firms control fuels, minerals, and metals more tightly than agriculture, partly because extraction requires heavier capital investment, but mainly because those commodities are more valuable than cash crops. Anglo American, the South African mining conglomerate, is involved in ten African countries, reaching as far north as Mauretania. The degree of foreign control can be illustrated by a description of Gabon: 97 per cent of private investment is in the

*Some of the data presented here are culled from the conference papers; a selection, edited by Peter Lawrence, will be published by ROAPE/James Currey under the title, *The World Recession and the Food Crisis in Africa*.

mining sector (including oil); almost no foreign private investment is in transformation (that is, it concerns the export of raw materials); the petroleum sector is completely controlled by French, British and American firms; the same is true of iron ore and manganese; uranium is in French hands; the only other export is wood.

Almost all countries experience balance of payments deficits; the lack of foreign exchange is causing an acute reduction of imported goods that has played havoc with industrial production, the maintenance of infrastructure, transportation, and the provision of basic social services. The militarisation of resource allocation has grown so rapidly that arms imports are now comparable to total aid flows and are central to both the debt crisis and the import squeeze; armed conflict, provoked by policies of destabilisation (as for example in Angola and Mozambique), withdraws large regions and millions of people from production. Four of the five countries experiencing famine are at war.

Although not as deeply in debt as Latin America, Africa has been forced into more repeat agreements with the International Monetary Fund than any other continent and has therefore had to accept economic policies dictated by the IMF — currency devaluations, export incentives, wage freezes, elimination of price controls, and reductions in government expenditures including education, health and social services (Loxley 1984; Sutcliffe 1984). These economic policies have far-reaching political, social, and ecological consequences of life-threatening dimensions.

Health Effects of the Crisis

There are no accepted indicators of health, only of disease, and most of those are measures of death. The high death rates that prevail in Africa, especially among infants and children, are reflected in extremely short lifespans: in 26 of 51 African countries average life expectancy at birth remains under 50 years. It is under 40 years in five countries:— Gambia, Guinea, Guinea Bissau, Sierra Leone, and Somalia. Perhaps one needs no other index of exploitation.

As newspaper headlines and shocking TV footage remind us daily, Africa's chronic food shortage turned, under fraught conditions, into an acute dearth of sustenance in 24 countries. Food production rose at less than half the rate of population growth in the 1970s and actually declined 15 per cent in 1981-83 (Loxley 1984). Twenty per cent of the population of sub-Saharan Africa depends on food imports and food aid. No fewer than 100 million people are thought to be malnourished. Mass starvation is reported in Eritrea, Ethiopia, Chad, Mozambique, and Sudan.

With rising levels of deprivation the causes of death become non-specific and any acute infection is fatal. Death rates remain constant even when a disease (like smallpox) is totally eradicated or full prevention is achieved by total immunisation (as against measles). When the burdens of poverty, crowding, malnutrition, and infection are great, the specific causes of death seem to be interchangeable. Even the best health services appear to make no impact when standards of living fall below subsistence levels.

Africa has the highest birth rates in the world and the fastest growing population. Although most of the population is still rural, annual rates of urbanisation run over 4 per cent. With more than 45 per cent of the population under fifteen years of age in almost all countries, the number of young and elderly dependents that must be

supported by the working population is extremely high; the dependency ratio (the combined population under fifteen and over sixty-four years as a percentage of the population between those ages) is typically over 90 per cent in Africa whereas it is under 60 per cent in the industrial market economies.

The labour migration systems instituted internally, regionally, and internationally by colonial regimes in countries like Algeria, Burkina Faso, Kenya, Mozambique, and South Africa, left a legacy of ill-health that has yet to be measured. Not only did the migrants themselves contract diseases, fall victim to industrial accidents and injuries, and suffer mental illness, but also the families they left behind experienced increased food shortage and ill health. Nor did migration cease with independence: France, Germany, and Britain still receive migrant workers from Africa, regional migration continues in both western and southern Africa, and the scale of internal migration is greater than ever — both rural and urban, legal and illegal, forced and voluntary.

Forced migration describes the plight of many refugees. Most labour migrants are forced by economic necessity to leave their homes; they cannot earn sufficient to support themselves and their dependents in their local economies. But refugees are forced out by political situations like civil war; they are inevitably the poor, who could not pay their way as immigrants to the advanced market economies. With no economic opportunities in their land of political asylum, and often arriving in a depleted state of health, their survival is in jeopardy.

Refugees are more numerous on the African continent than on any other; over three million are known to be in camps. The state of their health in camps located in Ethiopia, Somalia, and Sudan (to name those most recently seen on television) is precarious. Hosted by countries that have few health and social services to begin with, refugees pose an overwhelming challenge to the international community.

Causes of Ill Health

It is public health dogma that Africans suffer from infectious diseases, much as Europeans did a century ago, whereas chronic diseases afflict the countries of the North today. This doctrine is the public health version of modernisation theory; it holds that as 'backward' Africa develops, it too will experience the chronic diseases associated with industrialisation and urbanisation. That modernisation theory is patently flawed has been demonstrated by article after article in the pages of *ROAPE*. In this issues of the *Review* we show that the public health version is equally faulty.

Not only have diseases like schistosomiasis, leprosy, VD, and tuberculosis been wrongly labelled (they are chronic conditions, not highly contagious diseases like measles), but also chronic diseases have reached epidemic proportions in Africa. The dimensions of an epidemic are revealed less by its physical appearance in demographic space than by its historical development, its common social history. Though victims of chronic diseases do not die in physical promiximity in a short span of time, they die in epidemics nonetheless.

Epidemics of occupational accidents, injuries and illness would probably be found to occur more commonly in the South than in the North, if anyone kept track of them, as would hypertension and diabetes. Chronic malnutrition in Africa is analogous to the chronic diseases of obesity so widespread in the North (in fact,

African traditional diets based on sorghum and millet are better balanced and more nutritious than contemporary European and American diets, only Africans do not eat enough, whereas people in the North overeat and are malnourished).

Underlying these epidemics North and South is the modern phenomenon of stress, and it is a neo-colonialist attitude to believe that only 'civilised' Northerners could suffer its consequences. Stress is closely associated with social disorganisation and family breakdown, problems as common in the bantustans of South Africa as in the ghettos of New York. Alcohol consumption and cigarette smoking are strategies for survival under stress, albeit potentially self-destructive ones. These strategies, which are falsely portrayed as habits of individual choice in the North, have spread so rapidly and are now so prevalent in the South as to reveal clearly their epidemic character. They are not the only indications that chronic diseases afflict countries in the South as well as those in the North. The current epidemic of AIDS, a viral disease in which the body is unable to fight infection as a result of chronic malnutrition, repeated bowel infection, and antibiotic resistance, is of greater proportions in central Africa than in San Francisco (See Briefing).

Stress is a response to capitalist social relations; it is an expression of our reactions to the extraction of surplus from all social activity, not only from production at the workplace. Since the introduction of migratory labour systems this extension of extraction has been characteristic of capitalist development in Africa — and has been denied by proponents of the economic theory of dualism for almost as long. Our failure to understand the nature of capital's strategy has led us to overemphasise processes like proletarianisation in our analysis of twentieth century developments in Africa and thus to overlook, until very recently, the exploitation of women — and almost to miss the crisis of social reproduction.

Studies of the urban proletariat identified struggle with strikes and other worker responses (e.g. Cohen) and, only more recently, with food riots (viz. Seddon); a few analysts identified protest with peasant resistance (e.g. Cliffe) and with fights between herders and farmers (viz. O'Brien). Analysts of the crisis of social reproduction tended to concentrate on the consequences of capitalist exploitation rather than on struggles against it (e.g. Bush). Public health workers in Africa failed to see the political significance of popular resistance to their measures or the state's use of public health (workers and measures) during epidemics to tighten its control over labour.

The progressive policy of capital in the twentieth century is to incorporate reform and respond to the need for goods and services in order to organise work politically, far beyond the mine, plantation, and factory. The dates of the introduction of that policy vary — late nineteenth century in western Europe, early twentieth century in North America, and post-World War Two in Africa. African independence posed a new problem for capitalists: for the first time capital and the state were no longer identical, in the sense that they were now of different nationalities. Except in South Africa and Namibia where virtual identity is maintained, capitalists have been forced to accommodate a variety of economic and political organisations, from open market economies and transparent puppet regimes (e.g., Liberia, Zaire, and bantustans like the Ciskei) to opaque non-market economies and 'one-party' states (e.g., Algeria, Angola, Guinea, Mozambique, and Tanzania). A single strategy that could be applied in all cases has been difficult to find, hence the rapid turnover of unsuccessful approaches ('import substitution', 'redistribution with growth', 'basic needs'). With the loss of state identity, capitalists could no longer command the

repressive force they wielded in the colonial era; even the most transparent of puppet regimes (e.g., Sebe's Ciskei) can balk and be recalcitrant. On the other hand, capitalists have learned to deflect struggle from themselves to the state, so that in many countries, especially where unemployment is 20 to 40 per cent, the confrontation is between labour and the state.

The post-colonial state inherited certain functions relative to the provision of health and social services that were assigned by capital in the colonial era. (The very size of the post-colonial state may be related to capital's problem of preserving profit; that is, where the indigenous private sector had been impoverished, as it sometimes deliberately had been by the colonial regime, the post-colonial state was forced to provide a greater range of services to a larger population than in countries where the private sector flourished). Independence dissolved the close identity of capital with the state and obscured the colonial relationship, making it seem that health and social policies were the products of state planners rather than the fruits of labour's struggle with capital.

The restoration of the rate of profit in industrial capitalist countries by reducing the value of both constant capital and labour power is a function of the IMF during the current world recession (Loxley 1984). While World Bank loans drive African countries to increase the production and export of primary commodities, the IMF turns the international terms of trade against their world countries. The cuts in social spending mandated by the IMF have widened the gap between social needs and social services. The effect of higher export quotas on working conditions in agriculture and mining can be likened to speedups in industry: producers must work harder and the acreage under cash crops must be expanded, increasing the threat to the environment as well as to food production. But to conclude that the crisis consists in World Bank and IMF policies, which reduce living standards for populations already at dangerously low levels of consumption, is to miss the class conflict in the crisis of social reproduction.

Popular Resistance

The extension of struggle against capital parallels the extension of the extraction of surplus from worksites to all social activity. Strikes and work-stoppages are not the only forms of struggle, nor are worksites the only places where struggle occurs. The 1983-84 Ciskei bus boycott is an example of a working class struggle that did not take place at the worksite. Rent strikes in Mamelodi (1985) and school boycotts in Soweto (from 1976) are others.

Food riots and 'bread' riots have occurred in Egypt (1977), Morocco (1981 and 1983), Sudan (1979), and Tunisia (1983). In all four countries the governments backed down and rescinded the contested price rises. In Morocco the rioters obtained cash from the central government and the unemployed were given jobs on public worksites opened for them after the riots. In Sudan direct state intervention ensured adequate supplies of bread and meat to Khartoum, while the police erected road blocks to prevent peasants from entering the city.

Direct appropriation is another instance of struggle and it takes several forms. Squatting is one: in South Africa, blacks evicted from white farms have squatted on unoccupied farms; for example, in Upper Kabusi Valley, there are more than 3,000 squatters on vacant farms threatened with resettlement in the Ciskei. Theft is another form of direct appropriation: white ranchers are abandoning their farms on

the borders of the Ciskei because stock-theft is so common, and white farmers have lost tens of thousands of rand in fruit stolen from their plantations. Extensive theft and the possibility of bantustan consolidation have caused land values near the Ciskei border to drop from 300-400 rand per hectare to 60 rand per hectare.

Resistance is clearly demonstrated in black markets, illegal migration, and flight, all of which have occurred extensively and have been well documented in Africa. Less easily traced are instances of refused cooperation: how much of the current fall in agricultural production is due to peasant refusal to produce or to sell products through government channels? Apparently quite a lot in Tanzania. How much of the failure of public health programmes is due to people's refusal to submit to vaccination campaigns, anti-malarial house-spraying with DDT, and family planning?

In the colonial period, quarantine measures were used, ostensibly to arrest the spread of disease, but ultimately to control the influx of workers. To resist quarantine was to resist unjust arrest. Colonial health officials justified residential segregation on the grounds that a *cordon sanitaire* was needed to control disease, but in fact ghetto concentrations simplified the task of the police, as is still obvious in South African black townships today. Violations of the *cordon sanitaire* were acts of resistance. In colonial Mozambique, the links between health care, the military, and the police were direct and explicit: health care was dispensed by the coercive arm of the state. To reject medical care was to reject colonialism.

Crises of social reproduction, whether they take the form of epidemics or famines, are brought about by the profit imperatives of capitalism. In Africa, for a combination of historical, economic, political, and ecological reasons, the profit squeeze has caused living standards to fall below subsistence levels. On the other hand, prior higher standards of living during the post-World War Two era represent the gains of an earlier cycle of struggle for independence. The crisis of profit entails class conflict. The response of capital and the states it has coerced is to use the crisis to reorganise and discipline labour by invoking repressive police powers of arrest, inspection, and fines, and to increase control of the workforce by strengthening the public health administrator's ability to use invasive regulations. In documenting the health effects of the crisis, we need to respect people's modes of organisation — whether around health or other social issues — and to recognise that their struggle for health is ultimately a struggle for freedom.

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