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Fragmentation of Health Care Delivery Services in Africa: Responsible Roles of Financial Donors and Project Implementers.

John Adwok[1*] Ellen Hope Kearns [2] Bryan Nyary[3]
1 Consultant Surgeon, Nairobi Hospital, P.O. Box 21274, 00505, Nairobi, Kenya
2 Healthcare Administration, School of Public Service Leadership, Capella University, Minneapolis, MN, USA
3. American Society for Clinical Pathology Institute for Global Outreach, Chicago, IL, USA
*E-mail of the corresponding author: jadwok52@gmail.com

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Abstract
The recent unprecedented availability of funds to alleviate health care problems in many African countries has been lauded as an important gesture from Western governments and financial donors. However, this type of funding often comes with constraints as the donors identify which projects to fund, who will implement them, and how to run them with little to no local community participation in the decision making process. Moreover, these vertical projects tend to lure away health care workers from the public sector with better pay incentives, and this leads to a further deterioration of existing health care facilities and services. Decreasing life expectancy and increasing infant mortality in many African countries is a relevant indicator to the failure of this type of funding for projects that fractionate instead of support public health care services(Garret, 2007).. Some analysts believe this trend could cause more harm to health care systems in Africa (Hsiao, 2007; Garret). More donor focus should be directed at developing the public health system as a whole, rather than concentrating on noble but largely ineffective ”favorite” vertical projects. Furthermore, donors funding should implement sustainable, locally-owned and –driven projects that increase, rather than deplete, indigenous human capacity and serve to improve in-country public health care services.
Key Words: Healthcare delivery, donor funding, African countries, fragmentation of services

Introduction

Until about 15 years ago, the poor and sick of the developing world were ravaged by a multitude of diseases, and it was generally beyond their ability to receive necessary treatment due to a lack of health care infrastructure, capacity, and resources. Thanks to the efforts of Western governments and a long list of charity organizations, faith-based organizations, non-governmental organizations, and philanthropists, billions of dollars were made available to combat these diseases (Hsiao, 2007; Garret, 2007). Aside from being considered a form of public diplomacy, this unprecedented generosity was also attributed to the realization by donors that it is a moral duty to stop the spread of tuberculosis (TB), malaria, avian influenza, and other lethal diseases.[2]. Without undermining the benevolent efforts of these generous people, the fact that microbes know no borders may have encouraged this form of investment in self-protection (Garret). Yet, the focus and style of the actual funding has raised issues relating to general public health in recipient countries. The role of donors in health care provision in Africa has been blamed for its current fragmented nature. Donor focus on financing vertical health care projects in African countries undermines public health care development through fragmentation of services, depletion of scarce human capital, and lack of involvement of local communities in decision making and ownership.

“Inappropriate” Donor Funding

The current selective system of donor funding for health care projects in Africa has become a cause of concern to international health organizations and local governments. Hsiao (2007), a leading expert in health care financing and a professor of economics at the Harvard School of Public Health, argues that “more money for health is a necessary but insufficient condition for better health….money can be transformed into equitable, efficient, and effective healthcare only when appropriate financing methods are used and institutional capacity and human resources are in place. These sentiments are further supported by Garrett (2007), an expert on global health, who argues that much more than money is required, as it takes states, health care systems, and some local infrastructure to improve public health in developing countries. Short of these conditions, more money for health may actually do harm. The setting of the global health agenda unilaterally by donors maybe impeding the improvement of public healthcare systems in developing countries.

Diseases that capture the public’s imagination, like HIV/AIDS, or diseases with a potential for rapid global spread, like hemorrhagic fever, drive most project funding in sub-Saharan Africa. According to Gostin (2007)

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"these funding streams skew priorities and divert resources from building stable local systems to meet everyday health needs." Although they may have good intentions, rich countries and philanthropists have a tendency to set priorities that may not reflect local needs and preferences (Gostin). Basically, funding is tied to Western interests as they place pressure on recipients to achieve narrow targets. The donor-enforced infectious-disease programs that are not integrated into public health systems are typical examples. Moreover, when the funding arrives, the assistance tends to be fragmented and uncoordinated. Relief agencies and non-governmental organizations (NGOs) often establish programs that compete with each other or with local government and business. Furthermore, lack of harmonization between these organizations results in unnecessary duplication of efforts, which is a waste of material and financial resources that could be better directed elsewhere.

Thousands of NGOs, aid agencies, and humanitarian groups vie to spend the millions of dollars allocated for fighting donor-selected diseases in Africa. Various researchers argue that the activities of these groups may work against the whole health care system in developing countries (Green, 2004; Garret, 2007; Hsiao, 2007; Marek, Eichler, & Schnabl, 2004). Recipient countries seek to improve the health status of their populations, but NGOs and aid agencies are obliged to operate from the donor country's perspective as Western governments consider external assistance as a basic foreign policy issue that is subject to the donor country's political and economic considerations (Schieber et al., 2007). The conflicting interests and priorities of donor and recipient inevitably result in a fragmented and uncoordinated health care system. Schieber et al. argue that "the most effective way to avoid such preference mismatches is for donors to support country-driven and -owned programs, financed through aid that is provided as general budget support and not targeted to specific projects." Perhaps donor countries are restricted from supporting recipient budgets directly by their tax-payers, who prefer to provide aid for specific programs such as HIV/AIDS, malaria, and TB. Yet, current evidence indicates that these imposed health care conditions rarely lead to improvement in the public health.

Western governments and populations are concerned about stopping serious epidemics like HIV/AIDS and TB, which are easily transmitted and have global health implications. Although their efforts to control these diseases are commendable, donors pay little attention to the effects of selective funding in controlling these maladies on the overall public health system of the afflicted countries. For example, instead of setting targets aimed at fighting single diseases, the donor community could focus on achieving increased maternal survival and increased overall life expectancy (Garret, 2007). When these two markers rise, it often indicates a "population's other health problems are also improving."(Garret). Although adult mortality from AIDS and TB are reducing life expectancies in various African countries, child survival remains the major driver of life expectancy. The highly acclaimed victories against diseases like malaria and HIV/AIDS may ease the conscience of philanthropists who contribute to global health projects. Yet, these benefactors may not be aware that their generous contributions might be negatively impacting the very fabric of public health care systems in African countries.

Major donor nations should consider how the current focus they place on their funding may have adverse outcomes. In the absence of more efficient and equitable health systems, many African countries will not be able to improve their programs for the prevention and control of diseases to meet specific health goals (Dodd & Cassels, 2006)... These goals include reducing child and maternal mortality, as well as rolling back HIV/AIDS, tuberculosis, and malaria. According to Dodd and Cassels, "none of the poorest regions of the developing world are currently on track to meet their target level of child mortality—60 deaths per 1,000 live births in 2015." Child mortality in poor sub-Saharan African countries was still at 170 deaths per live 1,000 births in 2003--nearly the same level as that of 1990 (Dodd & Cassels). Considering that more funds have been available to improve these very mortality rates, there must evidently be conceptual and implementation errors. Not surprisingly, there is also evidence that life expectancy in many African countries has declined in the last decade. In the midst of generous healthcare funding, life expectancy has actually been declining in many African countries. According to Garret (2007), global gaps in life expectancy have widened in the last 10 years. In Japan, the society with the longest lifespan, a girl born in 2004 will have a life expectancy of 86 years and a boy an expectancy of 79 years. These life expectances would be 34 years and 37 years, respectively, in Zimbabwe. (Garret). If the current fragmented funding does not integrate public health systems, things could get much worse. Western donor communities should thus shift their targets and recognize that getting rid of AIDS, TB, and malaria are best understood "not simply as tasks in themselves but also as essential components of larger goals (Garret) Meeting basic survival needs could be inexpensive and simple and should become a priority for funding by powerful donor countries. Improving vaccination programs and basic water sanitation as well as funding indigenous business to manufacture insecticide treated bed nets could save millions of lives annually in Africa (Gostin, 2007). Another concern is the movement of the available essential health care workers from public health care systems to take up jobs in donor-funded projects.

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Healthcare Brain Drain

The infusion of large sums of money by donors for specific diseases such as HIV/AIDS and TB has drawn away ”better-qualified” health care workers from public health care institutions in African countries. Better pay and other incentives have been a formidable magnet and created health workers' flight from the basic public healthcare system (Garret, 2007) The issue of internal as well as external migration has reached crisis levels in many developing countries. This claim is supported by Awases and colleagues who found that approximately 25% of health workers in African countries intend to migrate to other countries—usually in the West (Chatora & Tumuli, 2004). The main reasons given for migration include poor salaries and working conditions, lack of opportunities for professional development, unclear career paths, conflicts, and wars (Chatora & Tumuli). Ailing economies and increasing poverty have further encouraged African health care workers to leave public health care institutions in the thousands to take up similar jobs with NGOs involved in high-profile and well-funded projects. Further, the current international shortage of health care workers has also compounded the problem.

Estimates in 2004 indicated a shortage of four million health care workers in the world. Aging populations in Western countries increasingly demand more care from limited numbers of health care personnel, which compels their governments to recruit from developing countries in an effort to fill the gap (Garret, 2007). The *Journal of the American Medical Association* estimated that if these trends continue, the United States could face a shortage of up to 800,000 nurses and 200,000 doctors by 2020 (Garret). In the last ten years, it is estimated that 1,670 doctors and over 3,000 nurses emigrated from Kenya. Paradoxically, this brain drain is tacitly encouraged by Western governments and donor communities through implicitly practiced recruitment activities. Admittedly, the lure of a better life and professional advancement could be an irresistible magnet for young, poorly paid health professionals.

A constant struggle to escape poverty is a major part of daily life in developing countries—more so for well-educated and -trained young people. Low public sector salaries in African countries make it difficult to attract and retain staff, especially in remote rural areas, and can also encourage corruption (Dodd & Cassels, 2006). Therefore, it comes as no surprise when many health care workers abandon their low-paying jobs and join health care NGOs in search of a better quality of life. The generous funding of the donor-preferred health care projects and the lucrative salaries offered act as a formidable magnet for the poorly paid health care workers in Africa.

In the first six years of its existence, the Bill and Melinda Gates Foundation had donated $6.6 billion USD for global health programs—many in African countries (Garret, 2007). It is estimated that nearly $2 billion USD was spent on programs to control TB, HIV/AIDS, and other sexually transmitted diseases—mainly using locally recruited staff to implement the programs. Given the extreme shortages of health care staff, any further recruiting by NGOs of workers from the public health sector could have catastrophic results by collapsing the public health care sector in African countries. Governments have been reluctant to increase salaries of healthcare workers above the regular civil service guidelines because of fears of inflationary spillover effects. However, selective pay increases and other incentives may be the only option to stop bleeding the public health sector of its human capital. The activities of the donor-funded NGOs may be causing havoc to the public health care provision system. Yet, it would be unrealistic and shortsighted to fail to acknowledge their achievements.

In spite of their concerns about donor focus and NGO activities in their countries, African governments realize the considerable benefits NGO efforts bring to the health care delivery system. The use of donor funds to contract with non-state entities like NGOs has its positive attractions for both donors and African governments. According to Loevinsohn and Harding (2005), contracting provides the possibility of ensuring greater focus on the achievement of measurable results, especially if contracts define objectively verifiable outputs and outcomes. Moreover, it overcomes the constraints that commonly prevent governments in developing countries from effectively using the resources made available to them—absorptive capacity issues (Loevinsohn & Harding). Some of these projects, like the HIV/AIDS and malaria projects, have saved the lives of thousands of poor Africans. However, the question remains whether this has been achieved at a greater price to the target communities who resent the depletion of their health care manpower as well as their exclusion from the health care ”reforms” process.

What the donors and the NGOs prescribe as health care priorities for funding may not be regarded in the same light by African communities. In fact, promoting such projects—though targeted at improving the health of community members—may invite resentment and possible acrimony (Green, 2004). Typical examples include the complaints in the public media by communities in Northern Nigeria a few years ago against the World Health Organization (WHO). A routine poliomyelitis vaccination program was misconstrued by “misinformed” communities in the area as an attempt to infect their children with lethal diseases like HIV/AIDS by Western governments. Besides ignorance, cultural beliefs and residual suspicions from negative colonial experiences play

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a role in this negative attitude.

Community Participation

Local communities resent the attitude of donors and project implementers who more often than not exclude them completely from major decisions pertaining to their health. Various researchers have criticized neglect of the commitment to foster participation by communities in decisions about their health care (Hsiao, 2007; Green, 2004). Green argues that it is pragmatic and rational to assume that better health outcomes are likely to be achieved "through services whose design and management have been informed by inputs from, and are owned by, individuals and communities." Admittedly, the donors are experts in international health care matters and may claim to know what is best for Africans. However, this kind of attitude may invite resistance that could lead to the failure of a whole project.

Evidently, the views of international agencies with their financial leverage and technical expertise dominate the reform processes seen in developing countries today. Universal prescriptions from these "experts" failed to take into account the contextual differences between health systems and to recognize the inevitable failure of a single blueprint (Green, 2004) At a process level, "the reforms were often perceived as donor driven with little local ownership and thus, even where elements might have been relevant, the package was resisted." (Green) It is possible that this basic oversight or failure could have led to the loss of millions of dollars in failed projects. The shunning of the noble efforts of western governments and donors to save lives may be due to ignorance by African communities—entailed by the perceived lack of ownership by the local people.

In their enthusiasm and overzealous efforts to save the world by controlling lethal diseases "originating" from Africa, it seems as if the donor community may have overlooked the importance of ownership. According to Garrett, no provision exists to allow the world's "poor to say what they want, decide which projects serve their needs, or adopt local innovations." (Green, 2004). It seems possible that this grand public and private effort to save the African, and therefore the world, could push "poor countries into even deeper trouble in yet another tale of well-intended foreign meddling gone awry." (Garret, 2007) The war against disease in poor African countries is a shared responsibility of medical professionals, governments, multilateral organizations, NGOs, communities, the private sector, and other stakeholders (Goodman, 2005) The donor community may literally be sabotaging its projects by failing to bring the recipient communities on board as the invested funds would fail to achieve the desired results . Overdependence on donor funds by recipients also comes with its own problems. Massive infusion of funds into poor African countries leads to reliance and dependency (Gostin, 2007).Less dependence on donors for selected activities would allow the African health authorities to chart their own health care destinies to meet their specific needs and depend less on donors.

Many African countries spend little of their gross domestic product on health care. Although Kenya at the time of writing spends $14.20 USD per capita on health annually, up from $6.50 seven years ago, it remains very low (Garret,2007). Military spending and other perceived needs often take precedence to health (Gostin, 2007)). Concerns about misappropriation through corruption, incompetence, or excessive bureaucracy discourage donors from trusting host governments with donor health care funds. The World Bank estimates that roughly 50% of all foreign health funds in sub-Saharan Africa are spent on nonexistent services, counterfeit drugs, and bribes (Gostin). This should, however, not be a reason to completely exclude local communities and governments from involvement in projects that are essentially meant to better their health. Recent improvements in governance and democracy in many African countries, and the emergence of well-trained professionals, will hopefully improve the prevalent bad reputation and lack of transparency.

Conclusions and Recommendations

There seems to be an urgent need to review donor policies on funding health care projects in African countries. The current focus on vertical health care projects may be playing some role in alleviating serious infectious diseases that threaten international and local health—as exemplified by the huge sums spent on controlling HIV/AIDS, tuberculosis, and malaria. However, health indicators such as child mortality and life expectancy have been deteriorating in spite of the increased funding to improve the health of Africans. This decline has been attributed to the neglect of public health systems through underfunding and the loss of its health care workers to the better-funded donor projects and migration to developed countries.

Although aggravated by poverty, low salaries, lack of professional advancement, and run-down health care institutions, this migration trend should not be allowed to continue as it fosters the complete collapse of health care services in Africa. Developed countries need to come up with local solutions and train more health care workers to look after their aging populations and avoid virtually robbing Africa of its badly needed health care capital.

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There is obviously a need to go back to the drawing board and create health care projects that are more sustainable in African settings and encourage the participation of African health care workers. Concentrating on developing the whole public health system should be the overarching concept in this direction. Further, any vertical health care project should use prudent and selective recruitment practices while involving and seeking the input of local communities in order to gain their full cooperation in the process.

Lack of community ownership and involvement could lead to loss of large sums when projects fail to achieve their goals. Fear of misallocation of health care project funds may have deterred donors from entrusting money directly to African communities or health care authorities. It is no secret that corruption is rampant in developing countries, and donors have probably learned to be cautious from previous experience. Unfortunately, bypassing the communities seems to have worsened the situation and new strategies aimed at encompassing community cooperation in "their" projects need to be developed.

The improvement of governance in African countries in recent years, coupled with the emergence of a well-trained professional health care workforce, could be used to rejuvenate the ailing health care systems. Even outside the budgetary framework of recipient countries, donor funding could be utilized much more efficiently and effectively than hitherto practiced by initiating projects that will eventually lead to a more sustainable and improved local and global health

References

Chatora, R. R. & Tumuli, P. (2004). Primary health care: a review of its implementation in sub-Saharan Africa. *Primary Health Care Research & Development, 5,* 296-306. doi: 10.1191/1463423604pc220oa

Dodd, R. & Cassels, A. (2006). Health, development and the millennium development goals. *Annals of Tropical Medicine & Parasitology, 100* (5*),* 379-387. doi: 10.1179/136485906X97471

Garrett, L. (2007). The challenge of global health. *Foreign Affairs, 86*(1)*,* 14-38. Retrieved July 13, 2008, from Academic Search Premier database.

Green, A. (2004). Have health sector reforms strengthened PHC in developing countries? *Primary Health Care Research & Development, 5*(4)*,* 289-295. doi: 10.1191/1463423604pc219oa

Goodman, T. (2005). Is There A Right to Health? *Journal of Medicine & Philosophy, 30,* 643-662.doi: 10.1080/03605310500421413

Gostin, Lawrence O. (2007, July 11). Meeting the Survival Needs of the World's Least Healthy People. *JAMA: Journal of the American Medical Association*, *298*(2), 225-228. doi:10.1001/jama.298.2.225

Hsiao, W. C. (2007). Why is a systemic view of health financing necessary? *Health Affairs, 26*(4), 950-961. doi:10.1377/hlthaff.26.4.950

Loevinsohn, B. & Harding, A. (2005). Buying results? Contracting for health service delivery in developing countries. *Lancet, 366,* 676-681. doi: 10.1016/S0140-6736(05)67140-1

Marek, T., Eichler, R., & Schnabl, P. (2004). Resource allocation and purchasing in Africa: What is effective in improving the health of the poor? Retrieved July 8, 2008, from http://siteresources.worldbank.org/AFRICAEXT/Resources/No74.pdf

Schieber, G. J., Gottret, P., Fleisher, L. K., & Leive, A. A. (2007). Financing Global Health: Mission Unaccomplished. *Health Affairs, 26*(4)*,* 921-934. doi: 10.1377/hlthaff.26.4.921

First Author: John Adwok, MBBS, MMED (Surg), FCS (ECSA), FRCS (Edin.), FACS, Ph.D.
Formerly of the Department of Surgery, School of Medicine, University of Nairobi, Nairobi, Kenya
Consultant General and Endocrine Surgeon, Nairobi Hospital
Second Author: Ellen Hope Kearns, Ph.D., MASCP, SH (ASCP), FRSA
Healthcare Administration, School of Public Service Leadership, Capella University, Minneapolis, MN
Third Author: Bryan Nyary, MBA(C)
American Society for Clinical Pathology Institute for Global Outreach, Chicago, IL

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