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Creating African Futures in an Era of Global Transformations:

Créer l'Afrique de demain dans un contexte de transformations mondialisées : enjeux et perspectives

Desafios e Perspetivas

بعث أفريقيا الغد في سياق التحولات المعولمة :
رهانات و آفاق

Healthcare Delivery and The Mdgs: Lessons from Neoliberal Policy in Sub-Saharan Africa

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**CODESRIA**

08 - 12 June / Juin 2015

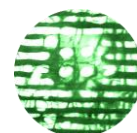
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Abstract

The last three decades have witnessed tremendous health sector reforms globally due, primarily, to political restructuring, improving quality care delivery, and biotechnological advancement. But reasons for these reforms are not uniform with sharp contrast between high income countries and low/middle income countries. In sub-Saharan Africa (SSA) health sector reform since the 1980s has witnessed significant evolution and in the process governments have introduced user-fee, experimented with various forms of health insurance, and encouraged public-private partnership guided by neo-liberal policy towards improving health equity and increasing accessibility with the overall goal of achieving universal coverage. Fiscal constraints, starting from the early 1980s, which necessitated a partnership with the Britton Woods' institution and leading to varying structural adjustment programmes, have conspicuous effects on health care delivery in all countries of the sub region with lessons to be drawn towards achieving the Millennium Development Goals (MDGs) and beyond. This paper describes health reforms embarked upon by sub-Saharan countries and chronicles public health care development from the 1980s with reference to key features of actors, process, design and context. A comprehensive review of the literature and relevant documents forms the basis for analysis and discussion. The review is guided by three overarching questions: What social and economic conditions necessitated health reforms in SSA? How well have health reforms addressed issues of health quality, accessibility, and equity? How have the reforms improved or worsened health conditions of citizens? Salient lessons to be drawn from the forty-year experience of SSA on health care delivery are highlighted and the future prospects are discussed. Efforts by regional governments to meet IMF conditions, the World Health Organization's MDGs, and other international health partners' demands without the prerequisite capacity and structural machinery to match the design and execution of health reforms are discussed within the broad context of political exigencies and technical knowledge that serve to unveil the dismal performance of health sector reform in SSA. It brings to bold relief sub-regional responsibilities in taking ownership of health programmes by designing health policies that are both endogenously crafted and sensitive to local conditions and contexts in meeting future health goals.



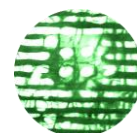


Introduction

Over a billion people cannot still afford needed health services globally with about 90% of that population in low and middle-income countries (LMICs) and over three-quarters of that population in sub-Saharan Africa (SSA). The last three decades in particular, have witnessed tremendous health sector reforms globally due, primarily, to political restructuring, improving quality care delivery, and biotechnological advancement, but reasons for these reforms are not uniform with a sharp contrast between high income countries and LMICs. While the need to incorporate biotechnological invention to health care delivery and the enhancement of human resources in high income countries are constitutive of core reforms in the health sector, LMICs on the other hand, have been driven by financial and political considerations with varying degrees of health reforms ownership (Gilson, 1997; Gureje, 2005; Oluwole, 2008). For instance, while health reforms in Latin America have focused on social security systems, health insurance expansion and the diversification of health care delivery, countries in sub-Saharan Africa are concerned with the procurement of consumables, the introduction of user fees and experimentation with health insurance schemes (Quaye 2004; Wang'ombe, 1997; Mwabu, et al, 2004). For this reason, health reforms are unique unto themselves but with some pattern of convergence discernible in regions and continents. Consequently, even though LMICs have long initiated various strategies and programmes to achieving universal health care services, these initiatives have resulted in varying successes among LMICs.

In SSA where health indices are most appalling (WHO, 2013), governments in the sub-continent have developed health policies from the 1980s to sustain health goals after the economic downturns that afflicted most African countries in that decade. Appropriately referred to as the lost decade in Africa due to huge economic losses as a result of currency devaluation, low agricultural yields and exportation, lingering political crises, and a reversal of socio-economic gains, most Africa governments turned to the Britton Woods institutions for financial assistance, and in the process, developed policies that are externally driven by Western neoliberal ideology with low endogenous contents. The result has been uneven successes of health goals with regards to accessibility, equity, and quality of service. While results are not uniform in specific terms, a general pattern of low performance may be discernible, with lessons to be learned from the experiences. Generally, some progress has been made but this is not significant with current health indices indicating that the sub-continent lags behind other regions of the world in key health indices accounting for 76% of child and maternal mortality world-wide, highest prevalence and incidence rates of HIV/AIDS, poor accessibility to health services and limited universal coverage, all of which are partly indicative of incongruous health policies, weak regulation by the state, reliance in external donors, and low budgetary allocation to the health sector (WHO, 2012).

In this paper, a systematic review of the literature is conducted to chronicle the evolution of health policies in sub-Saharan Africa since the 1980s and the evaluation of the

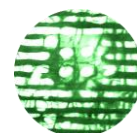


progress made to date. The paper is guided by three overarching questions: What political and economic conditions necessitated health reforms in SSA? How well have health reforms addressed issues of health quality, accessibility, and equity? How have the reforms impacted health conditions of citizens? To put the paper in context, the next section outlines the historical conditions that led to mass reform in SSA, while subsequent sections provide two case studies, which form the basis for analyzing and examining the interaction between institutions, interests, and ideas in the policy process and the final outcome. The final section discusses the SSA position in relation to global health trends and how they exert pressure on policy formulation and the achievement of health goals.

Contextualizing health sector reform in SSA: the build-up

Between 1956 and 1967 over thirty countries in SSA had gained political independence with a justifiable hope for social and economic progress of citizens. The patriotic zeal of nationalist leaders at the dawn of independent African states starting with Sudan in 1956 and followed shortly by Ghana in 1957 was coloured by an aggressive ideology that embraced African values of *Umbutu* and *Ujaama* that favoured communal collectivism in contrast to capitalist individualism. The aversion of African leaders for Western capitalism was summarized by Nkrumah by noting that African leaders

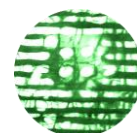
inherited a colonial economy ...[and] We cannot rest until we have demolished this miserable structure and raised in its place an edifice of economic stability, thus creating for ourselves a veritable paradise of abundance and satisfaction...Socialism is the only pattern that can within the shortest possible time bring the good life to the people. (Quoted in Meredith, 2005:144-145). In the same spirit, Modibo Keita of Mali envisioned “a system where there will be no unemployment, and there will be no beggars, and where each will eat if hungry” (Cited in Meredith, 2005: 146). The euphoria that greeted this independence was followed with high expectations flagged by nationalist politicians with the pledge to provide education, health services and improve the general quality of life. The underlying assumption was once Africa gained political freedom, unprecedented progress in all fronts will inevitably follow. This was deemed possible with most African countries gaining independence coinciding with a seemingly patriotic zeal of nationalist leaders and an economic boom in African agricultural commodities (cocoa, groundnut, coffee, rubber, tea) in the post war era, leading to increase in foreign currency reserves. Indeed, most SSA countries had a measure of social and economic progress and general improvement of quality of life during the first two decades after independence, underpinned by the prevailing ideology that tilted towards a socialist agenda (albeit, African socialism). But this social development was not to last for long as the countries were soon bedeviled with both political and economic crisis that was to plunge them into chaotic circumstances that will spiral their progress downward.



Economic troubles and the collapse of a promise

Debt (due to poor balance of trade as a result of mass importation of finished goods and the lure for foreign products), mismanagement of resources (due to poor governance and corruption as a result of coups); and collapse in tax revenue (as a result of corruption and lack of fiscal discipline) all led to poor maintenance of public services so that social amenities including general hospitals and teaching hospitals were starved of funds. At every level the capacity of governments to function was fast diminishing. Inflationary levels resulted in the erosion of quality of life and general standard of living leading to low morals, dishonesty at the workplace, and gross inefficiency of civil servants. For example Meredith (2006) noted that the purchasing power of the civil service in Tanzania and Uganda tumbled in real terms between 1970 and 1985 by 90%; while thousands of qualified health personnel either resorted to moonlighting or migrated to Europe and America for greener pasture. Estimates suggest that about sixty thousand middle- and high-level state managers emigrated out of Africa between 1986 and 1990, leading to a dislocation in the civil service characterized by absenteeism, endemic corruption, and low morale, which affected the quality of delivery (Meredith, 2005:368). Consequently, in most parts of SSA including Ghana, Ivory Coast, Guinea, Senegal among others, medical facilities became unavailable while infant mortality rose from 80% to 120% (UN, 2005). In east Africa especially in Tanzania and Kenya, shortages of consumer goods, equipment and spare parts buckled the economy creating a dysfunctional health system. The general response of governments to the near collapse of the social system was to turn to the West for a quick fix; but the negotiated loans only served to delay reforms rather than implement the policies that were tied to the loans. By the end of the 1980s, little had changed for the better and by the end of the 1980s, external debt stood at over \$160 billion. Debt servicing alone, starting from the 1990s, accounted for 25% of exports of goods and services while the purchasing power of exports fell so drastically that by the end of the 1990s it had reduced by 23%. The fall in commodity prices led also to the loss of income to the tune of \$50 billion between 1986 and 1990 (Meredith, 2006; Economic Commission of Africa, 2013). Because public finance had become highly dependent on donor support, policies became externally dictated. The dominant factor for health reforms in the 1980s was therefore to generate revenue after the economic downturn of most African states starting from that decade. The objective therefore was not to expand coverage per se or to improve accessibility and equity but rather to prevent the collapse of the state and to sustain political control by the government of the day.

On the global stage, emerging African countries were of great importance to the West and East with a contestation between the blocs. While erstwhile colonial masters schemed to ensure that both economic and political relations continued with their former colonies due to the enormous mineral resources of the continent, the Eastern bloc was determined to make a strong presence on the continent by initiating and strengthening ties with the emerging nations of Africa. Most African leaders adopted the philosophy that development and





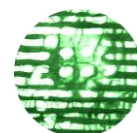
modernization go together and these should be orchestrated and directed by the government underpinned by Western economic rationality.

Evolution of healthcare policies in SSA

The first two decade after independence in SSA, even in very poor resource countries, witnessed a significant progress in the health sector in terms of increase in health personnel, expansion of health services and greater access to health services by citizens initiated first by nationalist government and later supported by international partners. While the later is a welcome development in facilitating national progress, the partnerships induced greater challenges to SSA on planning and managing resources, and translating policies into actions and reaching health targets. From the late 1980s onwards, health policies became influenced and shaped by various international organizations (primarily the World Bank, WHO, UNICEF) and bilateral and multilateral organizations through various agreements. The first major influence came via the Alma-Ata Declaration of 1978, which formally adopted the primary health care (PHC) as a holistic framework for the provision of a comprehensive, universal, equitable, and affordable health care services for all countries” (WHO, 1978). Unanimously adopted by all member states of SSA, along with other nations, this framework was based on practical, scientifically sound, and socially acceptable methods and technology that is universally accessible to individuals and families in the community. Core constituents of PHC, which included integrating it to existing health systems, bringing health care close to the people and constituting the first point of call for health problems, and utilizing formally trained village health workers in underserved population, did not however, consider the underlying challenges of economic crunch and political instability that were building up in SSA during this period.

For PHC to succeed it was envisaged that government needed to be restructured through a decentralizing process by transferring some responsibilities to second and third tier levels of government. Even though some form of decentralization was achieved, in practice they were disempowered as a result of tight fiscal disbursement (Okojie, 2009). Although some measure of success was realized, the ultimate target of Health-for-All by year 2000 was not achieved (Oluwole, 2008). Reasons for the failure include the volatile political climate prevailing at that time in SSA with over half of the countries experiencing some form of political crisis including civil wars or natural disasters. In addition, government could not sustain its commitment to its citizens due to the prevailing economic problem in the sub-region. Although some analysts have attributed the failure to inadequate funding; insufficient training of health personnel, the underlying factors were primarily political instability and economic woes.

By year 2000 it was clear that PHC had failed and WHO decided to roll out a new health initiative underpinned by SAP based on privatization, cost recovery, and the encouragement of private health providers. The general focus of the World Bank and IMF was on financial



and macroeconomic goals rather than social sector reform in contrast to PHC. The conditions tied with the massive loans that were given to SSA made it impracticable for SSA to make any significant progress in all fronts (Olukoshi 1996). In addition to the dismal performance of government due to SAP was the mass exodus of highly skilled health personnel leaving the health sector (especially in rural areas and public hospitals). The consequence was that all gains that were recorded prior to SAP were reversed and by the mid-1990s health indices had reached their lowest ebb. As indicated in Tables 1 and 2 below, for example, the progress made in reducing infant mortality from the 1960s till the end of the 1970s became progressively less significant from the 1980s onwards, especially between 1980 and 2000.

Table 1: Trends in under-5 mortality (per 1,000 births) in selected SSA countries by region

Region/country	1960	1965	1970	1975	1980	1985	1990	1995	2000
Central Africa									
Cameroon	258	235	214	196	172	150	141	156	173
Central Africa Republic	340	286	240	202	189	177	164	152	141
Democratic Rep. of Congo	276	257	239	222	207	202	202	202	202
Eastern Africa									
Kenya	204	179	158	139	115	104	97	114	134
Tanzania	158	149	139	127	109	84	74	94	123
Uganda	223	194	187	186	185	180	160	153	150
Southern Africa									
Botswana	173	159	147	118	95	71	63	65	68
Namibia	244	200	164	134	110	90	74	59	47
Swaziland	224	217	196	172	143	119	108	108	108
West Africa									
Ghana	214	201	188	171	157	141	122	109	97
Nigeria	279	255	234	214	196	179	165	153	143
Senegal	297	288	279	265	216	175	150	148	148

Source: Hill and Amouzou (2005)

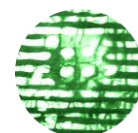


Table 2: Life Expectancy at Birth for Sub-Saharan Africa, 1960–2005

Region	1960	1970	1980	1990	2000
Sub-Saharan Africa	42.4	46.3	49.0	47.6	45.9
Eastern Africa	43.4	47.3	49.4	46.7	45.7
Middle Africa	41.0	45.3	47.0	44.3	43.4
Southern Africa	50.7	54.4	59.6	59.6	47.7
Western Africa	40.3	43.9	47.1	47.2	46.3

Source: United Nations 2005.

Case study I: Health policy reform in Nigeria

Health reform in Nigeria is typical of most SSA countries except perhaps South Africa due primarily to its unique political and economic history. In the 1980s and 1990s, Nigeria had followed the general process of being signatory to health goals set by WHO and other international agencies and, in the process, accepted both loans and technical assistance to achieve health needs in the country. But this was without much success. When the country returned to democratic rule in 1999, the public health system was completely dysfunctional and fragmented into varying forms ranging from public health centres that were still under the ambit of government; unregulated private health providers; licensed and unlicensed chemist shop owners who procure and dispense drugs to the public; a plethora of traditional health practices and religious healing homes among other forms of healthcare delivery (FMoH, 2010).

The public health sector, constitutive of the federal, state and local government health departments, was also fragmented operating with meager resources and poor coordination from the federal Ministry of Health. The system was heavily over-burdened with infrastructural decay, poor condition of service and low morale among the few staff that stayed behind after a mass exodus of health personnel following the introduction of structural adjustment programmes in the mid-1980s and the deterioration of condition of service afterwards. The situation was most deplorable in rural areas due to the abandonment of community health posts built in the 1970s in consonance with the primary healthcare initiative (Lambo, 1991). Thus, by the turn of the century only few healthcare posts were available in rural communities with a heavy concentration of public and private healthcare facilities in urban centres resulting in less than 50 percent of accessibility among rural dwellers (Okojie, 2009).

Health insurance and ‘Health for All’

In 2002, a national health insurance scheme was launched by the Obasanjo administration with a better focus on health inequities in the country and a broader scope than the 1999



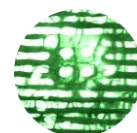
Decree that first established the scheme. The major objectives of the new improved scheme include:

- ensuring unhindered accessibility of the citizens to quality healthcare service;
- protecting families from financial hardship of huge medical bills;
- limiting the rise in the cost of healthcare services;
- ensuring the equitable distribution of healthcare costs among different income groups;
- maintaining high standard of healthcare delivery services;
- ensuring efficiency in healthcare services;
- ensuring the equitable distribution of healthcare facilities;
- providing funds to the health sector for improved services; and
- ensuring equitable patronage of all levels of health care (Lecky, 2007).

The overall goal of the scheme was to improve the quality of life of the citizens. The primary functions of the scheme include registering of health maintenance organizations (HMOs) and healthcare providers, issuing appropriate guidelines to maintaining the scheme's viability and determining, after negotiation, capitation and other payments due to healthcare providers by the HMOs. In its operation, an employer with a minimum of ten employees may pay contributions under the scheme calculated as ten percent from the employer and five percent from the employees' basic salary and lodged with any HMO of their choice for quality treatment. Consideration for capitation payment with respect to each person registered and liability to pay the specified contributions are required under the scheme (Onwujekwe et al., 2011).

The scope of the scheme in terms of health services is restricted to consultation, prescription and supply of drugs, diagnostic tests, consultation with a defined range of specialists, hospital care in a public or private ward for a specified period of admission for physical or mental disorders, a range of prosthesis and dental care as defined and eye examination and care but excluding spectacles. Finally, simple preventive measures including immunization, family planning and antenatal and postnatal cares form an integral part of the scheme (Onwujekwe et al., 2011).

Expected advantages of the scheme include ensuring that a patient in need of a physician or requiring any form of healthcare service would have easy access within a reasonable distance with an effective referral system. In addition, the scheme is designed to protect Nigerian families from the financial hardship of huge medical bills that are usually associated with an out-of-pocket system of healthcare, thereby limiting increases in the cost of healthcare services and ensuring availability of funds in the health sector for constant supply of quality consumables at cheaper price. The health scheme will help in maintaining high standards of healthcare services and ensuring equitable distribution of healthcare cost among different income groups (<http://www.nhis.gov.org>).



Case study II: South Africa

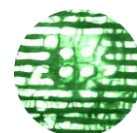
Unlike the Nigerian case, the democratic government of SA in 1994 inherited a heavily skewed health care system that favoured the wealthy white population who patronized the private health services at the detriment of the black majority who are poor and relied on public health services characterized by the unequal distribution of resources between the private and public sectors. Secondly, health programmes were curative oriented rather than preventative, with the majority of the black population without access to health insurance. The Mandela government was therefore faced with the task of correcting the imbalance by proposing two major policies: the Reconstruction and Development Programme (RDP) and the National Health Plan (NHP). These policies were to unify and equalize care by:

1. Shifting the focus from curative and private to preventative and community-based. In doing so, the government placed financial emphasis on primary health care providers rather than on tertiary institutions.
2. A district health system (DHS) was introduced to decentralize and regionalize health care. This was achieved by dividing the existing health provinces into 50 health regions from which 170 health districts were delineated with lateral communication among the provincial governments.

To achieve equal distribution of care among racial groups, socio-economic class and geographical areas, the “forceful affirmative action” was introduced in the provinces. Thirdly, government embarked on the expansion and implementation of a welfare scheme that provided free services to all income level groups. All these reforms were to:

1. Reduce or eliminate discrimination in the public health sector
2. Increase accessibility among disadvantaged groups
3. Enhance inter-provincial equity
4. The overall unification/integration of the health system.

The above objectives were however, not fully met/achieved. Rather than shore up financial commitment to disadvantaged provinces, resources were depleted to cater for disadvantaged provinces at the expense of stable provinces. Little was achieved in terms of removing the divide characterized by the private qualitative sector catering for the rich minority and the ill-equipped public poor sector servicing the poor majority, furthermore, the race, gender, and class inequalities still exist; while free services also brought with it unintended outcome such as the influx of patients seeking for western health services, creating undue pressure on resources, overcrowding of facilities, all resulting in overstretched health personnel leading to the overall decline in the quality of care in the public sector. The economic empowerment of some blacks has led to the emergence of a relatively small black elitist class, leading to the expansion of the demographics of the insured but also leading to a more prosperous private health sector even though this was not anticipated in the policy. No concurrent increase in staff personnel between 1997 and 2008 despite population increase and an increase in health burden due to HIV/AIDS. This may account for the poor performance of the public



health sector around this period onward. The headcount of staff in 1997 and 2008 indicated that there was 36,000 staff shortfall from 251,000 to 215,000.

To address these unplanned outcomes, the ANC in 2012 submitted the White Paper on National Health Insurance (NHI) to achieve the following goals:

1. Improve access to quality care health services
2. Pool risks and funds for equity and solidarity
3. Procure services on behalf of the citizens
4. Efficiently mobilize and control key financial resources
5. Strengthen the public health sector for improved systems performance.

Health care reform in SSA: issues arising

The contrasting conditions and experiences of both countries presented notwithstanding, they provide useful information regarding the challenges that confront health service delivery in SSA generally as they relate to health care reforms. Health reform has often been analyzed mainly from a financial perspective (Gilson, the SAZA study, Walt and Gilson, 1994; Gilson, 1997); technical; poor resource management; and inadequate health personnel, while neglecting the quality of governance and international factors that often shape policies in SSA. Health policy crisis in SSA is thus both internally and externally generated, demonstrated by poor governance characterized by corrupt government officials so that in the context of health care provision, reforms cannot be sustained. On the other hand, international partners grossly ignore local contexts in imposing health goals. For policy development, it is therefore imperative to strengthen governance by encouraging transparency and accountability while simultaneously communicating policy changes to health care providers and the public. Decentralization of health care management in SSA has not been very successful in the sub-continent primarily because financial autonomy has not been provided and backed up by technical as noted by capacity Okojie (2009).

Equally important is the need for international partners, in their bid to assist SSA, identify key issues such as health manpower, capacities, and sociocultural factors before health targets are imposed. But more importantly, is the need to give conditions that support political and social reforms besides singling out the health sector. The poor progress in infant mortality from 1985 onwards indicates the failure of health policy in the sub-region after the adoption of the conditions of the World Bank and the SAP imposed by the IMF. Severe cuts in government budgets on health and large lay-offs of health personnel or their exodus to other countries or engaging in private practice had significant negative effects on meeting health targets. However, what triggered the problem in the first place was the mismanagement of funds by succeeding corrupt leaders and the downturn of the economy especially of agricultural products and the fall in oil prices. What is clear is that SSA could not sustain the welfare scheme/agenda of providing free (or heavily subsidized) health services to citizens.



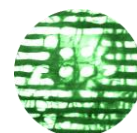
This development demonstrates that both local factors and the international community can work together to either facilitate achieving health goals or subverting them.

In addition, population growth has significantly impacted on health care delivery even though SSA government has focused more on urban centres it has not been matched with urban population growth estimated at 75% translating to the doubling of urban population every fifteen years and leading to an estimated urban population of 278 million (Malmberg, 2007). This population transition and an increasing urbanized society mean that for government to meet health care challenges funding of that sector needs to be increased including the provision of basic social amenities, improved sanitation and expansion of existing health facilities. Clearly, the underperformance of the health sector is not only a reflection of poverty; political leadership, urban growth with poor infrastructure, economic and political stability and effective planning through realistic policies are all interwoven in explaining health performance in SSA.

Designing Health policy in SSA: Adopting an inclusive perspective

We can deduce from our analysis that SSA imputes in health care policies have been greatly circumscribed after its financial romance with the Britton Wood institutions starting from the 1980s onward with the adoption of externally crafted health policies and the conditions and target goals associated with them. The externally crafted health policies became self-serving and did not reflect the socio-political realities of African public spheres. This lack of local articulation and poor integration is attributable to the socio-political contexts that necessitated the reforms in the first instance and how African leaders attempted to circumvent the political problems and the tension the economic downturn created, which enabled them to hold on to political and economic power. At the global level, in an effort to have a strong economic power/hold on African countries and expand its neoliberal ideology, the West was quick to disburse funds (albeit loans) to these political and economic impoverished leaders. In the process, it ignored the shortcomings of these African leaders and simultaneously imposed its open market philosophy without recourse to the larger population that may not benefit from such arrangements.

Consequently, the disconnect between states and citizens, defined by military dictatorship and pseudo-democracy, created a much wider gap between the privileged few that can access health services and the underprivileged majority who cannot. This arrangement paralyzed civil organization and incapacitated the underprivileged majority to critically challenge or actively participate in government policies and practices – creating a “social inertia” that guaranteed the failure of health policies. Thus, health policies in SSA from the 1980s have been self-serving and delimiting in the partnerships that were forged with international organizations, which obliterated local inputs and ignored socio-cultural traditions. Such partnerships, from a broader sociopolitical context, achieved two major goals. First, it perpetuated insipient African leaders in power by strategically positioning them in the power



structure of their various states/countries, thereby legitimizing their continuous hold to political and economic control but ignoring positive social engineering. Secondly, the ideological project that serves to propagate the relevance of international donors and their grip on SSA countries was accomplished as all states that entered into health partnership with international partners are still faced with poor health indicators; a state they were in before they initiated the partnership. The disparity in health services, increase in infant, child and maternal mortalities (table 1) are all indicators of the self-serving agenda of health policies that were crafted by donor agents and hoisted on African leaders and their people. Critical analysis of the sub-continent, serves to indicate that health policies must be designed sensitively for the benefit of not only a few but the majority in the society. While the MDGs and other global health targets may serve as impetus for governments to accelerate and expand health care delivery, caution needs to be taken. The political context that nests health reforms on the sub-continent must first be addressed before any meaningful policy can be achieved.

Conclusion

Various factors may be adduced to health problems in SSA, which include weak regulation by states due to self-serving heads of state; poor regulatory capacities and monitoring systems, exacerbated because donor partners were not primarily interested in outcomes but to maintain a strong hold for other economic and political exigencies; more patronage in political systems as a result of the winner-takes-it-all syndrome and the crushing of all political opponents thereby silencing civil/social movements; the fortuitous reliance on external donors who inevitably dictate the content of policies; and the poor capacities for planning and managing resources as a result of the exodus of professionally qualified health personnel.

The disparity in healthcare services, increase in infant, child and maternal mortalities and other health indicators must be analyzed in the context of health policies that were crafted by donor agents and imposed on African leaders and their people. Critical analysis of the sub-continent serves to indicate that health policies must be designed sensitively for the benefit of not only a few but the majority in the society. While the Millennium Development Goals and other global health targets may serve as impetus for governments to accelerate and expand healthcare delivery (Fryatt et al., 2010), caution needs to be taken. The political context that nests health reforms on the sub-continent must first be addressed before healthcare policies can be satisfactorily translated into meaningful achievement.





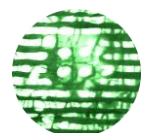
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