

EXTERNAL ACTORS, GOOD GOVERNANCE AND HEALTH CARE DELIVERY IN AFRICA

Benjamin Uchenna Anaemene¹

Introduction

The post-Cold War period ushered in a new era in the history of global health. The period witnessed a rapid proliferation of actors involved in health issues, with an attendant increase in the number of and available resources for global health initiatives aimed at improving health, especially in the developing countries including Africa. Writing in 2008, McColl found 'more than 40 bilateral donors, 26 UN agencies, 20 global and regional funds and 90 active global health initiatives' (McColl 2008) These initiatives were accompanied by significant resources. It has been estimated that global financial investments in health increased phenomenally from \$5 billion in 1990 to about \$14 billion in 2005 (Ruger 2007) and \$21.8 billion in 2007 (Ravishanka 2009)

This development holds true of the involvement of external actors in Africa's health sector since the 1990s. External assistance accounts for 16 percent of total health expenditure in sub-Saharan Africa far higher than any other region in the world (USAID 2008, 25). For instance, bilateral and multilateral donors, as reported by OECD, increased their aid for health from \$3.9 billion in 2000 to \$19.9 billion in 2009 (OECD 2011). In terms of geographical distribution, Africa is the biggest recipient of development assistance for health. Approximately 40 percent of total aid went to the continent in 2009.

The African experience is attributable to two factors. First, the Structural Adjustment Programme imposed by the World Bank and International Monetary Fund (IMF) in the face of the serious economic crisis that confronted African states in the 1970s and 80s resulted in severe cuts

¹ Ph.D in History and Strategic Studies from the University of Lagos; Lecturer in the Department of History and International Studies, Redeemer's University, Nigeria. E-mail: anaemeneb@run.edu.ng

in state spending on education, health, and other social services and made external intervention inevitable. State failure in the provision of social services led to the externalisation of responsibility for health and the proliferation of actors working in the field of health across the continent. Another factor is the collapse of the Cold War system and the growth of globalisation, which brought about several revolutionary transformations in international health. The consequence of this development is the frequency with which states address health issues through their foreign policies; a reflection of the movement of health from the margins of low politics into a situation in which health now significantly features in all four foreign policy functions of national security, global economy, political and social development and the protection and promotion of human dignity through humanitarianism and human right policies (Fidler 2005, 3). Thus, tackling the developing countries' diseases, particularly Africa, became a key feature of many developed states' foreign policies. According to Garret, "some see stopping the spread of HIV/AIDS, tuberculosis, malaria, avian influenza and other major killers as a moral duty. Some see it as public diplomacy. And some see it as an investment in self-protection given that microbes know no bounds" (Garret 2007, 14).

Apparently, the growing number of external actors has been accompanied by an increasingly fragmented aid architecture and diversity of governance arrangements at the country level that is challenging national systems and management capacity in African states (USAID 2008, 28). In addition, many of the initiatives also lack mechanisms of accountability, transparency, and evaluation in the way they operate in African countries. The key issue, then, is how good governance can be institutionalised and entrenched to ensure full maximisation of the benefits of the activities of these actors for future sustainability. Without any shadow of doubt, several external actors have been playing roles, which either constrain or promote health care in Africa. The dynamics of the role being played by these actors, whether negative or positive, are not sufficiently studied, analysed, appreciated and understood.

The central argument in this article is that despite the fact that this development has had both positive and negative consequences on Africa the debate about the role of external actors in health care delivery in Africa has dwelt extensively on the degree they should participate neglecting the emphasis on how they participate, under what conditions and with what consequences. The aim of this article, therefore, is to examine the involvement of external actors (bilateral donors, multilateral agencies and international NGOs) in health care delivery in Africa illustrating the nature, pattern, dimensions, and dynamics of such engagements in the context of popular concerns with good

governance.

External Actors in Africa

Several external actors (state and non-state) are involved in the provision of assistance for health in Africa. There has been a huge increase in the number of and diversity of actors involved in global health since the 1990s. Health is an explicit and central part of the mandates of some of these actors, but more and more organisations with minimal health mandates are implementing their own programmes. The external actors include:

1. National Governments

At the core of the system are national governments, with their specialised health ministries, departments or agencies, such as the US National Institutes of Health, and in the case of donor nations, the health programmes of their bilateral development cooperation agencies. Bilateral agencies active in the African health sector, which includes the Department for International Development (DFID), United States Agency for International Development (USAID), Canadian International Development Agency (CIDA) and Japanese International Cooperation Agency (JICA), have played important roles in providing health assistance to African countries through government-to-government agreements known as bilateral aids (Walt, Buse & Harmer 2012). Apart from direct funding to the government, the bilateral agencies also channel funds through some UN agencies, including WHO for health-related projects. In the 2000s, the number of governments providing bilateral aids to Africa increased, to include China, India, and the Persian Gulf States, among others (SIX 2009).

2. United Nations System

United Nations System is another important actor. The World Health Organisation (WHO) is the UN-designated specialised agency in health expected to play a leading role in coordinating international health activities. The World Health Organisation has played a central role in health development of Africa since its inception in 1948. In doing this, the WHO also acted beyond its original mandate. The WHO is now joined by many other players, some with a primarily financial investment function and others with mixed-finance policy operational functions. As Ruger and Yach have shown:

Health debates have moved out of cloistered health departments and the WHO and are regularly a part of G8 and other multilateral meetings. The world economic forum has sponsored deliberations about health issues ranging from HIV/AIDS and vaccines to obesity and tobacco control. The UN Security Council has addressed HIV/AIDS, Malaria and Tuberculosis, the Bill and Melinda Gates Foundation and pharmaceutical companies such as Merck, Pfizer, Novartis, and GlaxoSmithKline play more important roles (Ruger & Yach 2009)

Other organisations within the UN system actively involved in providing health assistance to African countries are the United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Children Fund (UNICEF), United Nations Office of Drug and Crime Control, (UNODCCP), United Nations AIDS Programme (UNAIDS) and World Bank. For instance, UNDP focused on poverty reduction and coordinates United Nations operational activities. UNICEF focused on the rights of children and issues related to child health. UNODCCP focused on prevention of drug abuse and related issues. UNFPA, for its part, spearheaded population issues. Other organisations include United Nations Fund for Women (UNIFEM), which promotes gender mainstreaming, the Food and Agriculture Organisation (FAO), which promotes food security and the United Nations High Commissioner for Refugees (UNHCR), which is concerned with the protection of refugees.

United Nations AIDS Programme (UNAIDS) collaborates with other members of the United Nations (UN) theme group on HIV/AIDS to scale up joint activities. The World Bank has emerged as the most important intergovernmental organisation working on global health issues and a major player in Africa's health sector. Since the 1980s, the World Bank has served as the largest funder of global health issues (Youde 2012). It has integrated them into its mandate and its health funding has proven of vital importance to many African states. However, the activities of the World Bank in Africa face serious criticisms for prioritising a neo-liberal vision and promoting the interest of the Bank funders over the need of the countries receiving aid. Other regional agencies, such as the European Union and the African Development Bank, also increased their interest in Africa. For instance, the EU and the Federal Government of Nigeria entered into an agreement to revitalise the Primary Health Care (PHC) system with special emphasis on immunisation services, especially polio eradication. The European Union made a donation \$41.4 million, in support of UNICEF-assisted water and sanitation projects in Nigeria (WHO 2002). This represented the largest contribution by the Union to a development agency in any part of the world.

The pluralistic landscape has been enriched by a set of innovative and influential hybrid organisations or global health partnerships (GHPs), such as the GAVI Alliance, which works to improve the functioning of global markets for commodities for the Acquired Immunodeficiency Syndrome (AIDS), tuberculosis and malaria and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). The original rationale for establishing these GHPs was to better focus health aid in areas of perceived neglect and to simplify the aid architecture in these areas (Dodd, Schieber, Fleisher & Gottret 2007). They are governed by representatives both from within and from outside national governments.

Africa's health sector has been increasingly influenced by decisions that are made in other policy-making arenas, such as those governing international trade, migration and the environment (Dodd, Schieber, Fleisher & Gottret 2007). Actors in these arena influence health even though that is not their primary focus. A major example of such an organisation is the World Trade Organisation, which has shaped domestic and global intellectual property rules relating to pharmaceuticals among other trade-related issues.

3. Non-Governmental Organisations

International Non-Governmental Organisations (NGOs), increasingly referred to as Civil Society Organisations (CSO), have made critical contributions to health development in Africa. These CSOs are typically voluntary, non-formal and non-commercial associations of individuals, who share some common cause or goals. They include church missions providing care to isolated rural communities, and agencies, such as Oxfam, Rotary International, and Doctors without Borders (Médecins San Frontières) among others. The proliferation of actors getting involved in international health concerns has led to the diffusion of authority and increasing difficulty in coordinating action. In Africa, CSOs have focused on delivering health services directly. They filled the gaps where government health services were absent or inadequate (Lee 2010). The emergence of HIV/AIDS drove much of the growth of CSOs in Africa. When governments proved themselves unable or unwilling to extend services to HIV positive persons, CSOs came to the forefront of providing care.

Historically, Oxfam International focused on providing assistance and relief to those affected by a disaster. In 2000, the organisation shifted its focus to addressing the structural causes of poverty and injustice, particularly in Africa. Today, Oxfam International organises its activities around a commitment to five broad areas of rights, namely the right to a sustainable livelihood, the right to basic social services, the right to life and security, the right to be heard

and the right to identity (Oxfam 2007). Health figures prominently in Oxfam International's work to provide essential services and ensure the right to basic social services and to life and security. In its advocacy work, it has condemned the inequities in access to health services and vital pharmaceuticals as well as the international trade and intellectual property rules that prevent those in poor countries from realising their right to health. Oxfam International has also chastised the international community for under-providing health services, charging high healthcare fees in poor countries and relying too heavily on the private market. Regarding direct service provision, Oxfam generally partners with local organisations to establish health care clinics and ensure access to clean water and sanitation. For instance, one project, the Joint Oxfam HIV/AIDS Project (JOHAP), works in South Africa to ensure delivery of home-based services (Smith 2015). In addition, it also incorporates a variety of efforts to foster economic development and provide a means of living for communities afflicted by HIV/AIDS.

Rotary International – a service club with more than 1 million members worldwide – has taken the lead in the global polio eradication campaign. The Rotary's Global Polio plus Programme contributed \$688.5 million to the fight against Polio in Africa (Smith 2015). It also provided volunteers to vaccinate millions of people in Africa. The efforts of Rotary International, working in conjunction with the WHO, cut the number of polio cases from 350,000 in 1988 to roughly 1,600 in 2009 (Youde 2012: 99). Religious CSOs have also played significant roles in helping to reduce the spread of polio. In Northern Nigeria, rumours spread that polio vaccines sterilised Muslim girls and were part of a plot against Muslims. It was possible to counter these claims through the involvement of Muslim religious leaders and organisations, who convinced many objectors that it was in their interest to receive the vaccine and that it will not sterilise Muslim girls (Kauffman & Feldbaum 2009).

Doctors Without Borders/Médecins Sans Frontières (MSF) has been active in providing medical aid where it is needed in Africa – in armed conflicts, epidemics, natural disasters, and other crisis situations (Medecins San Frontieres, <http://www.msf.org.za/about-us/where-we-work.>). MSF was particularly visible during the fight against Ebola virus disease in West Africa in 2014 – setting up Ebola treatment centres as well as providing services, such as psychological support, health promotion activities, surveillance and contact tracing in the affected countries (Medicins Sans Frontieres, <http://www.msf.ca/en/ebola>) It has continued Ebola activities by running support clinics for Ebola survivors and has spent over \$15 million on tackling the epidemic. MSF also run longer-term projects designed to tackle the health crisis and support people who access health care.

4. Philanthropic Organisations

There are many philanthropic organisations currently involved in health and disbursement of packages of assistance in that regard in Africa. Examples of such philanthropic organisations include Bill and Melinda Gates Foundation, Bill Clinton Foundation, Rockefeller Foundation, and Wellcome Trust. These foundations play a big role in Africa; an indication that private philanthropic actors can play a significant role in helping to shape the agendas for major international issues. These actors are not pushing other actors out rather they are entering areas where state actors have largely failed to go. In Africa, Bill and Melinda Gates Foundation is associated with efforts to combat malaria and polio. One example of the Gate's Foundation efforts to build effective partnerships in Nigeria is its funding and support for the eradication of polio through international bodies, such as the World Health Organisation (WHO), United Nations International Children Education Fund (UNICEF), Rotary International and the World Bank (Gates Foundation²). In partnership with all stakeholders, Gate's Foundation is committed to the implementation of the National Polio Eradication Emergency Plan. Other examples include grants to the Society for Family Health to improve care for newborns and pregnant women in various communities in Northeast Nigeria. These have been its priority for several years. However, its work is much more far-reaching addressing a multitude of challenges in the area of health.

5. Private Industry

The corporate sector has been involved in health activities over the last decades in Africa. It is instructive to note that more than 1000 companies are members of the Global Health Initiatives established to increase the quantity and quality of business programmes fighting HIV/AIDS, tuberculosis and Malaria (Six 2009). For instance, companies, such as Heineken, Anglo-America, and Coca-Cola, have introduced antiretroviral treatment programmes for their workers in Africa.

Historicising External Actors Involvement in Africa's Health Sector

External actors' involvement in Africa's health sector dates back to the colonial era, precisely after the Second World War. Such assistance came

2 <http://www.gatesfoundation.org/Media-Center/Press-Releases/2012/09/Gates-Foundation-to-Open-Office-in-Abuja>

mostly from the United Nations Organisation and its specialised agencies and was channeled indirectly through the various colonial administrations. The post-war period witnessed notable advances in the volume of aid from the United States. In addition, due to the great wealth of the United States, much of the help derived from the then UNO was also from American pockets – they helped in solving African health needs. In Nigeria, for instance, the switch from a colonial to a technical assistance structure led to an increase in the number of agencies, which supplied international medical aids to Nigeria (Schram 1971). Available records show that between 1949 and 1953, the WHO was engaged in the fight against malaria and other diseases in the country in line with the Organisation's strong offensive against the diseases that cause serious damage after the Second World War (Beigbeder 1998). This was made possible by Britain's membership of the WHO, as one of the founding members after the Second World War. However, much was not achieved during the period because Nigeria was sovereign void.

External assistance for health continued to flow into Africa in the post-independence era. However, it was not until the 1990s that Africa began to experience an exponential rise in the number and diversity of external actors. This scenario can be traced to the global economic recession, which disrupted the development project of most African states. The attainment of independence by African countries coincided with the period when long term planning and state direction was acknowledged as the most promising route to modernisation and development. As a result, the first generation of African governments was committed to fostering a developmental state (Nkandiwire 2001). The African developmental state sought during this period, to intervene to accumulate surpluses from the agricultural sector and use them to fund import substitution driven industrialisation (Saul & Leys 1999) This accounted for the rapid annual growth rates experienced by African countries during this period. As Thandika Nkandiwire rightly argued, in the period between 1967 and 1980, no less than ten African countries enjoyed annual growth rates of more than 6%, with Kenya and Nigeria, for example, outperforming Malaysia and Indonesia (Nkandiwire 2001).

Similarly, available evidence also indicates greater improvements in Africa's health during the first decades of independence, suggesting that African crises in health are of more recent origin. Interestingly, between 1960 and 1980, most African countries made significant advances in extending health care coverage. In addition, larger scale campaigns were launched against specific infectious diseases, health facilities were expanded and there was a significant increase in the number of trained health workers. For instance, in 1960 tropical Africa had one qualified doctor for every 50,000

people; by 1980, this has become one for every 20,000 (Illife 1995). The most significant impact was on endemic childhood diseases.

This propitious beginning in terms of health care delivery was halted by the global economic recession in the 1980s. It would be recalled that in the heyday of economic growth, most African countries obtained loans from Western commercial banks. Unfortunately, the economic crisis in the 1980s made it virtually impossible for most African countries to redeem their debts. It was in the bid to contain the crisis in the economy that most African countries began to obtain loans from the international capital markets (World Bank and IMF). This led to the introduction of Structural Adjustment Programmes (SAPs), formulated to ensure that the developing countries including Africa that were entangled in external indebtedness were able to save funds towards fulfilling their obligations.

The implementation of SAP with its harsh conditionality negatively affected the health sector and the health status of Africans (Loewenson 1993). These included a shift from direct provisioning by government, which essentially entails greater reliance on private voluntary services, instituting a number of financial measures like introduction of user fees and contracting out to the private sector as a way of improving efficiency and patient satisfaction. As a corollary, the government expenditure on health in sub-Saharan Africa declined from an average of 6.2% of GDP in 1972, and 5.3% of GDP in 1982 to 1.6% in 1995. (World Bank 2000). In Nigeria, for example, health spending as a proportion of federal government expenditure shrank from an average of 3.5% in the early 1970s to less than 2% in the 1980s and 1990s. (Ogunbekun, Ogunbekun & Orobatan 1999).

Consequently, health care systems became dysfunctional across the continent creating near catastrophic conditions. More than 200 million Africans have no access to health services because of the near collapse of acute hospital services, characterised by frequent drug shortages, run down physical structures and the efflux of highly skilled but demotivated medical specialists. This has left diseases to rage unchecked. The successes recorded during the early 1970s were followed after 1980 by a major slowdown in the decline of mortality rates. The past two decades have witnessed the emergence of new infectious diseases, AIDS and Ebola, and the recrudescence of old scourges like tuberculosis and malaria. Consequently, there was the erosion of the capacity of virtually all African states, state failure led to the externalisation of responsibility for social services. Christopher Clapham has described the scenario as the “de-stating of external relations with Africa” (Clapham 1996). In particular, the responsibility was assumed by external actors across Africa. In essence, external aid became an ever more vital part of the African health

system.

The end of the Cold War and the impact of globalisation gave further impetus to external assistance for health in Africa. This is ascribable to the growing importance of health in the global political agenda. An important consequence of this development is the frequency with which states addressed health issues through their foreign policies. Health was conceptualised as central to national security, economic development, and human rights. Moreover, the importance of health is underscored by the redefinition of national security to include issues of health to make the concept of health security more relevant to the challenges states face in the post-Cold War era. Health issues began to be framed as security threats by virtue of their negative impact on economic and political stability both within countries and across borders. For instance, in 2000 the United Nations Security Council adopted a resolution identifying HIV/AIDS as a threat to international peace and security (UNSC, <http://www.un.org/docs/scres/2000/sc.2000.htm>). Thus, tackling health problems in developing countries including Africa became a vital feature of many developed nations' foreign policies.

Why the Emphasis on Good Governance?

Governance is a more encompassing concept than government and refers to the totality of ways in which a society organises and collectively manages its affairs (UNDP 1997). Global governance is the extension of this notion to the global stage (Weiss 2000) It includes the formal and informal processes that shape the way we collectively address issues of global importance such as public health. Global governance is distinct from national governance in one respect, the absence of central government at the global level. The rationale for using a good governance lens is the recognition that the challenge of achieving good governance among the diverse external actors in Africa's health sector has attracted serious attention. Yet only a little attention has been given to the problem of protecting health in governance processes. It has been argued that good global governance for health should exhibit at least the following traits:

1. *Participation* – the degree of ownership and involvement that stakeholders have in the political system
2. *Fairness* – the degree to which rules are applied equally to every one
3. *Decency* – the degree to which rules are formed and implemented without humiliating or harming particular groups of people
4. *Accountability* – the extent those with governing powers are responsible and responsive to those affected by their actions

5. *Sustainability* – the extent to which current needs are met

6. *Transparency* – the extent to which decisions are made in a clear and open manner (Hyden, Court & Mease 2003)

Yet, the achievement of these goals is hampered by governance challenges caused by the proliferation of actors involved in Africa's health sector. While this diversity may constitute evidence that the international community takes global health seriously, the proliferation of actors getting involved in global health governance and indeed Africa's health sector complicates coordination. It must be emphasised that the World Health Organisation once directed and coordinated international responses to health concerns on its own, but the diversity of actors demonstrates the inability of the WHO to coordinate action and ensure that resources are being used effectively, that programmes do not significantly overlap and that local needs are addressed. With the WHO as the recognised authority, global health was generally hierarchical from the 1950s up to the 1980s. This architecture included the international organisations that made up the United Nations system with relatively clear lines of authority down to the regional players and the developing countries being served.

However, the architecture was completely disrupted in the 1990s. This was because of the entry of many new players into global health and the influence of other global forces that reshaped human society. As a corollary, global health architecture became fragmented, with interactions and authority dispersed across UN health agencies, the World Bank, philanthropies, business organisations, bilateral and the country being served. Ilona Kickbusch and Kent Buse captured the dramatic nature of this change when they wrote that:

Throughout the 1990s...the number of institutions and organisations with an interesting, and impact upon, health grew exponentially but became increasingly fragmented. The international public health scene came to comprise both global and regional agencies, including the regional development banks the European Union (EU), the numerous national and international nongovernmental organisations (NGOs). WHO no longer played a leadership role and had become one player among many (Kickbusch & Buse 2005).

One clear implication of this new development is that many players are not bound by the rules of the past. This shift was disorienting for a sector long accustomed to established rules and practices. The new actors invented their own practices and created relationships with other organisations and governments, sending out communications and coordinating across players instead of operating hierarchically through traditional regional players and WHO. In practice, donors often function as competitors. Due to the

increasingly fragmented relationships among these global health actors and the decline in the WHO's authority, it is no longer clear where decisions about overall strategy and governance should be addressed: Walt, has argued that:

While this pluralism of activity and partnership has raised the status of health on the policy agenda and changed the balance of power, it has also led to concerns about overlapping mandates, competition, duplication of health activities, poor coordination and more recently about issues of governance (Walt, Buse & Harmer 2012).

Thus, in the absence of clear authority, the policy is now being decided ad hoc by a variety of organisations. For example, since the late 1990s, the World Economic Forum has played a significant role in trying to set the health agenda and has launched many new initiatives such as Product Development Partnership Initiative (Rosenburg, Hayes, McIntyre & Neil 2010). The effect is that it has compounded national policy making in Africa. It is disconcerting to note that the contemporary health landscape is still characterised by fragmentation, lack of coordination and even confusion.

There is a disjuncture between the issues that external actors and African recipients prioritise. While attention to priority diseases has initiated much-needed increases in external assistance for health, these priorities are not necessarily in line with the recipient country government's overall plan for the health sector. In Rwanda, for instance, donors earmarked \$46 million for HIV/AIDS in 2005, when the country had a 3 percent prevalence rate, and only \$18.3 million for malaria, which was the biggest cause of mortality (Ntawukuliriyayo 2006). Likewise, a significant portion of health aid is tied in many cases to short-term numerical targets such as increasing the number of people receiving specific drugs, decreasing the number of pregnant women diagnosed with HIV, or increasing the number of bed nets handed out to children to block disease-carrying mosquitoes. They tend to be 'top-down' in nature and are largely driven by donor agendas rather than the country's own needs and priorities. This practice, known as 'stove piping' tend to reflect donor interests more than recipient needs. Garret describes the situation starkly:

From an operational perspective, this means that a government may receive considerable fund to support, for example, an ARV-distribution program for mothers and children living in the nation's capital. But the same government may have no financial capacity to support basic maternal and infant health programme, either in the same capital or in the country as a whole. So HIV-positive mothers are given drugs to hold their infection at bay and prevent passage of the virus to their babies but still cannot obtain

even the most rudimentary of obstetric and gynaecological care or infant immunisation (Garret 2007, 22)

In addition, many of the initiatives also lack mechanisms of accountability, transparency, and evaluation in the way they operate in the country. They focus on short-term result thereby raising a real question about future sustainability. Few donors understood the fact that it would take at least a full generation to improve public health substantially and that effort should focus less on particular diseases than on broad measures that affect populations' general wellbeing.

Experience with the US foreign assistance for health is bedeviled by several problems. One major problem of US foreign assistance for health is the poor coordination between the various US agencies operating in-country as well as with other donors. Although the US endorsed the Paris Declarations on Aids effectiveness, it is disconcerting to note that, it has made little or limited progress towards its goals in the area of aids harmonization. This uncoordinated effort has resulted in the fragmentation of public health and health care systems in Africa. Moreover, US aid is tied in many cases to short-term numerical targets such as increasing the number of people receiving specific drugs, decreasing the number of pregnant women diagnosed with HIV, or increasing the number of bed nets handed out to children to block disease-carrying mosquitoes. They tend to be 'top-down' in nature and are largely driven by US agendas rather than the country's own needs and priorities. One of the major deficiencies of the US assistance for health stems from its annual appropriation cycles, which constrain the potential for long term planning. A strong emphasis on measurable results and the potential for financial penalization if results are not achieved can have negative effects on sustainability and the setting of appropriate targets. For instance, in 2007, it was made clear to implementing partners at President Malaria Initiative (PMI) conference in Tanzania that it would be difficult to convince Congress to authorise the following years budget if they could not present strong results for the present year, even when it was recognised that many of the required interventions would take a year to show effect (Global Health Watch 2007). Furthermore, the high number of donors present in health, the large number of separate health programmes and the high volume of resources can create significant transaction costs for government.

Part of the problem also is that not all the funds appropriated end up being spent effectively. A 2006 World Bank report, estimated that about half of all funds donated for health efforts in sub-Saharan Africa never reached the clinics and the hospitals at the end of the line (World Bank 2006) According to the bank, money leaks out in the form of payments to ghost employees,

padded prices for warehousing, the siphoning of drugs to the black market, and the sale of counterfeit-dangerous medications.

One negative impact of this state of affairs is internal brain drain as manifested by the loss of health workers from the public sector to better-funded initiatives and NGOs offering better remuneration. Many of these initiatives pose a serious burden on the capacities of countries to absorb the health aid and instead of representing prioritised contributions to sustainable change, funds are simply fuelling an 'aid industry' of fragmented assistance (Angemi, Oyujii, Aziz & Kyamukama 2017). This has made it difficult for most African governments to pursue consistent national strategies to develop their health systems.

From Compromise to Action

The attempt at institutionalising good governance to ensure aid effectiveness in health found its first articulation in the Paris Declaration on Aids Effectiveness in 2005 and reaffirmed in the 2008 Accra Agenda for Action and the 2011 Busan Declaration. The Paris Declaration reflected lessons learned over several frustrating decades of aid activity, which led donors to conclude that sustainable development depends primarily on efforts at state (as opposed to international or sub-national level) and that aid needs to focus on facilitating country-led efforts not on trying to replace them. Global health has been affected by the Paris/Accra Agenda both of which require country-level coordination.

It is worthy at this point to mention some processes relevant to the harmonisation and alignment agenda. One of such processes is the agreement of the Three Ones promoted by UNAIDS. It aims to establish one agreed upon HIV/AIDS action framework that provides the basis for coordinating the work of partners, one national AIDS coordinating authority, one agreed upon country-level monitoring and evaluation system. (World Bank/WHO 2006) Various agencies including UNAIDS, GFATM, bilateral donors and other international agencies agreed to the harmonisation and alignment in the HIV/AIDS through the concept of the Three Ones. The Three Ones are a response to the criticisms, particularly from Africa that support for HIV/AIDS lacked coherence. The diversity of routes and sources of technical and financial assistance for HIV/AIDS are overwhelming local capacity creating enormous transaction costs and distorting human resource deployment, as staff are drawn from national services to externally funded projects. The three ones principles attempt to address these dysfunctions in coordinating national HIV/AIDS responses. Subsequently actions were taken by the Global Task Teams

on Improving AIDS Coordination (GTT) among Multilateral Institutions and International Donors. In June 2005, the GTT was established, with plans to coordinate the HIV/AIDS response further. It specifically recommended a scorecard-style accountability tool to examine the performance of national partners in creating a strong HIV/AIDS response and international partners in providing support according to the GTT recommendations.

Another process is the establishment of new, innovative financing mechanisms. Innovative financing mechanisms attempt to address aid shortfalls and the failures in the supply of global public goods for health. These innovative financing mechanisms include; the International Finance Facility for Immunisation (IFFIm), designed to accelerate the availability and increase the predictability of funds to be used for health and immunisation programmes; the Advance Market Commitments (AMC) for vaccines is a financial commitment from donors to subsidise the future purchase of a vaccine not yet available, if an appropriate vaccine is developed and if it is demanded by developing countries; and UNITAID previously known as the International Drug Purchase Facility and finance through a tax on airline tickets. It is designed to provide long-term and predictable financing for drugs and diagnostic kits to fight HIV/AIDS, TB and malaria. It is delivered through existing institutions such as GFATM and its aim is to ensure long-term access to high-quality drugs and commodities, and to increase and diversify their production and to lower prices.

The World Health Organisation has made several attempts at coordination. It is a key player in convening the International Health Partnership and related initiatives. An earlier initiative to establish better coordination and alignment of global health initiatives referred to as the 'Health 8' (H-8) has been extended to the International Health Partnership (IHP). The 'Health 8' refers to the group of eight major health-related agencies WHO, World Bank, GAVI, UNICEF, UNFPA, UNAIDS, THE Global Fund to fight AIDS, Tuberculosis and Malaria and the Bill and Melinda Gates Foundation, which meet informally to discuss ways to scale up services and improve health-related MDG's outcomes. The IHP+ is an 'attempt to bring 23 countries, 13 organisations and civil society to work together in partnership to improve health outcomes through a single harmonised in-/country compact where development partners work in the context of existing in-country mechanisms through a single cost result oriented national health plan with the objective of scaling up effective coverage as a means of achieving the targets set by the health-related Millennium Development Goals (Gostin & Amok 2009).

In terms of the financial aspect, the IHP+ launched a High-level Taskforce on Innovative Financing for Health System with the UK government

pledging €500 million contribution (Sridlar, Khagram & Pang 2009). The IHP+ was a commendable effort towards coordination and accountability as well as greater country ownership. However, at this stage, there is not enough evidence to judge the success of IHP+ but the focused nature of its initiatives raises concerns about how it would coordinate with other non IHP+ health initiatives as well as adequately address developing world concerns. WHO also went as far as establishing a clear institutional policy on public-private interactions to guide officials on how to manage these interactions approximately (Ritcher 2004). In Nigeria, for instance, an innovation specific to the health sector and championed by the WHO has been the establishment of the expanded Interagency Committee on Health (ICC) (ICH) made up of all partners in health (WHO 2002). The Minister of Health is the chair of this committee. ICC also held meetings with state governors. With active participation and support from WHO, some coordination platforms were developed and strengthened to ensure a successful health sector reform in the country. There are varieties of these coordination platforms. Prominent among them were: the interagency coordinating committee for polio eradication and routine immunisation; the health systems forum; Malaria partnership; Integrated Maternal, Neonatal and Child Health partnership (IMNCH); and the Country Coordinating Mechanism for global fund activities (CCM). The most prominent of these is the Country Coordinating Mechanism for Global fund activities (CCM). The Global Fund's Framework Document of 2002 outlined the need for a national commitment to multi-sectoral approaches, including a coordinating function that would preferably be an existing body, and where no appropriate body exists, a Country Coordinating Mechanism should be established. The CCM is the Global Fund's national entity for providing core governance functions. The roles of CCM include: coordinate the submission of one national proposal for funding; select one or more appropriate organisation to act as the Principal Recipient (PR); monitor the implementation of activities under Global fund approved programmes including approving major changes in implementation plans as necessary; evaluate the performance of these programmes of Principal Recipient/recipients in implementing a programme, and submit a request for continued funding prior to the end of the two years of initially approved financing from the Global Fund; and to ensure linkages and consistency between Global Fund assistance and other development and health assistance programmes in support of national priorities, such as poverty reduction strategies or sector-wide approaches (Dickinson & Druce 2010).

Since its inception, CCM Nigeria had managed to secure grant approval from GFTAM to the tune of \$500 million. The current CCM Nigeria

structure consists of three committees namely the Executive, Oversight, and Resource Mobilisation committees. The WHO provides technical support for these committees. It adopted the concept of ‘three ones’ – one plan, one coordinating body and one monitoring and evaluation system – as the basis for support to the implementation of activities (WHO 2008).

Under the aegis of ICC, WHO, UNICEF and other partners developed an operational coordination model for National Programme on Immunisation (NPI), Tuberculosis (TB), Roll Back Malaria (RBM), African Programme on Onchocerciasis Control (APOC) and HIV/AIDS. In some states, partners including Department of International Development (DFID), Canadian International Development Agency (CIDA), the UN System, United States Agency for International Development (USAID) and the World Bank worked under the leadership of state governments towards what could be described as Health Sector-wide Approach (SWAP).

Conclusion

We have shown in this article that governance challenges (in relation to the activities of external actors) constitute a serious obstacle to the attainment of better health outcomes in Africa. Undoubtedly, external assistance for health is needed to supplement public and private sector financing for health in Africa, which remains dismally low in comparison to financing targets. A variety of global aid mechanisms have emerged in recent years, many of which aim to improve coordination among donors and increase the effectiveness of donor spending. However, there are still challenges associated with external assistance for health, such as disease-and intervention-oriented funding and mismatch with country priorities.

Thus, given the lack of coordination and accountability among numerous health initiatives, Garret has argued that the only organisation with the political credibility to compel cooperative thinking is the World Health Organisation (Garret 2007, 22) This is because the WHO has a responsibility, as the primary health authority in the world, to safeguard public interest on global health. It is also the only legitimate entity for setting a central agenda for governing global health. Therefore, the proposal by Lawrence Gostin is particularly instructive at this point. He proposed that the WHO should take full advantage of its treaty-making capabilities and establish a Framework Convention on Global Health that binds all major stakeholders to the aims of building capacity, setting priorities, coordinating activities and monitoring progress (Gostin 2007). The WHO member states should back

the organisation in the exercise of this responsibility.

African states can only maximise their gains from external assistance for health if they take leadership in coordinating health activities in their countries within the context of a comprehensive national health plan. Experience to date in Rwanda lends credence to this view. The Rwanda health sector is dominated by donor project support, with donors contributing 43 percent of all health sector funding and government 32 percent. Out of pocket expenditure accounts for the remaining 25 percent. Unlike, many African countries where such donor assistance has contributed to the verticalisation and fragmentation of services, the Rwandan Ministry of Health has managed to direct donors to align their contributions with national policies through a donor mapping study and a systematic costing of the health sector strategic plan. Each year all donors meet with government to evaluate progress made and plan for future activities. As a result, Rwanda has become the only African country with near-universal health coverage. Immunisation rates at 95 percent are among the highest in sub-Saharan Africa. Those using insecticide nets increased from 4 to 70 percent of the population between 2004 and 2007. Rwanda is experiencing impressive progress in health in view of the above intervention. The infant mortality rate had dropped from 107 per 1000 live births in 2000 to 62 per 1000 live births by 2007. Similarly, under-five mortality fell from approximately 170 to 103 per 1,000 live births (Paulin, Sekabaraga & Soucat 2008)

In the final analysis, the proliferation of new aid mechanisms should not detract from African governments' commitment to finance health care for their citizens. This is because the provision of health care is principally a national responsibility. African countries owe their citizens a comprehensive package of essential health goods and services under its obligations to respect, protect and fulfill the human right to health.

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ABSTRACT

The structural adjustment programme imposed by the World Bank and IMF in the face of the serious economic crisis that confronted African states in the 1980s resulted in severe cuts in state spending on social services including health. State failure in the provision of social services led to the externalisation of responsibility for health and the proliferation of actors working in the field of health across the continent. Despite the positive and negative consequences of this development on Africa, the debate about the role of external actors in health care delivery in Africa has dwelt extensively on the degree they should participate neglecting the emphasis on how they participate, under what conditions and with what consequences. Using qualitative data techniques, this article examines the involvement of external actors in health care delivery in Africa illustrating the nature, pattern, dimensions, and dynamics of such engagements in the context of popular concerns with good governance. It found that governance challenges constitute a serious obstacle to better health outcome in Africa. It posits that African states can only maximise their gains from external assistance for health if they take leadership in coordinating health activities in their countries within the context of a comprehensive national health plan

KEYWORDS

External Actors; Good Governance; Health; Africa; Aid.

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