

**HOW 'INCLUSIVE' ARE THE WORLD BANK'S  
POVERTY REDUCTION STRATEGIES?  
AN ANALYSIS OF TANZANIA AND UGANDA'S  
HEALTH SECTORS**

By

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## **ABSTRACT**

This project examines the World Bank's Poverty Reduction Strategy Papers (PRSPs) and their commitment to improved health policy for sub-Saharan Africa. The new 'country-driven' and 'comprehensive' focus implies a departure from past development policies and includes room for countries to strengthen internal social policy. Ideologically, it appears that the World Bank has altered its neo-liberal mandate and is shifting toward a more 'embedded' or 'inclusive' liberal mandate that promotes domestic protections for developing countries. Through a comparison of Tanzania and Uganda, this paper measures the possibilities for 'inclusive' liberalism by analyzing policy changes within the health sectors, with specific focus on funding, access and equity and collaboration efforts. The project concludes that although PRSPs include social welfare principles that resemble a new model of 'inclusive' liberalism, this change is not yet producing 'pro-poor' health policy as a result of an inability to translate broad World Bank principles into tangible goals.

### **Keywords:**

World Bank, poverty reduction strategies, health sector reform, Tanzania, Uganda

*To my mom and dad*

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## LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CDF	Comprehensive Development Framework
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
HIPC	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
IFI	International Financial Institution
IMF	International Monetary Fund
I-PRSP	Interim Poverty Reduction Strategy Paper
LIDC	Low-Income Developing Country
MDG	Millennium Development Goals
MOH	Ministry of Health
NEPAD	New Partnership for African Development
NGO	Non-Governmental Organization
PHC	Primary Health Care
PMS	Poverty Monitoring System
PRGF	Poverty Reduction Growth Facility
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
REPOA	Research for Poverty Alleviation
SAP	Structural Adjustment Policy
SWAp	Sector-Wide Approach
TB	Tuberculosis
TRIPS	Trade Related Intellectual Property Rights
UNCTAD	United Nations Conference on Trade and Development
US	The United States
WHO	World Health Organization
WTO	World Trade Organization



## INTRODUCTION

It appears that an ideological gap exists between the international financial institutions' health policy mandates of the 1980s and 1990s and the health policy platforms of today. In particular, there are policy differences between the World Bank's original 1993 'top-down' health mandate, which represented a critical step away from viewing health as a human right (World Bank 1993), and current steps toward nationally created health policy approaches through the World Bank's Poverty Reduction Strategies (PRS) (Klugman 2002). Over time, the International Monetary Fund and the World Bank have been dominant actors in the economic development processes of sub-Saharan African nations. This dominance continues today with the Poverty Reduction Strategy Papers (PRSPs), which call for a 'country-driven', 'comprehensive' and 'long-term perspective' towards development (IMF 2005). However, World Bank-led PRSPs stress the importance of building strong social sectors, such as health and education, which represent a considerable step away from their earlier emphasis on economic growth through structural adjustment policies (SAPs). This paper explores the extent of this policy shift within the World Bank, by examining both the possible international conditions that may have stimulated this perceived change, as well as examining the effectiveness of PRSPs in strengthening health sectors in two sub-Saharan African nations, Tanzania and Uganda.

Theoretically, this paper asks whether health policy has been changing in recent years away from its neo-liberal mandate as a result of changes in the international sphere

through globalization. The emergence of embedded liberalism after World War II and the reasons behind the inclusion of social policy protections are explored and compared to today's similar turn to the protection of social policies by the international financial institutions. Ruggie (2003) defined the post-war embedded liberal 'compromise' as "economic liberalization embedded in social community" (94). Drawing from this earlier theory of embedded liberalism, this paper asks whether processes of globalization are helping to contribute to the inclusion of domestic social policy within international development platforms that may represent a second phase of embedded liberalism. This paper identifies globalization as defined by Held and McGrew (2002), as "a historical process which transforms the spatial organization of social relations and transactions, generating transcontinental or inter-regional networks of interaction and the exercise of power" (2). Initially, the paper examines forces associated with globalization, including an increased focus on health as a public good, or globalization from 'above', and pressures from civil society and NGOs to view health as a human right, or globalization from 'below', in order to determine possible reasons behind the World Bank's apparent shift in policy.

More specifically, this project explores whether the World Bank's Poverty Reduction Strategy Papers truly represent a greater commitment to strengthening 'pro-poor' social policy approaches to development, as well as determining whether health is actually being targeted as a prerequisite for successful development. Furthermore, it asks if a shift in World Bank health policy is occurring, to what degree is this shift occurring, and does it represent a significant departure from the World Bank's earlier orthodox liberal approach to development? The paper uses the case studies of Tanzania and

Uganda in order to determine the effect of PRSPs in the building of stronger health care sectors. In analyzing the health sectors, this paper defines health according to the World Health Organization's 1978 definition of Primary Health Care (PHC). The WHO defines health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity" (WHO 1978). Furthermore, the "ideology and implementation of primary health care (PHC) emphasize universal access and coverage, PHC's role as the site of first contact, coordination and integration of services and programmes" (Kekki 2003: 1).

This project concludes that although the World Bank's PRSPs include social welfare strategies that resemble a model of embedded liberalism, these policies are not yet producing strengthened health policy. The paper demonstrates that domestic health policy needs continue to be neglected through the implementation of 'top-down' World Bank policy, which fails to consider the specific needs of the poor within Tanzania and Uganda.

In examining PRSPs in two African countries, this project aims to contribute to literature that focuses on the changing roles of international organizations in the health sector. As has been discussed in recent years (Chen, Evans, & Cash 1999, Woodward & Smith 2003), global health has received greater attention in response to a growing realization that the consequences of health transcend borders and are no longer simply national issues. Furthermore, previous insufficient attention toward health through, for example, the impact of structural adjustment policies on health policy and the deterioration of African health through the onset of HIV/AIDS crises, are critical international issues that have demanded attention from all relevant actors including

citizens, governments, medical personnel, aid workers, and researchers. Currently, health sectors in African countries are a focus for many donor groups in order to reduce poverty and the threat of disease, but in past years limited attention was paid to the importance of building stronger health sectors within the development platforms for these nations.

Although much has been discussed about the World Bank's Poverty Reduction Strategies and their significance for development, specific research pertaining to health within this new mandate has been conducted less frequently. This project aims to contribute to the ongoing development literature about the World Bank's changing policy mandate (De Beyer et al 2003, Best 2003) while applying these concepts to health sectors.

Furthermore, although much literature exists on new forms of embedded liberalism (Ruggie 2003, Porter & Craig 2004, Best 2003), this paper intends to add to the emerging debate about the extent of and possibilities for 'social inclusion' within the liberal environment of today.

## **Methodology**

This paper uses qualitative analyses in order to determine whether a shift towards embedded liberalism is occurring through the World Bank's health mandate. Relying mainly on secondary sources and World Bank and IMF document analyses, including country-specific PRSPs, this paper examines the new mandate of these IFIs by looking broadly at the five concepts of PRSPs in terms of their significance for development, as well as their effectiveness so far in achieving "pro-poor" health development in Tanzania and Uganda (Laterveer, Niessen & Yazbeck 2003). The World Bank's five core principles of the PRSP approach revolve around a framework that is 'country-driven', 'results oriented', 'comprehensive', 'partnership-oriented', with a 'long-term perspective'

(World Bank 2005). These World Bank core principles of poverty reduction revolve around the major principles of participation and governance advocated by the organization. As mentioned, these concepts are applied to the health sector of Tanzania and Uganda, weighing their impact and influence on the shaping of policy. This project aims to determine whether a significant departure from the World Bank's previously neo-liberal mandate is occurring through the creation of new 'pro-poor' health policy, and if so, whether this shift is having a positive effect on the development of health sectors.

In order to measure whether participation and governance within World Bank development policy are successfully creating 'country-driven' poverty reduction strategies, the paper looks at the specific cases of Tanzania and Uganda and examine both the level of participation and the governance strategies employed, and whether 'pro-poor' strategies are being implemented and producing results according to the specific needs of populations. Within this analysis, Tanzania and Uganda are the two chosen comparative cases as a result of their geographical proximity, relatively similar-sized populations, and comparable economic history with the World Bank through participation in structural adjustment programs as well as their early entry into the PRSP process.

In its attempt to determine whether PRSPs represent a step towards viewing health as a development priority, this project uses various indicators to measure whether health has undergone initial reform as a result of poverty reduction strategies, including levels of health financing, levels of access and equity of health care provisions, and collaboration measures taken between different forms of governance and development partners. Collaboration measures are gathered by examining the various initiatives taken by the government and other actors to work together to create policy in a cohesive

manner. Based on recent statistics within the health sectors of Tanzania and Uganda, levels of funding, access and equity, and collaboration initiatives are the determinants of the initial success of Poverty Reduction Strategies.

Examination of the social determinants of health suggests that the above policy measures are reasonable indicators for later health improvements. Although it is clear that funding is needed to improve health policy, it has also been accepted that the social and economic conditions within society also contribute to poor health and need to be addressed through policy (Wilkinson & Marmot 2003). Broadly, improvements to policy in terms of access, equity and collaboration are meant to address some of the social conditions that contribute to poor health. For example, unstable social conditions including social exclusion, unemployment, and poor nutrition affect many people within sub-Saharan Africa and contribute to poor health (Wilkinson & Marmot 2003). Along with funding, this paper is addressing policy concerning access and equity within the health sector. According to the WHO, “public health policies should remove barriers to health care” in order to “eliminate absolute poverty and reduce material inequalities” (Wilkinson & Marmot 2003: 17). In other words, health access opportunities and good health for the population would result in increased productivity and therefore decrease poverty levels. For instance, policy measures such as the elimination of user fees could potentially promote greater equality and partially address the broader social issue of social exclusion. Furthermore, the third indicator, collaboration within the health sector, aims to address social issues such as isolation and a lack of social support experienced by individuals and communities within countries. In pointing to these social determinants of health, the World Health Organization advocates the implementation of policy that

addresses social conditions in order to improve the overall health of the population (Wilkinson & Marmot 2003). Discussion of the social determinants of health is linked to the approach that views health as a 'public good', affecting populations across borders. The 'public good' argument is discussed further below and may be one factor contributing to a new form of embedded liberalism.

## **THEORETICAL APPROACH**

### **Neo-liberalism Versus ‘Inclusive’ Liberalism**

The role of health care in development has been the subject of much debate between neo-liberal and critical (or ‘basic rights’) development groups (Evans 2004). In past years, and to some extent today, dominant neo-liberal development organizations have not accepted health as an integral part of the development process, but viewed it as an ‘aspiration’ that could be achieved through sound economic development policy (Evans 2004). As a result of this approach, health policy has rarely been a major priority within mainstream development organizations. For instance, organizations such as the World Bank have traditionally viewed health through a “reductionist” lens that sees it simply “as physical well-being and poverty linked only to economic need” (Villar 2004: 109). In other words, with an increase in income, social development will occur, followed by an increase in health of the overall population. Therefore, economic growth has been the central concern of liberal-based organizations, with social development only becoming a greater concern once wealth is accumulated. However, this ‘trickle-down’ approach has proven to be problematic for many developing countries, as economic growth has often failed to occur, or social programs have continued to suffer despite economic growth. For example, SAP implementation in the 1980s and 1990s has been criticized for its focus on economic growth and its lack of attention to social development. Although SAPs were successful in achieving growth in some developing countries, this growth was not translated into improved living conditions, including



health, in many countries. Since the implementation of SAPs, the World Bank has determined that an altered approach to development is necessary, as indicated through their current promotion of economic growth in combination with poverty reduction (World Bank 2005). In short, past neo-liberal development perspectives have not viewed health care as essential to the development process, making the PRSP platform a transition from past policy.

In order to increase the importance of socio-economic rights in the development process, it has been argued that a conception other than the neo-liberal approach to development needs to be accepted by the international community. Amartya Sen's (1999) definition of development as freedom is consistent with the human rights approach to health, and helps to further explain the importance of a "multidimensional" approach to development (Villar 2004: 109). Social opportunities, including health, are considered necessary in Sen's definition of freedom, as economic, political and social dimensions of development all interact to create 'freedom' for society:

Freedoms are not only the primary ends of development, they are also among its principal means ... Political freedoms (in the form of free speech and elections) help to promote economic security. Social opportunities (in the form of education and health facilities) facilitate economic participation. Economic facilities (in the form of opportunities for participation in trade and production) can help generate personal abundance as well as public resources for social facilities. Freedoms of different kinds can strengthen one another (1999: 10-11).

For Sen, the path to development is not linear as many neo-liberals may suggest, but involves interaction among economic, political and social opportunities to expand "human capabilities and the quality of life for individuals" (1999: 144). Sen's approach to development is critical for health, in that it raises the importance of socio-economic

freedoms, and focuses on overall quality of life, rather than simple economic wealth. In terms of health, Sen's analysis suggests that health policy should be an intrinsic part of the development process, both contributing to and resulting from increased development.

Although the neo-liberal platform of prioritizing economic growth over social programs has prevailed in recent years, it seems that discourses (World Bank 2005, WHO 2004, UN 2005) surrounding health are leading to altered development platforms that are inclusive of health policy. Indeed, finding a balance between neo-liberal and basic rights perspectives seems necessary for 'pro-poor' development to be successful within the international development regime. Certainly, more powerful actors such as the World Bank and IMF help shape the direction of development in the south, and poverty reduction policies must work within these organizations' mandates in order to be feasible in the international sphere. As mentioned, processes associated with globalization have increased international involvement in health. Two major debates - public goods and basic rights perspectives - should be mentioned here, as they have helped influence international actors' involvement in health and contributed to the changes within development platforms that now include health as key sectors as a means to achieve poverty reduction. Both debates help to explain why a shift may be occurring within international organizations' conceptions of development and their new approach to health.

First, discourse surrounding health as a global 'public good'<sup>1</sup> has gained attention in recent years, as the international community has come together to address global health needs. Changes in global health in recent years have affected the way that countries and

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<sup>1</sup> The traditional definition of a pure public good applies here, being both non-excludable and non-rival in consumption (Woodward & Smith 2003). A *global* public good is defined as "a public good with benefits that are strongly universal in terms of countries...people...and generations" (Kaul et al. 1999: 509-510).

international actors respond to health demands. As Woodward and Smith (2003) indicate, traditionally, while communicable disease has been viewed as a public good, good health has more generally been viewed as a private good, as it reflected strong national health systems and individual choices to stay healthy. However, Chen *et al.* (1999) point out that new cross-border health threats such as the growth of HIV/AIDS and new environmental threats have changed this conception, and argue that “globalization is blurring the traditional line between public and private in health” (285). In other words, communicable, as well as non-communicable diseases no longer remain within the confines of one nation, but affect many people in all nations. The participation of international organizations such as the UN, WHO and perhaps the World Bank in the health field can be partially explained through the ‘public good’ argument. As Jamison, Frenk and Knaul (1998) articulate, “although responsibility for health remains primarily national, the determinants of health and means to fulfill that responsibility are increasingly global” (515). Reaction to the growing threat of global disease has provided international organizations with an increased incentive to promote health within developing countries, thus creating a form of globalization from ‘above’ as health-related policy is driven by the public good rationale. Although the World Bank’s role in the health sector is also linked to growth opportunities, the public good debate and the need to regulate a global problem certainly may have influenced its most recent involvement (Kaul & Faust 2001).

Secondly, as global attention continues to be drawn towards African health crises, discourse surrounding the concept of health as a human right has become central for some outside policy circles. In contrast to the public goods argument above, proponents

of a development agenda that view health as a human right are often civil society organizations and NGOs who create a push for improved health policy from 'below'. As Tony Evans (2004) indicates, the international financial organizations have previously not accepted basic rights arguments, and the dominance of the liberal viewpoint has continued as processes of globalization intensify. Also according to Evans, the right to health is defined as "what we as a society do collectively to ensure the conditions in which people can be healthy" (2004: 8). In terms of viewing health as a human right, civil society groups, NGOs and, at times, influential organizations such as the WHO and its Alma Ata Declaration of Primary Health Care (WHO 1978) have been influential in creating a discourse that focuses on the importance of making health a right in the South. Contrary to Evans, Ruggie (2003) argues that globalization has encouraged new voices, including those within civil society organizations to speak out and influence health policy at the international level. Ruggie points to civil society organizations, in the form of nongovernmental voluntary associations, which contribute to new forms of governance by influencing the state, international organizations, and corporations. In other words, civil society has increased the possibility for third world global participation, and has perhaps influenced powerful actors such as the World Bank to alter their social policy strategies and view health as a basic right.

When examining health in the context of globalization, there is a debate (Fidler 2004) as to whether new policy efforts have been driven from above through international organizations, or from below through civil society organizations and the human rights argument. In general, it can be stated that the public good argument encourages targeted health policy that focuses specifically on the elimination of particular

global diseases, more so than comprehensive public health policy. Furthermore, the human rights argument focuses more on the provision of comprehensive and accessible primary health care for all citizens. Although it is debatable as to what extent the public goods or human rights approaches have influenced the World Bank specifically, it seems that the public goods argument helps to explain the more recent involvement of international organizations within the health sector. Initiatives such as the UN's Millennium Development Goals (MDGs), and the WHO's 3 by 5 Initiative and Stop TB Strategy are examples that focus specifically on global health threats in developing countries (UN 2005, WHO 2006). Although the promotion of health seems to be based on the public 'good' argument, where Northern countries and organizations play the role of 'watchdog' in order to protect the spread of disease, it can also be argued that this involvement in global health is based on self-interest. The risk associated with global health and the view that health in the developing world poses a potential risk to the North helps to explain the increased attention toward health, as well as the specific focus on disease. In examining the World Bank's new focus on health policy, both the public goods and human rights arguments are considered as possible incentives for this change, and are used in determining whether PRSPs represent a strategy that is a truly 'country-driven', 'pro-poor', and 'comprehensive' effort to address health issues.

## **The World Bank**

Specifically, in terms of the World Bank, although it may be influenced by the public goods and human rights arguments, there may be other factors related to past and current economic growth opportunities that have altered its development mandate. It is possible that changes in World Bank development policy have derived from both a

negative international reaction to structural adjustment policies as well as the recognized need to create a healthy population in order to enhance productivity in the development process (World Bank 1996). As noted previously, the neo-liberal development policies of the 1980s and 1990s have been highly criticized throughout the international community as top-down, macroeconomic policies that do not consider social welfare. For example, as Cheru (2002) maintains, “in the social sector, debt servicing and the adjustment policies pushed to free up foreign exchange needed to service the debt have worsened social welfare in the areas of health, education and poverty reduction” (302).

Furthermore, since the World Bank and IMF changed from the original form of SAPs in the 1990s, public health care systems in sub-Saharan Africa have continued to lack the capacity to deliver basic health services to the majority of the population. However, as Pender (2001) notes, partly due to the general failure of SAPs, “there is a strong sense in which the World Bank implicates itself in the failure of development, and acknowledges a degree of responsibility” (405). In order to combat problems associated with SAPs, and in an attempt to create a more socially conscious model for development, the World Bank’s PRSP approach attempts to alter its approach to funding and conditionality in order to confront poverty in developing countries (Pender 2001).

Furthermore, related to the Bank’s renewed focus on poverty is the recognition that a healthy population is necessary in order to achieve economic growth. Although the World Bank has altered its focus on economic growth to include poverty reduction, increased growth and productivity continue to be central goals in the development process. According to the Bank, “investing in people-through education, health, nutrition, and other aspects of human development is crucial in the struggle to raise living standards

and reduce poverty in the developing world” (World Bank 1996). The Bank maintains the view that productivity is the key to development, and that a healthy population is vital in order to have the capacity to increase productivity. Although it is difficult to pinpoint the source of change for the World Bank’s development policy, it seems that a variety of factors have helped to influence the socially conscious poverty reduction package that exists today.

In examining a possible shift in direction within the World Bank, this paper explores whether the Bank has adopted an embedded liberal perspective that represents a legitimate shift in focus toward the poor and health policy in the south. John Ruggie’s definition of ‘embedded liberalism’ stems from the interventionist policies of the financial institutions after World War II, and points specifically to the inclusion of social objectives within the liberal international economic order (Ruggie 1982). Ruggie’s post-war era of embedded liberalism coincides with Keynesian economics and the global mindset at the time to provide domestic security for states to avoid another serious economic depression. In addition to Keynes, Karl Polanyi (1957) influenced the post-war transition to embedded liberalism and contributed to the evolution of the term ‘embedded’ liberalism that Ruggie later coined. Essentially, Polanyi warned of the dangers of adhering to strict orthodox liberalism, as he thought that unregulated markets would produce negative effects on society (Cohn 2005). Polanyi pointed to instances in history such as the Great Depression to argue that the “market economy if left to evolve according to its own laws would create great and permanent evils” (1957:130).

Influenced by both Keynes and Polanyi, Ruggie stated that post-war embedded liberalism “would be multilateral in character” and “its multilateralism would be

predicated upon domestic interventionism” (1982: 393). In short, domestic actions that protect national stability such as social intervention would be ensured within the international order of economic transactions. As Best (2003) contends, post-war states “were to be granted the financial tools necessary to pursue their own ‘favorite experiments’ within the large global economy, through the provision of IMF credit, some exchange rate flexibility and the right to control capital flows” (365). In short, embedded liberalism developed as a means to avoid the negative side effects associated with free market society, including the deterioration of domestic needs such as health and education. Although the specific economic conditions associated with embedded liberalism have changed since the post-war period, the basic principles, including social protection in the midst of market-led liberalization are relevant here, and can be termed ‘inclusive’ liberalism (Porter & Craig 2004). For example, Porter and Craig point to the relevance of Polanyi’s ‘double movement’ today, where the first movement involving economic liberalization, or neo-liberalism, creates a need for a second movement where it becomes necessary to “mitigate the social disruptions of market-led liberalization” (2004: 391). Indeed, it seems that the neo-liberal approach of the World Bank in the 1980s and 1990s has since shifted to include a new form of embeddedness, or a more ‘inclusive’ liberal approach for the development of the South.

As can be seen through the public goods and human rights discourses, it appears that international organizations have adjusted their mandates in recent years in order to become supportive of social policies in developing countries. Furthermore, it looks as though processes of globalization have encouraged a resurgence of embedded liberalism, both globally and within developing countries. Indeed, according to Porter and Craig



(2004) it appears that the poor are being increasingly included in ‘globalization’ and the ‘global economy’ as new concerns are being addressed within market liberalization such as “security, stability, risk, safety, inclusion and participation” (392). As mentioned above, the public good argument helps to explain recent global attention toward health, as international actors have been addressing rising health concerns that have spread through processes of globalization. Furthermore, according to Ruggie (2003), globalization has also changed traditional governance structures from previously simple state-led governance toward an influx of actors that alter the state’s ability to govern and influence powerful international actors. As Ruggie (2003) argues, embedded liberalism in the post-war era was initiated by states wanting domestic control within economic liberalization, enabling industrialized countries with strong governance structures to implement domestic protections. However, through globalization

Significant institutional developments *are* evolving at the global level, among them the emergence of what we might call a global public domain: an arena of discourse, contestation and action organized around global rule making – a transnational space that is not exclusively inhabited by states, and which permits the direct expression and pursuit of human interests, not merely those mediated by the state (Ruggie 2003: 104).

In other words, new governance actors, such as civil society groups, have arisen through globalization, creating stronger voices to push for social inclusion in less developed countries. These new governance structures may have developed because of current global trends, including increasing levels of poverty, widespread disease, and the increasing dominance of international financial institutions, which created a “backlash” against these processes associated with globalization (Ruggie 2003). Although Ruggie implies that globalization from ‘below’ may be contributing to new forms of embeddedness, it is not evident to what extent civil society groups have been able to

influence development policy in the South. However, processes associated with globalization, including growing global insecurities, have certainly contributed to a renewed, and perhaps 'inclusive', focus on health in the South.

Although these links between globalization and an 'inclusive' platform can be identified, it is unclear to what extent the financial organizations have accepted a new policy mandate and rejected growth-oriented policies of the 1980s and 1990s. Authors such as Best (2003) and Porter and Craig (2004) have discussed liberal "re-embedding" or "social inclusion" within the policy mandates of the global financial institutions. Many of these newer perspectives stem from Polanyi's (1957) and Ruggie's (1982) conceptions of embedded liberalism, whose influences both may apply to current societal changes through globalization. Indeed, development initiatives such as the World Bank's Poverty Reduction Strategies (PRS) represent an evolution from structural adjustment policies in that they focus on local involvement and on the building and strengthening of social programs such as education and health.

Furthermore, new development principles put forth by the Bank including participation, ownership, partnership and governance represent a renewed vision of development. Although the extent of this departure has not been clearly determined, it is evident that the World Bank has attached a more 'embedded' approach to its development policy rhetoric. According to Porter and Craig (2004) "Poverty Reduction Strategies sketch the elements of a consensus embracing global with local, the IMF with children in sub-Saharan communities, inclusive values with sharp disciplinary governance frameworks" (389). Furthermore, Best (2003) identifies changes in the current financial regime that formulate a "re-embedding" of liberalism, such as a shift

within the IMF and World Bank that “appears at first to indicate a recognition of the social costs of disembedded liberalism [or neo-liberalism] and a corresponding openness to negotiating the needs of particular states” (373). In short, this renewed form of embedded liberalism appears to accept the importance of social policies within the development process, while at the same time noting that the inclusion of civil society participation and different governance structures are also vital as globalization intensifies.

Although ‘inclusive’ liberalism represents perhaps a progression or continuation from the previous neo-liberal mandate of the World Bank, some authors (Best 2003, Porter and Craig 2004) have argued that this recent shift lacks many of the attributes of Ruggie’s conception of embedded liberalism. In particular, the focus on domestic stability that was critical for Ruggie as the reasoning behind embedding social policies, has not been evident within the World Bank and their Poverty Reduction Strategies. Furthermore, it is unclear whether the World Bank principles of governance and participation are being adequately applied to new development initiatives in the health sector. However, this paper weighs the effectiveness of the PRSPs and health policy through a renewed embedded liberal lens, looking for evidence that suggests that a shift toward ‘inclusive’ liberalism is happening with regard to health in areas such as domestic, or ‘country-driven’ social policy formation, including the successful participation of local groups and the collaboration of governance structures that work seriously towards the strengthening of health services as a part of their overall commitment to Poverty Reduction Strategies.

## **POVERTY REDUCTION STRATEGIES AND HEALTH**

The World Bank and IMF have significantly helped to shape development processes in lower-income countries. Although the development platforms of these organizations have changed over the years, the neo-liberal ideology of the financial institutions and their dominance of the development process within many African nations have been recognized and critiqued (Turshen 1999, Cheru 2002, O'Manique 2004). Although once dominant, World Bank-led development policies associated mainly with economic growth-oriented structural adjustment policies are now generally regarded as insufficient, and the need for the building of social programs has become accepted as necessary to achieve growth. International programs such as the United Nation's Millennium Development Goals (MDGs) and the New Partnership for African Development (NEPAD) are among those that have included targeted health approaches within their development strategies. More than ever, international organizations are focusing on health policy within Africa, and are contributing to the overall growth of social programs in efforts to reduce global poverty.

In order to help combat poverty in Africa, the World Bank's newest strategy in eliminating poverty includes improving health, as the Bank has been working to focus on poverty reduction in low-income developing countries. To achieve this, the World Bank and IMF initiated partial debt forgiveness through the Heavily Indebted Poor Countries (HIPC) Initiative in 1999 in conjunction with the Poverty Reduction Growth Facility (PRGF), which is aimed at becoming "more accommodating to higher public

expenditure, in particular pro-poor spending” (IMF 2005: 1). While the HIPC Initiative has allowed debt relief for many LIDCs, the PRGF has set out a new framework for spending that aims specifically to benefit the poor (Gariyo 2002). Furthermore, these PRGF-supported programs are framed around “comprehensive, country-owned” Poverty Reduction Strategy Papers (PRSPs) which include a focus on the health sector as a vital element of the development strategy (IMF 2005). These programs are intended to focus on health care policy specifically for the poor in terms of funding, participation of civil society, and altered governance and ownership strategies. Overall, the more recent development rhetoric set forth in the PRGF indicates that the World Bank has altered its previous economic growth-oriented strategies, and has increased its focus on poverty reduction while pursuing growth.

Although broad changes within the Bank’s mandate have occurred, it is unclear whether this development platform has significantly changed since the 1990s, and whether these changes are contributing to positive policy results within national health sectors in Africa. The paper argues that a balance must be found in the new policy mandate that embraces social development at the micro-level, while at the same time fitting into the dominantly liberal macroeconomic international order. In short, by examining various health policy initiatives, this paper looks to determine whether the World Bank has significantly altered its development policy and promoted successful ‘embedded’ strategies to improve health policy in Africa. Finally, the following section explores whether a gap exists between the rhetoric and the reality of poverty reduction within the health sectors of Tanzania and Uganda, and examines the potential areas where policy improvements are needed.

## **World Bank Policy Goals in Sub-Saharan Africa**

Changes in the World Bank's development mandate can be identified in examining the principles within the Poverty Reduction Strategies set forth for approximately 70 low-income countries (World Bank 2005). As mentioned, the poverty reduction process embodies the two broad principles of governance and participation, as development strategies should be "prepared by the government through a *country-driven* process, including broad participation that promotes *country ownership* of the strategy and its implementation" (Klugman 2002: 2). For the World Bank, PRSPs have the potential to be successful because they are framed to look inwards towards the individual needs of African countries through 'participation' and 'governance'.

In terms of participation, *The PRSP Sourcebook* (Klugman 2002) identifies that participation should be achieved at both the macro and micro levels when creating policy and should strive toward concrete policy outcomes. At the broader country level, interim PRSPs (I-PRSPs), followed by full PRSPs are intended to outline and guide the country's measures toward participation throughout the process. For example, in the health sector, an I-PRSP may initially identify stakeholders that are relevant in the policy-making process, and actually outline how participation will be achieved. At the micro level, poverty reduction strategies are intended to encourage negotiation and collaboration between various stakeholders, including civil society (Klugman 2002). Ideally, this micro-level participation is intended to allow the voices of the poor to be heard and to enable them to help shape the policies that will eventually contribute to poverty alleviation.

Further, PRSPs advocate the principle of governance within their development mandates. The World Bank defines governance as

The exercise of power through a country's economic, social, and political institutions in which institutions represent the organizational rules and routines, formal laws, and informal norms that together shape the incentives of public policymakers, overseers, and providers of public services (Klugman 2002: 271).

Essentially, the World Bank advocates 'good governance' in order to effectively implement domestic policies. Furthermore, unlike SAPs, governments under the PRSPs are encouraged to take an active leadership role in the development process. This concept is linked to the idea of participation, but also goes further, allowing a 'partnership' to occur between donor and recipient countries. According to the World Bank, PRSPs are to be developed "in partnership and consultation not only with donors, but also with representatives of domestic civil society and poor people themselves in order to ensure both national ownership and that development resources benefit the poor" (Abrahamsen 2004: 1456). Furthermore, the World Bank and IMF have identified important ways that good governance can contribute to poverty alleviation through 'empowerment' of the poor, "improving the capabilities of the poor", and providing them with greater economic opportunities. (Klugman 2002: 275-6). In other words, under the poverty reduction mandate, governments have been given more responsibility to create policy and financial platforms that will work for the poor.

In terms of health, governance and participation are intended to play major guiding roles in the implementation of successful health policy. The indicators to be discussed in this paper including funding, access and equity, and collaboration, are all included within the objectives of the World Bank's PRS and are based on principles of

governance and participation. Objectives for improving the health system include increasing funding and distributing funds more effectively through the health sector, including “possible reallocations of budgets to reach poor people better” (Klugman 2002: 205). Ministries of health have been given increased responsibility to distribute health funds in a way that focuses on the poor through avenues such as strengthening primary health services that serve the most disadvantaged segments of the population. Also, the PRSP platform emphasizes a need on the part of governments to increase access and equity within the current health systems of poor nations through focused policies. Finally, there is a recognized need within the PRSP platform that governments must work with other actors including NGOs in order to create better services as well as sectoral cohesion that provides better and more consistent care for poor people. “There has to be coordination between government and the other actors in the health system, such as donors, NGOs, and community organizations” (Klugman 2002: 204-205). Certainly, the policy goals under PRSPs contain greater commitments towards building the health sector in terms of the needs of the poor. Although there is no concrete blueprint for action within Poverty Reduction Strategies, this is done intentionally, in order to give individual countries more freedom to shape development to their specific health needs. However, this principle is also problematic, as it is the World Bank and the IMF who give the final approval of policy formulation under the PRSPs, creating a complicated balance between country ‘ownership’ and World Bank approval over that ownership. The following section examines health policy formation in both Tanzania and Uganda since the implementation of PRSPs in 2000.



## **Empirical Results at the National Level: Tanzania**

Tanzania has participated in the Poverty Reduction Strategy Papers since 2000, one year after the initiation of the PRSP program, and has released subsequent reports on progress since that time. As an LDC Tanzania has a GDP per capita of \$621 and ranks 164<sup>th</sup> out of 174 countries on the 2003 Human Development Index (HDR 2005). Furthermore, it is estimated that 59.7 percent of Tanzania's populations lives on less than \$2 per day, and there are only 2 physicians available per 100,000 births in the country, making it one of the poorest countries in the world and in great need of health sector development (HDR 2005). Over the years, Tanzania has remained in good standing under World Bank and IMF financing, as it has managed to maintain about a 5 percent growth rate in the past few years but, according to the IMF, has had difficulties working "on the linkages between macroeconomic developments and poverty" (IMF 2004c: 1-2). The current socio-economic setup in Tanzania has been shaped by economic and social reforms introduced in 1986, which included a transformation from a socialist state to a market economy. Although Tanzania followed SAP prescriptions closely in the 1980s and 1990s, the reforms were unsuccessful as indicated by increases in poverty during that time despite levels of economic growth. Furthermore, under SAPs, Tanzania experienced a heavy decline in public health care funding as it significantly reduced spending within social sectors in its attempt to achieve economic growth (Turshen 1999).

Although Tanzania struggled economically prior to the 1980s, the country went from having a relatively strong public health care system under its socialist government where it allocated 7.5 percent of total government expenditure on health in 1978, to spending a low of 3.9 percent under SAPs in 1989 (Kopoka 2000: 11). Prior to 1986,

Tanzania was able to provide free medical access to its population, as health services in hospitals were nationalized after the Arusha Declaration of 1967<sup>2</sup> (Turshen 1999). However, privatization of medical services was a phenomenon in Tanzania during structural adjustment reforms, and the Tanzanian government relied on the private sector as well as NGOs to help administer most health services. Furthermore, the public health sector had to turn to user fees under World Bank reforms in order to help finance health services. For example, in 1993 it was estimated that NGOs operated 45% of all hospitals in the country and levels of inequity increased as private clinics tended to be placed in major centres rather than in poorer areas where they were needed most (Turshen 1999: 87, Benson 2001). Under private control of health care, little collaboration occurred between the government and NGOs. Rather, Tanzania's government focused closely on the World Bank prescribed macroeconomic reforms, and allowed NGOs to administer the delivery of health care on their own basis.

Overall, Tanzania is a country that has followed World Bank economic prescriptions closely in the past, adhering to the conditionality measures. The government was not obliged to have a sense of 'ownership' over public health under the World Bank, and little 'participation' existed between NGOs, civil society and the government in terms of health care policy. Rather, NGO-led health delivery mainly operated separately from government-run health, creating an "unruly melange of external ideas and initiatives" that resulted in a loss of government control over the health development process (Buse & Walt 1997: 449). Today, Tanzania continues to work with the World Bank, but is now focused on restoring the health care system that was

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<sup>2</sup> Tanzania's 1967 Arusha Declaration by Julius Nyerere outlined its new economic policy of 'socialism and self-reliance', which focused on rural development through the creation of Ujamaa villages (Nyerere 1967).

neglected under SAPs. This new strategy includes a focus on increased funding, better access, and greater collaboration between civil society and the government. It was not until the 2000 implementation of PRSPs that a long-term development strategy that focused specifically on health care and poverty alleviation was initiated in Tanzania under the World Bank.

## **Funding**

An examination of the World Bank's commitment to increased funding is the first step toward looking at the prospects for success under the Poverty Reduction platform. In terms of public health spending, Tanzanian records indicate that the amounts allocated each year have risen from 7.5% of the government expenditure in 2000 to 8.7% in 2003 (PRSP 2003: 34). Although an increase has occurred since 2000, the 2003 PRSP document acknowledges that the funding allocation is lower than anticipated and greater efforts need to be taken between the Ministry of Health and donors to increase resource allocation. Moreover, the Tanzanian health sector is still overwhelmingly funded by NGOs and the private sector. According to the World Health Organization, 46 percent of health care expenditure is publicly funded, and 53 percent is privately funded, which predominantly includes NGO services (WHO 2005). Furthermore, user fees are employed by the government in order to help fund the public system. However, according to Turshen (1999), service fees are not an entirely effective way to finance the health system, as reviews have revealed that "on average fee systems yield only 5 percent of operating costs, and if collection costs are added in, the receipts are even smaller" (50). When analyzing the increases in public spending under the PRSPs, as Bond and Dor (2003) state, evaluation of increased public health spending has to be put into a broader

context under PRSP reforms. For example, the above numbers on increased public spending disguise the “lack of data on actual spending, due to a combination of the recent introduction of PRSPs and the poor tracking of program spending” (Bond & Dor 2003: 613). In general, because the PRSPs do not reveal how or where the increased health funds are being spent, it is difficult to assess whether increased public funding is being directed toward the poor.

According to the 2003 Poverty Reduction Progress Report, the World Bank and IMF as well as the Tanzanian government recognized the need for increased health care funding. The 2003 PRSP states that the annual goal for funding was \$9 per capita, while 2003 real expenditure was \$6 per capita. Further, the report notes that even greater financial support is needed in order to combat disease in Tanzania:

The health sector is still under-funded. The target for [the Ministry of Health] has been set at US\$ 9 per capita, although according to the World Development Report (1993) US\$ 12 is an absolute minimum to ensure sufficient resource allocation to priority areas such as malaria, TB and HIV/AIDS (IMF 2004).

In other words, not only is health still under-funded, but its targets do not even come close to the minimum required to counter prevalent disease. Furthermore, Verheul and Rowson (2002) point to flaws within the PRSP process that have led to Tanzania’s inability to reach adequate levels of funding in health. The authors suggest that rather than limiting the budget, Tanzania should ask for increased donor assistance, and “clearly indicate the financing gap for health, in order to challenge donors to fill this gap” (392). Although it is clear that the health sector is under-funded in Tanzania, the report does suggest that incentives are in place to increase financial support under the PRSP program. For example, efforts have been made to create a ‘resources allocation formula’ by the

Tanzanian Basket Finance Committee. According to the 2002/03 PRSP, the resource allocation formula “aims at redirecting resources to main priorities in the health sector, with a special focus to areas where the majority of poor and vulnerable groups live” (33). Further, the Tanzanian Ministry of Health recognizes the need to increase public health funds in order to address major health needs in the country. However, the PRSP also reveals a definite gap between projected and actual funding within the country, suggesting that external relief organizations must provide funds where the government cannot.

### **Access and Equity**

Increased access and more equitable health delivery are policy goals under the World Bank PRSP mandate. Vulnerable groups in Tanzania such as women, children and those living in rural areas have considerably less access to health facilities, and a commitment to provide better services to these groups has been outlined in the PRSPs (PRSP 2003). Although a major goal for Tanzania under the PRSP program is to increase health access to the population primarily in rural areas, greater equity has not yet been achieved at a significant level. However, according to the 2003 PRS Progress Report, greater access for rural communities has been accomplished. In a Tanzanian Household Budget Survey in 2001, it was found that “about 91.4% of the population are less than 10 km from a health facility and 75.4% are less than 6 km” (IMF 2004b). Despite this optimism, other indicators reveal that there are considerable obstacles toward equitable service within the current health system. For example, a 2004 study commissioned by Research for Poverty Alleviation (REPOA) suggests that continued use of the Tanzanian user fee system is contributing to inequity within the health system (Laterveer, Munga,

Schwerzel 2004). Although user fees were developed for wealthier citizens, REPOA found that the waivers and exemptions meant to protect the poor were not being adequately administered. Rather, an adequate waiver system for the poor was “non-existent”, while user fee collection appeared to exist as common practice for all patients regardless of their income (Ibid. 2004: vi).

Furthermore, it has been acknowledged that the presence of the user fee system most seriously affects the most vulnerable populations of society, those being primarily women and children (Laterveer *et al.* 2004). With the user fee system in place, many poor members of the population simply do not use the public health system because they cannot afford to (Ibid.). For example, current statistics indicate that only 36 percent of women who give birth in Tanzania are attended by skilled health personnel (HDR 2005). Furthermore, in 2003 it was estimated that only 38 percent of children under five receive adequate rehydration and nourishment when experiencing health problems<sup>3</sup> (HDR 2005). Although the 2002/03 PRSP outlines potential strategies for increasing health equity for women, children, and rural populations, little success has been achieved since implementation. For example, measles immunization rates for children rose slightly from 74% to 79% in 2002, and the ministry has set aside additional funds to help provide adequate children and maternal services (PRSP 2003: 43). However, it appears that little concrete action has been undertaken to help disadvantaged groups in Tanzania gain better access to services.

Although user fees appear to contribute to inequity within the health system, their use continues to be supported by both the World Bank and the Tanzanian government. As

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<sup>3</sup> The UNDP HDR defines this as “Children with diarrhoea receiving oral rehydration and continued feeding (% under age 5) 1, 1994-2003” (HDR 2005).

Laterveer *et al.* argue, because the poor are the most disadvantaged by the user fee system, the “[user fee system] does not correspond with the commitment to reducing poverty in Tanzania as articulated by the Poverty Reduction Strategy” (2004: vii). Indeed, the reluctance to address this issue under PRSPs appears to be a result of a lack of commitment on the part of the poverty reduction platform to make access and equity a priority. For example, according to Bond and Dor (2003) the World Bank and IMF have not been proponents of eliminating the user fee system in Tanzania. However, even though the World Bank has not encouraged the removal of user fees under their current ‘pro-poor’ strategy, it seems that the Tanzanian government is also not entirely eager to eliminate the fees. For instance, Tanzania’s 2001 PRSP states that “user fees have improved availability, access, provision and use of services by beneficiaries as drugs are now available all the time” (43). Although the PRSP supports the continued use of user fees, critics contend that there is no concrete evidence that user fees have helped improve the system. For example, the REPOA report determines that public health facilities have been experiencing a severe shortage of drug supplies and that user fees have contributed to increased marginalization of the poor (REPOA 2004). The neglect on the part of the Tanzanian government as well as the international financial institutions to address the potential problems associated with user fees suggests a lack of commitment towards equitable health development and the ‘pro-poor’ policies that they advocate.

### **PRSP Actor Collaboration**

Achieving public-NGO collaboration in Tanzania seems essential in order to build ‘pro-poor’ health policy through the PRSP process. Measuring NGO integration and collaboration with government-led health care in Tanzania involves a close assessment of

the extent of the private-public divide, as well as examining what is being done under PRSPs to close the gap and encourage collaboration. Although NGO-led development has been criticised for its potential to be short-term and often northern-based, it appears that the Tanzanian health sector still relies on NGOs to deliver the majority of its services. For example, not only do NGOs provide the majority of health services in Tanzania, but out of 91 health sites that deliver antiretroviral drugs for AIDS, 30 are either run by NGOs or are privately owned (Mwaluko 2004: 6). These statistics indicate that NGOs continue to play an important role in Tanzania's health care delivery system. Further, as discussed above, the lack of public funding available to the government creates a dependence on NGO-run health care. However, an important goal under the PRSP process is to integrate and align private, NGO, and public health services in order to create a more cohesive and 'pro-poor' system.

In terms of resource allocation in the health care sector, some coordination measures have been undertaken in Tanzania under the PRSPs. According to the WHO, the key approach in Tanzania to donor coordination in the health sector is based on the 1999 sector-wide approaches (SWAs), which emphasize "joint and comprehensive planning and programming" (2005: 14). Although SWAs were introduced separately from PRSPs initially, the World Bank has continued support of the government-created SWAs Committee through the PRSP process, where all donors, including NGOs and the private sector, are attempting to coordinate health funding and basic policies (WHO 2005). Essentially, this coordination involves the pooling of funds as well as the synchronization of basic health policy between the government and donors in support of health sector development and a focus on the poor. However, problems associated with



collaboration efforts include a lack of donor participation, and ensuring that health services become sustainable under the short-term contribution of many donors (WHO 2005). In terms of aligning donor policies through the SWAp that focus specifically on the poor, Tanzania has not been entirely successful. For example, Foster and Mackintosh-Walker (2001) point out that Tanzania has made no real commitment to allocate the pooled funding to primary health services, and has only briefly acknowledged that greater 'equity' needs to be generated within the SWAp. Although this example shows that collaboration attempts have been initiated between donors and the government, funding cooperation has not occurred with specific efforts to benefit the poor. It seems that policy initiatives still have to be aligned between the government and civil society, and common goals and actions have yet to be agreed upon.

While funding efforts have been initiated under the SWAp, little collaboration has occurred between the government and NGOs in terms of creating complementary health policy. However, according to the 2003 Tanzanian PRSP, workshops have been conducted with civil society as part of the PRSP process on the subject of poverty alleviation. The report states that "the objectives of these workshops were to raise awareness among sector ministries, regional secretariats, NGOs, local authorities, academia and other stakeholders on the PMS [Poverty Monitoring System] and link it with the local Government Monitoring and Evaluation system" (IMF 2004b: 61). In short, the report indicates that collaboration efforts have been undertaken and discussion has occurred on the subject of poverty alleviation. However, even though issues have been discussed between these groups, there is no evidence of concrete policy formation or efforts toward aligning health delivery systems as a result of consultations. In fact,

authors Gould and Ojanen (2003) reveal in their study of the participatory process in Tanzania that civil society groups had almost no influence in the implementation of policy reformulation under the PRSPs. Rather, the authors claim that “the social and ideological foundations of the PRS are narrow, representing the views of a small, homogenous ‘iron triangle’ of transnational professionals based in key government ministries and donor agencies in Dar es Salaam” (2003: 7). Further, although the concerns of some contributors from civil society, including village representatives, were recorded at meetings, it seems that commitments toward priority sectors such as health and education were in the end placed second by more influential contributors to ‘longer-term structural issues’ (Gould & Ojanen 2003: 7). Overall, despite claims of participation between NGOs and government, there is little evidence of true collaboration thus far.

Although the PRSP within Tanzania has made efforts to integrate funding and policy among NGOs, civil society, and the public sector, these efforts have so far been unsuccessful. The IMF itself has stated that greater participation has occurred in the formulation of PRSPs, but there has been a “failure to translate this into strengthening existing domestic institutional processes” (2004a). In short, although some participatory actions were undertaken when creating the PRSP, the suggestions put forward to improve policy have not been embraced. As Nelson (2002) observes, government consultations with civil society and NGOs have appeared to be leaning toward ‘broad’ consultations rather than focusing specifically on the poor to determine what steps need to be taken to contribute to poverty alleviation. Overall, the initial PRSP within Tanzania suggests that although preliminary steps have been made to create collaboration, actual participation

has lacked depth and concrete steps toward creating improved policy have not been taken.

### **Empirical Results at the National Level: Uganda**

Like Tanzania, Uganda joined the World Bank's PRSP platform early after its introduction, having completed a full report by 2002 (World Bank 2004). Although Uganda ranks 144<sup>th</sup> out of 177 countries on the United Nations HDI and 4.1 percent of people live with HIV/AIDS (HDR 2005, CIA Factbook 2005), it has also been praised by the international community for its economic growth under structural adjustment programs, and most recently, for its participation under the PRSP approach (Muhumuza 2002, Dijkstra & van Donge 2001). Indeed, Uganda has been complimented by the international community for its sense of 'ownership' over the poverty reduction process, having implemented its own 'country-driven' Poverty Eradication Action Plan (PEAP) in 1997, and prior to the initiation of the PRSP. Despite praise, poverty levels have remained high in Uganda, with 55 percent of the population living below the poverty line and with only 44 percent of the population having access to an improved water source in 2002 (HDR 2005). Although Uganda has been deemed successful in its adherence to economic liberalization as well as its ability to lesson the severity of the AIDS epidemic (O'Manique 2004), there are clearly existing levels of high poverty perpetuated by a fragile health sector that the PRSP and the PEAP are attempting to address.

There are opposing views on whether Uganda's development since the 1980s represents a 'success'. On the one hand, Uganda's recent economic success has been measured by its ability to achieve substantial growth under SAPs from the late 1980s (about 6% annually), as well as maintain a strong relationship with the donor community,

including the World Bank (Dijkastra & Van Donge 2001). In terms of health, Uganda has been “touted as the African AIDS success story and the model to emulate” even though health has not been a development focus under SAPs (O’Manique 2002: 136). However, praise of Ugandan participation in SAPs has been criticised as overly optimistic (Muhumuza 2002, O’Manique 2002), as statistics point to high levels of poverty and weak social sectors such as education and health. Within the health sector, current numbers indicate that only 5 physicians exist per 100,000 Ugandans and only 39 percent of total births are attended by a skilled professional (HDR 2005). Although Uganda has managed to lower HIV/AIDS prevalence considerably (to 4.1 percent) since it peaked to about 29.4 percent in 1992 (O’Manique: 136), the health sector as a whole was not made a priority under the economic reforms of SAPs. Rather, government involvement in the funding and provision of health services remained considerably low, and the private sector was left to largely administer all services not considered ‘essential’ (O’Manique 2002). For example, in 1997 only 20 percent of total health expenditure was provided by the government, while the remainder was provided by donors, households and employers (MOH 2000). Furthermore, user fees were implemented in the 1990s as a way to supplement health funding in the public sector, and the health sector as a whole become increasingly fragmented as the government focused on specific programs such as HIV/AIDS and immunization services rather than primary health care (PHC) (Turshen 1999, O’Manique 2002). As a result of the withdrawal of government-run health services, NGOs largely administered health services, while the government followed the World Bank’s advice of “providing policy guidance, coordinating and monitoring the private

sector and NGOs, and ensuring that government bureaucracy did not get in the way” (O’Manique: 139).

Therefore, Uganda presents an interesting case when examining the current application of the PRSPs. Although it has been relatively successful economically under SAPs and maintains a courteous relationship with the World Bank, its social sectors, including the health sector, have struggled because of a lack of funding and government capability. Although the government has been successful in decreasing AIDS prevalence considerably, significant government funding and attention have not been applied to other essential areas in the health sector. As a result, the health of Uganda’s population has declined, with life expectancy being only 46.2 years in 2005 (compared 46.8 in 1980), levels of immunized children declining from 47% to 37% in the past five years, and overall quality of health care becoming depleted (CIA Factbook 2005, Globalis 2006, Jeppsson *et al.* 2005). However, as a result of its adherence to economic reform under structural adjustment policies, Uganda was the first country to be given some debt cancellation under the World Bank’s HIPC initiative (Eberlei 2003). In an effort to utilize the funds made available through partial debt forgiveness, Uganda enacted its first PEAP in 1997, leading to greater efforts to address poverty in conjunction with its economic stability. The paper now turns to an examination of Uganda’s health sector, looking for steps taken under the PRSPs toward stronger policy through funding, access and equity, and collaboration efforts.

## **Funding**

Uganda’s health care funding appears to have risen since implementation of the PRSP in 2000. According to Uganda’s PEAP, its 2002/03 budgetary expenditure in

health was 9.6%, with projections for its 2013/14 expenditure to reach 15.9% (Uganda 2003, PEAP 2004: 199). These numbers indicate a significant rise in health funding from 1997/98 when the budget allocation for health was 6.8% (PRSP 2000: 23). However, there seems to be a constant discrepancy each year between budget projections for health and actual expenditure for health, indicating that the MOH is having difficulty reaching projected rates of health funding (see PRSP 2003: 25). Furthermore, it is difficult to determine why projected funding for health has not been provided under the PRSP. Gumisai Mutume (2003) argues that PRSPs are not making a large difference in alleviating poverty and addressing sectors like health because Uganda has close to 20 other loans worth over US \$1 billion, with which the PRSP has no influence. Mutume points to the Panos Institute who claims that the conditions under these separate loans “are likely to undermine the achievement of PRSP goals” (quoted in Mutume 2003: 3). In short, Uganda still works with conditionality that may limit its ability to adequately fund the health sector.

When putting together its initial PEAP, Uganda created a Health Sector Strategic Plan (HSSP), which “defines a minimum health care package and a health care delivery mechanism for reducing ill health in the country” (Uganda 2003: 108). Essentially, this package is focused especially on the poor, and includes necessary health coverage needed to adequately serve the population, such as immunization services, HIV treatment, health access measures and the hiring of health workers. The Ugandan government has estimated that the cost to deliver the minimum health care package to the population is US \$28 per capita (Uganda 2003). However, public health expenditure has remained much lower than the estimated figure, being approximately US\$ 6 per capita per annum,

which includes donor funds (WHO 2005b: 7). Furthermore, the Ugandan 2003 PRSP notes that the WHO cost estimation of the total health care package is about US \$34 per capita, significantly higher than both current spending levels and the projected levels of spending by the government itself (Uganda 2003: 113). Clearly, the Ugandan government has been and will continue to be unable to meet the needs of its citizens as outlined in the health package, as long as it continues to under-fund the health sector. Although Uganda has produced an ambitious health package that looks to accommodate the health of its poor population, it has been unable to obtain sufficient amounts of funding to reach the projected health standards under the PRSP.

### **Access and Equity**

Under the Ugandan PRSP, increased access and equity within the health sector are critical goals aimed to increase the overall health of its poor population. As a result, Uganda's Ministry of Health has made significant efforts under the new health mandate to increase levels of access and equity within the sector. First, Uganda is one of the few countries to have addressed the issue of user fees within the public health system. User fees were introduced by the Ugandan government beginning in 1988 under SAPs in order to help finance health care (Okello *et al.* 1998). However, the administration of user fees by the government was criticized for its inability to create consistent and coherent user-fee policies, often negatively affecting the poorest members of the population who could not afford fees and would often avoid using the public system (Xu *et al.* 2005).

Therefore, under the World Bank-initiated PRSP, Uganda removed user fees on primary health services in 2001 in order to promote greater health access for the poor (Ibid.).

According to the Ugandan government, prior to the abolition of user fees, cost of health

services was the most cited reason for not using health services (Uganda 2003). As a result of the removal of health fees, utilization rates by the poor have increased substantially, leading to higher access levels across the country.

Although the poor are more likely to use the public system since the removal of user fees in 2001, the 2003 PRSP cites 'quality of services' to be the most recent outstanding issue in promoting access and equity. The report expresses concern that usage of health facilities still coincides with level of income, stating, "the majority of consultations are with private facilities, and the poor are proportionately more likely than their wealthier counterparts to depend on the public sector. In 2002, 44 % (19%) of households in the poorest (top) quintile who consulted a health unit used a public facility" (PEAP 2004: 163). Although use of health services has increased by the poor, it has also been acknowledged that 'out-of-pocket' expenses have increased for the poor since the removal of user fees. In particular, Xu *et al.* (2005) as well as the Ugandan government (PEAP 2004) note that the availability of drugs has decreased since the abolition of user fees, requiring poor patients to buy drugs from the private sector, or go directly to the private sector when needing medical attention. In other words, drug supply cannot keep up with demand as user fees have increased use of the public system and created an influx of people requesting drugs.

In terms of promoting equity within the PRSP mandate, there has been acknowledgement by the Ugandan government that women and children as well as the rural population, have special health needs. However, significant policy efforts have not been initiated to make the system more equitable for these groups. According to the 2004 PEAP, reproductive health services have not improved:



Whereas the rates of antenatal clinic attendances have continued to improve (92% attended at least once), the proportion of deliveries conducted in health facilities has declined from 25.2% in 1999 to 20% in 2002/3. The 2000/01 UDHS found the contraceptive Prevalence Rate (CPR) to be 23%, which is still below 30%, the minimum level necessary to impact on fertility. Constraints include low access to maternity services. . . shortage of inputs such as qualified midwives, reproductive health drugs and supplies, and poor attitudes by staff towards mothers (PEAP 2004: 166).

Although reproductive health results have been unsuccessful under the current PRSP process, the MOH has set up a ‘Task Force on Maternal and Infant Mortality’ with a report to “address the maternal and infant mortality under a multi-sectoral approach” (PEAP 2004: 166). Furthermore, reproductive health commodities have been made a priority under the 2004 PEAP, including the assurance of free drugs and supplies for pregnant women, and family planning supplies for couples. In terms of children’s health in Uganda, the 2004 PEAP has set forward a goal to immunize all children against all ‘priority’ communicable disease (167). Finally, the 2004 PEAP pledges to “operationalise village health teams across the country” in order to make health services more equitable within the rural populations of Uganda. Although Uganda’s most recent PRSP sets forth goals to make the health sector more equitable for disadvantaged groups, concrete policy changes toward these goals are not yet evident.

### **PRSP Actor Collaboration**

Compared to many sub-Saharan African countries under the PRSP mandate, Uganda has been relatively successful in creating an inclusive and participatory process in the health sector among donors, NGOs and civil society. Uganda’s government was able to create greater collaboration among various stakeholders in the health sector through the creation of a SWAp as well as advocating the ‘pro-poor’ approach and

emphasizing participation in the creation of their annual PEAPs and PRSPs. Indeed, Uganda was widely praised (Hutton 2004) for its ability to initiate its 2000 PEAP under a legitimate and participatory process, later turning that document into its first PRSP for the World Bank. Although collaboration measures have been deemed successful, there are some problems within Uganda's health sector in terms of coordinating policies of the various health care providers, as well as implementing all health needs voiced by civil society within the PEAP.

First, it is evident that Uganda was able to organize collaboration and consultation measures among NGOs, government and donors when creating the goals for poverty reduction under the PRSP. Although the final draft of the 1997 PEAP was largely written by government officials, NGOs and civil society groups<sup>4</sup> were invited to help draft the final version of Uganda's 2000 PEAP (Eberlei 2000). Led by the Uganda Debt Network and Oxfam, NGOs set up workshops where various civil society groups were invited to participate in the drafting of the PEAP and help shape policy proposals for critical social sectors, including health (Ibid.). In the creation of its PEAP, Uganda is largely identified as a 'success story' in terms of embracing the principles of ownership and participation (Mutume 2003, Eberlei 2000).

Indeed, Zie Gariyo of the Uganda Debt Network and a major player in the consultation process, noted that the government gave NGOs considerable freedom in their discussion and provided the discussants with information in order to help expand capacity and meaningful dialogue (in Mutume 2003). Furthermore, many of the suggestions from NGOs were fully incorporated into the draft document (Ibid.). However, it has also been noted that some goals put forward by civil society, including

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<sup>4</sup> Both the Ugandan PEAP and PRSP seem to use 'NGO' and 'civil society' interchangeably.

the need to address financial issues in the health sector and the logistics of improving the health sector specifically for the poor, were not outlined in the final document (Eberlei 2000). Furthermore, Gariyo identifies some current challenges in creating a legitimate NGO-government consultation process when creating policy. For example, he contends, “some government officials still regard [civil society] participation merely as an exercise to legitimize the government agenda” (Gariyo 2002: 61). Although Uganda managed to create a fully participatory PRSP process, criticisms from NGOs and civil society organizations exist, as their suggestions in terms of health were not fully included in the final draft of the PRSP.

Like Tanzania, Uganda has initiated a SWAp to the health sector that is supported by the World Bank and works in conjunction with the PRSP and its ‘pro-poor’ mandate. As mentioned above, Uganda’s essential health package was also part of its SWAp, where a national strategic health plan was implemented to help align the fragmented health system and distribute health services to the local communities (Jeppsson *et al.* 2005). There have been mixed reviews on the initial successes of Uganda’s coordination efforts through its SWAp. Since its implementation, pooled government and donor funds have been increasingly allocated (government expenditure increased to 2/3rds) to primary health services for the poor (Foster & Mackintosh-Walker 2001: 4). Furthermore, although sufficient funding has not yet been created to administer its ‘essential health package’, the package focuses heavily on increasing services to the poor, and has been praised for its attempt to coordinate policy with an explicit pro-poor focus.

In addition, greater coordination efforts have been taken through the SWAp and the PRSP to increasingly integrate NGO facilities within the public funded health system

(Foster & Mackintosh-Walker 2001). In fact, NGO facilities are administering funds from the central government for their 'general operations' and "some NGO facilities have been designated as the lead facility within their sub-district, and receive the PHC conditional grant funds" (Ibid: 58). However, Jeppsson *et al.* argue that participation of local authorities in shaping the SWAp have been limited, and that the SWAp focuses more on centralized "simplification of procedures between government and their development partners, rather than address[ing] service delivery problems as related to quality of care" (2005: 317). Nevertheless, one of Uganda's current goals under the SWAp for health is to give local officials and NGOs more influence over the shaping of policy, including the role of 'whistle-blower' over the central government in order to increase transparency and accountability (Foster & Mackintosh-Walker 2001). Overall, although some problems persist in its early stages, Uganda has seemed to focus its SWAp in health on poverty reduction with a clear emphasis on coordinating health policy and collaborating with NGO health-care providers.

### **Analysis of PRSPs in Tanzania and Uganda**

Marginal steps have been taken in Tanzania to increase funding, promote greater health equity and encourage participation and collaboration with NGOs. Overall, no significant policy changes have been introduced within the country in order to stimulate poverty alleviation. Indeed, funding allocation has only increased to 1.2% of government expenditure over three years, no efforts have been made to reduce the equity problems associated with user fees, and collaboration between the government and NGOs has occurred on an infrequent and superficial basis. Although the PRSP program has only been in place for about six years, the World Bank has not displayed genuine commitment

through Tanzania's PRSP and the HIPC Initiative toward improving the pro-poor development of the public health sector. Furthermore, it is clear that the World Bank-prescribed principles of 'governance' and 'participation' have not been successful in Tanzania in terms of creating country-driven, pro-poor health policy. Although the principle of governance in theory sounds practical, there may be problems with its implementation in a country such as Tanzania. As Paul Nelson argues, "the paradoxical concept of 'ownership' means, in the case of the PRSP, that governments adopt a [World Bank] mandated participatory process to develop a *national* plan that implements *international* anti-poverty objectives" (2002: 22). Moreover, it is difficult to determine if the health sector has struggled because Tanzania has not fully embraced the poverty reduction strategy as set forth by the World Bank, or whether the specific poverty reduction measures that were initiated are too restrictive for Tanzania to strengthen its health sector.

Although Uganda has been more successful in creating health policy with a 'pro-poor' focus under PRSPs, it also struggles to implement policy that meets all the necessary elements of the goals set forward. It has increased levels of funding but has been unable to create enough funding to implement its 'essential health package'. Although it has made greater efforts to increase equity, it has not been able to focus on health services that will help the poorest members of society. Finally, although it has been largely successful in creating greater collaboration with NGOs, there are still problems in creating sectoral cohesion between public and private health care providers. Certainly, Uganda has been more successful than Tanzania in creating a development process that is truly participatory and appears to be led through the 'good governance' of

the Ministry of Health. However, despite its ability to follow the broad guidelines put forward by the World Bank, Uganda still struggles to create health policy that meets the needs of its poor population.

Although Tanzania and Uganda have experienced different results under the PRSP process, both have struggled to create policy that has enabled health care to become decidedly 'pro-poor'. Therefore, it seems that poverty reduction strategies have not embraced a truly 'embedded' or 'inclusive' form of liberalism within their mandates. Firstly, based on the limited expenditure increases in both countries since 2000, it seems that health has not been prioritized as an essential sector that needs protection in the development process. Secondly, levels of access and equity, critical indicators in determining the prioritization of health in creating poverty reduction, have not been significantly altered in recent years. As mentioned earlier, Tanzania continues to administer user fees, and has made almost no mention of promoting greater health equity for vulnerable groups such as women, children and the elderly. Furthermore, although Uganda has set targets to promote equity in health for women and children in its last PRSP, there is no evidence that action has taken place. Thirdly, although Uganda has been relatively successful in creating increased collaboration within the health sector, much of this success was initiated within the country under the PEAP rather than under the World Bank-prescribed PRSP. Alternatively, Tanzania has struggled to create alignment and collaboration with NGOs and the private sector in terms of policy, and its SWAp is only at its preliminary stages.

Based on these indicators, health policy has not been protected and promoted as an essential sector for poverty reduction under the PRSPs. Furthermore, based on

Tanzania and Uganda, the PRSP approach does not contain legitimately 'inclusive' policies that protect social sectors in the face of economic liberalisation. The following section examines the potential problems that have undermined the successful implementation of 'inclusive' policies in sub-Saharan Africa, and discusses the possible international barriers that are preventing a legitimate shift toward 'pro-poor' policy in the World Bank's development mandate.

## **PROBLEMS IN ACHIEVING ‘INCLUSIVE’ POLICIES**

While the PRSP development process appears to have become more socially inclusive as it has increased its focus on social policy, in reality it seems that many principles of the neo-liberal approach to development still exist. As can be seen in the Tanzanian and Ugandan case studies, initial results in strengthening health policy in both countries, although different, have been limited. Uganda has seen some greater success in strengthening its health policy, but both countries struggle in implementing strong health policy that will help to alleviate overall poverty levels within their respective populations. In short, it seems that current development policy may be situated somewhere between rejecting the purely economics-focused perspective and attempting to embrace a form of embeddedness that protects domestic social sectors. In order to explain the lack of success in creating ‘pro-poor’ policy under PRSPs, many critics point to neo-liberal principles that still exist within development policy in sub-Saharan Africa, and their inability to truly commit to protections for the poor through social sectors (Bond and Dor 2003, Verheul and Rowson 2002, Craig and Porter 2003, Owusu 2003). The most serious criticism of PRSPs and their attempt to achieve inclusion is that they continue to follow a neo-liberal mandate while touting poverty reduction. Extreme critics such as Jubilee South have called PRSPs “Structural Adjustment in Disguise” (quoted in Bond & Dor 2003: 611) while others have described inclusive liberal policies like those put forth in PRSPs “the best ideological shell of neoliberalism today” (Anderson in Craig & Porter 2003: 55). Although steps have been taken by the World Bank to get away from purely



growth oriented neo-liberal approaches, they are still reflected in the new development approach embodied through PRSPs, and true inclusiveness has not yet been achieved.

Although the above analysis suggests that internal problems such as a lack of resources and capacity have contributed to the inability for poverty reductions strategies to be successful, it also seems that international factors have contributed to these perceived 'internal' problems. In other words, developing countries' complex relationships with donors, international organizations, and the global economy have made achieving national poverty reduction strategies very difficult. Furthermore, global influences, or globalization from the 'top-down' continues to be extremely influential in the way that health policy is formulated at the country level. Indeed, in examining health policy implementation in both Tanzania and Uganda, it seems that the global public good argument is an important rationale behind the World Bank's current policy. Northern interests, driven possibly by global health threats, appear to be a major force behind the renewed focus on health policy in Africa. Below is an analysis of the PRSPs and some possible explanations that have led to their difficulties in achieving social 'inclusivity' for development internationally and in sub-Saharan Africa.

## **Macroeconomic Policy and Poverty Reduction**

While PRSPs promote a renewed focus on the poor, it is also clear that they have retained many of the same economic policies that existed under structural adjustment policies. According to a report put forward in 2002 by the United Nations Conference on Trade and Development (UNCTAD), PRSPs only differ from SAPs in that they include increased spending for the social sectors and introduce 'safety nets' in order to lessen the adverse effects of SAPs on the poor. Although these steps have been taken toward a

potentially 'embedded' framework, the UNCTAD report clearly articulates that little has changed within PRSPs, and that "current policy advice continues to contain all the main elements of the first generation of economic reforms, designed to 'get prices right'" (2002: 6). In short, participating countries under the PRSP approach continue to be tied to many of the growth-oriented economic reforms that have been advocated since the beginnings of the Washington Consensus, including liberalization and "greater openness and rapid and close integration into the world economy" (UNCTAD: 57). Overall, the UNCTAD report questions whether enough has changed within the development platforms put forth by organizations like the World Bank to produce changes that will contribute to positive internal development. Although the World Bank has prioritized poverty alleviation in its pursuit to achieve economic growth in developing countries, it seems that the major development focus continues to concentrate on economic growth, while attention toward health continues to be insufficient. Indeed, the UNCTAD report reveals that the growth-oriented strategies of the PRGF and the PRSPs continue to center mainly on economic reforms similar to structural adjustment policies and place limited emphasis on protecting vital domestic policies such as health and education.

In addition to an ongoing focus on economic growth strategies, existing international policies may be contributing to problems for internal development in the south. Although PRSPs focus on domestic social reforms that can help decrease poverty, they do not address possible international reforms that could alleviate poverty in LIDCs. For example, Craig and Porter (2003) note that PRSPs fail to comment on the realities of international power relations and how these relations affect economic development for the poor. The authors point to "unequal market power, consolidating corporate power,

restricted migration and access to rich economies, and local political realities” as critical barriers that effect economic development and the success of poverty reduction policies (2003: 55). Furthermore, Craig and Porter suggest that the principles outlined in the ‘inclusive’ PRSP approach can appear to be a sort of ‘charity’ or ‘policing’ for the poor while powerful international actors continue to benefit from “existing property and power distributions” (Ibid. 55). Along similar lines, Verheul and Rowson (2002) question the level of dedication toward health policy within PRSPs by pointing to international trade agreements under the WTO such as the Trade Related Intellectual Property Rights agreement (TRIPS) and the General Agreement on Trade in Services (GATS).

Indeed, it seems that the effects of international agreements on the poor and on national health policy need to be carefully “assessed on their potential health impact” if a genuine commitment to improve the health of the poor is to be a real priority (Verheul & Rowson 2002: 391). For example, the issue of drug accessibility in Uganda since the removal of user fees needs to be seriously examined beyond the country itself to explore any links to TRIPS and patent laws. Furthermore, in both the Ugandan and Tanzanian cases, factors attributed to GATS, such as the ‘brain drain’ of medical personnel needs to be further analysed in terms of the negative effects on the overall development of the health sectors. Moreover, the authors point out that further analysis needs to be undertaken to assess the effects of current macroeconomic policies on the poor at the household level. Indeed, it seems that international organizations are reluctant to make ‘pro-poor’ changes at the macro-level but are willing to encourage internal changes in developing countries that continue to benefit international trade and finance. Overall, there seems to be limited progress within the PRSP approach toward aligning and linking

international policies and agreements to country-specific poverty reduction programmes. The lack of 'pro-poor' policy at the international level affects any attempts to create poverty reduction policy domestically, as the effects of global interactions and agreements inevitably affect internal development efforts.

Unlike post-war embedded liberalism where industrialized countries had powers to protect domestic policies in the midst of economic liberalization, developing countries today are attempting to protect and strengthen social sectors while participating in economic liberalization, all of which is ultimately controlled by more powerful international actors. Ruggie (2003) explains the difficulties for developing countries to participate in the embedded 'social community' in both the post-war era as well as today:

The developing countries, of course, never enjoyed the privilege of cushioning the adverse domestic effects of market exposure in the first place. The majority lack the resources, institutional capacity, international support and, in some instances, the political interest on the part of their ruling elites. As a result, large parts of the developing world have been unable to exploit the opportunities offered by globalization for achieving poverty reduction and sustainable development (94).

Although Ruggie emphasizes the possibilities for globalization to create a resurgence of embedded liberalism, including changing governance structures and a stronger global civil society, he also recognizes that the developing world has been largely unable to take advantage of these possibilities. Indeed, although Southern based organizations like NEPAD strive to "halt the marginalisation of Africa in the globalisation process and enhance its full and beneficial integration into the global economy" (NEPAD 2006), many countries have been unable to take advantage of international market opportunities, while they lack the capacity to protect themselves domestically from external forces. Even though the World Bank's PRSPs include principles that are intended to promote

and strengthen the domestic capacity of developing countries while working towards economic liberalization, major problems, including domestic restrictions through conditionality and a lack of international support limit the ability to protect the poor through embeddedness.

### **Policy for the Poor?**

Much of the literature surrounding PRSPs and their attempts to promote poverty reduction in conjunction with economic growth suggests that in order for PRSPs to become more 'inclusive', there is a need to systematically research and analyse the poverty-health links within specific countries. For example, in a study put forward by Laterveer *et al.* (2003) that examines the I-PRSPs published by participating countries, the authors show concern with "the lack of country-specific data on the distribution of disease, the composition of the burden of disease, the prevailing health system constraints and the impact of health services" within the poverty reduction documents (143). In short, the authors find that very little progress has been made in determining what the specific health needs of the country are, and therefore are unable to implement policies that address specific needs. The World Health Organization is also critical of the PRSP process, stating that the commitment is based on "assumptions about what works to reach the poor, rather than a systematic evaluation of the specific needs in the local situation" (WHO 2004). Finally, Laterveer *et al.* (2003) argue that in order for countries to formulate explicit pro-poor national policies they need to include "an explanation of the adopted health approach, setting long-term and medium-term health objectives, a detailed time-line, measurable indicators and the costing of proposed policies" (143). In short, many groups outside the World Bank and IMF argue that this new focus on health policy

does not contain the necessary 'local' elements in which to understand health needs within African countries.

Indeed, although the PRSP approach is advocated as a 'country-driven' approach, it seems that much of the social policy implemented continues to be 'top-down'. A possible problem associated with the World Bank and IMF's new policy mandate is that policy objectives reflect the desires of international actors rather than the needs of domestic actors. According to Best (2003), the international financial institutions are "embedding from the top-down rather than the bottom-up" (376), and are ignoring vital domestic needs. Although Best refers specifically to the global financial architecture, her critique of top-down inclusive liberalism may also apply to the World Bank's 'pro-poor' strategies. For example, both the WHO (2004) and Verheul and Rowson (2002) point to the similar health policies put forward by countries participating in PRSPs as indicators of the lack of insight and analysis when creating policy and examining specific poverty-health links. As seen in the Uganda and Tanzania cases, the most common policy step toward building health sectors is to increase the 'basic package' put forward by the MOH, formulate a SWAp in the health sector, and to integrate more targeted health approaches such as specific vaccination programs or HIV/AIDS treatment programs. However, as Verheul and Rowson state, "the question is whether these priorities really reflect national priorities or merely donor wishes, with large funds being available to tackle the major communicable diseases" (2002: 392). The authors question whether policy implementation through PRSPs is being created on behalf of the poor, or whether Northern interests are simply being addressed through specific targeting of communicable disease.

Again, the lack of country-specific policy within the PRSPs suggests that the multilateral organizations are driven by the public goods argument where global interests, rather than national interests, are being implemented through policy. These popular targeted or 'vertical' approaches to health may not necessarily complement the principles put forth in the Alma Ata Declaration on Primary Health Care which many developing countries have accepted as important in order to serve the health needs of their populations. In addition to encouraging the implementation of specific policies, the World Bank and IMF also continue to be advocates of increasing private health services within the PRSPs (Verheul & Rowson 2002). Although greater privatization of services may benefit the health system in some countries, the World Bank seems to be emphasising reform for all countries, regardless of the unique domestic conditions from one country to another. Therefore, it seems that forms of conditionality exist within health reform of the PRSPs, implying that the strategies are not as 'country-driven' as advocated. Certainly, the focus of poverty reduction strategies in the health sector has been questioned as the implemented policies have been limited in scope and similar across many participating African nations.

### **Unequal Partnership: 'Good Governance' and 'Participation'**

A major problem with PRSPs and their potential to strengthen social policy appears to be their inability to create the 'partnerships' and the true country 'ownership' that they promote. As mentioned earlier in the paper, these broad terms set the basis for legitimizing PRSPs, but are problematic when applied and analysed at the country level. According to Lister (2000) in a study that focuses on partnerships between NGOs and governments, the most commonly noted problem toward the formation of equitable

north-south partnerships is that donors ultimately control the money. Of course, like an NGO-donor relationship, despite any rhetoric of an existing 'partnership', in reality the World Bank and IMF also have ultimate control of the development process. Certainly, without access to funding and the ability to control spending according to their specific needs, there is no means for an LIDC to shape its own development policy. Further, Lister goes on to argue that partnerships are "a Northern-imposed idea which is deeply tied-up with the need for northern aid agencies and NGOs to establish legitimacy for operations in the South and demonstrate their 'added value' in the development process" (2000: 229). In other words, the rhetoric of partnerships may actually help legitimize conditionality and donor interests rather than help promote more equal and understanding relationships between the parties.

Also related to partnerships is the concept of 'ownership', which emphasises that countries involved in the PRSP process 'own' and are therefore responsible for the development policy that they create. In addition, good governance and participation are two principles tied to ownership, as they both contribute to the creation of policy and help to legitimize a sense of country-level control over the development process. Again, it seems that a problem within the PRSP process and its ability to truly achieve inclusivity is that these development principles are difficult to apply in realistic terms. Opportunities for conditionality and a tendency to 'blame' governments for poor policy choices are two negative side effects of the development rhetoric of PRSPs. In other words, because donors define the terms of 'governance' and 'participation' and their roles in the PRSP process, they are able to control the sort of policy development that occurs, and increase funding based on the condition that governments apply these principles to their poverty



reduction strategies. As Owusu (2003) states, PRSPs rely on ‘policy-level’ conditionality which is based on the idea that “aid is more effective in countries with good policies” (1661). Although countries such as Tanzania and Uganda have the ability to create their own policies through PRSPs, these policies are ultimately approved by the World Bank in terms of the levels of ‘good governance’ and ‘participation’ involved, as well as the type of policy developed, before funds are administered. As a result of these development principles, participant countries have a strong incentive to create policy based on World Bank desires rather than what would best achieve poverty reduction in that particular country. Furthermore, as Busumtwi-Sam (2003) argues, “donors have managed to convince themselves that if conditional lending fails to achieve objectives, the problem is not with the programmes themselves, but with the failure on the part of the recipients to implement them properly” (100). In practice, the failure to achieve poverty reduction may simply perpetuate World Bank criticisms of ownership and governance practices in developing countries as well as maintain the Bank’s reluctance to take responsibility of the suggested development initiatives.

Furthermore, although ‘participation’ is a cornerstone of the new inclusive development agenda, there seems to be major problems in the way participation is achieved in policy-making as well as how participation is conceptualized at both by both donors and recipients. Under the PRSP initiative, the World Bank envisions civil society as

Participants in planning, setting priorities and choosing public actions and calls on governments to decide when, where, and how to promote participation in national level policy formation, the budget process, monitoring and evaluation and/or in poverty analysis (Nelson 2002: 20).

In reality, organization of civil society and NGO ideas and initiatives into coherent poverty reduction policy has proved to be difficult in many countries. Degrees of consultation have been varied, and in the case of Tanzania, virtually non-existent as there are no concrete guidelines for countries in terms of acquiring civil society input. Furthermore, the World Bank equates NGOs with civil society groups, defining them both as “organizations that have a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious or philanthropic considerations” (World Bank 2005). This generalization has created problems, as critics have pointed to northern-based NGOs as potentially being detrimental to the development process in the South, while also pointing out that civil society and the state are often interdependent and cannot be easily separated (Nelson 2002, Busumtwi-Sam 2003). Overall, it seems that the role of civil society in the participation process is not clearly defined within PRSPs. Although PRSPs may represent a step towards a more embedded liberal approach through their inclusion of civil society and encouragement of country-driven approaches, in practice local ‘ownership’ over the process through both participation and governance is weak. Domestic actors, both governmental and civil society, have had difficulties putting into practice the development principles of the World Bank. Finally, it seems that the PRS principles of ownership, participation, and governance do not adequately reflect country-specific needs at the ground level. The case studies within this paper reveal that it is difficult to translate these broad ideals into domestic policy that addresses the specific health needs of the country.

## **CONCLUSIONS: NEW DIRECTIONS FOR GLOBAL HEALTH POLICY?**

Within development circles, the Poverty Reduction Strategy Papers are considered a major achievement in terms of prioritizing social sectors in the development plan for LIDCs. Their ‘country-driven’, ‘comprehensive’ and ‘long-term perspective’ towards development implies a departure from past development policies and includes room for countries to protect and strengthen internal social policy. On the surface, it appears that the World Bank and IMF have altered their neo-liberal mandate and are shifting toward a more embedded, or inclusive liberal mandate. Through a comparison of Tanzania and Uganda, this paper has strived to measure the possibilities of inclusive liberalism by analyzing increased domestic protections for the poor within the health sector, with specific focus toward funding, access and equity and collaboration efforts. After examining Tanzania and Uganda, I conclude that although the World Bank’s PRSPs include social welfare principles that resemble a potentially successful model of embedded liberalism, this change in mandate is not, at least yet, producing ‘pro-poor’ policy in terms of health care. Moreover, given the continued underlying reliance on neo-liberal ideology and practices, I suggest that the current development platform will unlikely realise the ideals projected.

Although PRSP policy results have been different in Tanzania and Uganda, in both countries initial success in terms of health policy appears to be limited. An excerpt

from the introduction to Tanzania's third PRSP indicates that social services, including health services, continue to be inadequate in the development process:

Distinct effort has been made to improve delivery of social services such as education, health and water. However, more effort is still needed in virtually all areas. Challenges due to unmet development needs emanate from various angles. There is insufficient translation of macro level achievements to the micro level – hence the need for closer analytical work on growth-poverty linkages and how growth could better benefit the poor. Greater attention also has to be paid to quality and equity issues in the delivery of social services, like education and health; combating the spread of HIV/AIDS and commitment to governance issues (Tanzania's Third Poverty Reduction Progress Report 2003, 1).

Unlike Tanzania, Uganda has had more success in building stronger health policy under the PRSP process. However, problems persist in terms of acquiring adequate funding to implement proposed policies:

The health sector is slowly recovering from the decline in social services experienced during the 1970s and 1980s. The Health Sector Strategic Plan is being implemented in a phased manner, reflecting resource constraints. Priorities include hygiene and sanitation; immunisation; malaria control; information, education and communication; reproductive health and HIV/AIDS. Under the HSSP Government has upgraded infrastructure, abolished user fees in public facilities, provided subsidies to the not-for-profit sector, and upgraded training and enhanced drug availability. As a result, the usage of the public health system has expanded dramatically, though the impact on health outcomes is not yet known (Uganda PRSP 2005: xxiv).

Although Tanzania and Uganda have experienced different outcomes under the PRSP process, with Uganda being more successful in terms of participation levels and increasing equity, significant strengthening of health policy has not occurred in either country since implementation in 2000. Conclusions to be drawn from these results are that the PRSP framework does not provide an adequate, or entirely 'new' development platform to build health sectors and promote poverty reduction, and that international

conditions, including a predominantly neo-liberal macroeconomic order are not conducive to LIDC needs.

Although new international attention has been directed toward African social policy through the PRSP process, this attention does not necessarily indicate a move toward inclusive liberalism. In reality, in examining the health sectors of Tanzania and Uganda, it seems that many neo-liberal principles of development continue to exist while both countries encounter difficulties in reaching the policy goals put forward for poverty reduction. While international development policy has increased its focus on poverty reduction in low-income developing countries through PRSPs, growth-oriented macroeconomic policies, a failure to examine what constitutes 'pro-poor' policy and an inability to translate broad development principles into effective practice have not contributed to any significant rise of inclusive liberalism. In other words, the World Bank's poverty reduction strategies are inclusive only in rhetoric.

Furthermore, although processes of globalisation may have helped to stimulate an international focus on poverty reduction and the potential for a more embedded development structure, many developing countries have had difficulty in benefiting from economic forces of globalization. In short, Poverty Reduction Strategies continue to reflect 'top-down' policy formulation that is influenced more by global health insecurity rather than human rights, efficiency, or an altruistic desire to strengthen primary health services. So far, the implications of this public good perspective imply that health sector policy in both Tanzania and Uganda often serves Northern interests, and that comprehensive primary health care is not a major priority within the newest development platform as the World Bank suggests. Furthermore, individual health needs within

African nations are not being adequately addressed through the continuation of 'top-down' policy that considers global interests before the interests of the poor. Finally, although the rhetoric of 'pro-poor, comprehensive, country-owned' development policy is in place on the part of the World Bank and IMF through the PRSPs, in actuality there has been little genuine commitment toward the building of social sectors that emulates a form of embedded liberalism.

Even though initial results within health sectors are not significant under the PRSP process, it is important not to completely dismiss future possibilities for inclusive liberalism. Poverty reduction strategies do represent an evolution in language, if not yet in substance, from earlier growth-oriented neo-liberal platforms. This suggests that the World Bank may be dedicated to building social programs as part of a global public good development strategy. While more emphasis on health as a human right may be necessary in order to achieve the stated objectives, this global public good approach may be a positive step for health since a renewed focus on strengthening public health care in Africa seems vital in order to achieve sustainable development that works to alleviate poverty and enhance security. In addition, PRSPs are still a relatively new framework and could potentially be tailored to suit country-specific needs for sustainable development that achieves poverty reduction. However, it has not been determined definitely what avenue 'works' to create poverty reduction, and it seems that if they are to achieve this promise, 'new' World Bank strategies need to include tangible goals that truly work from the ground-up, and that strive to implement policies that produce concrete health results for the particular needs of individual countries.

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