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## Governing the Health System in Africa

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Today, health systems in all countries, rich and poor, play a bigger and more influential role in people's lives than ever before. Health systems of some sort have existed for as long as people have tried to protect their health and treat diseases. Traditional practices, often integrated with spiritual counselling and providing both preventive and curative care, have existed for thousands of years and often co-exist today with modern medicine.

Years ago, organised health systems in the modern sense barely existed. Few people alive then would ever visit a hospital. Most were born into large families and faced an infancy and childhood threatened by a host of potentially fatal diseases – measles, smallpox, malaria and poliomyelitis among them. Infant and child mortality was very high as were maternal mortality rates. Life expectancy was short.

Health systems have undergone overlapping generations of reforms in the past years, including the founding of national healthcare systems, and the extension of social insurance schemes. Later came the promotion of primary health care as a route to achieving affordable universal coverage - the goal of health for all. Despite its many virtues, a criticism of this route has been that it gave too little attention to people's demand of health care, and instead concentrated almost exclusively on their perceived needs.

Primary health care became a core policy for WHO in 1978, with the adoption of the declaration of Alma-Ata and the strategy of 'Health for all by the year 2000'. Over twenty-five years later, international support for the values of primary health care remains strong. Preliminary results of a major review suggest that many in the global health community consider primary health care orientation to be crucial for equitable progress in health.

No uniform, universally applicable, definition of primary health care exists. Ambiguities were present in the Alma-Ata documents, in which the concept was discussed as both a level of care and an overall approach to health policy and

service provision. In high income and middle income countries, primary health care is mainly understood to be the first level of care. In low income countries where significant challenges in access to health care persist, it is seen more as a system-wide strategy.

The institutional context of health policy-making and health care delivery has changed. Government responsibilities and objectives in the health sector have been redefined, with private sector entities, both for profit and not-for profit, playing an increasingly visible role in health care provisions. The reasons for collaborative patterns vary, but chronic under-funding of publicly financed health services is often an important factor. Processes of decentralisation and health sector reforms have had mixed effects on health care system performance.

The growth of private health insurance markets and private clinics are pointers to a growing stratification of the health market in line with the intensified income and social differentiation that has occurred over the last two decades; it is, however, also a development which poses new policy-making, managerial and regulatory challenges to which governments and professional associations have to respond. Similarly, the growth of the popular market for alternative medicines and the rediscovery and popularisation of the institutions of the 'traditional'/faith healer point to the crisis in the formal health sector and popular coping strategies that are being adopted. They also open new terrains of power, rights and standards which elicit regulatory responses of their own. The increase in the illegal production and distribution of fake and sub-standard drugs points to an opportunistic entrepreneurial logic, seeking to profit from the African health crises and the problems of the health system.

Changes in the health system brought about by the explosion of the HIV/AIDS pandemic, the persistence of malaria as a major killer, and the resurgence of diseases like tuberculosis which were previously under control, have implications for the governance of health systems in so far as they are correlated with the diminished capacity of the public health facilities to cope with a complex range of expanded needs. This diminished capacity proliferates through all spheres of the health systems, ranging from the drain of talents to the collapse of personnel management training structures designed to produce and reproduce critical human resources.

The various participants of this Institute on Health, Politics and Society in Africa have from their various disciplinary perspectives addressed some of those aspects of health system governance in Africa. At a time when the African continent is faced with one of the most severe health crisis in its history, most symbolic of the crisis is the challenge of HIV/AIDS. Today, the average life expectancy in sub-Saharan Africa is forty-seven years, without AIDS, it would be sixty-two. As more adults perish, the education of children is compromised. In Swaziland, school enrolment has fallen by 36 percent, mainly because girls have left school to care for sick relatives. The ILO estimates that in SSA, 200,000 teachers will die

from AIDS by 2010. A report from the Ivory Coast indicated that during the 1996-97 academic year, more than fifty percent of deaths among elementary school teachers were from AIDS, and 280 teaching hours a year were lost because of teachers being absent.

### **The Concept of Stewardship in Health Policy**

Stewardship can be defined as a function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry. It requires vision, intelligence and influence, primarily by the Health Ministry, which must oversee and guide the working and development of the nation's health actions on the government's behalf.

Outside the government, stewardship is also a responsibility of purchasers and providers of health services who must ensure that as much health as possible results from their spending. In terms of effective stewardship, government's key role is one of oversight and trusteeship.

### ***What Is Wrong with Stewardship Today***

Ministries of Health in LMIC have a reputation for being among the most bureaucratic and least effectively managed institutions in the public sector. The ministries are fragmented with vertical programmes, or ritual chiefdoms, dependent on uncertain international donor funding.

The notion of stewardship over all health actors and actions deserves renewed emphasis. Much conceptual and practical discussion is needed to improve the definition and measurement of how well stewardship is actually implemented in different settings. However, several basic tasks can already be identified:

- (i) Formulating Health Policy – Defining the Vision and Directions.
- (ii) Exerting influence – approaches to regulations.
- (iii) Collection and using intelligence.

The first function encompasses a range of activities intended to ensure that the health research system demonstrates quality leadership, is productive, has strategic directions and operates in a coherent manner rather than as a collection of fragmented and uncoordinated activities. It should aim at creating or promoting a 'research culture', that recognises the need for evidence-based decision making and the importance of health research as a vital component of health development. In this way, it has a fundamental influence on all the other functions since it establishes the framework for their implementation.

### ***Stewardship***

Stewardship can be divided into a number of distinct sub-functions. These include: strategic vision, overall system design and policy formulation; priority-

setting, performance and impact assessment; promotions and advancing; and setting of norms, standards and ethical frameworks.

At country-level, these functions include the development of rational health research policy, translating it into a rational plan and priorities, and overseeing its implementations. These functions also include improving links and coordination with the initiatives of various and the creation of a supportive environment that fosters dialogue and networking among the various stakeholders.

### ***Government Stewardship, Community Involvement***

Responsible health sector oversight and pro-equity commitments by the state are essential to building and maintaining health systems based on primary health care. However, government must engage with and respond to communities in a two-way relationship if they are to perform their stewardship role effectively. Community involvement – including the dimensions of participation, ownership and empowerment – is a key demand-side component of the health system, necessary to promote accountability and effectiveness.

As stewards of the health system, ministries of health are responsible for protecting citizens' health and ensuring that quality health care is delivered to all who need it. This requires making the best choices given the available evidence, and systematically privileging the public interest over other competing priorities. The responsibilities ultimately rest with governments, even in the context of decentralisation where lines of accountability may be blurred. When the right structures are in place, effective governance and vigorous community involvement support each other.

### **Financing**

Financing for health research comes from a number of sources. If the resources available are to be used effectively and efficiently, consistent with research priorities, mechanisms are needed to ensure coordination and to monitor resource flows over time, both within and between levels. Financing refers to financial resources for health research, resource mobilisation, and the national capacity to monitor where and how research funds are being spent.

### **Knowledge Generation**

This function encompasses the production of scientifically validated research. Each country needs to be able to generate knowledge relevant to its own situation, to allow it to determine its particular health problems, appraise the measures available for dealing with them, and choose the actions likely to produce the greatest improvement in health. This should not be seen as the exclusive preserve of universities or research institutes, but equally public/health services and non-governmental organisations.

### ***Utilisation and Management of Knowledge***

The generation of new knowledge is only a part of the research process; for knowledge to be used, it should be shared with other researchers and communicated, in a suitable format, to the different users/stakeholders. It needs to be translated into policy or action or absorbed into the existing knowledge/technology base. Low income countries, in particular, need to ensure that health research brings tangible benefits to the health status of their people. This implies a need to strengthen the link between researchers, policy-makers, health and communities. A critical aspect is the need to improve interactions and connectedness, both horizontally and vertically, through accelerated and creative use of new information technologies.

Activities include promoting an information culture, constructing closer links and fostering communication amongst stakeholders, ensuring that research results are retrievable, generating demand for research, converting research results into user friendly end products, promoting use of information and communications technologies, and developing databases of national exports.

### **Capacity Development**

A long-term, system approach to the development and maintenance of research capacity is needed, addressing such issues as the depth and range of research competencies, gender disposition in education and training, institutional mix and capacity, and the fostering of sustained collaboration, along with clear plans that include provision for monitoring and evaluation. Efforts need to focus on both the quantity and quality of skills available, not just in research techniques, but also over a broad range of related areas.

### **The Politics of Health in Africa Before and After Aids**

The AIDS epidemic challenges the very notion that even rudimentary public health can be achieved in Africa. A litany of statistics testifies that the epidemic continues to spread largely unchecked, erasing hard-gotten gains in public health. In the hardest hit countries, decreasing life expectancy raises the spectre of demographic decline. Flare-ups in HIV incidence in groups in the North that had succeeded in controlling the epidemic suggest that successes in curbing the epidemic (such as in Senegal and Uganda) are fragile, temporary advances in a long war.

It would be a mistake to view AIDS as an isolated case, an exception that confirms the rule. Rather, AIDS should be taken as symptomatic of historically deep social conditions that have provided a ripe environment for infectious diseases on the continent. (Nor is Africa an exception in this regard, as indicated by burgeoning epidemics in China, Central Asia, and Eastern Europe). While the notion of 'tropical diseases' obscures the political nature of the ecology of disease in Africa, which first took root in the inequalities of the colonial period, the particular conditions under which AIDS emerged - in the North and the South,

among rich and poor – challenged easy geographic determinism. Indeed, simple determinisms of any sort – cultural or economic – have not withstood scrutiny. Just as there is no ‘African sexual system’ rooted in African culture, HIV prevalence does not demonstrate a linear relationship with economic variables. The fastest growing epidemic was in the richest country (South Africa), and there are no differences in sexual behaviour between high and low prevalence cities.

Not coincidentally, the AIDS epidemic surged throughout the continent at the same time as deep cuts, mandated by structural adjustment programmes, were being made to public health services, a gap that was largely replaced by a proliferating private sector comprising a vast range of actors drawn from the biomedical and various other healing traditions. This only added to the epidemic’s bio-social complexity: breakdowns in public health may have unwittingly amplified epidemics by diminishing control of other sexually transmitted infections or by increasing unsafe use of injection equipment, both of which intensify HIV transmission. Current attempts to dramatically expand access to lifesaving treatments for the disease have called attention to the inadequacy of public health systems in Africa, and heralded yet more calls for health sector reform.

Thus, the AIDS epidemic has raised the stakes of health sector reform in a continent grown too used to bearing a heavy burden of preventable and treatable infectious diseases. Indeed, the inability of health services in Africa to deliver improved health for all has been known, debated, and addressed since the first flush of post-colonial optimism dissipated in the 1970s. Primary health care and the Bamako initiative have been succeeded by a series of reforms: cost-recovery, sustainability, decentralisation, empowerment etc. To this list of reforms must be added a long list of experiments for delivering health, piloted by a broad range of non-state actors ranging from grass-roots community groups to trans-national NGOs whose own budgets dwarf those of African states. Nothing much seems to have worked. Why has it been so difficult to deliver the goods in Africa? Does this mean that African health systems just might be ungovernable? Is the economic situation so dire, the politics so messy and corrupt, the biological terrain so pathogenic, the culture so recalcitrant?

Clearly, we do not think so. Nor do we believe that the failure to deliver health for Africans can be easily pinpointed to a definite cause. Certainly it is by now quite clear that health in Africa is dramatically under-funded and that there are insufficient resources for health to be a sustainable option for Africa if it is expected to pay for it by itself (Commission on Macro-economics and Health). But the economic determinant of ill health in Africa should not blind us to the fact that economic policies are the result of political processes. This only confirms countless other examples from the past century that demonstrate that health is above all a political matter, of which biology and epidemiology are the expression. Epidemics of cholera, tuberculosis or HIV are the embodiment of politics: wars that spread refugees across the land, breakdowns in public health, policy

failures. Governing the health system in Africa is an eminently political affair. The truism that politics is always local in many ways does not hold in Africa, where economic and Bretton Woods' institutions largely decide social policy and agencies are run from distant capitals on other continents. While it is tempting to view the current focus on 'good governance' as a Bretton Woods' flavour of the month that is, as usual, predicated on some idea of deficiency on the part of recipients, the focus on governance has the advantage of putting politics front and centre and provides a unique vantage point for addressing both the global and local politics of health. It draws attention to the processes that lead to policy, and that refract how policy plays out at the local level.

If African health systems are ungovernable, it may be in large part because powerful international donors work at cross-purposes, setting competing agendas, cycling policies at a rate that defies bureaucratic assimilation, fragmenting health efforts, and undermining local systems of accountability. This hypothesis remains to be verified, as curiously little attention has been paid to how global forces constrain and shape local governance, but it is an example of the kind of exploration the focus on governance allows. Too much emphasis has been placed on policies and their eventual failures, rather than on the broader social processes – global and local – by which policies are developed and enacted. Thus, we propose to use governance as a lens onto the politics of health in Africa in the broadest sense, to explore the practices that shape the conduct of individuals, families, communities, organisations, and governments with the goal of improving health.

For instance, in the case of AIDS, initial efforts to combat the epidemic failed largely because raising awareness did not translate into changes in sexual behaviour, particularly given the structural constraints on individuals living in poverty to which policy makers in Northern countries, steeped in an individualistic health promotion ideology, were blind. Emerging evidence indicates that the epidemic's spread was not, in fact, due to behavioural factors but was mediated by concurrent epidemics of sexually transmitted infections and, perhaps, improper use of injection equipment. This suggests that the focus on sexual behaviour may have been a massive policy failure, and implicates global policies that cut back health services in the spread of the epidemic. Others have argued that the focus on human rights, while laudable, has weakened attempts to control the epidemic, particularly by insisting on voluntary testing. Current attempts to expand access to treatment are long overdue, but concern has been expressed that this risks overwhelming what little health care infrastructure is left in Africa and undermining fledgling attempts to reinforce primary health care. Finally, the emergence of a transnational AIDS activism in Africa has been significantly able to shift policy, but it remains to be seen whether this dynamism can be used to leverage meaningful additional resources and harnessed to implement needed health sector reforms. AIDS has fundamentally called into question the governance of health in

Africa, and will mark a transformation of the politics of health in Africa that will have global repercussions. The success of African AIDS activists in achieving the reform of international intellectual property laws to allow importation of generic AIDS drugs is so far the most salient example, but others will likely follow as the inability to deliver the drugs draws international attention to African health systems.

Understanding – and improving – governance of African health is more than a matter of prescribing mechanisms intended to increase accountability and transparency. It requires taking stock of how global policies and local politics interact, the trans-national channels through which political pressure is exercised, as well as how a broad spectrum of therapeutic alternatives is made available to, or shunned by, health-seekers. Health systems in Africa largely surpass what is accessible through the public system to encompass a patchwork of providers, whether these are biomedical entrepreneurs, churches, NGOs, or ‘traditional’ healers. Health systems also encompass shifting systems of social solidarity that insure against risk: there may be private health insurance for a few and some free health services here and there, but it is mainly extended social networks (which may be more or less based on varying notions of kinship) that insure against health risk. Thus, it is more apt to speak of a proliferating *therapeutic economy* where therapeutic transactions may be valued in other than monetary terms, and where affliction is not necessarily understood in a strictly biomedical idiom. The therapeutic economy is a strikingly hybridised one, where irrational use of bio-medicines coincides with the industrially produced traditional remedies, and where affliction is simultaneously understood and treated in biomedical and spiritual terms. It will be necessary to come to grips with this creolised therapeutic world, as attempts to govern health through a purely biomedical model and the illusion of its rational management are destined to run aground in the messy therapeutic politics of the real world.

## Conclusion

There is recognition that accountability, transparency, and vigorous citizen participation are essential to achieving a viable society, sustainable economic growth, and equitable distribution of benefits and risk of growth. Yet African countries are characterised by persistent and in many cases worsening social, economic, gender, and health inequalities. This theme runs across the articles in this volume ‘Governing the African Health System’.

Some of the key issues discussed in this volume include corruption in hospitals, transparency in Primary Health Care (PHC) delivery, citizen participation in decision-making regarding health care, and the empowerment of traditional birth attendants among others. Health sector reforms have also been widely addressed; with decentralisation, financing of health care delivery, and traditional medical practice being the key issues.



This volume on ‘Governing African Health Systems’ has re-focussed the debate on what makes a good health system. What makes a health system fair? And how do we know whether a health system is performing as it could?

It is our goal to clarify the uses of social science research, to provide evidence on how the health social sciences have influenced our thinking about health care issues, and to underscore some promising and relevant areas of research for the future.