The damage of declining public investment on services

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Liberalisation and privatisation policies, and the new terms of international trade, have had negative impact on the national economy and the socio-economic status of the population. The decline in public investment in services has reflected negatively on human development, as indicated by the decline in calorie intake and the increase of the population under the poverty line. It was also reflected in the almost total failure to realise any of the government's targets in the fields of health, education, drinking water or sanitation.

Factors affecting human development

In 1996, the proportion of people under the poverty line in northern Sudan stood at 84.6% in the urban areas and 93.3% for the rural population and no state had a rate lower than 76% for urban centres and 80% for rural areas. Poverty and nutritional deficiency rates are expected to be much higher in war-torn southern Sudan, for which accurate figures are not available. The civil war, which has extended geographically and increased in intensity, has had very high costs in terms of human lives, with an estimated 2.9 million dead since 1983. The war has destroyed natural and financial resources while generating social and political instability. Environmental degradation caused by war, drought and mismanagement of resources has also resulted in lower bio-productivity.

Liberalisation and privatisation policies, and the new terms of international trade, have had negative impact on the national economy and the socio-economic status of the population. That impact is reflected especially in the collapse of the national manufacturing enterprises, because of their weak competitive position vis-à-vis imports. The economic embargo, declared and undeclared, against Sudan for most of the 1990s, has curbed the inflow of development aid, loans and investment. This has been the result of the ruling regime's international and foreign policies.

Official Development Assistance (ODA) per capita fell from USD 32 in 1989 to USD 3 by 1995 and to less than USD 0.50 by 1997. The suspension of ODA and limited flow of Foreign Direct Investment in the productive sector also contributed to the outflow of capital and savings (to buy imports) at a far greater rate than the inflow generated from exports. Foreign loans, far from solving economic problems, have themselves become an additional problem by causing a reduction in public expenditure. Sudan's external debts had grown to USD 24 billion, by the end of 1999, a rise of 77.4% over ten years, with a massive annual debt service of over USD 1.3 billion.[1]

Employment, wages, child labour and vagrancy

According to the Ministry of Manpower statistics (1990), the national unemployment rate is 16.5%; the rate is 13.0% for males and 28.0% for females, and 15.5% in rural areas and 19.6% in urban areas. Ironically, in the states where the public sector is the largest employer, unemployment is higher, mainly because of the laying-off of workers in conjunction with the requirements of Structural Adjustment Programmes (SAPs) and privatisation policies.

The fact that per capita income increased from the equivalent of USD 284 in 1996 to USD 288 in 1999 is rather misleading, as the purchasing power of money has seriously deteriorated through high inflation. Escalating prices and a freeze on wages are indicators of the deteriorating conditions of public sector employees and wage earners in general, and explain the exodus from the public sector.

Working children constitute 10% the total labour force and 24% of the total child population. Another social phenomenon, closely linked to child labour, is child vagrancy and homelessness. Available figures suggest some 66,000 children in Sudan are living in the streets, a rise of 5.4% between 1996 and 1999. This number is estimated to have risen by 13.9% in 2002.

Health indicators

Morbidity and mortality under-recorded

The leading five diseases (malaria, pneumonia, diarrhea, nutritional deficiency and septicemia) have together a morbidity rate 20.2% higher than the national rate, and more than 64% higher than the overall rate. However, these figures only reflect the sick people who are admitted to hospitals and recorded. A large number of disease incidents are not reported because of geographical inaccessibility and lack of health awareness. Many people have no access to health institutions, particularly after the introduction of the cost recovery programme within the SAPs package that was aggressively implemented between 1996 and 1998.

In 1997 it was estimated that 98% of the children under five and 81% of mothers in North Darfur had anaemia.[2] While the infant mortality rate shows a downward trend in the northern regions during the period from 1993 to 1999, the rate has increased for southern Sudan. The lowest rate recorded is in Khartoum, an indicator of the urban concentration of services. The maternal mortality rate has risen sharply from 365 per 100,000 live births in 1995 to 504 in 1999, an increase of 38% in four years.[3]

AIDS

According to official statistics, diagnosed AIDS cases rose from two in 1986 to 2,607 in 1999 to 8,222 (4,190 confirmed AIDS cases, 4,032 HIV carriers) in April 2002.[4] The average annual rate of increase between 1996 and 1999 had been as high as 27% and the prevalence rate is now 1.6%. Over 71% of the diagnosed cases are males, of whom 93% are in the 15-49 year-age group. During the last two years, the spread of AIDS that was denied before, was officially recognised, and more recently the government formed a council entrusted with taking the necessary measures to combat the spread of AIDS. Promotion of safe

1 H. A. Abdel Ati, «International Commitments and Developments since 1992 and their Implications for the Implementation of Agenda 21», in Sustainable Development in Sudan Ten Years After Rio Summit: a Civil Society Perspective, Khartoum, 2002.

2 UNICEF, Situation Analysis of Women and Children in the Sudan, Country office, Khartoum, 1999.

3 A. Ali, The Role of Population Education in the Process of Family Welfare in the Sudan, Ph.D. thesis, Geography Department, Faculty of Arts, University of Khartoum. 2001.

4 See the Ockenden Report in Abdel Ati, op. cit.

sexual behaviour, awareness and education seems to be the most effective means of fighting the disease, but very little has yet been done in this respect.

Basic education: dropout and absenteeism

School dropouts and absenteeism are serious problems. The average annual completion rates for the period 1996-1999 were 53.6% for both sexes, 50.8% for boys, and 57.2% for girls. School facilities (e.g., buildings, teaching materials) and training of teachers, which directly affect academic attainment and educational efficiency, are extremely poor in the vast majority of schools. The percentage of trained teachers in northern Sudan, which was 75% in 1991, dropped to 68.3% in 1996 and to 54.7% in 1999.[5] Regional variations are enormous, e.g. 86% in West Darfur, 67.1% in North Kordofan, and 50% in Gezira State.

Water: 90% of epidemics due to lack of drinking water

The overall water situation in the country is grim. Based on World Health Organisation estimates of per capita needs, current supply constitutes respectively 58.2%, 24.4% and 35.9% of urban, rural and total water requirements.[6] According to the WHO, about 90% of major epidemics in the Sudan are water-borne and water-related, causing the death of some 40% of children under five years of age.[7] Sudan's government has set the goal of universal access to safe drinking water and sanitary means of human waste disposal. To achieve that goal, the Comprehensive National Strategy (CNS) (1992-2002) gives priority to the following strategies: protection of water from pollution; increased community involvement; low-cost appropriate technology; and the availability of 18 litres per capita per day (L/C/D) for rural areas and 90 L/C/D for urban centres.[8]

Rural water supply

The total volume of rural water supply in all states of Sudan is estimated to be 528,336 cubic metres yielding an average per capita daily supply of 0.025 cubic metres for rural population. A sizable portion of supply is sometimes lost to evaporation and waste. The contribution of boreholes to the total supply is most significant, amounting to 69.2%, followed by hand pumps (12.1%), the system of rainwater collecting known as *hafirs* (11.8%), sand filters (6.4%) and wells (0.5%).[9]

Some regions, especially rural areas, have an acute shortage. Average per capita daily consumption ranges between a maximum of 35.3 litres in Khartoum and a minimum of only 2.3 in West Darfur State. For potable water the maximum and minimum figures in Sudan are 35.4 and 1.5 L/C/D respectively.

The rural water sector has depended for a long time on foreign funding, with some local community participation. Shrinking public investment has adversely affected progress in rural water supply programmes. The three-year programme carried out under the CNS had very low achievement rates during the period 1992-1995. The higher rates of achievement in the hand pump programme are primarily a result of the strong support from UNICEF, effective community participation and the appropriateness and cost effectiveness of the technology used.

Urban water supply

The last decade witnessed a surge in rural-to-urban migration. The urban population grew from 6.8 million in 1993 to 10.3 million in 1999 (a 51.5% increase). This has increased the pressure on the already limited urban water services. The target of the government is to provide piped water supply connections to 85% of the urban population by the year 2002, with the remaining 15% being served by public stand posts.

Targeted urban water consumption (90 L/C/D) had not been met up to 1999 in any of the 26 states of the country. The achievement rate was 56.8% for all the urban population; the highest rate was in Khartoum (81%) and the lowest recorded rate was in the Bahr El Ghazal region (13.6%). As for the type of supply, about 30% of all urban population had connections in 1999 (35.1% of the target) and no state had over 40% of its urban population with house connections. Thus, none of the CNS goals of urban water availability, type and quality of supply are expected to be achieved by the end of the CNS period (2002). Nor has the issue of regional disparities been addressed.

Concluding remarks

The decline in public investment in services has reflected negatively on human development. This is indicated by the drop in per capita calorie intake and the increase in the already high percentage of the population under the poverty line. It is also reflected in the almost total failure to realise any of the targets set by the CNS in the fields of health, education, drinking water or sanitation. Several trends merit special mention:

- Despite GDP growth, the positive trade balance and the increase in foreign debt, there is a decline in the development budget and social expenditure. Possible explanations are the high expenditure on the war (defence and security) and the halting of ODA and trade sanctions the country was subject to for most of the 1990s.
- Although incidence of disease was reduced, infant and maternal mortality have increased, which can only be attributed to poverty and/or poor services.
- The marked increase in child vagrancy is very much linked to the decrease in school enrolment and high dropout rates. With the increasing number of girls in the street as well, this poses the threat of spread of AIDS.
- All the indicators used confirm that great regional disparities persist. ■

5 UNICEF, 1999, op. cit.

6 Water and Sanitation Project 2000; Tables 28 and 34.

7 UNICEF, 1999, op. cit.

8 WHO puts the need at 20 L/C/D for rural areas, 100 for Khartoum and 80 for the other urban centres.

9 UNICEF, 1999, op. cit.

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