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Editor's Introduction

by Meredeth Turshen

Health is a pervasive everyday experience that embodies the expression of fundamental economic, social and political forces that structure and determine our lives. Despite this centrality, health in Africa was not an accepted subject of scholarly study outside schools of public health. Before the 1970s health was viewed as a specialized field best left to physicians and to anthropologists interested in traditional medicine. In the past two decades, that perception has changed dramatically as historians, political economists, sociologists, geographers, environmentalists and others published their research and expanded the field from African health and medicine to health services and the health sector as an important part of the economy.

Paralleling the development of scholarship is the increasing attention of nongovernmental, bilateral and multilateral aid agencies to African health and health care. The United States has been prominent as a funder of health projects undertaken by NGOs, USAID, and multilateral organizations such as UNICEF, WHO, and the World Bank. With this expansion, debates previously confined to unpublicized meetings of national and international medical consultants are politicized as never before and are now commonly reported in the press. It is at this nexus of political concern and scholarship that ACAS enters the debates.

This issue of the ACAS Bulletin highlights several salient health problems in Africa. The aim is to bring the issues to the membership of Africa scholars whose primary field is not public health or medicine. We hope to appeal to those who are concerned about deteriorating living conditions on the continent and wish to know more about the health situation, its causes and consequences, from a progressive perspective. We would like feedback--tell us whether this issue fills a gap and whether it is useful in teaching or if there are other subjects you want to know more about.

The topics selected are among the ones currently debated and likely to be of interest in the classroom--female genital mutilation, AIDS, health policy changes as a consequence of structural adjustment programs, the shift of policymaking from WHO to the World Bank, and the health problems of Africa's growing population of refugees, most of whom are women and their dependent children. The plight of women refugees is illustrated in an article on Rwanda. As editor, I am responsible for this selection of articles written in the main by Africans. My purpose is to publish African voices in a field still too often dominated by white medical men. The article on female genital mutilation best illustrates the very different viewpoint that African women hold on this controversial issue, and it demonstrates the importance of learning these views.

We hope this issue of the ACAS Bulletin will provide useful background to some of the debates around US aid to Africa, which will be presented in the next issue. Readers are invited to send their contributions to Jim Cason (see page 33 for details).

Female Genital Mutilation in Africa: Some African Views

by Salem Mekuria*

An estimated 90 million women in Africa have undergone genital mutilation,[1] a practice commonly and wrongly referred to as female circumcision. It is carried out in about twenty-five African countries and in some parts of the Middle East and Southeast Asia. This ancient and harmful practice, which is justified on cultural grounds by most of its practitioners, has remained a taboo subject for hundreds of years. Despite decades of efforts by a few dedicated health practitioners, educators, religious groups and activists within the African countries where it is practiced, relatively little formal discussion of its effect on women's lives has occurred within Africa or elsewhere. This silence in turn has helped sustain its persistence long after its perceived usefulness as a ritual passage to womanhood.

In the last couple of years, however, a few major events have played a key role in bringing the issue to public attention in Europe and North America, sparking intense interest in the subject by the popular media. While covering the 1993 United States intervention in Somalia, many journalists from western countries were first introduced to the subject, and their often graphic reports widened the awareness about female genital mutilation at home. From France came reports of legal cases involving Malian immigrants who were convicted for excising their daughter. In 1992, American novelist Alice Walker's popular fictionalized account, Possessing the Secret of Joy, featured an African woman who was traumatized by female genital mutilation. Following the publication of this novel, Walker collaborated with British filmmaker, Prathiba Parmar, in the making of Warrior Marks: Female Genital Mutilation and the Sexual Blinding of Women, a film made in the Gambia, West Africa. It was accompanied by a book with the same title. The African woman of Possessing, Tashi, is a sexually dysfunctional, psychotic murderer and martyr, as symbol of us all, a victim without agency or positive will. In 1992, Gloria Naylor's Bailey's Cafe introduced us to Mariam, an Ethiopian Jew, who, mutilated, pregnant and rejected by her people, miraculously wandered into the neighborhood of Bailey's Cafe to be salvaged and nurtured by an American woman.

The American media, with their unique appetite for sensation, embraced such developments and presented female genital mutilation as the major new disaster threatening the African continent. Television programs on female genital mutilation appeared on ABC's Day One, Night Line, PBS's Charlie Rose and Charlayne Hunter-Gault's Rights and Wrongs. Walker was interviewed on NPR's Fresh Air and Talk of the Nation. The print media also had its share of coverage, with New York Times columnist A.M. Rosenthal seemingly taking the lead in condemning the practice. MS., Newsweek, Essence, U.S. News and World Report, and a host of others still continue to keep this issue in the public mind.

With such extensive coverage one would assume that critical background information and context have been firmly in place, setting into motion plans of action for the eradication of

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* This article is a condensation of several essays by African women edited into one piece by Salem Mekuria who is an assistant professor of art at Wellesley College and an independent film maker, from Ethiopia. The contributors are: Rashidah Ismaili AbuBakr from Niger, Associate Director of the Higher Education Opportunity Program at Pratt Institute in New York; Asma Abdel Haleem, a lawyer from the Sudan and a board member of the Center for Women, Law and Development in Washington, D.C.; Seble Dawit, a lawyer, an Ethiopian, working as an independent consultant in human rights; and Nahid Toubia, a physician from the Sudan and executive director of the Research Action Information Network for Bodily Integrity of Women (RAINBOW) in New York.

[1]Female genital mutilation is a practice that involves the "surgical" removal of part or all of the female external genitalia. Reasons most frequently cited by people who practice it include traditional or religious dictates, for hygiene, to secure virginity, to prevent promiscuity and to control sexuality. The equivalent of the simplest form for males is castration.

female genital mutilation. But to get such a meaningful outcome, there must be a dialogue and a sharing of agendas between the people who are in the forefront of this struggle, the Africans on the continent, and the crusaders in the West. However, the writers, broadcasters and proselytizers about this issue in the US and in Europe, Westerners themselves, seldom seem to go beyond treating it as yet another gruesome, primitive pre-occupation--a nightmarish freak show presided by loathsome old women. While a few African professionals have been given minor supporting roles in this debate in the U.S., the tone and focus has neither been initiated nor shaped by Africans.

The first evidence of an effort to bring the voice of Africans into this one sided debate was a New York Times Op Ed piece by a group of African women represented by Seble Dawit and Salem Mekuria. In it, we urged that an examination of the practice of genital mutilation should not be isolated from other traditional practices, harmful or beneficial, and should be seen as part and parcel of all practices that subjugate and oppress women around the globe. We also pointed out that the terms of any discourse which deals with issues such as female genital mutilation, a traditional practice whose roots go very deep into the cultural and social fabric of various societies in Africa, or the agenda for its eradication, cannot and should not be defined in the absence of those who are directly affected by it.

The current representation of and discussion about female genital mutilation, be it in literature, film or other popular media, not only ignores the critical voices of Africans, but makes no attempt to present the context within which the practice perpetuates itself. Although we will not have enough space to respond to all that has been said and done in the short period of the past year, we would like to take this opportunity to address the intervention by Alice Walker and Prathiba Parmar, which seems to have caught the feminist imagination elevating female genital mutilation to the position of signifier for all the evils of gender oppression. We believe that Walker's novel, Possessing the Secret of Joy, the highly popular film and book co-produced with Parmar, Warrior Marks: Female Genital Mutilation and the Sexual Blinding of Women, have uprooted the problem of genital mutilation from its context, reduced all other struggles by African women to one issue, transplanted it, kidnapped it, and placed it in the hands of some liberal feminists who are more concerned with the preservation of the clitoris over and above the humans of whom it is only a part. The scene is now one in which the proverbial professional mourners weep louder than the bereaved. "We talk a lot about power, usually male power, in the women's liberation movement. But seldom is the power some groups of women have in relation to other groups of women acknowledged."

Like all forms of literary and visual production, feminist production reflects the class position, concerns, ideological orientation, and overall world view of those individuals. In our opinion, a revolutionary/empowering production best articulates the interests of the majority of women, especially those from the so-called "Third World," which includes the continent of Africa. Empowering feminist production has the responsibility to expose not just the practices, but the institutions, structures, and systems that embody and perpetuate the oppression of women. Through a clear analysis of the contradictions that are inherent in these, such works should name, articulate, and denounce the identified forms of oppression, creating consciousness specifically targeted at the oppressed. They should validate the humanity and dignity of the victims, depicting them as people who possess the potential to change the oppressive conditions that militate against their full realization, infusing them with a spirit of determination and a thirst for revolutionary change. The feminists' task, therefore, is to facilitate the empowerment process; not to take it over, or to dominate the victims' struggle.

Warrior Marks, the book and the film, both set in a village of the Gambia, do more harm than good to the cause at hand. The story begins with Alice Walker's re-telling of how she lost one eye when she was three years old, and how, for years, she felt handicapped and isolated. She referred to her brother who inflicted this wound on her as a "warrior" with a gun, and the blinding or her eye, a warrior mark. She blames her parents for giving her brother the gun and by implication for allowing him to mutilate her. She then goes on to say: "It is my visual mutilation that helped me to "see" the subject of genital mutilation." (Warrior Marks, p.18) The warrior/macho syndrome may be to blame here, but, what leap of imagination, what historical suspension bridge could link two drastically different acts. Without diminishing Walker's pain and loss, we would argue that the equation she draws and the basic premise of the film is erroneous. Her mutilation was intended to injure her and this may have excluded her from her community, while the tradition of genital

mutilation of women and girls is primarily intended to protect them from greater harm and to include them into their communities. If her basic premise is wrong, how sound then are the rest of the arguments that permit her to locate herself as the speaker for the voiceless?

Indeed, the depiction of the victims of this oppressive practice in Warrior Marks is so demeaning that the overall effect is one of denigration rather than empowerment. The African women subjects are presented as a collection of helpless bundles of mutilated creatures, stereotypes who are far from being living, dignified human beings. They are pitied and patronized, instead of being cherished, nurtured, and invested with faith as human subjects potentially capable of understanding and changing the conditions that dehumanize them. "The painful debates around the question of differences between women are a reminder that, when arguing the case for a feminist gaze and an effective feminist intervention in mainstream culture, it is prudent to consider just who is looking at whom!" (The Female Gaze, Shelagh Young)

In Warrior Marks, the book, Walker tells us of big Mary, a Gambian woman whose daughter, little Mary, has recently been circumcised. Among other things, Walker tells us that she asked big Mary about sexual pleasure, and proceeds to inform her about the harm done to a woman's sexual response by genital mutilation. "'Well,' she replied, 'my sex life is perfectly satisfactory, thank you very much!' (How would you know, though, I thought.) I said a heartfelt Good for you! slapped her palm, and let it go." (Warrior Marks, p.44) This negation of big Mary's experience patronizes and effectively reduces Mary to a minor who is oblivious to what she is missing.

In the same manner, Walker confronts an elderly woman who is identified as a circumciser. The woman is dressed up for the filming occasion and sits looking proudly at the camera. Walker proceeds to ask her what she uses to perform the mutilation. The old lady declines to answer, claiming that it was a secret, that no one is supposed to speak about it. Undaunted, Ms. Walker blurts out the answer to her own question.

The village is the most internal culture and geographic manifestation of self within the African experience. What goes on in the village reflects a historical continuum of traditional culture. The old woman is the most private personage in the village. And in the case of this particular village, the Secret Society women are among the most respected personalities. In fact, one of Walker's informants in Senegal related to her that in their language, there were no words with which to discuss female genital mutilation. So, does the power to appropriate the master's language give Walker and Parmar the license to humiliate respected elders, the mothers and grandmothers, who must insist on the un-speakability of this archaic practice, mainly because it is not within their power--linguistic, social, or political--to articulate the experience? What was accomplished by this macho gesture? Does Alice Walker, with her thousands of dollars and hours of film, really think that she has the only answer to this intractable problem? Is this answer the one she proposed through Tashi, in Possessing the Secret of Joy, to assassinate the mother/mutilators?

As the camera roamed, giving us glimpses of those multicolor clad images of African women lazily sauntering by, it seemed to be probing Freud's "Dark Continent" in search of the missing or "blinded" genitals. Walker condemns the practice with statements about her deep love for African children. Surely she can't mean to malign African parents' capacity to love their children and to protect them from danger! It is hard to believe that Alice Walker is not aware of the implications of such an invasive approach. Are we now to focus our attention on Africa as a continent of physically mutilated, psychologically deficient, and mentally deranged women who, as she presumes in her book, have to "chew on their sticks to keep from exploding?" (Ibid.)

A puzzling but contemptuous attitude permeates Walker's book and Parmar's film. While locating female genital mutilation as one among a host of oppressive practices to which the African woman is subjected, the writer and filmmaker proceed to make it clear that they are in the Gambia to deliver their own version of things. They are out to scold and condemn, and have no time for explanations and/or discussions with the very people whom they have gone to such great lengths to save. They hardly discuss, in any meaningful way, the wider context within which possible methods of eradicating female genital mutilation can be effected. Much like the early explorers of the "Dark continent," their journals are riddled with notations of the harsh climate, their greedy guides and the discomfort of being in an underdeveloped country.

What was truly lost in this situation was the educational moment. Perhaps, with a little more careful planning beforehand, and serious and

meaningful consultation and collaboration with grass roots activists, Walker and Parmar would have produced a book and film which African educators could use as part of a larger continent-wide campaign against the practice. A better approach might have been a willingness to examine how various cultures and groups of parents across time and place have honestly believed this violent act to be a loving one and ultimately for the benefit of their children. The diverse and diffuse situations in which FGM is considered acceptable becomes significant only in seeing the true complexity and depth with which the tradition is entrenched in a wide variety of cultures. The fact that various forms of female genital mutilations still persist suggests that the groups who perform the practice have a strong sociological investment in it.

Commonly cited reasons for the preservation of the practice include: cleanliness, aesthetics, prevention of stillbirths, promotion of social and political cohesion, prevention of promiscuity, improvement of male sexual pleasure, increased matrimonial opportunities, good health, fertility and for preservation of virginity. (The Circumcision of Women: A Strategy for Eradication, Olyanika Koso-Thomas, p.5) Some societies believe that undergoing this practice has a healthy calming effect on women as well as help them to regulate fertility. It is also important to note that in most African societies, fertility is a tool of negotiation for women to earn power within the family and the society at large. By undergoing genital mutilation, women are prepared to negate sexual feeling and to view themselves only as fertile beings, as if by removing the sexual parts of themselves they retain only their fertility. Furthermore, women are socially expected to show that they have no sexual desires. This is not uniquely an African condition. It exists in every society where unequal gender relations dictate the conditions under which women have to live.

The persistence of female genital mutilation in Africa cannot, therefore, be separated from the power imbalance in gender relations, from the low levels of education, economic and social status of most women. The latest United Nations figure shows that 75% of African women over the age of twenty-five are illiterate. (The World's Women, UN Publication, 1991, p.46) At fifty years, African women have the lowest life expectancy in the world (Ibid., p.56), with maternal mortality rate of 675 per 100,000 live births. (Ibid., p.58) Europe has less than 75 per 100,000. Furthermore, it belongs squarely within a **continuum of gender oppression** that includes the murder of female children, less health care for girls, less nutritious foods, less schooling, harder work, child marriage and early pregnancy, breast implants/reductions, anorexia nervosa, and the millions of dollars we spend on cosmetics and harmful diet programs. All of these stem from an ideology of women as producers and reproducers, objects, imperfect as we are, to be shaped and molded, cut and tucked, into a more appealing commodity for man's pleasure. Neglecting to make the connection between the physical pain suffered in female genital mutilation and other, less obvious yet equally powerful ways in which women suffer, results in a shallow--if not irresponsible-- analysis of the issue.

The current furor in the West about female genital mutilation, and particularly here in the U.S., strips the practice from the social and political reality of gender relations. How effective can this ultimately be in helping African women? Raising the social status and economic independence of the African woman are factors as important in and integral to determining her overall health and happiness as will be stopping her genitals from being excised.

The work of several women's groups in Africa are instructive in supporting our argument. Maendeleo Ya Wanawake Organization in Kenya, after successfully doing qualitative and quantitative studies among four national groups, is now implementing strategies for eradication developed by women from and for their regions. The Uganda chapter of the Inter Africa Committee trains traditional circumcisers for other profitable vocations and has seen exciting results. The Association for the Progress and Defense of Women's Rights (APDF) in Mali works closely with the government to develop policy level intervention on female genital mutilation within the framework of violence against women. There are several other groups working to eradicate this practice in every country where it exists. Our task should be to find out how all these groups are faring, ask them what they need to advance their struggle and how best they can use our special talents.

Those both inside and outside of the "village" can help to socially and economically empower the women who are our elders, to come together and find a rite that will achieve the desired ritualistic need. As the "village" consists of men and women, children and elders, they too must be included in the process. If outside

agencies would like to help, let them sponsor a Council of Women to come together from the four corners of Africa and other areas of the globe, to develop a non-invasive, non hazardous means of ritualizing passage and status. Encourage positive usage of various holy books--the Torah, the Bible, and the Koran--to point the way. Support the work of locally based African women who live daily the realities and can propose sensible interventions. But, for any of this to have meaning, we must first locate and challenge our own position as rigorously as we challenge that of others.

Health Issues of African Refugee Women: Challenges and Possibilities

Kabahenda Nyakabwa, M.Sc.

Introduction

The principal purpose of this paper is to illustrate that despite considerable efforts made by the United Nations to respond to their specific needs, refugee women are far from achieving the objectives set by the UN Decade for Women: Equality, Development and Peace.

Regional conflicts, such as those in Ethiopia, Liberia, Somalia, Sudan and Rwanda, have had a devastating impact on the physical, social, psychological, emotional, and sexual well-being of African refugee women and their dependents, who constitute a significant proportion of refugee and displaced populations (Camus-Jacques 1989, Forbes-Martin 1992, UNHCR Feb. 1995). Women, whether in refugee camps or in their countries of origin, are the backbone of their societies (Forbes-Martin 1992). Because of the vital role women play in the survival of children and families, and in the sustenance of their national economies, the ill health of African refugee women has serious implications for successful repatriation and resettlement and effective participation in development. It is imperative, therefore, that the UN and other agencies that assist refugees take more effective measures to respond to the needs of African refugee women.

Health Issues of Women Refugees

Sexual Exploitation

Sexual abuse, rape, prostitution, and consequently sexually transmitted diseases and mental illness are the most common health problems that specifically affect the health of African refugee women (AIDS Analysis Africa 1995, 10-11; Aitchison 1984; Demeke 1990 News From Africa Watch 1993; Nyakabwa and Lavoie 1993; Physicians for Human Rights Record 1991, 3). Statelessness, lack of rights, refugee experience, gender, and the total breakdown of community and traditional protective systems expose women to violence and sexual exploitation when they do not have male kin to protect them against external aggression (Nyakabwa and Lavoie 1993).

In the course of flight and in refugee camps, women's health is compromised through violations of their physical safety including sexual exploitation, rape and prostitution. Women often have to render sexual favors to border guards and military personnel in order to cross a border (Forbes-Martin 1992). Once inside the camps refugee women are sometimes subjected to further sexual harassment and exploitation by bandits, as in the case of Somalis in Kenya, guards, and refugees from within other clans (News from Africa Watch 1993). At times women have to render sexual favors to male distributors of food and other rations in exchange for basic commodities (Forbes-Martin 1992; News from Africa Watch 1993; Taft 1987).

The need for increased local and international protection of refugee women from rape and sexual exploitation is urgent. This is the only way that women can be spared from sexual torture by male refugees, camp guards, or the police.

Rape

Rape is another health hazard that refugee women face during flight and inside refugee camps. The rape of Somali refugee women in Kenyan camps, Liberian refugee women in Cite d'Ivoire, and Rwandan refugee women in Tanzania and Zaire has been well documented (AIDS Analysis Africa 1995, 10-11; Physicians for Human Rights Record 1991, 3).

As News from Africa Watch has illustrated, Somali women were "being raped both because they are refugees and because they are women...it is their gender which motivates their attackers to target them --as women--and to do so with a sex-specific form of abuse--rape." Rape, which refugee women experience because of their gender, statelessness and lack of protection by their countries of asylum, leaves indelible marks on their physical, emotional, and sexual health. Survivors of this ordeal in Kenya reported medical disorders associated with sexual trauma, including "venereal diseases,

infertility, miscarriage, menstrual disorders, abdominal pain, vaginal discharge, persistence of severe and/or chronic pelvic pain and insomnia." (Refugee Participation Network 1994, 19). In addition, women are exposed to the risk of sexually transmitted diseases, HIV and AIDS as a result of the rapes and/or prostitution.

The rape of women refugees has critical implications for their health, their personal and community development, and their status in society (Nyakabwa and Lavoie 1993). In African society, a woman who is raped is subjected to triple victimization: first as a victim of her gender, second as a victim of a crime for which she has no redress, and third as a victim of a society that further victimizes her by blaming her for a crime that she did not commit. In addition to her lower social status and lack of rights, a woman who is raped is in a far worse situation than other women because she loses everything: her chastity, her self-esteem, as well as peer, community and family support. To escape the social stigma, some women may resort to suicide. The testimony of a 16-year old Somali rape victim mirrors the plight of raped women in African society. "Now I am treated like a prostitute, the only thing I want now is to be buried alive and disappear from this world" (cited in INSCAN 1993, 3).

Prostitution and Sexually Transmitted Diseases

Another problem that poses a major health hazard for female refugees particularly in the current period of the AIDS epidemic, is prostitution. In addition to the trauma and stress of refugee experience, is the risk of HIV infections, which are considered a growing public health threat because of increased exposure from rape and prostitution in refugee camps, notably in Tanzania and Zaire. A recent study carried out by the John Snow Institute and the African Medical Research Foundation (AMREF) on refugees in Tanzanian camps found that prostitution and HIV/AIDS are causes for concern. Male refugees apparently turn to prostitutes out of boredom while unaccompanied women are forced into prostitution for economic reasons. The study reported that as a result of "rape and forced marriage, both of which are common, an estimated 12,000 to 15,000 women will be pregnant by the end of 1995" (AIDS Analysis Africa 1995, 2).

The atrocious sexual crimes committed against the women of Rwanda are now coming to light (Montreal Gazette 1995, B3). This situation demands immediate and urgent attention at the UN level. It is estimated that up to 5,000 pregnancies resulted from the rapes. Because adoption is culturally unknown in Africa, unwanted babies are left by the wayside and are dying of neglect and starvation (ibid.). Since abortion is not only illegal, but also socially unacceptable, some women are resorting to clandestine and very dangerous abortion practices, while those who chose to carry pregnancies to term face a life of misery and seclusion as the probability that a man will "marry a woman who has had the child of a militiaman" is very slim (ibid.). Such women fall into the "the women-at-risk" category and deserve special protection. "Lack of accessible and adequate health services and trained medical personnel implies that complications from pregnancies and septic abortions cannot be effectively treated and the result is death of some refugee women of child-bearing age (Forbes-Martin 1992, 3).

Mental Trauma

Physical assault, rape, robbery, family separation, loss or death of relatives and friends, and the collapse of social support systems, result in mental trauma (Jablensky et al. 1994). According to the UNHCR, "depression and post-traumatic stress disorder often follow such experiences (UNHCR Guidelines 1991, 53). However, mental illness among African women refugees is both a pervasive and complex issue (personal interview with Caroline Lavoie). The western mental health model based on psychiatry is inappropriate to African situations because the majority of Africans, in particular those of rural background, understand mental sickness to be a function of heredity and or witchcraft and not a consequence of trauma. Furthermore, people suffering from mental illness tend to be stigmatized, and this affects both their social relations and their chances of third-country resettlement. Consequently, there may be a tendency to hide and to avoid seeking help. Culturally sensitive programs need to be implemented, and cultural interpreters should be employed in order to respond effectively to the needs of such refugee women.

The UN Response

In the last decade the United Nations has undertaken considerable efforts in ameliorating the situation of women all over world. Programs responding to the specific needs of refugee women have been implemented.

During the past decade, issues of refugee

women have received greater attention within the UN system. Following the UN's declaration of 1975-1984 as the Decade for Women's Equality, Development and Peace, a World Plan of Action was adopted and it drew special attention to the specific problems faced by refugee women. In July 1980, the mid-decade meeting in Copenhagen adopted specific resolutions relating to refugees and displaced women (Forbes-Martin 1992, 94). The meeting "urged the UNHCR, in co-operation with other concerned UN agencies, to establish programs necessary for dealing with the special needs of displaced and refugee women, especially in the areas of health, education and employment." (ibid.)

In 1988, a gender-sensitive program known as "women-at-risk" was implemented. The aim of this program was to identify women at risk and to offer an opportunity for resettlement in third countries to women who would not otherwise have qualified. These include refugee women who are vulnerable due to traumatic experiences such as rape, torture, and loss of family members.

In 1989, the UNHCR created the position of Senior Coordinator for Refugee Women to coordinate UNHCR initiatives on behalf of refugee women. In 1990, the Executive Committee approved the Policy on Refugee Women, which was subsequently endorsed by the General Assembly. More recently, the UNHCR recruited rape counselors to assist rape survivors in Kenyan refugee camps and in Bosnia-Herzegovina. A Women Victims of Violence (WVV) project was also implemented in October 1993 to support women survivors of rape in Kenyan refugee camps. The WVV project aims to empower refugee women through training of their leaders, and conducting seminars in all refugee camps in Kenya, the sensitizing of police working in refugee areas to the rights of refugees in general and those of refugee women in particular (UNHCR Information Bulletin, 1994, 10). Nonetheless, one of the major challenges facing the UNHCR is lack of adequate resources to expand its activities and programs to cover all refugee populations. As Mrs. Sadako Ogata, the High Commissioner has stated, "If the UNHCR is to have a real impact on anything other than the superficial symptoms of current refugee-producing crises, a concerted effort is required within the United Nations family as a whole in its efforts to address the political, humanitarian, and economic dimensions of current emergencies." (Ogata 1993, 295)

Challenges

The formidable challenges and dilemmas faced by the UNHCR and other international relief agencies must be acknowledged. Ad hoc camp conditions, along with exceptionally large numbers of refugees, plus the political, social, cultural, and religious contexts of the countries of first asylum in which the UNHCR and other agencies operate, all contribute to make these challenges awesome.

In dealing with emergency situations, the non-political nature of the mandate of the UNHCR essentially means that its intervention in a given refugee situation depends on the good will of the host government and poses several problems. Due to political sensitivities and the agencies' fear of expulsion, the UNHCR and other agencies may not be in a position to intervene effectively to stop abuses and injustices meted out to refugees. They often find themselves in a doublebind, in that speaking out against the violence of the police and camp guards may result in their own expulsion. Yet, should they leave, many more refugees would suffer as they would no longer have anyone to advocate on their behalf. For example, in the wake of expulsions of Somali refugees and the rape of Somali refugee women in Kenya in 1993, the UNHCR could do no more than object through diplomatic channels (BBC Summary of World Broadcasts 1993; News from Africa Watch 1993).

In addition to gender inequalities and absence of women's rights, cultural and religious barriers often impede the effective intervention of foreign workers. Despite the prevalence of rape, sexually transmitted diseases, and rape-related pregnancies, the majority of refugee women may come from religious backgrounds that do not accept contraception and do not discuss sexual matters openly, particularly when the interlocutor happens to be someone from another culture. The threat of STDs, HIV/AIDS notwithstanding, both male and female refugees resist using safer sex devices such as condoms. A survey of Rwandan refugees in Ngara camp in Tanzania found that 89% the refugees knew that condoms prevented the spread of STDs and HIV, although only 14% had used them (AIDS Analysis Africa 1995).

Other challenges to relief workers include the apathy demonstrated by women refugees towards contraception and the lack of communication among themselves. According to a UNHCR official, "women have to be

mobilized to help themselves but if the women are not motivated, it is not going to be helpful." Without their will to participate, these goals cannot be accomplished.

Relief work regarding issues of nutrition, STDs, HIV/AIDS, can only be effectively accomplished through the re-education of both male and female refugees. This education requires relief workers to help refugees transcend cultural and religious beliefs and practices which have inadvertently exposed them to health hazards. This has been effectively achieved in Kenya where male and female relatives are counselled to overcome stigmatization of raped women. According to Pat Marshall, the UNHCR Resettlement Coordinator in Ottawa, "Education has proved to be a valuable means of responding to local customs that prove harmful or dangerous to women...providing women with information about their rights can also be a dynamic means of overcoming cultural constraints and increasing the participation of women in UNHCR-funded activities."

Possibilities

The concentration of large numbers of refugees in refugee camps for long periods of time constitutes a problem as well as an opportunity. Refugees may temporarily lose their homes but not their physical, social, and intellectual capabilities. The vital role of women in human survival places refugee women at the center of the balance of production, reproduction, and sustainable development (Smyke 1991, 5). Refugee women should be seen as agents of change and not victims of it. Empowering refugee women will ultimately contribute to more stable societies in Africa.

Refugee camp settings offer an environment where large numbers of people can be reached for the provision of basic education, skills training and other forms of developmental assistance. The UNHCR, the Red Cross, CARE, Médecins sans frontiéres (MSF), and other humanitarian agencies are provided with a unique opportunity to educate camp dwellers and equip them with survival and conflict resolution skills, so that they will be able to leave these camps healthier than when they arrived.

Refugee camp settings should provide an excellent opportunity to train women, and mothers in particular, in preventive health care and sanitation. An example of such training is the successful HIV/AIDS education program implemented by relief agencies such as AMREF, CARE, Population Services International (PSI), and the Red Cross, among camp dwellers in Tanzania (AIDS Analysis Africa 1995).

Strategies for Action

The importance of women in the sustenance of their families and their societies cannot be overemphasized. However, African refugee women cannot play a useful role in their societies unless they are healthy and involved politically in the decisions affecting their future. To that end, the following strategies are proposed for implementation at the UN and local levels.

At the UN level:

1. Human rights education and conflict resolution skills must be integral components of all relief work.

2. The UNHCR must be the avant-garde for raising public awareness through the UN system and at other educational fora regarding the plight of women refugees and the issues affecting their health.

3. Refugees generally, and refugee women in particular, are not only a concern for the UNHCR and the international agencies, but also a concern for the world community. There should be a mechanism at the UN level for ensuring that countries which are signatories to the UN Convention and which provide asylum to refugees live up to their obligations. It is lack of adequate international and local protection that has exposed refugee women to sexual violence in refugee camps in the former Yugoslavia, Kenya, Rwanda and Zaire.

4. The recruitment of more female protection officers and counselors must be encouraged. The UNHCR and other relief and humanitarian agencies need to gather female health-related data and to present it to decision-makers within the appropriate UN bodies and funding agencies.

At the local level:

1. Basic primary health care must include increased attention to maternal and child health, family planning and safer sex education, as well as gynecological and STD screening services and these must be available and accessible to all refugees.

2. There should be more female health workers, adequate clinic hours, and convenient health services targeting women and children who constitute a significant number of refugee

populations.

3. Refugee women must participate fully in the planning and implementation of health services.

4. Health-care workers and traditional birth attendants among refugee populations must be identified and trained to take-over management of health care facilities when staff of international organizations such as MS, CARE, and the Red Cross finally leave the field.

5. Because male refugees who are trained to serve as medical assistants often leave camps for resettlement abroad or employment outside the camps (Forbes-Martin 1992), training programs should target more women because they tend to be are more stable.

6. More culturally sensitive programs should be implemented. Expatriate NGOs tend to favor their expatriate staff and in most cases programs put in place ignore local sensitivities, bypass local institutions and marginalize local resources (Minear 1993, 235).

7. Culturally appropriate mental health services in refugee and settlement camps need to be established to handle cases of emotional trauma associated with fleeing persecution, physical violence, uprootedness and lack of traditional support systems.

Conclusion

In conclusion, this paper has demonstrated that African refugee women are much further than any other group of women from attaining the objectives set by the UN Decade for Women: Equality, Development, and Peace, and that the African refugee crisis has had a devastating effect on the physical, psychological, and sexual health of African refugee women.

The example of Rwanda has demonstrated that local integration, voluntary repatriation and third country resettlement may not be durable solutions to the African refugee crisis. After more than 30 years in exile, the Rwandan refugees have forcibly regained their country and created a further refugee crisis of unprecedented proportions. This indicates that UN must move beyond short-term ad hoc emergency relief measures and focus on long-term solutions that will help to prevent the root causes of refugee movements. Long-term aid with the objectives of human rights education, gender equality, conflict resolution skills and democratic governance will prove much more effective than short-term emergency measures.

As long as "priorities of refugees continue to be based on ideological criteria such diplomacy and respect for the principle of non-interference in the affairs of sovereign states instead of objective assessments of the needs of refugees" (Walkup 1994), African refugee women and children will continue to bear the brunt of Africa's social and political malaise. There is a need for urgent action at UN level to put an end to this state of affairs.

References

AIDS Analysis Africa (January/February 1995): 11-12. "A First: AIDS Work With Refugees."

Aitchison, Roberta. 1984 "Reluctant Witnesses: The Sexual Abuse of Refugee Women in Djibouti." Cultural Survival Quarterly Vol. 8, no. 2, 26-27.

BBC Summary of World Broadcasts. 27 July 1993. "Kenya: Government Denies that Somali Refugees Have Been Forcibly Repatriated."

Camus-Jacques, G. 1989. "Refugee Women the Forgotten Majority." in Refugees and International Relations, Gil Loescher and Laila Monahan, eds. Oxford: Oxford University Press.

Demeke, T. 1990. "Refugee Women's Survival Strategies and Prostitution in Eastern Sudan." Paper Presented at the Refugee Participation Network 7.

Forbes-Martin, S. 1992. Women Refugees. London: Zed Books.

International Settlement Canada (INSCAN). Winter 1993. Vol. 7, No. 2. "Somalis in Canada." Carleton University, Ottawa: Research Resource Division for Refugees.

Jablensky, A. et al. 1984. "Refugee Mental Health and Well-being: Conclusions and Recommendations." In Antony J. Masella, Thomas Bornemann, Solving Ekblad, and John Orley, eds. Amidst Peril and Pain: The Mental Health and Well-Being of the World's Refugees. Washington, DC: American Psychological Association.

Minear, L. 1993. "Making the Humanitarian System Work Better." In Kevin M. Cahill. ed. A Framework for Survival: Health, Human Rights, and Humanitarian Assistance in Conflict and Disasters. New York: Basic Books.

Montreal Gazette. 4 March 1995, B3. Lindsey-Hulsum. "The Smallest Victims: Unwanted Babies of Women Raped During Rwandan Genocide are Dying of Neglect."

Nyakabwa, K. and Lavoie, C. 1993. "Sexual Violence Against Refugee Women in the Horn of Africa." Paper Presented at Conference on "Gender Issues and Refugees: Development Implications" York University North York, Canada, 9-11 May 1993.

News from Africa Watch. 1993. "Seeking Refuge, Finding Terror: The Widespread Rape of Somali Women Refugees in North Eastern Kenya." Vol. 5, No. 13, 4 October. Africa Watch Women's Rights Project.

Ogata, S. 1993. "The Plight of Refugees: Issues and Problems Affecting Their Humanitarian Needs." In Kevin M. Cahill. ed. A Framework for Survival: Health, Human Rights, and Humanitarian Assistance in Conflict and Disasters. New York: Basic Books.

Physicians for Human Rights Record. Summer/Fall 1991. "Liberia: Women and Children Gravely Mistreated." Boston, MA.

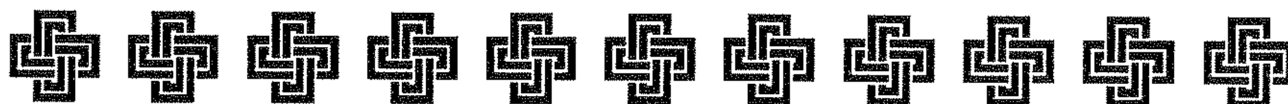
Refugee Participation Network. March 1994. No. 16. Fouzia Musse. "Women Victims of Violence: Rape in Kenya's Refugee Camps."

United Nations High Commissioner for Refugees (UNHCR), Ottawa. February 1995. "Refugees at A Glance."

UNHCF Information Bulletin, Nairobi. September 1994. "Women Victims of Violence Project (WVV)."

Taft, J.V. 1987. Issues and Options for Refugee Women in Developing Countries. Washington DC: Refugee Policy Group.

Walkup, Mark. 25 October 1994. "The Organizational Culture of UNHCR: The Myths of Humanitarianism and the Dysfunction of Benevolence." Unpublished Paper. University of Florida, Department of Political Science.



Women as Victims of Power Conflicts: The Case of Rwandan Refugee Women

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Editor's Note: As we go to press, Rwandan government soldiers have closed the Kibeho camps at gunpoint, in the process massacring an estimated 2,000 to 8,000 people, and Zaire is threatening to expel the 1.2 million Rwandans sheltering in camps along its border. The New York Times reported that fourteen people from Ndera camp were beaten and stoned to death when they returned home (May 1, 1995). The situation described in this article is critical, and the solution called for--an international forum where Rwandan women of all ethnic backgrounds could meet and find common grounds for a lasting peace--merits the closest attention and widest possible support.

Many articles were written in the aftermath of the genocide that killed up to one million Rwandans and uprooted another two million. But to date the international community has made no effort to analyze the social, political, and psychological impacts of that war on uprooted Rwandan women, especially Hutu women who are suffering both as refugees forced to flee their country, abandoning their homes, jobs, and possessions, and as women with specific needs including the need for special protection against political manipulation, sexual and physical abuse and exploitation, and sexual discrimination in the delivery of goods and services. The civil war took the form of a genocide, which placed all Tutsi on one side as victims and all Hutu on the other as killers. Hutu women caught up in the war face an additional burden: the stigma of being labeled as killers.

Hutu women are not killers, many are victims of the ethnic conflicts fomented by those who fight for power in Rwanda. What did the civil war accomplish for women? It deposed one government and installed a different one. What we deplore in these circumstances is the weak position that women are always in; they can do nothing to stop or prevent such catastrophic events from happening. As in many other situations in their lives, women suffer from men's delusions of grandeur and, because of their status as women, they suffer most the consequences of men's games.

This article attempts to analyze some of the conditions of Rwandan refugee women in order to make the international community aware of their situation, to look beyond the political manipulation of ethnic identity, and perhaps try to help alleviate their suffering.

In order to evaluate the current situation, it is necessary to understand Rwanda's patriarchal social system and its impact on the refugee crisis. Specific problems of Rwandan women cannot be understood without discussing gender relationships. In Rwanda, a common saying is, "l'homme c'est le roi," and male domination is reflected in all sectors of life; women are totally dependent on men's decisions and will.

Ethnic identity

Rwandan women do not choose their ethnic affiliation, nor do they pass theirs on to their daughters. Under the patriarchal system in Rwanda, women inherit their ethnic identity from their father. During Belgian occupation every Rwandan over seventeen years old was required to carry an identity card that named the bearer's ethnicity. These cards played a major role in engraining ethnic tensions in the population. Even when groups intermarried, the father's ethnicity was passed on to the children, perpetuating divisions between groups. The identity cards enabled the Belgian colonizers to enforce ethnic divisions and create a system in which the numerically smaller group of Tutsis (15% of the population) ruled the majority Hutu (83% [other small groups account for 2%]). Ethnic identification continued to exist after independence from Belgium, more because of social class than physical differences. The relationships of these two groups were those of rulers and ruled, and women were also affected by those social subdivisions.

Women's work

The sexual division of labor is an important aspect of the patriarchal life of Rwandan women. In the rural areas, women do most of the domestic work by themselves, while at the same time they also bear and rear children. Often a pregnant woman continues to have responsibility for heavy farming tasks such as carrying water and taking care of domestic livestock, even as she is carrying a one year-old baby on her back. Men help women in farmwork but not with domestic duties at home. This sexual division of labor persists in the refugee camps where women have to walk very long distances to find firewood or to carry water in order to prepare food for the whole family. Men's only duty in the camps is to carry the heavy food sacks that have to be hauled long distances into the camps.

Gender and Education

Patriarchy plays out in unequal educational opportunities. Traditionally, girls leave school much earlier than boys because agricultural, domestic, family, child rearing, marketing and bartering duties are so onerous that women need their daughters' help as early as possible. The man, especially the husband, is the master of the household and he is the only one allowed and able to make decisions even for his wife; the woman is required to fulfill all the needs of her 'master'. For many men, the good girl is not necessarily the highly educated one, because if she is economically independent, she will not be easily subordinated. The good girl is the one who respects her husband in all circumstances without arguing. This situation has a very big impact on the education of girls in the country, and it reduces women's opportunities when they have to compete with men on the job market.

Girls do not get the same opportunities as boys for secondary education because many parents believe that a girl's diploma is her husband. It is also said that there is no need to invest in the education of a girl, because immediately after she graduates, it is time for her to marry and go to her husband's family. Girls' education is seen as an investment in another family's interests.

Things changed a little when some parents realized that girls who had a diploma were helping their families better than boys, for example by building a modern house for their parents before marrying. Even so, today more boys than girls attend secondary school because of the patriarchal system and because mothers need their daughters to help them in domestic duties, and also because the society as a whole still insists that all girls must be married.

Intermarriage

Intermarriage between Hutu and Tutsi is commonplace, but the exchange is not equal. More Tutsi women marry Hutu men than the reverse. One reason was that, under Belgian rule, more Tutsi than Hutu girls got the chance to attend school and, after the revolution in 1959, the new Hutu leaders who needed educated wives married Tutsi. This was also an opportunity for Tutsi who were evicted from power to keep a position in the ruling class through their daughters. The marriage of Tutsi men to Hutu women, though it did occur, was not common because as a minority the Tutsi wanted to preserve the purity of their ethnicity. It was also uncommon because Hutu girls did not like to marry Tutsi men because of class differences; they wished to avoid the situation of being treated as an inferior by their family-in-law.

Women are sometimes confronted by many problems in intermarriages because it is always the woman who is mistrusted, especially during periods of conflict when one ethnic group turns against the other. The woman finds herself caught between her natal family's interests and the interests of her husband and in-laws, so much so that it becomes impossible for her to reconcile both sides. You can imagine the trauma of women in this situation when the two ethnic groups are in conflict and start to kill each other. Such conflicts exist even when husband and wife belong to the same ethnic group but do not come from the same geographical area. Even in a period of peace, in-laws always try to create problems in an intermarried family.

The Gender of Relief Workers

Another impact of the patriarchal system in Rwanda that is replicated in refugee camps is the predominance of men among employees; in relief organizations, particularly CARE International, the locals working with refugees are all men. One reason is that more men than women speak French, which is mastered only at the secondary school level. Given the fact that boys are privileged before girls to attend secondary school, most girls seldom learn any language but Kinyarwanda, which restricts their opportunities for advancement. Rwanda is a

bilingual country: Kinyarwanda is spoken at home and French is taught in school as the official language for education, business and government. The most important requirement for social mobility and empowerment is to be able to understand, speak, read and write French. Thus refugee women were not qualified to do some of the jobs available in the international relief organizations because of the language handicap. Only men who have mastered French could get access to those jobs.

Patriarchy and Land

Under existing laws in Rwanda, property passes through male members of the household. Women's property, including land, passes to their sons, and women without sons face many problems especially in the countryside where land is the most valuable property. The situation is more dramatic for widows who face the suspicion of being responsible for their husband's death, a pain added to that of losing their loved ones. Widows in Rwanda are seen as bad luck. Their life is difficult even in periods of peace because many of them are stripped of their property by in-laws after the death of the husband, or they are forced to marry one of their in-laws to keep the deceased husband's property within the family. In the situation of war today, many widows and single mothers who head their households now face the risk of losing their property.

Lack of trust

An aspect of the Rwandan society related to geography rather than ethnicity or patriarchy is the division of the country into two main blocks, north and South, which are politically opposed to one another. This factor also plays a major role in the separation of different groups and reinforces the mistrust already existing in the Rwandan community. Relief workers were made aware of this problem in the refugee camps:

> We were told by various Rwandans themselves that the lack of trust among individual members of the community particularly does not help women's efforts for advancement, because there are few natural structures through which they can work with each other to improve their situation. The UNICEF officer in Kigali told us that day care centers have never been successful for working women in Rwanda because they do not trust another person taking care of their children. The same type of distrust among neighbors has impeded many efforts to develop income-generating projects at the community level. This insistence on privacy and independence probably means that development will be extremely slow, because even if a woman learns a new skill or a new piece of information (about the benefits of family planning, for example), she may not share her knowledge with a neighbor or friend. (Wulf 1994:29)

The lack of trust and a strong need for privacy are reflected in refugee camps and camps for displaced people, where each family immediately tries to built a small house for more privacy; this special need makes emergencies even more difficult. Unaccompanied women suffer from this situation because they have to build a small house by themselves which is not easy.

The Refugee Crisis

The exodus to Goma in July 1994 was described as the most rapid and large-scale population movement of recent decades. Within hours, one million or more desperate people, relieved of many of their possessions by the Zairian soldiers at the border, arrived in Goma, a small town on the northern shores of Lake Kivu without the infrastructure to support such a significant and rapid influx of people (Moran 1994). In that situation of intense stress and overcrowding, worsened by the lack of food and clean water, a cholera epidemic started and more than 20,000 people died, many of them women and children.

The situation in the Goma camps illustrates the kind of distress women face as refugees. Women were in a quite critical position in that situation of total breakdown of social order. They suffered greatly from the lack of organization and became the real victims in a Darwin world where only the fittest survived. According to the International Rescue Committee,

> Only the strongest could meet the challenge to walk far distances and wait in lines to receive food, medicine, and shelter. Women trying to care for their families faced the greatest challenges. More often than not, they walked away from lines empty- handed. From the beginning there had been no organization among the people to care for or protect

themselves. The camps were in complete disarray. Along with outbreaks of cholera and dysentery, signs of malnutrition and mental disorders began to surface. The refugees found themselves in dire circumstances--life-threatening diseases, a gross lack of food and shelter, lack of leadership, sheer exhaustion, the loss of loved ones, and hostile threats from the military and each other. (Moran 1994:11)

What could women do in that competitive situation where everything conspired to exclude them? "When village chiefs for example were asked to create lists of persons needing medical attention for a tent-to-tent visit program, the list consisted mostly of men." (ibid.) Rwandan refugee women in Zaire found themselves and their children without any support system. Many did not know how or where to go for shelter or food rations. Two weeks after their arrival in Zaire, 67% of female heads of household had no appropriate shelter or food, nor did they display the will to procure them. Many laid down and died with their children next to them. It was not uncommon to find a mother with two or three of her children lying dead next to each other. It is not surprising that women gave up; it was not possible for them to do anything.

Many of those who fled to Goma had already experienced harsh conditions in the camps for displaced people inside the country. Most of the refugee population in Goma are people from the northern part of the country who had suffered the trauma of the war since its beginning in October 1990. Refugees in the Goma camps are Hutu because, after the Rwandese Patriotic Front (RPF) took power in Rwanda in June 1994, the former Hutu Government fled to Goma and Bukavu. Along with the Government large numbers of Hutu from northwest Rwanda crossed the border, as did many people from other areas who took refuge in the west when Kigali (the capital city) was attacked.

Most of those who died of cholera and other diseases, most of those who were being denied food and shelter, who were desperate, who were ill-treated by the Zairian soldiers but also by the Rwandan military and militia, most of those who became mentally ill--are Hutu women. Many are rural women, others are nurses and teachers, many are mothers and wives, and some are innocent girls who don't know anything about the real motives of the war and had never been involved in the killings but who also experienced the loss of loved ones. They are now refugees only because a Tutsi Government ousted a Hutu one. They are now suffering and living stressful life conditions because of ethnic conflicts and power struggles. Why?

Why did all of these women have to flee when it was obvious that they had not been involved in the killing? There were no women in the militia, but women had to flee with the militia. Women did not participate in the politically and militarily motivated killings, but they are the ones who are suffering the most in the aftermath of the war.

Impact of Refugee Policies on Women in the Camps

The critical situation of refugee women is worsening as the international relief community adopts new policies. Those policies- -to stop food and all kinds of help for Rwandan refugees in the camps--are meant to force refugees to return home. As such they violate rights of the refugees who need protection against forced return to their countries of origin. The situation is still unclear in Rwanda, as returning Tutsi occupy land and homes abandoned by fleeing Hutu.

In her Washington Post article, "Rwanda: Help the Victims, Not the Murderers," Catherine O'Neill asks, "Why are they helping the murderers and not the victims?" (January 1995). She proposes that humanitarian aid be stopped for refugees and instead that help be given to people and the Government inside Rwanda, because "Those camps are run by murderers, thieves and the politicians who planned and implemented the slaughter of Tutsi people." She forgets that those camps are mainly populated by women and children who are not "murderers, thieves or politicians" but victims of war. She states that "What has happened in Rwanda should force policy makers in the United States and in the United Nations to reconsider some of their suppositions. Should people be entitled to international relief on a long-term basis just because they march across an international border? If they are able to stay in their country and work on their farms, should the United Nations spend millions to keep them alive and organizing themselves for a political struggle that might have genocidal intentions?"

O'Neill believes the answer is no, but I think that there is no clear answer. By answering no, it means that you agree that aid should be cut for those refugees. But if those people were able to stay in their homes, they would not choose the life of a refugee, especially in a camp like Goma

where even basic needs for food, water and shelter are not met. Who will suffer the most from the application of that policy? Why have people been fleeing Rwanda since October 1990? What are they afraid of? What kind of structures have been created in Rwanda for the returnees? Why are some refugees who returned to Rwanda now leaving the country for a second time? Why are some Tutsi, those who remained in Rwanda and are called "old Tutsi" in the media, now leaving Rwanda? Where are the interests of refugee women in this situation?

Refugee women are the real victims in this situation and their human rights are being violated. On the one hand, they do not feel that they can return home because of the insecurity created by the RPF's retaliatory actions against Hutu and because of the unresolved issues of homes and land now occupied by the 'new' Tutsi who arrived from exile. On the other hand, women cannot stay in refugee camps because they are being denied aid on the grounds that there are militia in the camps. By cutting the food aid for those refugees, the situation worsens for women already at risk in camps where militia threaten even aid workers and refugee women become the prey of the militia.

Many of those women, especially widows and single women who are the heads of their households, not only face the risks of the unprotected, they also face the problem of losing their property because now their rights of property are uncertain. This situation has an impact on refugee women's decision to return home because they may not be able to survive.

Is There a Solution to this Situation?

The situation of the Rwandan conflict is complex but the refugee situation can be solved if there is an attempt to find a fair solution that puts the interests of women and children first. Women are real economic resources and these resources have often been underestimated. The Rwandan crisis provides a good opportunity for Rwandan women to step forward in the search for a lasting solution for the country, a solution that allows the two ethnic groups to live together in peace, sharing everyday life, without one group feeling the need to leave because another stepped into power. Women must make an effort to bring both sides together. The international community can help women initiate such a meeting and help in the implementation of their recommendations. Women should initiate discussions and interactions between the present government in Kigali and the refugees outside the country.

Rwandan women can use the crisis as a tool to change some traditional practices and introduce positive changes that will provide women with access to land, credit and technology. Now that the country is facing a large number of widows and single- woman headed households, old laws, such as the law of succession and land-property, have to be revised. If women are to be able to use the land, they must have secure rights. These concerns can profitably be discussed only in a forum where women have a voice and the right to express themselves. There are now many single mothers in Rwanda who will have to take their destiny in their own hands without the help of men. New structures have to be put in place to meet their needs and especially to protect them. They need protection to feel confident and strong enough to work and provide all their needs by themselves for their families.

The fears of women refugees have to be understood before the United Nations forces them to return to Rwanda where they feel unsafe. The refugees should be given the chance to express themselves and explain why they don't want to go back home. The Rwandan Government must demonstrate that it can guarantee the safety of returning refugees and that it will help them recover their property. Sima Wali, founder of Refugee Women in Development, an NGO that advocates respect for the rights of women refugees, writes: "The physical protection of women and children upon return to their homes must be guaranteed. In order to ensure the safety of at-risk populations, it is important to assign joint teams of international agencies and female returnees to develop workable protection plans and monitor their implementation...Monitoring to reduce human rights violations will succeed only when all parties, including refugee service providers and refugees themselves, work together" (Wali 1995:342).

Regarding the situation of Hutu refugee women, a dialogue has to be initiated between them and the Tutsi refugee women who went back to Rwanda; the two groups should share their suffering and try together as women to find a solution to their problems. Women of both groups suffered more than men in their lives as refugees because of their gender. Both experienced discrimination, hunger and all kinds of abuses because of their gender. Not many women in both groups are involved in politics and power plays, but many have suffered abuse and starvation--even at the hands of men of the

same ethnic group. Both groups have to go beyond ethnicity and discuss the situation as women who need long-lasting peace for their families and their country. Women share the same feelings of caring and nurturing and they can be united as women, united by their gender to save the country from collapsing. By putting gender first, Rwandan women will have a forum to discuss their own problems, which are their families' problems and their nation's problems.

References

Moran, Mary. 1994. "Population at Risk: Fleeing Terror in Rwanda." Women's Commission for Refugee Women and Children, International Rescue Committee, New York.

Wali, Sima. 1995. "Human Rights for Refugee and Displaced Women." In Women's Rights, Human Rights: International Feminist Perspectives, edited by Julie Peters and Andrea Wolper. New York & London: Routledge.

Wulf, Deirdre. 1994. "The Camps for the Displaced Population in Rwanda." In Refugee Women and Reproductive Health Care: Reassessing Priorities. Women's Commission for Refugee Women and Children. New York: International Rescue Committee.

Disinvesting in Health: The World Bank's Prescription for Africa

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Health care in Africa is in crisis. The signs are compelling: from the resurgence of diseases previously controlled to the crumbling of health facilities; from the unconscionable downward trends in the quality of life for children to the exodus of health professionals. These signs are the health consequences of the continuing impoverishment of the mass of Africans, despite over ten years of adjustment programs designed and led by the International Monetary Fund (IMF) and the World Bank to address the economic crisis in Africa.

The World Bank's response is the benchmark publication, the World Bank Development Report 1993: Investing in Health [World Bank 1993a]. An accompanying publication, dealing specifically with Africa, is Better Health in Africa [World Bank 1993b]. These reports lay out the future global direction of health care into the 21st century. This paper explores the critical health financing policies recommended by the World Bank Development Report from the perspective of the broader shifts of health and development in Africa. Drawing on research in Plateau State, Nigeria in 1987 and again in 1992, the paper argues that, unlike the chilling World Bank position that espouses "this is all there is", options do exist. These options address the two fundamental inadequacies in the World Bank's vision of health care: the absolute need to increase resources for health, and the imperative to democratize health policy-making communities.

A New Context for Health and Development

In 1978 the World Health Organization (WHO) was the lead agency in health and development, as signaled by the important WHO-UNICEF document, the Alma Ata Declaration [WHO-UNICEF 1978]. Between Alma Ata and the publication of the 1993 World Development Report there has been a major discursive shift away from the language and practice of social welfare to that of market efficiency. As well, the period has witnessed powerful struggles for hegemony within the UN system itself, as WHO ceded leadership of health and development to the World Bank (see related article by Turshen). Under the Bank's leadership, economic issues have been elevated, while social concerns have been hived off and relegated a derivative status. IMF/World Bank-led economic stabilization and adjustment programs (SAPs) are the programmatic manifestations of the dominance of economic over social issues. The IMF, World Bank and multilateral banks, which together make up the international financial institutions, are the critical instruments of a new global order of "flexible accumulation" that gives much more autonomy to finance capital [Harvey 1989]. This new mode of capital accumulation has conditioned the discursive shift.

The 1993 World Development Report and Better Health for Africa are the germinal "workbooks" for realigning health care to market responses in Africa. Unlike the Alma Ata text, the World Development Report is studiously apolitical. Whereas concerns around inequity and poverty were central at Alma Ata, the Bank removes these issues from the realm of struggle; they reappear as questions of technical competency for health planners and economists. For instance, the report introduces Disability Adjusted Life Years (DALYs), which express the estimated loss of healthy life due to different diseases, to measure the burden of disease and for calculating cost-effectiveness of interventions. Those interventions best able to reduce the overall disability at an affordable cost are prioritized in a recommended minimalist basic care "package".[1] DALY calculations give the

[1] The Bank's prescription is to limit public sector health care to a "package" of selective PHC interventions--MCH, family planning, basic service, and education. Any services beyond this level--chronic care, laboratory services, X-ray, surgery, emergency care--are deemed to be more efficiently offered in the private sector.

appearance of being accurate, objective and value neutral. However, they mask deeper questions about the relationship between ill health and the processes of impoverishment underway in Africa. To uncover that relationship, the political and economic nature of these processes needs to be analyzed.

Broadly understood, contemporary Africa is a dissonant conjuncture of two elements. On the one hand, as formal sector activities stagnate under SAPs, transnational corporations (TNCs) are concentrating control over dispersed production sites through informal sector subcontracting to feed the export market. TNCs' interests are reproduced at the local level by state organized ruling classes who also profit from Africa's highly unregulated and exploitative labor markets. As vast numbers of jobs are discarded, or reconstituted within sub-sectors of labor in a new round of primitive accumulation [Meagher 1991], and as social programs are clawed back to service the debt, people struggle to create innovative survival strategies. The health consequences of these dynamics appear in Africa's distressing health statistics.

On the other hand, new forms of popular struggles are emerging, which Chazan characterizes as the survival of a "deeply democratic tradition ... ensconced in local political cultures" [Chazan 1988:130]. These struggles take on explicit dimensions--class, gender, ethnicity, religion--and occur around the everyday experiences of impoverishment--IMF riots, bread riots, petrol riots, which in turn spawn new rounds of state repression. In the health sector, popular struggles to provide health services and to create alternative approaches to health care emerge and re-emerge [Owoh 1995].

The international financial institutions play a critical role in facilitating the new order. The World Bank and the IMF are restructuring African economies under SAPs to ease transnational corporate control of African labor markets and export products [Chossudovsky 1992]. Popular struggles are neutralized and brought inside the global market agenda in a process of "globalization" of social welfare [Fowler 1992]. For instance, struggles around health are attenuated by opening sites of health care to private for-profit providers and non-governmental organizations (NGOs). Indeed, the private sector now accounts for more than three-quarters of all health spending in the Sudan, Uganda, and Zaire [World Bank 1993b:103], and in Kenya, NGOs provide 40% of health care services [Fowler 1992].

The World Development Report describes the prospects for health in Africa as bleak. However, it offers these strategies for moving forward: encouraging a greater role for the private sector; raising public sector efficiency through cost-sharing arrangements; and encouraging developed countries to target their aid to health care. The next section assesses these policies in terms of their contributions to efficiency and equity.

Financing Health Care

Privatization

The World Development Report encourages an expansion of the private sector based on its purported contribution to enhancing sectoral efficiency. The Bank argues that the private health sector is "an efficient means of pricing and allocating health goods and services," and that "competition from the private sector can also work to improve efficiency in the health sector as a whole and in public services in particular" [World Bank 1993b:108]. Thus far, little evidence is available to show that these policies actually work. Rather, experience indicates otherwise, as the following data from Nigeria reveal.

In Nigeria, the colonial political economy established a mix of public and private health care [Schram 1971; Ityavyar 1985; Owoh 1987]. With the introduction of SAPs in 1986, a marked change occurred in the balance between these sectors. For-profit facilities increased dramatically as health professionals shifted from the underfunded public sector to join entrepreneurs in the private sector. The expansion is concentrated in cities, and more money circulates in private care than in public and mission care combined [Plateau State Ministry of Health 1991].[1] In Plateau State, private facilities now serve 62% of the 30% of population who have access to health services.

As the naira, the national currency, continues to deteriorate, prices of all basic goods including drugs and services have increased from 100-700% [Olukoshi 1992]. In turn, both government and private health facilities have raised the cost of their services.

[1] The 1992 study of Plateau Sate, Nigeria found that between 1981 and 1991 private facilities had increased from 23 registered for-profit medical establishments to 645 for-profit and 149 mission facilities [Plateau State Ministry of Health 1991]. In the study, medical institutions are defined as hospitals, clinics, maternity homes, laboratory and X-ray centres.

The private sector operates in extreme laissez-faire conditions, often chaotic and dangerous, while many facilities operate unregistered [Owoh 1987]. Under SAPs, the capacity and willingness of the Nigerian state to regulate private facilities has declined even further. The institutions required to ensure adequate standards of care have been eroded, and the medical profession is not organized adequately to provide self-regulation. Furthermore, the legal system does not have the capacity to control provider behavior through malpractice suits.

The Nigerian data present a strong case for the inappropriateness of applying a market-driven model to health care in Africa. The problems of private firms operating in markets where there is no explicit public interest are magnified when private firms are charged with delivering a public good that requires universal and inexpensive access. As uninformed consumers with limited medical knowledge, lay people are open to exploitation, more so where education levels are declining [UNDP 1993]. As public services are undermined through budget cuts, people have little choice but to trust private professionals who are supposed to act in their best interests--as many do. But the private sector has its own structural interests that push health care costs upwards, and in the absence of strong public capacity to regulate and coordinate, is not held in check. Indeed, research shows that many Nigerian health practitioners and related professionals, such as pharmacists, are linked in a class/professional nexus that does not serve the public good [Ityavyar 1985]. Under SAPs the exploitive aspects of this nexus have been sharpened.[1]

Rather than enhancing sectoral efficiency and widening choice in the health sector as a whole, competition from the Nigerian private sector further reduces the capacity of the public sector to address health needs. The state has neither the commitment nor the countervailing strength to hold private interests in check.

User Fees

Cost-sharing, to use the euphemistic term for user fees, was first introduced in Nigeria in the 1980s for a limited range of services in an early attempt to meet budgetary shortfalls. In 1986, user fees were raised dramatically and covered a wide range of services--preventive, curative, laboratory, administrative, X-ray, and equipment.[2]

A number of critical concerns emerge when user fees are introduced, more so where communities are impoverished. The first is the effect on utilization rates. For instance, deliveries in Jos University Teaching Hospital dropped from an average of 800 to 160 per month following the introduction of fees, while home deliveries increased by 13% [Owoh 1987]. A second concern is the transfer of the burden of health care from the general population to the users of the system. As costs shift to those who use health services, the portion paid by the sick increases, and as a group, the sick are more likely to be poor. This places an inordinate burden on those least able to bear it.

A final concern challenges the "willingness" of African households to spend on health. Better Health for Africa argues that "there is convincing evidence that households and communities are willing to expend substantial out-of-pocket sums for health...indicating considerable scope for mobilizing private resources, even within poor communities" [World Bank 1993b:2]. There is evidence, however, that increased health costs are paid by foregoing adequate nutrition and education, especially for girls [UNICEF 1990; UNICEF 1992; Pearce 1994]. Just because people are "willing" to pay for services does not mean they are able. Moreover, it is questionable, in the current context of underpaid health workers, widespread corruption, and declining purchasing power, that such charges could generate sufficient revenue to finance social service improvements or expansion.[3] The

[1] For example, in the treatment of a large sample of cases of diarrhoea, it was found that expenditures were some thirty times higher than they need have been, largely because of the use of specialty antibiotics which were not required, but which were available only at pharmacies linked to particular physicians [Isenaklumhe & Ovbiawe 1988].

[2] Four groups were exempted from the increases: health workers and family members, TB patients, lepers and 'paupers'. In practice, the exemptions were difficult to apply [Private communication with Dr. Davou Bot, Christian Health Association of Nigeria, November 1994]. In Zimbabwe it was found that the policy of free treatment for those earning below Z$150/month, and for patients with certain chronic conditions, was also very difficult to implement [Renfrew 1992].

[3] A case in point is the Plateau State Ministry of Health that estimated the revenues from user fees to be N2,711,250 and N2,800,000 for 1990 and 1991

poorest countries cannot afford the estimated cost of US $12 per capita for the basic package. Clearly, to finance sound health care restructuring, sources of financing other than the poor must be found.

International Health Aid

Foreign aid provides an increasing portion of the financing of government functions. Two problems are associated with foreign aid as a source of health financing. The first is the amount of aid available. In 1992 UNICEF estimated that an additional US$900 million per year is required over the period 1993-95 to implement even modest health care goals. In 1993 the World Bank increased the estimate to US$1.2-2.2 billion per year. The required donor share, between US$637 millions and US$1 billion per year, would be about double the amount now provided from alternative sources, a prescription that is unrealistic in the present atmosphere of declining overseas development assistance.[1]

The second problem concerns contradictions between national and donor interests. As African countries comply with donor initiatives, "'vertical' administrative entities emerge parallel to existing health systems, bypassing instead of contributing to national capacity building" [World Bank 1993b:39]. Not only do some donors fail to contribute to national priorities, but also others run counter to the policy of the government. As the capacity of the public sector to undertake a leadership role in health care is undermined vis-a-vis the private sector, the government has less control of health care, coordination disappears, arbitrariness is heightened, and there is an increasing number of people nobody cares for.

The impact of foreign aid goes beyond the delivery of health care. Indeed, sovereignty itself becomes compromised. According to Fowler [1992:26], "sovereignty becomes meaningless in a situation where primary government functions--security, economic management, the selection and implementation of public policies--cannot be minimally guaranteed or undertaken unless externally negotiated and financed." Fowler, among others, calls for a reappraisal of NGO funding and development strategies.

What are the Options?

The World Development Report and Better Health for Africa present us with a chilling message: "This is all there is. This is the best that can be done given the present conditions." But is this the case? I argue that the Bank must be prepared to re-examine both the context and the process of health restructuring, if its concern for poverty, and the health consequences of poverty in Africa, is to be taken seriously. Two fundamental issues have to be addressed. First, there is an absolute need to increase financing for health. The Bank has questioned the present inter- and intra-sectoral maldistribution of public resources by African states, drawing attention to inappropriate tertiary level health spending and defense expenditures. Two further questions must be asked: How does the growing African debt, overseen by the World Bank, relate to the health crisis? What opportunities does a re-examination of the debt crisis offer for increasing budgetary allocations for health care in Africa?

The debt burden in Africa continues to increase with sub-Saharan Africa leading in debt accumulation, as new debts are acquired to pay off old debts. Total debt stock grew from US$84.3 billion in 1980 to US$210.6 billion in 1994. The total debt service ratio (total debt service to exports of goods and services) is 11.8%. More disturbing, however, is the growing problem of the debt owed to the Bank itself, a debt that cannot be rescheduled, cancelled or reduced. Multilateral debt consumes up to 45% of debt servicing for some sub-Saharan African countries [World Bank 1994].

An important aspect of the health crisis in Africa is the relationship of health spending to debt servicing. Countries classified as 'low' per capita spenders on health average only 0.5-0.6% of GDP. The Bank rightly points out the inappropriate level of spending on defense. In Nigeria, for instance, 1.4% of total government recurrent expenditure went to health care in 1990, while defense took 8.9% [World Bank 1993a:103]. But Nigeria also spent 42.4% of total recurrent government expenditure on debt repayment [[Central Bank of Nigeria 1990].

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respectively. Actual revenue was less--N1,339,698 (1990) and N777,536 (1991) [Plateau State Ministry of Health 1991].

[1] For instance, in Canada in 1991 the ODA/GNP ratio was 0.46%, in 1995 it is 0.38%. A 10% cut to ODA [minimalist projected 1995 budget figure] spread equally over the next three fiscal years, would reduce the ODA/GNP ratio to 0.32% in 1997. A 20% cut would shrink the ratio to 0.28% [maximalist projected 1995 budget figure].

Military expenditures pale in comparison to debt repayment, a fact not considered in the World Development Report.

Despite a succession of adjustment programs, the economic situation remains weak and far too high a proportion of national budgetary resources and foreign exchange reserves is diverted towards debt servicing. These resources could have been invested in schools, health, skills training, basic infrastructure, agriculture and economic development.

The presumption that the poor should pay for the health crisis needs to be re-examined in light of debt repayments. Other questions must be asked. What is the origin of the debt? Which social groups, both borrowers and lenders, are responsible for and benefitted from the debt? Which social groups are paying? An authoritative and growing body of literature suggests ways to move toward substantive debt cancellation and reduction [Government of The Netherlands 1990; UNICEF 1993; Mistry 1993; UNCTAD 1993; Helleiner 1994]. The World Bank can no longer stand outside the circle of responsibility and limit its engagement to debt collection and strong-arm prescription.

The second fundamental issue to be addressed is the need to democratize the health policymaking processes to ensure greater equity for the poor. The triumphalism of `market efficiency', reverberating in Africa's empty clinics and hospitals, does not provide adequate health care for the growing numbers of poor. When social commitment is reconstructed as market efficiency, the only entry for health and justice issues is through continual monitoring and evaluating of health markets. But the evaluation of health markets and the concept of market failure needs to include the effects of markets on both the structures of power and the processes of human development [Bakker 1992:28].

Diane Elson believes that "democratizing the resource allocation processes of market and state" is required to allow for greater control by people over their daily lives. Aspects of such a strategy would entail: [i] greater accountability and openness in the policymaking process at national and international levels; [ii] alternative international sources (to the World Bank and the IMF) of expertise for designing development strategies; [iii] tougher regulation of international firms including disclosure, financial and social accountability; [iv] a recognition that intervention in markets is not always a 'distortion' but may diminish bias; [v] use of a wider range of indicators, including human indicators, to judge the success or failure of programs; and [vi] developing more effective regulation of markets [quoted in Bakker 1992:30].

If health markets are to accommodate human development, alternative institutions that promote equity and democracy need to emerge alongside markets and be strengthened. The task is to monitor health markets and debate policy alternatives by extending the range of policymakers to include not only the World Bank, state actors, and international NGOs, but also local states, indigenous NGOs, health movements, and community organizations, in particular those who bear most directly the impact of the new direction for health. Given the largely negative consequences of SAPs, the environment for renewed democracy is hardly propitious, despite neo-liberal rhetoric to the contrary.

To conclude, an examination of the 1993 World Development Report's financing options shows that blanket prescriptions for privatization and user fees strengthen processes that deepen impoverishment. Needed instead is a careful analysis of the range of contradictory interests involved at the local, national and international levels, and a prior commitment to health and justice. This implies strengthening the positive aspects of states to ensure greater equity. Also, if we are to take seriously the Bank's stated interest in poverty, substantive work needs to be done around the debt, including multilateral debt. Health care should not be traded off against debt repayment. Finally, it is imperative to widen policymaking circles to ensure that health markets are monitored for equity and human development. The prospects are not heartening, given the conditions of the new global order, but the challenge cannot be abandoned.

References

Bakker, Isabella. 1992. "Engendering Macro-economic Policy Reform in the Era of Adjustment and Restructuring: A Conceptual Overview," Paper prepared for the North-South Institute Workshop: The Impact of Economic Policies on Women in a Period of Structural Change and Adjustment -- Toward a Framework, June 19-21. Ottawa, Canada.

Chazan, Naomi. 1988. The Precarious Balance: State and Society in Africa. Boulder, CO: Westview Press.

Central Bank of Nigeria. 1990. Annual Report and Statement of Accounts. CBN: Lagos, Nigeria.

Chossudovsky, M. 1992. "The Global Creation of Third World Poverty," Third World Resurgence No. 17:13-21, January.

Fowler, Alan. 1992. "Distant Obligations: Speculations on NGO Funding and the Global Market," Review of African Political Economy, No. 55:2-29.

Harvey, David. 1989. The Condition of Postmodernity. Oxford, UK: Basil Blackwell.

Helleiner, G. K. 1994. Debt Relief for Africa: A Call for Urgent Action on Human Development. UNICEF Staff Working Papers No. 11, New York: UNICEF.

Isenalumhe A.E. and, O. Ovbiawe. 1988. "Polypharmacy: Its Cost Burden and Barrier to Medical Care in a Drug Orientated Health Care System." International Journal of Health Services, 18 [2]:335-342.

Ityavyar, Dennis A. 1985. "The Development of Health Services in Nigeria 1960-85." Unpublished Ph.D. dissertation, University of Toronto.

Meagher, Kate. 1990. "The Hidden Economy: Informal and Parallel Trade in Northwestern Uganda." Review of African Political Economy. No. 47, Spring.

Mistry, Percy. 1993. "The Multilateral Debt Problems of Indebted Developing Countries," paper prepared for the seminar on Multilateral Debt coorganized by EURODAD and NOVIB on 6th December, the Hague.

The Netherlands Government. 1990. Africa Conference. Maastricht, July 2-4.

[The] New Internationalist. 1994. Winds of Change: The United Nations at 50, No. 262, December.

Olukoshi, Adebayo O. [ed.] 1993. The Politics of Structural Adjustment in Nigeria. London: Heineman.

Owoh, Kenna. 1987. "Politics of Obstetrics: Impact of Privatization in Plateau State." Unpublished M.A. dissertation, University of Jos, Nigeria.

_____. 1995. "Impact of Structural Adjustment on Health: Locating Room to Maneuver in Nigeria," in Rea L. Bloomberg, Cathy A. Rakowski, Michael Monteon, and Irene Tinker [eds.] Engendering Wealth and Well-being. Boulder, CO: Westview Press.

Pearce, Tola Olu; Toyin Falola [eds.]. 1994. Child Health in Nigeria. Brookfeild, USA: Avebury.

Plateau State Ministy of Health 1991. Annual Statistical Bulletin. Jos, Nigeria.

Renfrew, Anne. 1992. ESAP & Health: The Effects of the Economic Structural Adjustment Programme on the Health of the People of Zimbabwe. Harare, Zimbabwe: Mambo Press.

Schram, Ralph. 1971. A History of the Nigerian Health Services. Ibadan University Press, Nigeria.

UNCTAD. 1993. The Least Developed Countries 1992 Report. Geneva: United Nations Conference on Trade and Development.

UNDP. 1993. Human Development Report 1993. New York: United Nations.

UNICEF. 1990. Children and Women in Nigeria: A Situational Analysis 1990. Lagos: Federal Republic of Nigeria/UNICEF.

UNICEF. 1992. Africa's Children, Africa's Future, prepared by the Organization of African Unity and the United Nations Children's Fund for the OAU International Conference on Assistance to African Children, Dakar, Senegal, 25-27 November.

UNICEF. 1993. "Debt Relief for Africa: A Call for Urgent Action on Human Development" paper prepared by the United Nations Children's Fund, June.

World Bank. 1993a. World Development Report 1993: Investing in Health. Oxford: Oxford University Press.

World Bank. 1993b. Better Health in Africa. Human Resources and Poverty Division, Africa Technical Department.

World Bank. 1994. World Debt Tables 1994-95. The World Bank: Washington, D.C.

World Health Organization-UNICEF, Alma-Ata. 1978. Primary Health Care. Report on the International Conference on Primary Health Care, Geneva.

The World Bank Eclipses the World Health Organization

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The World Health Organization (WHO) came into existence in 1948, so it is now 47 years old; but rather than hitting middle age in full stride, it has been displaced by an older sibling, the 51 year old World Bank. WHO's budget has shrunk, especially relative to the Bank's lending for health-related projects, and like a much older, disabled person, WHO's affairs are increasingly handled by others. This paper analyzes the process of that displacement and describes the consequences for the health of poor people. It is a story of economic strategy replacing public health policy, a tale of the centralization of power in the hands of international bankers. This is not a conspiracy theory, but on the other hand, this is not an account of remote events in faraway places. The public hospitals of New York City are now threatened with closure or privatization; this shows that the same process is operating right here at home.

Like other specialized agencies of the United Nations, WHO raises its budget from annual assessments of members. The 1992- 1993 budget was $764 million, but income from other sources such as the trust funds for AIDS, tropical disease research, and onchocerciasis (river blindness) control more than doubled that sum, bringing the two-year total to $1.7 billion. The problem with raising additional funds in this way is that the donors--mainly the World Bank and industrial nations like the USA with their own research and trade agendas--have undue influence on WHO's policy (Walt 1994:136). Extra-budgetary contributions also enable donors to circumvent WHO's democratic structure, which is decentralized and gives power to regional offices located in Africa, Asia, Latin America, the Middle East and Europe. Donors have a penchant for funding the disease of the day rather than long-term basic health care; in recent years this disease has been AIDS, despite impressive evidence that malaria and tuberculosis are higher priorities in many regions.

How did WHO come to its present state of declining influence and power? How and why was it overtaken by the World Bank, one of the financial institutions created at Bretton Woods in 1944 along with the International Monetary Fund to control the flow of money? To answer these questions, we need some background information.

A Little History

In the mid-1970s, under pressure from several less developed nations and under the leadership of a newly elected Director General, Halfdan Mahler, a social democrat from Denmark, WHO stepped into the political limelight espousing the cause of the world's sick and poor. WHO successfully led the campaign to eradicate smallpox, the first disease ever to be eliminated through human effort. It gave developing nations useful policy instruments enabling them to negotiate with multinational corporations and bilateral aid agencies. For those with the political will to do so, WHO developed policies to bring primary health care to all people and gave countries a handle on planning their health services. To illustrate these policy instruments: under pressure from consumer groups, WHO challenged the infant formula industry by producing a code of conduct that restricts sales practices. It took on the pharmaceutical industry by publishing a list of 200 essential drugs to substitute for the average 3,500 to 5,000 marketed to less developed countries. The industry, through the International Pharmaceutical Manufacturers Association and through the national delegations of drug-producing countries, fought back, but when it could not win in the democratic forum of the World Health Organization, it simply marginalized WHO and convinced governments to swing behind the World Bank, which it could control.

The fight for primary health care is, to my mind, the most serious inter-agency struggle. In 1978, WHO working together with UNICEF issued a challenge: "Health for All by the Year 2000." To reach this goal, WHO proposed a primary health care service model--a broad package of preventive and curative services to be delivered by trained auxiliary personnel. This

strategy seemed revolutionary: primary health care represented progress over most previous programs, which relied on the delivery of curative services by physicians and nurses in urban hospitals. But the primary health care strategy failed because it was undermined by major donors. USAID cut the alliance between UNICEF, which the US controlled, and WHO. Together with UNICEF, the World Bank and other donors, USAID argued that ministries of health in poor countries could afford to offer services only for those diseases that can be prevented with immunizations or cured with antibiotics and other drugs. This so-called selective strategy pleases the pharmaceutical industry because it is drug dependent; it suits the World Bank because the Bank can lend money for drugs, which must be purchased with hard currency, always in short supply in poor nations.

The selective strategy is reductionist: it reduces health care to a drug prescription. It fails to address the real health problems of the poor and leads only to the 'medicalization' of underdevelopment and the enrichment of the pharmaceutical industry. Having entered the health sector, the World Bank decided to revolutionize the delivery of health care by taking a monetarist approach and bringing health service delivery into line with its other supply side recommendations. This entailed a reduced role for government and an increased role for the private sector.

Privatization

Privatization entails the use of government policies to shift provision and financing to the private sector. In 1987, the World Bank published its agenda for the reform of health service financing in developing countries; it recommended the privatization of health care and the use of both private voluntary and nongovernmental organizations to deliver services. The World Bank makes this policy although it knows that "the free play of market forces can generate levels of poverty that are socially unacceptable" (Cornia and deJong 1992:258).

According to WHO (1981:54-5), the private medical sector absorbs scarce health personnel trained mainly at the state's expense. It is predominantly curative in character, and its expensive practices lead not only to inflated total medical expenditure, but to excessive foreign exchange costs for pharmaceuticals and medical equipment in developing countries. It has a negative influence on medical education, both by its example of expensive methods and the effect created on students' attitudes by the future possibility of lucrative private practice. As the economic basis for the medical profession's guild-type associations and their ethos of individualism, private medicine undermines the attempts of government health services to discipline and rationalize diagnostic and therapeutic procedures on a cost-effective basis. Earnings in private practice set the order of magnitude of salaries paid to professionals in state service. Where private capital is insufficient to create separate hospitals, as in many developing countries, government facilities may be used in various ways by private medicine. For these reasons the private medical sector now has negative effects on the implementation of primary health care.

How does the World Bank impose its vision of private health care on developing nations? By tying loans for development aid to meeting certain "conditions," namely the reform (read reduction) of the public sector. This practice, known as conditionality, allows powerful institutions like the World Bank and the International Monetary Fund to impose their agenda on the governments of developing countries as the price of international aid. Conditionality transforms policies once considered internal matters, such as subsidies on basic foods or funding policies for health and education, into plans routinely subject to influence if not outright determination by the World Bank and the IMF (Stoneman 1993:87). In other words, the initiative for health policy has passed from the national to the international level and, at the international level, from a health agency to a financial group.

The World Bank and the International Monetary Fund are not democratic organizations; unlike the UN General Assembly and the World Health Assembly which operate on the principle of one nation, one vote, the Bank and Fund allocate voting rights according to levels of shares: Japan, USA, Germany, Britain and France hold about 45 percent of all shares. The Bank and the Fund are not accountable to developing countries. The question of accountability is serious because the Bank's influence in the health sector extends far beyond its own loan program, which totaled $3.4 billion for loans to population, health and nutrition projects by June 1993 (World Bank 1993:168). The Bank's policies inform much of the current practice of many other donors, and its economic reforms have brought about a shift

of provision from the state to nongovernmental organizations--directly, by encouraging donor financial support for NGOs, and indirectly, by squeezing state resources and obliging consumers to patronize the private sector (Gibbon 1993:16).

The Fate of WHO

By the end of the 1980s, WHO had abandoned primary health care in favor of a multiplicity of microprojects run by nongovernmental organizations, which donors can control more easily than direct aid to allegedly corrupt governments. The results of this policy switch are immediately noticeable. At the beginning of the 1990s in Latin America and Africa, tens of thousands of lives were claimed in outbreaks of cholera--the disease that instigated European cooperation in international public health in the nineteenth century. The current epidemic, which has killed the poorest of the poor living without the most elementary services in polluted, overcrowded shantytowns, underscores the failure of the new policy to alleviate the root causes of ill health. Basic concerns with the provision of latrines, safe water supplies, and adequate nutrition have yielded to preoccupation with private, curative, individual medical treatment.

Under Hiroshi Nakajima of Japan, the present Director-General who assumed the post in July 1988, WHO appears to be shifting its viewpoint. Though it worked closely with UNICEF on the development of the primary health care strategy in 1978, WHO was not associated with UNICEF's efforts a decade later to redress the decline in maternal and child health that followed in the wake of structural adjustment programs promoted by the World Bank and the International Monetary Fund.

Like other specialized agencies and the United Nations itself, WHO tends to mirror and transmit through its programs the balance of world power and the dominance of North over South. Smallpox eradication was carried out at the request of the United States, which largely funded and staffed the program; not all developing countries felt it was their highest priority or that it would improve overall health as measured by death rates, which failed to decline. Similarly, the Global Programme on AIDS corresponds to U.S. interests. The United States accounts for half of the world's cases of AIDS, and the U.S. Government promotes research on heterosexual transmission of human immunodeficiency virus (HIV) rather than on care of people with AIDS under conditions of poor and scarce health resources; it also cooperates in vaccine trials with governments so poor that their countries lack the health infrastructure needed to vaccinate their populations against HIV and will therefore never benefit from an eventually successful vaccine. WHO respected the UN Security Council embargo on Iraq during the 1991 Gulf War and played no role in the provision of essential medical supplies or care to the civilian population, tasks which it left to nongovernmental organizations, led by the International League of Red Cross and Red Crescent Societies.

If this trend continues, it seems unlikely that WHO will make a lasting change in the social inequalities between North and South, including inequalities in health care and chances of survival.

References

Cornia, G. A. and deJong, J. (1992) "Policies for the Revitalisation of Human Resources Development" in G. A. Cornia, R. van der Hoeven, and T. Mkandawire (eds.) Africa's Recovery in the 1990s: From Stagnation and Adjustment to Human Development, New York: St. Martin's Press.

Gibbon, P. (1993) "Introduction: Economic Reform and Social Change in Africa" in P. Gibbon (ed.) Social Change and Economic Reform in Africa, Uppsala: Nordiska Afrikainstitutet.

Stoneman, C. 1993. "The World Bank: Some Lessons for South Africa" Review of African Political Economy 58:87-98.

Walt, Gill. 1994. Health Policy: An Introduction to Process and Power. London: Zed Press.

World Bank. 1993. The World Bank Annual Report 1993. Washington, DC: The World Bank.

World Health Organization. 1981. "National Decision-making for Primary Health Care: A Study by the UNICEF/WHO Joint Committee on Health Policy." Geneva: WHO.

AIDS: A Review*

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Dar es Salaam, Tanzania

Some issues raised in Paul Farmer's AIDS and Accusation: Haiti and the Geography of Blame, are of particular relevance to Africa. Though published by the University of California, Berkeley, three years ago, its relevance to the current situation in Africa amply justifies the present review.

In the early 1980s, Haitians were regarded as the carriers of AIDS into the US. Scientists and journalists theorized that this dreaded disease had originated in Africa and entered North America from Haiti. Being a Haitian per se was sufficient, according to US health authorities, to put one at a higher risk for contracting AIDS. Even as late as 1990, when it was known that this disorder of the immune system follows from a viral infection, when the manner in which the virus is transmitted from one person to another was well documented, and when sensitive methods for detecting it were in use, persons of Haitian origin were singled out and banned from donating blood in the United States.

What is it about Haiti that apparently makes it unique in relation to the AIDS pandemic? Is there evidence to support the claim that AIDS came to the US from Haiti? What do the Haitians, including the more than one million resident in North America, consider to be the source of this malady? In AIDS and Accusation: Haiti and the Geography of Blame, Paul Farmer deals with these and related issues in a comprehensive yet eminently readable manner.

Farmer, a physician from Harvard University, spent a large part of the years from 1983 to 1990 in Haiti and much of that time in a rural village. His findings are presented on several distinct but intertwined planes. We are given an intimate and often moving account of the lives of the villagers and the first three AIDS cases among them; we get an analytic report on the unraveling of the AIDS epidemic in Haiti; we see the positioning of the spread of this disease within a broader social and economic context; and we also delve into an exploration of the history of Haiti and its relation to the rest of the world, especially, the US. A work with such a wide span is not expected to, so to say, fly with ease. Surprisingly, in my view, it not only does that but also manages to soar high into the stratosphere.

Did AIDS Move From Haiti to the US?

Reading this text one cannot but be astonished at the documentation provided by Farmer to show that the identification of Haiti as the source of the US AIDS epidemic was and remains without any scientific merit. Though the claim was made in prominent medical journals and repeated in the mass media, it was founded upon speculation and flawed research. Without any data, supposed animal sacrifices during voodoo rituals were implicated in the spread of the disease. A senior official of the US National Cancer Institute was reported as saying that AIDS possibly came to Haiti from Zaire as a result of a cultural exchange in the 1970s involving some 10,000 people. The fact remains that an exchange of such magnitude never occurred!

We learn from the data Farmer provides that Haiti is not that different from most other Caribbean nations in terms of the incidence of AIDS, and in fact, it is less affected than some! For Haitians living in the US, the impact of being singled out was, not unpredictably, felt in terms of loss of employment and housing opportunities and treatment as social pariahs. In Haiti itself, this distinction fostered a decline in the Haitian economy. In 1980, tourism was the principal earner of foreign exchange in Haiti. By 1983, after the AIDS accusations were aired, the tourist industry came to a virtual standstill.

* A version of this book review originally appeared in Swahili in the RAI, a weekly published in Dar es Salaam, Tanzania, October 8, 1994.

Or Did AIDS Come From the US?

From Farmer's conversations with the victims of AIDS in the village of "Do Kay", we discover that they have quite different perspectives on the issue of the genesis of the disease. (To preserve confidentiality, some names in text were changed). Manno, the school teacher thinks he has AIDS because someone has cast a spell on him; Anita, a young woman who ran away to Port-au-Prince at the age of fifteen, says she "caught it from a man in the city"; and Dieudonné, a young man, not only considers himself a victim of sorcery but also regards AIDS as a malaise deliberately sent to Haiti by the US. Of the three, only Anita takes a longer term view. In her perspective, it all began with the flooding, in 1956, of her native village by a dam constructed to provide electricity to Port-au-Prince. The loss, without any compensation, of fertile lands made her people move to higher rocky and dry ground. In the ensuing deepening of their poverty and disintegration of their traditional way of life, her mother succumbed to tuberculosis. Unable to cope any further, the teenage Anita then ran away to the city, only to be brought back by her father when she fell gravely ill. Anita comes closest to articulating a view of AIDS as a disease that thrives under systemic poverty. The reverse accusation towards the US is implicit in her point of view, though she may be unaware of it: the dam project was planned and financed from Washington.

Haitian doctors researching this epidemic provide appropriate illumination of the issues. Their work indicates that AIDS is a disease of recent origin in Haiti with the foci in the urban centers, especially where tourism was more developed. They point to the role of "economic homosexuality" in sparking off the deadly syndrome. In the tourist centers of Haiti, local men engaged in homosexual activity with the visitors in order to earn a living. To quote Farmer, "...evidence suggests that [AIDS] had been brought to the island by North Americans or by Haitians returning from North America and that sexual transmission and contaminated blood transfusion accounted for the majority of the early cases." (p. 222).

The Traffic in Haitian Blood

Also from Farmer, we learn the remarkable fact that, prior to 1975, the blood used to produce clotting factors for hemophiliacs in the US "came largely from Latin America and the Caribbean, notably from Haiti." (p. 240). At the height of the trade in Haitian blood, an estimated five tons of cheaply acquired plasma were annually sent to US laboratories. No evidence linking plasma imported from Haiti to the spread of AIDS among hemophiliacs in the US has been adduced, suggesting that AIDS was not present in Haiti before 1975 and not introduced to the US via this mode of transmission.

Farmer also notes that the person responsible for overseeing this trade on the Haitian side was none other than the leader of the Duvalierist death squads, the Tonton Macoutes.

Africa and AIDS

One issue of particular relevance to Africa is the perception that the AIDS virus was manufactured in a US military laboratory and deliberately spread to "undesirable" peoples. Not only do many Haitians, both those in their homeland and those resident in the US, hold this view, but also it is not uncommon among educated persons in sub-Saharan Africa. For example, an African-American scientist visiting Tanzania in 1993 was quoted in a local paper as stating that to be the case. This view is as much without a scientific foundation as is the theory of a Haitian origin for AIDS in the US. However, given the five hundred year history of domination of Haiti by the European-North American world, it is not surprising that such a viewpoint holds sway in that land.

In Africa, similar circumstances explain why such theories find favor. Though these conspiracy theories may generate psychological satisfaction among the victims and others, they are profoundly antithetical for several reasons. The evidence produced by their proponents tends to be sketchy and inconsistent; they may negatively impact efforts to control the disease; and most importantly, they divert attention from the question of why the disease continues to spread to that of how it got there in the first place. The two issues are quite distinct.

Paul Farmer makes an important point in this regard. North American tourism is no longer an important factor in the transmission of the disease in Haiti. That was so only at the inception of the epidemic. Now, the principal

societal characteristic that promotes the proliferation of the HIV virus, not only in Haiti, but in other parts of the world including the US, is endemic poverty. Like other sexually transmitted diseases such as syphilis and gonorrhea, once the organism gains a foothold in an environment where social misery abounds, it tends to establish a permanent residence there. Persistent poverty poses a generally insurmountable barrier to the control of even diseases that are curable or preventable through vaccination.

AIDS and Economics

Thus the campaign against AIDS has to be simultaneously a battle against poverty and for the control of all sexually transmitted diseases. Without addressing the economic basis of high risk behavior and of apathetic attitudes towards preventive measures, efforts to control the disease will just end up as grandiose speeches of the politicians or pretentious tomes in the medical journals. When unemployment rates hover around 50 percent, how can one put a damper on the commercial sex industry? When so many children die from malaria and diarrhea, can there be more concern about an insidious killer such as AIDS?

An inquiry into why AIDS continues uncontrollably to afflict Haiti or other countries also implies asking why the affected societies are plagued by seemingly enduring poverty. Not many researchers addressing the issue of AIDS have the intellectual audacity to pose, let alone attempt to answer, such a question. For Paul Farmer, this is but a logical consequence of his study, which links the persistent emergence of many new cases of AIDS to the pauperization of the population at risk in Haiti.

In a book dealing with AIDS, we are thus led to examine the economic history of Haiti over the past two hundred years. Why is Haiti the poorest nation in the Western hemisphere? The findings are, once more, quite astounding: Haiti is not poor but the vast majority of Haitians are poor. Throughout the past two centuries, Haiti, along with other Caribbean nations, was a large exporter of a wide variety of agricultural products. And of late, it has received a relatively heavy volume of investments in the light manufacturing sector. For example, until recently, Haiti was the largest producer and exporter of baseballs to North America, a fact of significance because baseball is the US national sport. It also exported a variety of toys, apparel and other items to North America.

But the wages in these mostly US owned industries and the prices of export crops paid to Haitian farmers have been and are extremely low. The Duvalier dictatorship, the military junta, and their death squads, known as the Tonton Macoutes or the Attachés, were instrumental in preventing the betterment of conditions and pay for Haitians. The workforce consists mainly of young women who are viewed as more docile than men. Attempts to organize independent unions were crushed by these agents; in fact, Aristide was overthrown hardly a month after he attempted to raise the minimum wage. Thus, while the multinational companies and their local cronies prospered, the people of Haiti subsisted in grinding poverty.

This brings us back full circle towards establishing an external link with the continued propagation of AIDS. Only now it no longer rests upon an emotional accusation of a military conspiracy but on cold facts of international economics. Farmer gives an instructive counterexample to buttress his point of view. Cuba, among all the nations of the Caribbean, is least affected by AIDS and has the most successful program for controlling its spread. This is so despite the presence of many Cubans in Africa in the 1970s and 1980s and despite the crippling economic blockade imposed by Washington. A question is then posed: If Cuba had remained under the economic aegis of the US, with Havana retaining its reputation as an international brothel, is it not conceivable that today it would be where Haiti is with regards to AIDS?

What holds for Haiti also holds for Africa. To fight seriously against AIDS here, we need to combat poverty as well. We need to look into the basic societal causes of the immiseration of the majority of the population. In this regard, we must question the so-called aid donors who, on the one hand, give Africa as many condoms as it is capable of consuming but, on the other hand, impose on the continent Reaganite economic prescriptions that just make the majority poorer than they were before. Is that an environment conducive to the control of AIDS or other infectious diseases, or for an entrenchment of these afflictions?

At the National Conference on AIDS held at the Muhimbili Medical Centre in September 1994, the Minister of Health gave grim statistical projections on the AIDS epidemic in Tanzania. One in seven adult Tanzanians may harbor the virus by the year 2000. He urged everyone to be concerned about this problem and take measures

to prevent its spread. There is a problem with the minister's exhortations. For the question is not just that of individual responsibility. What is the role of the government in this regard? Why is the government that he represents bent upon increasing unemployment, reducing expenditure in the health and education sectors, and decimating local industries, while corruption and graft continue to thrive? The most visible consequence of these policies is increasing numbers of beggars and prostitutes, many quite young, roaming the streets of the towns and cities of Tanzania. Is this an environment in which any infectious disease, let alone AIDS, can be brought under control? Father Aristide has an apt description for such speeches: "Hypocrisy". A government that is responsive to the needs of the vast majority, and which is democratically accountable to them, is a prerequisite for starting a genuine program of controlling the many health problems that affect the people of this land.

I conclude by highly recommending Paul Farmer's book to all. I do have some misgivings about the lack of depth on certain issues it deals with. But the book's overall capacity to provoke thought and inject a fresh angle into the consideration of this deadly scourge of the modern era deserves attention from doctors, nurses, teachers, high school and college students, as well as from concerned citizens.

Health Policy: A Book Review

Meredeth Turshen
Rutgers University

Health Policy: An Introduction to Process and Power by Gill Walt. London and New Jersey: Zed Books and Johannesburg: Witwatersrand University Press, 1994. 226pp, index, bibliography.

You are not an expert on health or health services, but you would like to respond to student demands for a discussion of health policy in your survey courses on Africa and classes on international development. How can you prepare yourself and what reading can you assign?

I recommend a new book by Gill Walt, head of the International Policy Programme at the London School of Hygiene and Tropical Medicine. Professor Walt is well versed in African studies; she has taught at Witwatersrand and the University of Cape Town, and she has worked in and written about Mozambique. She approaches health policy from the social sciences and examines people, governments, and international agencies; her interest is in revealing who drives policy, and she succeeds in demystifying how health policy is made.

The book begins with a political scientist's analysis of the political system as a whole and walks the reader through the role of political parties, pressure groups, and other players such as the media in health policy. An exploration of how power is distributed in society follows, and the interface of policy making and policy makers is examined next. I found subsequent sections on extra-governmental pressure groups especially interesting, given current debates about the burgeoning nongovernmental sector and its increasing role in lobbying. I also liked the discussion of international organizations, which occupy a growing place in deciding national health policy. The last chapters consider implementation, evaluation and research. Throughout the book there are references to the real world of health projects, with many examples selected from African experience.

Walt is a clear writer and thinker, who uses an accessible style that readers will find rewarding. This book will enable students to read original policy documents from governments, the World Bank, WHO, UNICEF and others more critically and with much greater understanding.

U.S. Aid to Africa: What Position Should ACAS Take?

A Call for Debate

by Jim Cason
Co-Chair ACAS Political Action Committee

Republican members of Congress are proposing massive cuts in U.S. foreign aid and the merging of the U.S. Agency for International Development with the State Department to ensure that foreign aid is directly linked to U.S. strategic interests. At this writing in early May the exact nature of the cuts in development assistance had not been finalized, but proposals included:

- cutting U.S. funding for the IMF, the World Bank and the World Bank's soft loan affiliate the International Development Association (which provides substantial funding for Africa);
- cuts in U.S. contributions to United Nations peacekeeping operations and to the United Nations Development Program;
- cuts or elimination of funding for the Africa Development Foundation; and
- elimination of the separately earmarked funds protected through the Development Fund for Africa (although some funding for Africa will be retained, without a specific earmarked amount for Africa many Washington groups fear Africa funding will be difficult to protect).

African Ambassadors in Washington, and several coalitions of African Non-Governmental Organizations have written to Congress particularly to protest the cuts in assistance to multilateral institutions such as the World Bank affiliated International Development Association. Other African scholars and activists continue to argue that assistance through these multi-lateral agencies has often undermined development.

In the U.S. a broad range of African advocacy organizations have mobilized to defend U.S. assistance to Africa. ACAS has received repeated appeals from organizations such as the Washington Office on Africa, the American Committee on Africa, Bread for the World and the African American Institute for assistance in lobbying for continued U.S. development assistance to Africa and maintenance of the specially earmarked funds in the Development Fund for Africa.

The decisions about how much U.S. assistance will go to Africa in the next fiscal year (Fiscal Year 1996) will be made in Congress this Spring and Summer. But the ACAS membership remains divided on how actively to push for continued US aid to Africa. Some agree with British analyst Joe Hanlon who argued recently that Africans should support the abolition of USAID to Africa because, as he argued recently, "USAID [is] a form of intervention so destruction that the term 'aid' can only be ironic." Others argue that if progressive allies in Africa are appealing for continuing assistance then ACAS ought to engage in the battle to protect US aid to Africa. A third position articulated by some activists is that ACAS ought to use its considerable research abilities to investigate the USAID program in Africa in order to expose the negative consequences of this assistance as part of an effort to reform USAID.

The next issue of the ACAS bulletin will attempt to address the question "What Position Should ACAS Take on US Aid to Africa?" Comments and proposals for contributions to this debate should be sent to Jim Cason, 6326 Forward Ave., Pittsburgh, PA 15217. Or via e-mail to "dialogos@igc.apc.org"

Peacekeeping, Development Aid: Key Congressional Actions Expected in May

by Africa Policy Information Center

The Africa Policy Information Center is distributing regular information on Congressional action on Africa. The latest update, produced in late April 1995, follows. To receive regular information via electronic mail please contact APIC at the address indicated at the end of this update.

As Congress returns from recess after the Easter vacation, the Republican majority will be continuing its drive to make fundamental changes in national priorities, on both domestic and international issues.

Cuts in the current year's budget (rescissions) voted by the House and Senate before the recess took $60 million from funds previously approved for the International Development Association (the World Bank's soft loan affiliate), $62 million from the African Development Fund (associated with the African Development Bank), $15 million from international peacekeeping, and $12.5 million from bilateral economic assistance. They also mandated an additional $125 million in additional foreign operations cuts to be specified by the administration's Office of Management and Budget. The supplemental bills including these cuts also failed to approve the administration's supplemental request for $672 million for payment of overdue U.S. peacekeeping obligations.

The proposal by Senator Mitch McConnell to remove $110 million from the bilateral Development Fund for Africa (one- eighth of the total $802 million) was, however, defeated by intense lobbying and grass-roots mobilization by a number of Africa advocacy groups, including the Washington Office on Africa, the American Committee on Africa, Bread for the World, Interaction, and others.

Coming up in May:

(1) Both the House and Senate will be considering budget resolutions for Fiscal Year 1996, which begins in October 1995. The roughly $20 billion international affairs "150" account, which includes development aid and peacekeeping as well as operating expenses for the State Department and other agencies, may be cut drastically, by as much as $2.6 billion to $5 billion. Since many items in the account, such as operating expenses and funding for Israel and Egypt, will be protected, a lower "150" limit will put the greatest pressure on the most vulnerable items: peacekeeping and development aid for other regions. Groups including Interaction <ia@interaction.org> and Church World Service <cwslwr@igc.apc.org> are spearheading the effort to keep cuts to this account under $1.5 billion.

(2) The House of Representatives has passed H.R. 7, which includes an accounting measure effectively prohibiting most U.S. support for UN Peacekeeping, by counting bilateral costs of U.S. operations approved by the UN (such as the Persian Gulf, the bilateral intervention in Haiti) against U.S. assessed obligations. The Senate will soon take up a similar bill (S. 5). Even if, as some Republicans say, there are loopholes that would still allow some U.S. contributions, the result would be a further drastic reduction in UN peacekeeping capacity. The Council for a Livable World (Tel: 202-543-4100; Fax: 202-543-6297) and the Washington Office on Africa <woa@igc.apc.org> are two of the groups actively opposing S.5.

(3) Development assistance will continue under intense pressure to be cut drastically. With aid to Israel, Egypt, Eastern Europe and the former Soviet Union enjoying greater political protection, Africa will be a particular target. Senator McConnell and others are expected to continue their push to eliminate the Development Fund for Africa as an earmarked account, leaving priorities within bilateral assistance contingent on strategic significance and short-term economic prospects for U.S. business. Senator Helms is pressing a proposal to merge USAID, the African Development Foundation, and the InterAmerican Foundation into a new agency which would marginalize sustainable development as a goal and not fund government-to-government programs at all.

Most Africa advocacy groups in the U.S. stress that they are not defenders of the USAID

status quo. But they argue that drastic cuts and guidelines specifically excluding the goal of sustainable development will simply work to further marginalize Africa, and be used to justify cuts by other countries and international agencies as well. (Thus the Canadian International Development Agency has also announced cuts, aimed particularly at the strong NGO programs of development education in Canada.) Groups such as Bread for the World <bfw@gmuvax.gmu.edu>, the Washington Office on Africa, and African Americans for Aid to Africa (c/o Washington Office on Africa) have stressed that reform in the direction of sustainable development depends on clearly identifying the goals of promoting self-help development and poverty reduction, and preserving funding levels for the bilateral Development Fund for Africa at the 1995 figure of $802 million.

The attack on funding for international involvement, however, builds on extraordinary levels of public ignorance about the actual sums involved. A new poll on peacekeeping by the Center for the Study of Policy Attitudes, reported by *The New York Times* today, showed that a majority of 67% of the U.S. public still express strong support for UN peacekeeping in general (down from 84% a year ago). But when the respondents were asked to estimate what percentage of the U.S. budget goes for international peacekeeping, the median response was 22% (the actual figure is equivalent to less than 1% of the U.S. defense budget alone). They also thought on average that the U.S. provides about 40% of UN peacekeeping troops, ten times the actual percentage. [More details of the poll are expected to be available soon.]

A poll earlier this year by the same agency (see summary below) showed parallel results on the issue of foreign aid. Such perceptions, combined with long-standing stereotypes of Africa as a hopeless and undifferentiated morass of violence and poverty, pose formidable obstacles to the many groups working to counter the drive to further marginalize Africa.

Attachment: Poll Reveals Contradictory Views on AID

A new study of American public attitudes on foreign aid was recently conducted by the Program on International Policy Attitudes of the Center for International and Security Studies of the University of Maryland. It included a poll of 801 Americans conducted January 12-15 (margin of error plus or minus 3.5-4%), focus groups, interviews and a review of other polls.

It found that:

1. An overwhelming majority of respondents (80%) embrace the principle that the United States should give some aid to help people in foreign countries who are in genuine need. Only 8% want to eliminate foreign aid entirely.

2. A strong majority (75%) says that the United States is spending too much on foreign aid. But this attitude is based on the assumption that the US is spending vastly more than it is, in fact. Asked to estimate how much of the federal budget goes to foreign aid, the median estimate of those responding was 15% -- 15 times actual spending [only about 1% of the budget]. (Other polls have found even higher estimates). Asked what an "appropriate" amount would be, the median level proposed was 5%. Asked how much would be too much, the median response was 13%, while 3% was seen as "too little" -- still 3 times present spending.

3. When informed about the actual amount of spending on foreign aid, the number who felt that the amount was too much was 18% -- down from the 75% who had previously felt that the US was spending too much. When informed, a strong majority (62%) favored either maintaining or increasing foreign aid spending.

4. The public wants to change the mix of priorities in foreign aid spending, putting less emphasis on securing US strategic allies and bases around the world and more emphasis on helping the poor and needy.

5. Support for spending on poor countries stems partly from a belief that the world is so interconnected that it is in the economic interest of the US to promote the development of Third World countries (63% agree).

6. Strong support also comes from the attitude that the US has a moral obligation to help nations in need (67% agree), while an overwhelming majority (77%) rejects the idea that the US should only give aid when it promotes the US national interest.

7. A strong majority (67%) supports the principle of giving aid to help countries move toward democracy, including former socialist countries, and 80% are unhappy about the

amount of aid that goes to countries that are not democratic or have poor human rights records.

8. Eighty-three percent believe there is widespread waste and corruption in foreign aid programs. A strong majority (58%) would be willing to pay more in taxes if they believed that more aid would get to the people who really need it.

9. To promote self-reliance, the majority (65%) is willing to spend more on aid that emphasizes trade and development and is willing to give poor countries preferential trade treatment.

The study *Americans and Foreign Aid: A Study of American Public Attitudes*, was conducted by the Program on International Policy Attitudes, a program of the Center for the Study of Policy Attitudes and the University of Maryland Center for International and Security Studies. An 8-page summary is available free from the Center for the Study of Policy Attitudes (CSPA), 11 Dupont Circle NW, Suite 610, Washington, DC 20036. Phone: (202) 232-7500. Fax: (202) 232-1159. Email: cspa@vita.org. Inquire to CSPA for pricing on the full study.

This update was prepared by the Africa Policy Information Center (APIC). APIC's primary objective is to widen the policy debate in the United States around African issues and the U.S. role in Africa, by concentrating on providing accessible policy-relevant information and analysis usable by a wide range of groups and individuals. APIC is affiliated with the Washington Office on Africa (WOA), a not-for-profit church, trade union and civil rights group supported organization that works with Congress on Africa-related legislation.

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To receive basic information on APIC and WOA, with a list of publications, send a blank email message to woa-info@igc.apc.org. [Note: Do *not* use the "reply" function in your mail program, which will send your message to woa@igc.apc.org. The address for an automatic response is *not* the same as for other substantive messages, which should be sent to woa@igc.apc.org. Please be patient on responses to other queries.]

For additional information:

Africa Policy Information Center
110 Maryland Ave. NE, #112
Washington, DC 20002.
Phone: 202-546-7961.
Fax: 202-546-1545.
Email: woa@igc.apc.org.

The Africa Policy Report

The Africa Research Project is pleased to announce the publication of the first issue of its newsletter, Africa Policy Report. The Africa Research Project is a research and education center based in Washington, DC. The Project publishes this report and maintains an extensive data base containing books, documents, hearings, newspaper and magazine articles, and other information sources (with a particular emphasis on US military policy toward Africa and on African security issues). Please direct all inquiries to Daniel Volman, Africa Research Project, 2627 Woodley Place, NW, Washington DC 20008, or telephone (202) 797-3608. Daniel Volman, a long-time specialist on US security policy toward Africa, directs the project and prepares the report.

Africa Policy Information Center

Guide to the 104th Congress
Africa Subcommittee Membership

Guide Notes

Capitol Switchboard number: 1-202-224-3121
Interest group ratings for 1993:
ACU (American Conservative Union)
ADA (Americans for Democratic Action)
AFL-CIO

U. S. Senate
Committee on Foreign Relations
Subcommitee on African Affairs

All Senate addresses are:
The Honorable [ ]
U.S. Senate
Washington DC 20510.

1. Nancy L. Kassebaum (R-KS)**
Chairman Phone: 1-202-224-4774
Fax: 1-202-224-3514
Email (not confirmed):
senator_kassebaum@kassebaum.senate.gov

Year first elected: 1978
Religious affiliation: Episcopalian
ACU: 64% ADA: 35% AFL-CIO: 18%

2. Olympia J. Snowe (R-ME)
Previously on Foreign Affairs Committee in the House of Representatives
Phone: 1-202-224-5344
Fax: 1-202-224-6853
Email (not confirmed):
senator_snowe@snowe.senate.gov

Year first elected: 1994
Religious affiliation: Greek Orthodox

3. John Ashcroft (R-MO)
Phone: 1-202-224-6154
Fax: 1-202-224-7615
Email (not confirmed):
senator_ashcroft@ashcroft.senate.gov

Year first elected: 1994
Religious Affiliation: Assembly of God

4. Russell D. Feingold (D-WI)**
Ranking Phone: 1-202-224-5323
Fax: 1-202-224-2725
Email (not confirmed):
senator_feingold@feingold.senate.gov

Year first elected: 1992
Religious Affiliation: Jewish
ACU: 12% ADA: 100% AFL-CIO: 91%

5. Dianne Feinstein (D-CA)
Phone: 1-202-224-3841
Fax: 1-202-228-3954
Email (not confirmed):
senator_feinstein@feinstein.senate.gov

Year first elected: 1992
Religious Affiliation: Jewish
ACU: 13% ADA: 85% AFL-CIO: 100%

** On the Africa Subcommittee in the last Congress

Note: Email addresses of the form senator_[last name]@[last name].senate.gov are reported to work. But unless the Senator has publicized an email address, as none of the five listed has to date, there is no guarantee that the electronic mailboxes are regularly checked. For the latest information, contact the Senator's office. Unlike the House, the Senate does not yet maintain a directory of email addresses.

U. S. House of Representatives
Committee on International Relations
Subcommittee on Africa

All House addresses are:
The Honorable [ ]
U.S. House of Representatives,
Washington, DC 20515.
None of these Representatives are yet among the minority (42 as of the last listing) of Representatives who have email addresses. This is likely to change quickly, however.
The most current information can be found through the Web server
http://thomas.loc.gov
through the House of Representatives gopher
gopher.house.gov
or through sending a blank email message to
congress@hr.house.gov.

1. Ileana Ros-Lehtinen (R-FL)*
Chairperson
Phone: 1-202-225-3931
Fax: 1-202-225-5620

Year first elected: 1989
District: 19th, parts of Miami and Dade County Religious Affiliation: Roman Catholic
ACU: 79% ADA: 30% AFL-CIO: 75%

2. Toby Roth (R-WI)*
Phone: 1-202-225-5665
Fax: 1-202-225-0087

Year first elected: 1978
District: 8th, Green Bay, Appleton
Religious Affiliation: Roman Catholic
ACU: 83% ADA: 25% AFL-CIO: 17%

3. Sam Brownback (R-KS)
Phone: 1-202-225-6601
Fax: 1-202-225-1445

Year first elected: 1994
District: 2nd, Topeka, Leavenworth, Pittsburg Religious Affiliation: Methodist

4. David Funderburk (R-NC)
Phone: 1-202-225-4531
Fax: 1-202-225-1539

Year first elected: 1994
District: 2nd, parts of Durham and Rocky Mount Religious Affiliation: Baptist

5. Steve Chabot (R-OH)
Phone: 1-202-225-2216
Fax: 1-202-225-4732

Year first elected: 1994
District: 1st, Hamilton County, Western Cincinnati Religious Affiliation: Roman Catholic

6. Mark Sanford (R-SC)
Phone: 1-202-225-3176 Fax: 1-202-225-4340

Year first elected: 1994
District: 1st, part of Charleston, Myrtle Beach
Religious Affiliation: Episcopalian

7. Matt Salmon (R-AZ)
Phone: 1-202-225-2635
Fax: 1-202-225-2607

Year first elected: 1994
District: 1st, southeastern Phoenix, Tempe, Mesa Religious Affiliation: Mormon

8. Gary Ackerman (D-NY)**
Ranking
Phone: 1-202-225-2601
Fax: 1-202-225-1589

Year first elected: 1983
District: 5th, Northeast Queens, northern Nassau and Suffolk counties
Religious Affiliation: Jewish
ACU: 13% ADA: 80% AFL-CIO: 100%

9. Harry Johnston (D-FL) **
Subcommittee Chair in last Congress
Phone: 1-202-225-3001
Fax: 1-202-225-8791

Year first elected: 1988
District: 19th, parts of Palm Beach and Broward counties, Boca Raton
Religious Affiliation: Presbyterian
ACU: 8% ADA: 90% AFL-CIO: 92%

10. Eliot Engel (D-NY)**
Phone: 1-202-225-2464
Fax: 1-202-225-5513

Year first elected: 1988
District: 17th, North Bronx, parts of southern Westchester
Religious Affiliation: Jewish
ACU: 5% ADA: 90% AFL-CIO: 100%

11. Donald Payne (D-NJ)**
Incoming chair, Congressional Black Caucus
Phone: 1-202-225-3436
Fax: 1-202-225-4160

Year first elected: 1988
District: 10th, parts of Newark and Jersey City Religious Affiliation: Baptist
ACU: 0% ADA: 100% AFL-CIO: 100%

12. Alcee Hastings (D-FL)**
Member, Congressional Black Caucus
Phone: 1-202-225-1313
Fax: 1-202-225-0690

Year first elected: 1992
District: 23rd, southeast, parts of Broward and Palm Beach counties
Religious Affiliation: African Methodist Episcopal
ACU: 4% ADA: 90% AFL-CIO: 92%

* On the Foreign Affairs Commitee in the last Congress, but not on the Africa Subcommittee
** On the Africa Subcommittee in the last Congress

Note and Request

A high proportion of the Subcommitee members, in both the Senate and the House, are new to African issues. Many, particularly on the Republican side in the House, are also new to Congress this year. In addition, all members of Congress face serious time pressures to deal with a multitude of issues. How much attention the Subcommittee members devote to Africa, and what views they advocate, will be highly influenced not only by their personal sympathies and ideological perspectives, but also by what they are hearing from relevant constituencies.

Priority states for building constituencies to educate Africa Subcommitee members and pressure them to take African concerns seriously are thus Kansas (1 Senator, 1 Representative), Wisconsin (1 Senator, 1 Representative), Florida (3 Representatives), New York (2 Representatives) and Maine, Missouri, and California (1 Senator each). Priority Congressional districts are indicated above for each Representative.

Among actions that would be appropriate for anyone concerned about a U.S. Africa policy responsive to African concerns:

(1) Pass on this update, particularly to Africa-concerned individuals and groups in the relevant states and Congressional districts.
(2) If you know of individuals or groups, again particularly in the relevant states and Congressional districts, who would be interested in receiving occasional short material on Africa policy and advocacy via email, please send, or ask them to send, their email addresses to woa@igc.apc.org.

Thanks to the Association of Concerned Africa Scholars (ACAS) for assistance in quickly compiling this list.

This material is made available by the Washington Office on Africa (WOA) and the Africa Policy Information Center (APIC). WOA is a not-for-profit church, trade union and civil rights group supported organization that works with Congress on Africa-related legislation. APIC is WOA's educational affiliate.

To receive basic information with a list of publications send a blank email message to woa-info@igc.apc.org.
[Note: Do *not* use the "reply" function in your mail program, which will send your message to woa@igc.apc.org. The address for an automatic response is *not* the same as for other substantive messages, which should be sent to
woa@igc.apc.org.
Please be patient on responses to other queries.]

For additional information:
Washington Office on Africa
110 Maryland Ave. NE, #112
Washington, DC 20002.
Phone: 202-546-7961.
Fax: 202-546-1545.
Email: woa@igc.apc.org

Organizing Grassroots Support for Continuing U.S. Aid to Africa

by The American Committee on Africa:

The American Committee on Africa is encouraging grassroots organizations around the U.S. to urge members of Congress to continuing providing development assistance to Africa and not to cut funding for poor people in the United States. As part of this effort ACOA organized a delegation of religious leaders to deliver petitions demanding continuing aid to Africa to senior White House officials in early April.

In addition, the American Committee on Africa's associated organization, The Africa Fund, has provided state and local elected officials with information to enable them to learn more about the importance of development assistance to Africa. As a result of these efforts the U.S. Conference of Mayors passed a resolution at its Winter Meeting in January 1995 passed a resolution calling on continued funding for the disadvantaged in the U.S. and in Africa.

The U.S. Conference of Mayors is encouraging cities around the country to pass similar resolutions during the next six months as part of its efforts to fight cuts backs in federal funding for development programs in Africa and in the U.S. A copy of the resolution is attached. For more information on these efforts contact the American Committee on Africa, 17 John Street, New York, NY 10038.

Resolution Passed by the United States Conference of Mayors International Affairs Committee at the Winter Meeting, January 1995:

Support for South Africa

WHEREAS, the old economic order -- apartheid, colonialism, and slavery -- helped devastate Africa, leaving it the poorest of continents;

WHEREAS, Congress created the Development Fund for Africa more than a decade ago to protect badly needed development aid to Africa;

WHEREAS, Congress earmarked $802 million for the Development Fund for Africa;

WHEREAS, African countries desperately need foreign aid to build schools and roads, purify drinking water, pay for immunization medicines and fight childhood diseases;

WHEREAS, Congress is debating destroying the safety net which secures survival living standards in the United States, thereby forcing states and cities to assume the burden;

NOW, THEREFORE BE IT RESOLVED, THAT the U.S. Conference of Mayors urges Congress to fulfill its responsibility in the United States by ensuring public and private investment in productivity- enhancing training and education for the disadvantaged; and call upon Congress to help Africa achieve sustainable development for Africa by maintaining the Development Fund for Africa at its current level.

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