

# View Point: Economic growth and child health in Sub Saharan Africa

BA O'Hare<sup>1</sup>, N Bar-Zeev<sup>2,3</sup>, L Chiwaula<sup>4</sup>

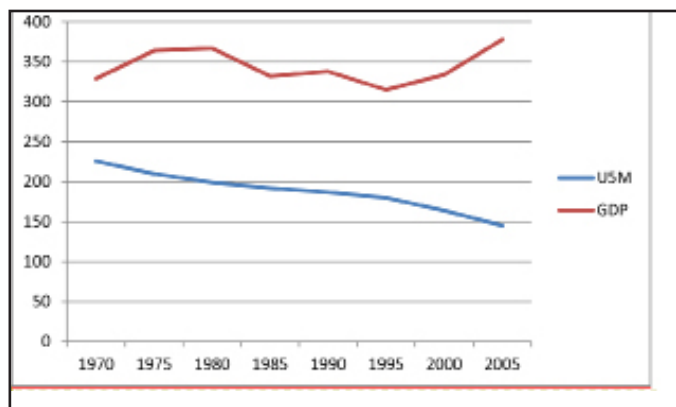
1. Department of Paediatrics and Child Health, College of Medicine, University of Malawi
2. Malawi-Liverpool-Wellcome Trust Clinical Research Programme
3. Institute of Infection & Global Health, University of Liverpool
4. Department of Economics, Chancellor College, University of Malawi

## Introduction

After independence most African countries witnessed growth in their economies and decreases in child mortality. However both economic growth and the gains in under 5 mortality slowed dramatically in the 1980s and 1990s<sup>1</sup>. The average under-5-mortality of countries in Sub Saharan Africa (SSA) reached a plateau's during the 1980s and early 1990s and only started to decrease again after 1995, this coincides with stagnant average incomes in SSA countries during this time period, see figure 1.

Figure 1: The average GDP per capita Purchasing Power Parity for countries in SSA excluding South Africa in USD and the U5M for these countries over the same period.

(Data from UNICEF, State of the World's Children 2011 and Gross Domestic Product per capita, purchasing power parity from the World Bank).



Comparing the annual rate of reduction in child mortality between 1970 and 2010 in two time periods, 1970 – 1990 and 1990 – 2010 and the GDP per capita annual growth rate over the same time period, two patterns emerge. Between 1970 and 1990 there was an association between the GDP per capita annual growth rate and the rate of reduction in under-five mortality; see figure 2. However, during the latter two decades there was no growth or shrinking of the average GDP per capita purchasing power parity (PPP) in the majority of countries in SSA, and no association with the annual rate of reduction of under-five mortality, see figure 3.

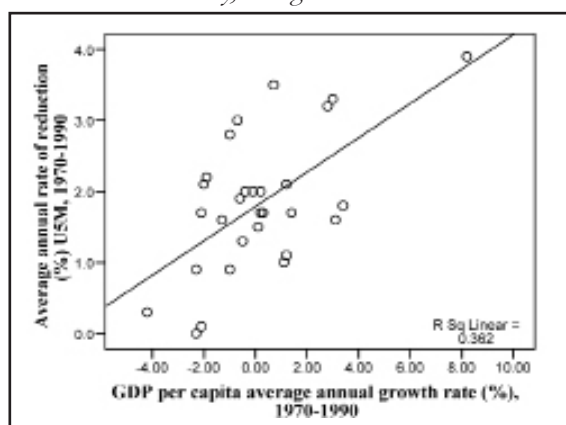


Figure 2: Economic growth and annual rate of reduction in child mortality, 1970-1990

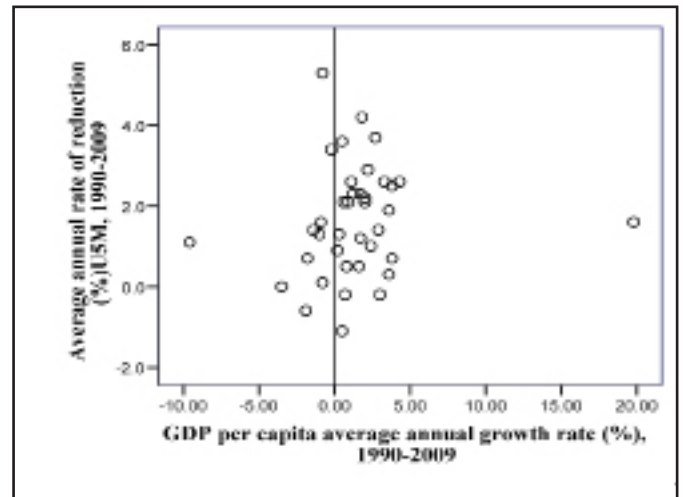


Figure 3: Economic growth and annual rate of reduction in child mortality, 1990-2009

## Is there an association between income, economic growth and child mortality?

Child mortality may be caused by distal, intermediate or proximal determinants of health<sup>2</sup>. Socioeconomic factors which have been shown to be important at the distal and intermediate level include income and maternal education<sup>3,4</sup>, the latter is influenced by the former<sup>5</sup>.

Many researchers have tried to establish the magnitude of the effect of country level income on average child mortality and they universally find that as income increases, child mortality significantly decreases. Research which has specifically looked at SSA confirms this trend for the continent<sup>6-9</sup>.

The majority of researchers control for variables which is known to influence child mortality, such as maternal education and health care, and still find a significant association between average child mortality rates and country level income. However, others point out that to control for intermediate determinants of health, such as maternal education is incorrect as these variables are a function of country level income and in fact are the mediators by which income influences mortality rather than being independent variables<sup>10</sup>.

Given that the economies of the majority of African countries were stagnant during the 1980s and 1990s and given the significant association between country level income and child mortality it is therefore not surprising that average under-five mortality during these decades reached a plateau.

## Why did economies in SSA stagnate during the 1980s and early 1990s?

In the 1970s many SSA countries took out large loans at a time of high inflation and low interest rates. In the 1980s there was an increase in oil prices and an increase in interest rates. At the same time there was a decrease in the price countries were receiving for their main exports, primary commodities. The interest rate on these loans spiraled and a debt crisis ensued. Commercial banks stopped lending money and the international community offered financial rescue provided the conditions of the International Monetary Fund (IMF) were agreed to. This gave the IMF huge leverage over indebted countries, in an era when there were strong neo-

liberal influences on international organizations. The resulting conditions dictated that countries opened their markets, decreased spending on welfare and oriented their produce towards export in order to earn foreign currency to repay the debts<sup>11</sup>. Few African countries had joined the WTO at the time of the Uruguay Round, but as a result of the conditions of loans, many had already liberalized their economies much more than required for accession. However accession to the WTO made the liberalization they had agreed to almost irreversible. The main instrument which countries have at their disposal when there are breaches of the international trade rules are sanctions but these are of limited usefulness to African countries given the small role they play on the international market stage, plus the cost of bringing a case before the WTO is prohibitively expensive for most African countries. Using loopholes, developed countries subsidize agricultural products<sup>7</sup> and set their tariffs at high levels thus limiting the import of agricultural products and processed goods, which negatively affects exporting African countries. Voting power within organizations responsible for economic governance, the IMF and the World Bank, is weighted towards economically powerful countries, which use this power to influence policy in their own commercial, financial and geopolitical interests. These interests may often be aligned with the interests of powerful groups within those countries, with lobbying muscle power. The WTO is theoretically one country one vote, but in reality the vote of African countries is often influenced using the tool of aid<sup>12</sup>. The Uruguay round has extended trade rules into domains such as services and intellectual property rights, these issues directly affects the cost of medication and seeds which greatly impacts the lives of the poor.

Policy decisions taken at the level of international organizations, including trade liberalization has resulted in changes to GDP per capita in many African countries in the last twenty years. The ongoing use of agricultural subsidies in the US, EU and Japan impacts the GDP of many western and central African countries<sup>13</sup>. Given the relationship between income and child mortality it is important that policies which may influence per capita income are considered carefully. Incoherent international policies such as giving aid to a country while undermining markets as a result of agricultural subsidies should be reconsidered. Policy decisions taken by our current system of global economic governance over the last 40 years has negatively influenced economic growth and therefore child health in Africa. Given this fact it is imperative that those interested in child health engage in the discourse around global economic governance.

## Acknowledgement

Dr David Woodward, independent writer and researcher who focuses on global economic governance, for his review of an earlier version of this paper.

## References

1. Cornia GA, Mwabu G. Health Status and Health Policy in Sub-Saharan Africa : A Long-Term Perspective. The United Nations University WIDER Working Paper 141. 1997;
2. Schell CO, Reilly M, Rosling H, Peterson S, Ekström AM. Socioeconomic determinants of infant mortality: a worldwide study of 152 low-, middle-, and high-income countries. *Scandinavian journal of public health*. 2007;35(3):288–97.
3. Summers L, Pritchett L. Wealthier is Healthier. World. World Bank, Policy Research Working Paper, No 1150,1993;
4. Filmer D, Pritchett L. The impact of public spending on health: does money matter? *Social science & medicine*. 1999;49(10):1309–23.
5. Houweling TA, Caspar AE, Looman WN, Mackenbach JP. Determinants of under-5 mortality among the poor and the rich: a cross-national analysis of 43 developing countries. *Int J Epidemiol*. 2005;34(6):1257–65.
6. Amouzou A, Hill K. Child Mortality and Socioeconomic Status in Sub-Saharan Africa. *Etude De La Population Africaine*. 2004;(1975).
7. Andoh SY, Umezaki M, Nakamura K, Kizuki M, Takano T. Correlation between national income, HIV/AIDS and political status and mortalities in African countries. *Public health* 2006 Jul;120(7):624–33.
8. Hague S, Gottschalk R, Martins P. Pro-poor growth: the evidence beyond income. The Sussex Economics Department and IDS ESRC Development Economics Conference, September 2008, University of Sussex..
9. Anyanwu J, Erhijakpor A. Health expenditures and health outcomes in Africa. Mortality. 2009; Development Research Division, African Development Bank.
10. Biggs B, King L, Basu S, Stuckler D. Is wealthier always healthier? The impact of national income level, inequality, and poverty on public health in Latin America. *Social science & medicine*. Elsevier Ltd; 2010 Jul;71(2):266–73.
11. O'Hare B, Venables J, Southall D. Child health in Africa: 2005 a year of hope? *Archives of disease in childhood*. 2005 Aug;90(8):776–81.
12. Jawara F, Kwa A. Behind the scenes at the WTO. 1st ed. Zed Books; 2004; Behind the Scenes at the WTO: The Real World of International Trade Negotiations ISBN-10: 1842773119.
13. Gillson I, Poulton C, Balcombe K, Page S. Understanding the impact of Cotton Subsidies on developing countries. UNCTAD Working Paper 2004;(May).