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## The Impact of Structural Adjustment Programmes (SAPs) on Women's Health in Kenya

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### Introduction

The late 1970s and early 1980s were a difficult period for many developing countries because of high inflation, slow rates of economic growth, and declining earnings from exports. These factors affected national incomes and resulted in large government deficits, which in turn caused deterioration in the standard of living of families in the developing world.

During the 1980s, stabilisation and adjustment packages were introduced in many developing countries in an attempt to stop further deterioration in standards of living (Dixon et al. 1995, Barhin 1998). The term 'adjustment' refers to a range of macro-economic and structural measures that were promoted in the first instance by the Bretton Woods institutions - the World Bank and the International Monetary Fund (IMF) - to restore internal balances and increase the role of market force in the economy. Adjustment policies therefore denote the various mechanisms designed to reduce imbalances in Third World economies, both on external accounts and in domestic resource use. Adjustment frequently involved cutbacks in government expenditure. Consequently, real government expenditure per capita fell in over half the countries of the developing world in the period 1980-1984 (Cornia et al. 1987).

The impact of adjustment measures on local economic conditions varied widely as did the degree and consistency of their implementation. In sub-Saharan Africa, SAPs were implemented in only a handful of countries during the late 1970s, but by the end of the 1980s, most countries were formally involved (Streefland et al. 1998). In Africa, economic restructuring was a major component of the process of globalisation. Globalisation is a post-Second World War

phenomenon that has become manifest in the last three decades. This is a process involving the construction of a world system (Aina 1996). Globalisation entails the restructuring of the global, national, local and household economies, as well as social structures and livelihood strategies. It has transformed the international and local division of labour, changed relations of production, employment, the provision of social services, cultures and so on. These processes have affected communities in rural and urban Africa (Aina 1996). SAPs were an important aspect of globalisation.

In Africa, the restructuring process, coupled with the implementation of SAPs, has had a devastating effect on the provision of social services such as healthcare and education. Cutbacks in government expenditure have created constraints in the provision of these services, leading to a decline in social welfare. Since SAPs touched on every facet of life in the relevant countries, it affected governance in a way no other policy package had done before.

This paper examines the impact of SAPs on women's health in Kenya. It argues that the reforms brought upon by SAPs led to a decline in the health of most women in Kenya. It further argues that SAPs, an imposition on developing countries by the Bretton Woods institutions, violated the rights of Third World societies through the denial of access to healthcare, which is a basic human right. Since women were the most affected group in Kenya, the paper calls for the engendering of health services in the country in order to meet the health needs of women.

### **Health Services in Post-independence Kenya**

From the 1950s through to the 1970s, Kenya, and indeed most African countries, made substantial progress in healthcare delivery. In the 1970s, relatively high prices for Kenya's exports, which are mainly agricultural produce like coffee and tea, coupled with low interest rates, made increased spending in healthcare provision possible. Healthcare related projects, as well as the number of state medical personnel, also increased during this period. Consequently, there was a dramatic decline in infant and maternal mortality rates as well as a rise in life expectancy. In Kenya, the overall mortality rate dropped from 20 per 1000 persons in 1963 to 13 in 1987. Similarly, life expectancy increased from 49 years in 1960 to 58 in 1987. Immunisation also rose to 70 percent by the 1980s and early 1990s (Republic of Kenya Development Plan 1997-2001).

From the 1980s, however, the situation began to deteriorate. The early 1980s saw large drops in national income as the prices of coffee and tea in the world market fell to record low levels. This situation was compounded by increased interest rates on government borrowing, making debt servicing a problem for many African countries. This was largely responsible for the introduction of SAPs, which exacerbated the situation.

The economic crisis in many African countries, coupled with SAPs, undermined the health of many people in a number of ways. First, the removal of farming

subsidies and the resultant rise in food prices threatened the ability of families to feed themselves and thus remain healthy. The increasingly harsh socio-economic conditions also affected many people's access to health services outside the public sector. Secondly, the reduction in government expenditure in the public health sector reduced both the quantity and quality of healthcare available to the general populace. Thirdly, SAPs brought about the introduction of user fees or cost-sharing in Kenya's social services sector in order to relieve the government of the financial burden of providing healthcare and education. The Bamako Initiative, which introduced user fees in the public health sector, meant that the beneficiaries of public health services, who hitherto received free medical care, would henceforth contribute to the financing of healthcare delivery. This meant transferring the cost of healthcare services to people who were already too poor to afford it.

At independence in 1963, the government of Kenya took the responsibility for financing public health services, thus relieving beneficiaries of the financial burden. But the cutbacks in government expenditure through SAPs hurt the poor and the vulnerable groups most because they were dependent on the previously subsidised social services. The negative effects of the SAPs were borne by the low-income population, the majority of who are women (Nzomo 1995). A World Bank study has shown that the poor suffered disproportionately from the effects of the economic decline of the 1980s and structural adjustment measures (World Bank 1991). Specific vulnerable groups, such as female-headed households, can be identified in both rural and urban environments.

Living conditions for urban and rural populations have clearly deteriorated since 1975. Public expenditure on health services has been low amidst increasing demand for these services. For instance, annual spending on health services per capita in Kenya declined from US \$982 in 1980/81 to about US \$6.2 in 1996 (Owino and Munga 1997). Today, the state can only cater for 50 percent of the total recurrent health expenditure. Meanwhile the majority of Kenyans are located more than eight kilometres from any form of health facility, and 40 percent of the rural population has no access to health services. There is also a general lack of quality healthcare due to under-staffing, under-stocking of medical supplies, corruption, and poor public health infrastructure.

### **Women and Health**

The World Health Organisation (WHO) defines good health as a state of complete physical, mental and social well being of the whole person and not merely an absence of disease and infirmity. Good health is a human right that should be enjoyed by all. Moreover, a society's investment in the health of its citizens is essential for economic, social and political development.

Women play a crucial role in society. Besides their economic importance, they are educators as well as healthcare givers. It is therefore imperative that their health be taken seriously if the health of the rest of society is to be enhanced. It is

the mother who first notices a cold, cough, a rise in temperature, or a gastro-intestinal condition that may arise in any member of the family (Wallace 1990). Besides, women have multiple roles as wives, bearers and minders of children, food producers, fetchers of water and fuel, nursing the sick and elderly, part of the paid labour force, etc. This visibility of women in every facet of life makes it imperative to focus on their health (Kamara 2000).

Yet, available information indicates that women as a group are the least healthy population in Kenya. Compared to men, women in Kenya have less access to medical care, are more likely to be malnourished, poor, and illiterate, and even work longer and harder. The situation exacerbates women's reproductive role, which increases their vulnerability to morbidity and mortality. Furthermore, women's roles as mothers and wives make them the primary health seekers and caregivers, which exposes them to infections. Women's economic dependence, exposure to violence, limited power over their sexuality, poor nutrition, inadequate access to safe water, sanitation facilities and fuel supplies, particularly in rural areas, all have negative effects on their health (UN 1996). As a group, women therefore need healthcare more than men do.

Discrimination against girls, often resulting from favouritism to sons in access to nutrition and health services, endangers their health and well being. Girls need but often do not have access to necessary health and nutrition services as they mature (UN 1996). There are also conditions that force girls into harmful practices such as female genital mutation, early marriage and childbearing. This is perhaps what forced Kenyan female members of parliament to call for the distribution of free sanitary pads to all adolescent girls in Kenya's rural areas in 2004.

Furthermore, women are subjected to peculiar health risks through childbirth. The lack of services to meet health needs related to sexuality and reproduction during pregnancy and childbirth is among the leading causes of mortality and morbidity of women of reproductive age in Kenya and the developing world. Maternal problems are preventable through access to healthcare, including safe and effective family planning methods. In many countries, Kenya included, the neglect of women's reproductive rights severely limits their opportunities in public and private life, including opportunities for education (UN 1996).

It is clear that provision of adequate healthcare, particularly to women, is critical to a nation's development. But how is the provision of healthcare services in Kenya? What has been the impact of SAPs on women's health in Kenya? What effect has the introduction of user fees in Kenya had on women's health?

### **SAPs and Women's Health in Kenya**

A 1992 World Bank Report shows that the implementation of SAPs had a negative impact on a variety of groups. These groups include women who form the majority of the poor in society, but who are paradoxically the critical providers of health at home. This is particularly the case among female-headed households

in both rural and urban areas. It is evident that the poor have suffered disproportionately from the effects of economic decline and the structural adjustment measures (Wallace 1991).

Economic decline and SAPs hit women harder than men. Being responsible for the well being of their families, women found it difficult to cope with increased burdens of disease and hunger. The retrenchment policies resulting from implementation of the SAPs also affected women more than men as women dominate the less skilled work force. As a group, women are less educated and their participation in formal employment is low. With SAPs came the rationalisation of formal sector employment, leading to the retrenchment of the less skilled cadres, mainly women. Cost-sharing policies in education and the healthcare sectors also affected women adversely. The removal of subsidies in the agricultural sector, and the resultant high cost of inputs as well as low returns on farm products, also adversely affected the living standards of women and children (Aina 1995).

A 1992 situational analysis by UNICEF shows that for every maternal death, about a hundred women suffer serious physical and mental complications (UNICEF 1989). Indeed, cases of such complications go unreported. During pregnancy, many women not only suffer infections, injuries and disabilities, but also receive no medical care, no special diet, no lighter workload or other considerations. SAPs worsened this situation.

Kenya has high rates of maternal and infant mortality. Reliable data are lacking but estimates based on the 1989 national census are at 74 per 1000 persons. Indications are that maternal and infant mortality increased with the economic recessions of the 1980s and the introduction of SAPs. A report by UNICEF points to a clear relationship between poor health among women and the introduction of SAPs (UNICEF 1990).

Family planning services help in reducing the rate of infant and maternal mortality. One of the immediate causes of major complications in pregnancy and childbirth is many or frequent births. Before the introduction of SAPs, family planning services were free of charge but that is now history. There is also the poor accessibility to medical facilities and essential services. The majority of rural women trek long distances to and from health facilities. Before the introduction of SAPs, health facilities were on average 6-7 kilometres away from most households, but many of them closed down while those that remained open lack basic amenities. At Nakuru District Hospital in Kenya, for example, expectant mothers are required to buy gloves, surgical blades, disinfectants and syringes in preparation for childbirth. In addition, they have to bribe hospital personnel in order to be attended to. This is usually too expensive for many women and they opt for traditional birth attendants.

Maternal mortality poses a major threat to women of reproductive age in Kenya. Data on maternal mortality are scanty, but in 1992 it was estimated to range between 150 and 300 per 100,000 births. The positive achievements in

reducing mortality rates between 1960 and 1980s appear to have been reversed. Breman and Shelton (2001) have demonstrated the relationship between SAPs and the deterioration in healthcare services. There is a direct relationship between reduced government spending on healthcare because of structural adjustment policies and increased rates of child and maternal mortality as well as malnutrition.

One of the major causes of maternal and infant mortality in Kenya is lack of prenatal care. Statistics indicate that the majority of the women who die in childbirth, or whose children die before, during, or shortly after birth, had not been visiting prenatal clinics. For example, a study of maternal deaths at Pumwani Maternity Hospital in Nairobi shows that 66 percent of these deaths occurred in women who received no prenatal care or received it late. One of the major reasons why women do not visit prenatal and postnatal clinics is lack of resources. As already noted, while there was a steady improvement in reproductive health in the 1970s, the introduction of user charges in government hospitals in the 1980s has led to a decline in reproductive health (Kamara 2000).

Besides, many government hospitals lack essential amenities. Once machines and equipment such as incubators break down, they are rarely repaired. A fee is required from patients who are already too sick or poor to afford it. As a result, many turn to traditional birth attendants (TBAs) who are cheaper. Moreover, drugs are either unavailable or corruption makes them difficult to get as corrupt medical personnel sell public hospital drugs to private clinics. Cases of drugs in government hospitals expiring before use are also common. All these problems have led to the search for alternative therapies as people lose faith in public health facilities.

Family planning services also help in reducing infant and maternal mortality. One of the major causes of complications in pregnancy and childbirth is many or frequent births. Closely related to this issue is abortion, which causes a significant number of deaths in Kenya. Suffice to say that abortion is a thorny issue in Kenya today. Induced abortion, for example, accounts for 50 percent of all maternal deaths recorded at Kenyatta National Hospital in Nairobi. Illicit abortions in Kenya are carried out by quacks in backstreet clinics because of the lack of reproductive health facilities and the fact that abortion is illegal in Kenya.

Besides problems related to reproductive health, there are other health problems among women in Kenya. Women, like other social groups, require healthcare if they are to remain healthy. But a Kenya Demographic Health Survey (1998) shows that a significant portion of the gains made during the first 25 years of independence rapidly eroded in a short period due to the introduction of SAPs. The factors undermining women's health included deterioration in the quality and quantity of health services, decline in nutritional status, increased poverty, and impact of the HIV/AIDS pandemic.

Other factors include inadequate facilities and poor service. The physical set up of any health facility determines patient flow. Most of the facilities in public hospitals are rundown and the privacy of patients, especially in maternity wards, is lacking. Overcrowding and congestion increases the risk of infections. Health

establishments also lack basic equipment. Where equipment is available, it is non-functional. Supplies such as protective clothing, cotton wool, and surgical gloves are inadequate.

Recent studies have shown that women are the major users of health services. They are also the main providers and promoters of preventive and curative healthcare. However, they do not make optimal use of the existing health services. The factors contributing to this include the inadequate quality and quantity of services, increasing cost, long distance to the medical facilities, negative attitude of medical personnel and lack of time and heavy workload. Furthermore, women bear the social and health burdens of their family. They cope with the increased burden of disease and hunger. SAPs resulted in increased burdens on women.

### **The Impact of Cost-sharing on the Health of Women**

The Bamako Initiative introduced user fees or cost-sharing in many developing countries. This aimed at relieving governments of the financial burden of providing public services. This resulted in cutbacks in budgets for social services, including healthcare. Given the centrality of healthcare to a nation's well being, the introduction of cost-sharing would definitely hurt the poor and other vulnerable groups such as women and children. This would be the case in Kenya where women form the majority of the unemployed and are thus outside the scope of insurance schemes. How were women in Kenya expected to cater for their health needs?

Decline in government spending on healthcare means a decline in well being, especially for the poor who cannot afford the services offered by private healthcare providers. Studies have shown that the introduction of cost-sharing in the public health sector led to a decline in the utilisation of formal health services. In a situation of deteriorating service delivery and worsening household budgets, the question of introducing user fees is difficult. There is a need to ask consumers to supplement government expenditure on health services. But in a situation of low household incomes, user fees for health services can bar many people from such services. In the rural health centres studied, the utilisation of services remained substantially low. When discussing the utilisation of government clinics, the cost of the services is cited as an important determinant for the quality, accessibility and acceptability of the services available. Similarly, availability of drugs and outreach services are important considerations. Low morale among health personnel due to poor motivation is also an important factor in the quality of services provided in public health facilities.

This situation makes the introduction of user fees a double-edged sword, potentially affecting service delivery as well as utilisation of the services. In January 2004, Kenyatta National Hospital, the largest public health facility in Kenya, introduced user fees for children under five years of age. This has had serious consequences. It has been reported that after the introduction of user fees at Kenyatta National Hospital, utilisation of services has gone down (*Daily Nation*, January 2004).

It is clear that the introduction of user charges in the public health sector has had negative effects on the poor, the majority of who are women. The partial privatisation of public healthcare, through the introduction of user fees, constitutes an assault on both the physical well being and dignity of poor women. Kamara (2000) reports that since the introduction of user fees in Kenya, there has been a dramatic drop in the number of hospital visits, while the infant mortality rate has risen and life expectancy has dropped. The introduction of user charges in the public health sector is in many ways a retrogressive measure. It makes healthcare cease to be a basic human right. Since these measures came with SAPs, the programmes may be considered to have been unjust and unethical.

### **Engendering Women's Health**

In view of the impact of recent changes on the health of women, there is a need to integrate gender into health research, both conceptually and methodologically. Research that analyses the health problems of communities anywhere in Africa can no longer afford to neglect gender issues. Since women play important roles as informal healthcare providers and educators, as they seek to meet the health needs of their families, their significance for social well being can never be underestimated. For women to be able to fully perform their social roles, it is necessary to focus on issues that affect their health (Kamara 2000).

The production and reproductive activities of women makes their role as providers and consumers of healthcare the most critical aspect in a debate regarding gender in health research. However, the prevailing concept of health is not gender-sensitive. Women's health is directly or indirectly related to their reproductive health status. McFadden (1992) argues that women are often assumed to have no specific health needs outside of their mothering roles, an assumption borne out by most of the existing health programmes that target women only during their reproductive years. The safe motherhood initiative (SMI), mother and child health (MCH), primary healthcare (PHC), all include the mother because of her productive function vis-à-vis the survival and development of the child. When a woman is not expectant or lactating, she is essentially marginal to the health system.

Thus, women's reproductive roles largely serve as the basis for the definition of what health means for women at the personal, household, community and national levels. Consequently, the idea of health as a basic human right is rarely extended to women. Nor do women themselves perceive it in this holistic sense. Yet, African women as a group are the least healthy people in our communities. They are stressed, overworked, depressed, and generally unhealthy. As this paper has shown, the effects of SAPs on women's health went beyond reproductive health. There is therefore a need for a broad-based concept of health that goes beyond the narrow focus on women's reproductive health.

Women's health needs should be redefined to mean the totality of well being: reproductive health as well as other health needs. Health as defined by the WHO

is a concept implying the totality of physical, emotional and psychological well being. For women, this concept means the right to a healthy existence as a human being whether one is lactating or not. The concept also empowers women as human beings. Health after all is a human rights issue and women everywhere are entitled to healthcare like everybody else.

### Conclusion

This paper has tried to show the impact of SAPs on women's health in Kenya. It has argued that there was a direct link between the introduction of SAPs and deterioration in women's health as the SAPs led to a decline in public expenditure on healthcare.

The paper recommends that the following issues be urgently addressed in the quest for health for all, including women. First, there is a need for the evaluation of the existing medical facilities currently available in Kenya, and challenges to the government as a steward of the people to provide affordable healthcare for all. Secondly, medical services should be made both accessible and affordable to all, especially to poor rural women. Lastly, women's health needs, special or otherwise, should be given prominence.

### Bibliography

- Adebayo, A., 1990, *Structural Adjustment for Socio-Economic Recovery and Transformation: The African Alternative*, UNECA.
- Aina, T., 1996, *Globalization and Social Policy in Africa: Issues and Research Directions*, Dakar, CODESRIA.
- Antrobus, P., 1989, 'Women and Development: An Alternative Analysis', *Journal for International Development*, 1.
- Baile, S., 1990, 'Women and Health in Developing Countries', *The OECD Observer*, December 1989/January 1990, pp. 18-20.
- Bijlmakers, L., 2003, *Structural Adjustment: Source of Structural Adversity*, Leiden, African Studies Centre.
- Cornia, G., et al., eds., 1987, *Adjustment with a Human Face*, Vol. 1: *Protecting the Vulnerable and Promoting Growth*, New York, Oxford University Press.
- Denmark, 1995, 'Structural Adjustment in Africa: A Survey of the Experiences', Report prepared by the Centre for Development Research, Copenhagen, for the Danish Ministry of Foreign Affairs.
- Giorgis, B. W., 1991, 'The Integration of Gender Analysis in Health Research', CODESRIA Workshop on Gender Analysis and African Social Science, Dakar.
- Kamara, E., 2000, *The Effects of Structural Adjustment Programmes on Women's Health in Kenya*, ed., *Africa in Transformation*.
- Kenya, Republic of, 1986, *The Seventh National Development Plan 1994-1996*, Nairobi, Government Printer.

- Kenya, Republic of, 1992, *Women and Children in Kenya: A situational Analysis*, Nairobi, Mangra Phics.
- Kenya, Republic of, 1994, *Kenya's Health Policy Framework*, Nairobi, Government Printer.
- Kenya, Republic of, 1996, *Economic Reforms for 1996-1998: The Policy Framework Paper*, Nairobi, Government Printer.
- Kimathi, W. and Omiya, P. J., 1994, 'The Growing Burden of Poverty on Women and Its Effects on their Reproductive Health Rights: An Analysis of the Kenyan Case', An IPPF Discussion Paper.
- Macgregor, J., 1991, 'Towards Human-Centered Development: Primary Health Care in Africa', *African Insight*, Vol. 21, No. 3.
- McFadden, P., 1992, *Health as a Gender Issue*, Centre for African Family Studies, (CAFS).
- Nasirumbi, H., 1995, *Health Policies as They Affect Gender and Development in Kenya: A Case Study of HIV/AIDS Policies*, Mimeo, July.
- Ngugi, R., 1999, *Health-seeking Behaviour in the Reform Process for Rural Households: The Case of Mwea Division, Kirinyaga District, Kenya*, Nairobi, African Economic Research Consortium.
- Nzomo, M., 1995, 'Summary of Research Findings on the Impact of SAPs on Females and Gender in Kenya', in Kivutha, K., ed., *Women and Autonomy in Kenya: Policy and Legal Framework*, Nairobi, Claripress.
- Olenja, J. M., 1991, 'Women and Health Care in Siaya', in S. Gideon, ed., *Development in Kenya: Siaya District*, Nairobi, Institute of African Studies.
- Owino, W., 1998, *Public Healthcare Pricing Practices: The Question of Fee Adjustment*, Nairobi, IPAR.
- Owino, W. and Munga, S., 1997, *Decentralisation of Financial Management Systems: Its Implications and Impact on Kenya's Healthcare Delivery*, Nairobi, IPAR.
- Smyke, P., 1980, *Women and Health*, London, Zed Books.
- Streefland, P., et al., 1998, *Implications of Economic Crisis and Structural Adjustment Policies for PHC in the Periphery*.
- UNICEF, 1990, *The State of the World's Children*, Oxford University Press.
- Wallace, H. and Kanti, G., 1990, *Healthcare of Women and Children in Developing Countries*, Oakland.
- Werner, D., 1994, 'The Economic Crisis: Structural Adjustment and Healthcare in Africa', *Third World Resurgence*, No. 42/43, pp. 10-17.
- World Bank, 1994a, *Adjustment in Africa: Reforms, Results and the Road Ahead*, Washington DC, World Bank.
- World Bank, 1994b, *World Development Indicators*, Washington DC, World Bank.