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Public Health and Global Interventions in Africa

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During the past 10 years, the scaling up of access to lifesaving HIV drugs in sub-Saharan Africa has been groundbreaking. In 2003, fewer than 100,000 people were on antiretroviral treatment (ART), and many of them were paying out of pocket or enrolled in clinical trials. In 2013, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS), 12.9 million were receiving the drugs, and most were enrolled in free treatment programs. This figure represents only 37 percent of HIV-positive people who need ART, and it conceals huge regional differences. (In Nigeria, only 20 percent of those who need ART receive it, while in Kenya the figure is 40 percent.) But it is a testament to what can be done once political will is present, and it demonstrates the ability of donors, African governments, and international organizations, as well as individuals and communities, to work together.

Free ART programs are the result of concerted international efforts and are made possible by a huge increase in the flow of resources from the global North targeting specific diseases in the global South, led by organizations such as the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria; the US President's Emergency Plan for AIDS Relief (PEPFAR); and the Gates Foundation. Taken together, these initiatives embody a shift toward a framework and paradigm that we now commonly describe as "global health." Investing vast sums of money in the control and treatment of specific diseases, and in targeted interventions such as immunization, has been spectacularly successful—if success is measured by the number of people in treatment, the drop in malaria deaths, and the increase in vaccination coverage.

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Global health initiatives also have wider impacts on African societies. ART programs in particular introduce new ways of thinking about one's body and health, and about biomedicine, since they involve lifelong treatment with pharmaceuticals. As the anthropologist Susan Whyte and her colleagues at the University of Copenhagen observed in a study of the first generation of people living on ART in Uganda, patients appreciate the new, well-funded HIV clinics because they represent concern and care in a setting where public health-care services are otherwise woefully inadequate.

The very success of global health programs should not blind us, however, to the fact that they operate within a specific framework and ideology of health-care intervention, which has major implications for the future of national health systems in African countries. Beyond their immediate goals, these high-profile interventions are fundamentally reshaping political and social landscapes in Africa, as well as ideologies of public health and infrastructures of health-care provision.

Global health interventions are composed of a mix of disparate forces, including philanthropic and donor funding, corporate social-responsibility initiatives, public-private partnerships, pharmaceutical marketing, and international activism. They may be motivated by Western security agendas as well as humanitarian concerns. They follow a model of health-care delivery based on vertical disease interventions (targeting a single disease such as malaria or tuberculosis) or selected interventions (such as providing rotavirus vaccinations to children under five). They deploy commodities or services with clear, measurable outcomes, such as supplying mosquito nets, administering vaccines and medicines, and training health professionals in a specialized form of health-care

delivery. Due to concerns about transparency and accountability, they focus on cost-effective treatment, assuming success can be measured in quantities of medicine, test kits, or bed nets distributed.

In this model, as the anthropologist Peter Redfield argues, health care is packaged in a technical, specialized assemblage rather than offered in a durable network of care. This, in turn, reflects a global shift toward a pharmaceutical model of public health. Health interventions are focused on disease, and disease interventions are focused on pharmaceutical treatment.

SIDESTEPPING THE STATE

Another feature of global health initiatives is that funders and donors prefer nongovernmental organizations as delivery partners, with the state playing a minimal, coordinating role. Although global funds operate within the language of "partnership" between Northern and Southern institutions, global health programs and projects bypass or intersect minimally with national public health-care systems.

High-profile interventions are fundamentally reshaping political and social landscapes in Africa.

Global health organizations wield huge economic power. In some African countries, according to the anthropologist Vinh-Kim Nguyen, PEPFAR and the Global Fund together have more funds at their disposal than the entire national health budget. The power to set agendas, priorities, and approaches lies largely in the hands of external donors, removing African governments from policy making in areas concerning the health-care needs of their citizens. This preference for disease-specific interventions delivered through NGOs has drained resources and expertise away from national health systems and undermined their sustainability.

While Africa has emerged as a prime arena for global health initiatives and interventions since the turn of the twenty-first century, it is important to note that the free HIV/AIDS treatment programs and other efforts focused on malaria and tuberculosis were introduced on the heels of the structural adjustment programs imposed by the World Bank and the International Monetary Fund (IMF) in the 1980s and early 1990s. These programs provided loans to help governments recover from fiscal crises; the loans came with conditions requiring the governments to implement economic reforms, typically designed to reduce state spending and encourage the private sector. Accordingly, structural adjustment discouraged state investment in health care and promoted privatization and the use of NGOs to deliver health services. This undermined years of progress in building up national health-care systems.

Coinciding with the height of the AIDS epidemic, structural adjustment removed state responsibility for health-care provision and protection at a time when citizens were most in need of them. Lack of medicines, equipment, and funds to pay salaries or repair buildings forced demoralized health professionals to leave the public system. Abandoned by their governments, patients without the means to pay for private health care were left to rely on the goodwill of foreign donors and NGOs. Health care became bifurcated: those who could afford it sought privatized health care, while the poor were left with the minimum level of care offered by voluntary and humanitarian organizations. By the late 1990s, many African countries saw increased mortality and morbidity rates and drastically lowered life expectancies, especially among the poor who could least afford to pay the "cost-sharing" user fees imposed by structural adjustment programs.

While the World Bank and the IMF now acknowledge that structural adjustment policies had a negative impact on health in many African countries, global health initiatives have done little to reinvest in national health-care systems or in the health professionals running them. Since African states are widely considered by donors to be corrupt and inefficient (a self-fulfilling diagnosis, since withholding resources from states makes them less efficient and arguably increases corruption, a point made by Thandika Mkandawire, a development economist at the London School of Economics), much of the new funding for health interventions is channeled through international NGOs.

Historian Guillaume Lachenal argues that in this context, global health initiatives should not be seen as a reversal or redemption of structural adjustment programs but as another stage in the fragmentation of Africa's medical institutions, implemented at the expense of those systems and the people working in them. These time-bound,

vertical disease interventions overlook many other health issues and diseases. In this framework, service delivery depends on the continued goodwill of donors and NGOs, raising doubts about durability and sustainability.

ILL-PREPARED FOR EBOLA

The 2014–15 Ebola epidemic in Guinea, Liberia, and Sierra Leone exposed this model's fundamental flaws. The lack of functioning health-care systems was a major factor in the rapid and uncontrolled spread of Ebola, which killed 11,315 people and infected nearly 29,000. According to Ashish Jha and colleagues from Harvard Medical School, the epidemic cast a spotlight on the fragility and chronic neglect of national health systems in the three West African countries ravaged by the virus, while also revealing the limits of humanitarian medical aid. Lachenal, too, argues that the Ebola crisis was not an anomaly or an accident that caused an unexpected breakdown in public health services. It was, he maintains, the logical consequence of two decades of political choices and actions: a "disaster, well prepared" not only due to the systematic undermining of African health-care systems by neoliberal reforms but also because it emerged in a political and institutional landscape shaped by the push for global health.

Even before the outbreak in Liberia, there were only 51 government-employed physicians in the entire country, attempting to serve a population of 4.3 million people. The collapse of weak infrastructures, for health-care delivery and also for electricity, water, transportation, and other public goods and services, exposed the weakness and failures of global health as a vision and framework for health interventions in Africa. Not surprisingly, people avoided government health facilities that had no running water, no protective gloves and clothing, no intravenous fluid, no ambulances, poorly functioning laboratories, intermittent electric power, and inadequate, overworked staff.

The World Health Organization (WHO) has been rightly criticized for not responding more quickly to the crisis. Yet the WHO had to coordinate with health systems on the ground that were not functioning. NGOs like Médecins Sans Frontières, though well-equipped to respond to medical emergencies, could not replace the state. The sorry state of health systems in Liberia and Sierra Leone was partly a legacy of the civil

wars that each country had recently experienced. But postwar reconstruction efforts, supported by Western donors, did little to build up or support hospitals, clinics, laboratories, and health workers.

As the anthropologist Mary Moran wrote in *Current History* in May 2015, health-care delivery in Liberia was left largely to a multitude of humanitarian aid organizations, to the point that three-quarters of government-owned health facilities were managed by NGOs. When the Ebola outbreak hit, patients were housed in hospitals and clinics that were unable to cope with them. Is it any wonder, given these conditions, that many West Africans had little trust in the ability of their health systems to care for them?

The Western media largely blamed West Africans' "irrational beliefs" for the distrust with which they viewed health workers and health-care services during the crisis. Yet this distrust was based on the experience that many citizens had of being abandoned by their government, and on the perception that their leaders were beholden to foreign donors and that international aid mainly benefited political elites. In Nigeria, Mali, and Senegal, by contrast, stronger states and health-care systems were important factors in the rapid response to the appearance of Ebola and early containment of the disease.

CANCER CRISIS

The problem of fragile national health care systems extends well beyond the countries affected by Ebola. Across Africa, despite global health interventions that have drawn attention to specific problems and deployed resources to deal with them, government health workers struggle to provide medical care amid chronic shortages of staff, equipment, and medicines. Patients, most of whom are poor, must pay for care in these systems. Ebola made headlines due to the dramatic intensity and, for a time, uncontrolled spread of the epidemic. Yet other serious health issues, including noncommunicable but fatal diseases such as diabetes and cancer, are largely unnoticed outside Africa and unaddressed by global health initiatives.

In her book *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic,* the historian and anthropologist Julie Livingstone argues that cancer in Africa is an epidemic that will profoundly shape the future of global health. In 2002, according to Livingstone, there were 650,000 new cancer cases across sub-Saharan Africa. (More recent figures are not available, reflecting the fact that cancer cases often are not diagnosed.) Rising cancer rates are partly linked to the rise in the HIV infection rates and use of ART medication across Africa. Exposure to toxins including radiation and asbestos, environmental pollution, and tobacco among populations that receive very little protection from their governments plays an unknown part.

Despite growing recognition that cancer rates are reaching alarming levels in Africa, the disease has received no sustained response from the global health community, perhaps because the global health framework, given its structure and logic, is ill-prepared to deal with the challenges posed by cancer care. The result, says Livingstone, is scientific neglect of cancer in Africa, a reversal of the situation in the 1960s and '70s, when cancer research in Africa received substantial funds and attention.

The reduction in research is reflected in a void in medical care for cancer patients. Diagnostic equipment, chemotherapy, radiotherapy, specialized treatment by cancer experts, and palliative care are available for the most part only in private laboratories and private hospitals, at great expense. For the majority of patients, this translates into delayed diagnosis and treatment, or none at all. Even though cancer is chronic, debilitating, and often deadly, counseling is generally available only in HIV clinics and is designed for patients diagnosed with that disease.

OVERSTRETCHED HOSPITALS

In Kenya, Tanzania, and Uganda the health-care landscape is not very different from the situation in Liberia. In Kenya, which had 1.6 million people living with HIV in 2013, 70 percent of financing for HIV/AIDS programs comes from external donors such as PEPFAR. But outside these global health initiatives, Kenya's national health-care system struggles to provide care in conditions of chronic underinvestment, and the delivery of health services relies heavily on NGOs. Government health-care facilities, including hospitals, host a patchwork of public-private partnerships funded by NGOs and Northern donors.

Meanwhile, despite a decade of economic growth in Kenya, the health budget has declined. According to the WHO, health expenditures accounted for 5.3 percent of the total government budget in 2013, the lowest level in East

Africa. Low public investment ensures that the burden of paying for health care falls largely on the individual patients, whether they can afford it or not. Antenatal care and services for children under five are now provided free of charge in government facilities, but the policy of "cost sharing," which was introduced in the Kenyan health-care system in 1989, requires patients to pay for everything else, from bandages to medicines and IV fluid.

In western Kenya's largest public hospital, where I am currently conducting ethnographic research funded by the Norwegian Research Council, there are inadequate staff levels and poorly functioning equipment. Health workers are overstretched, as is basic equipment such as oxygen machines, particularly in the medical and surgical wards, which receive no donor funding. An intern in the medical ward told me, "Here, we lose patients very often; they just come to die."

Hospital doctors described the frustration of prescribing a course of treatment only to find that the patient's family cannot afford it. Paradoxically, a patient receives better care if he is HIV-positive, they explained, because that qualifies him to enroll in an externally funded treatment program and get free antiretrovirals and clinical checkups. The care received by a patient with diabetes, typhoid, or an upper-respiratory infection, however, depends on what she can afford to pay. Since 1989, one consequence of this system has been a huge drop in the number of poor Kenyans seeking medical care in government facilities.

Global health programs and projects bypass or intersect minimally with national public health-care systems.

Cancer care in the Kenyan public health-care system is patchy and uncoordinated. In my hospital, a chemotherapy clinic that offered free treatment to patients with Kaposi's sarcoma (a type of cancer linked to HIV infection) as part of an American-funded clinical trial closed in 2015, leaving patients who could not pay for chemotherapy without access to any further care. (This is in Kenya's third-largest public hospital.) Chemotherapy is available at the clinic for patients with other forms of cancer, but it is relatively expensive and many drop out due to financial troubles.

In the hospital's pediatric oncology ward (which operates even though there is no oncologist on the hospital staff), children with Burkett's lymphoma are offered chemotherapy, but it is an NGO that donates these and other medicines. Recently the NGO began experiencing financial difficulties, leading to spotty deliveries of chemotherapy medicines. Radiotherapy is hard to find in the public system; patients who need it are referred to private clinics or to Kenyatta National Hospital in Nairobi, the country's largest public hospital, where they routinely wait 18 months for a first appointment.

Kenyatta National Hospital has the only two radiotherapy machines in Kenya's public health care system. When these broke down in March 2015, patients who were struggling to pay even for subsidized treatment faced bleak prospects if they could not afford private care. The clerk at the hospital's radiotherapy department told reporters from Kenya's English-language national newspaper, the *Daily Nation*, "After turning away one particular patient three days in a row, he said to me that he would just go home to die. I cannot explain how demoralizing it was for me."

According to the historian Steven Feierman, the lack of investment in African national health-care systems condemns them to a perpetual state of "normal emergency." Public hospitals and clinics, operating in the shadow of global health initiatives, have improved little since the days of structural adjustment. Health workers, demoralized and often unappreciated, struggle daily to provide care. Many leave for private practice, while others prefer to work in the NGO sector. Those who remain in the public system display great creativity in working with scanty resources.

Stronger Systems

Since 2008, an intense debate has continued in policy circles about whether targeted interventions strengthen health systems or whether strong health systems are needed to sustain such interventions. Advocates of the disease-specific model of global health argue that vertical interventions can have positive effects, for example by introducing global practices and standards, establishing supply chains, and training health workers who can further expand capacity. Critics of the vertical model, on the other hand, argue that vertical interventions weaken health-care systems by siphoning off health workers and channeling

funds into bounded enclaves. They contend that technical solutions, medicines, and diagnostic kits are no substitute for an effective health-care system, which is needed in order to make targeted interventions sustainable.

The debate about vertical versus horizontal funding is clearly an ideological one. While there have been recent moves toward an approach known as "health systems strengthening," these initiatives often operate more at the level of rhetoric than reality, given the fundamental distrust in the state that is characteristic of powerful organizations such as the Gates Foundation. Moreover, as anthropologist Katerini Storeng demonstrates in her research on the Global Alliance for Vaccines and Immunization (known as the GAVI Alliance), the recent talk about strengthening health systems has a narrower vision than the earlier, broader approach, which included a commitment to publicly funded health systems as part of overall social and economic development, based on the understanding that improved health systems could potentially help alleviate social inequality. Today, Storeng argues, we are offered a narrower and more technical version of what health system strengthening entails: "some vehicles here, some refrigerators there."

Since the quelling of the Ebola crisis, there has been an upsurge in concern about "fragile" national health-care systems, and a growing recognition of the collective failure to ensure the availability of staff, resources, and systems sufficient to deliver high-quality health services. As a report by the WHO argues, "The 2014 Ebola virus disease outbreak in West Africa highlights how, in the absence of a functional health system that can monitor the situation and quickly develop an integrated response, an epidemic can proliferate rapidly and pose huge problems." The report goes on to warn, "If the epidemic does not trigger substantial investments in national and subnational health systems and appropriate reforms in the worst-affected countries, the effects of the outbreak will exacerbate the preexisting weakness in [those] systems, which will become even more fragile."

It is very likely that the world will experience more severe health crises, in which case we face a choice. One option is to continue with a stopgap approach, which promotes NGOs as more effective than the state in health-care delivery while encouraging the intrusion of market forces into health systems. This approach would keep the provision of health care in Africa dependent on donors and their generosity. It certainly saves some lives and leads to some health improvements, but it does little to address increasing social inequality and the erosion of public-health systems.

The other, better option is to muster the political will to invest in the professionals, resources, and infrastructure that can provide quality care and will build up trust in the health system as a whole. NGOs and external donors will continue to play a role in African health services, but that role should involve supporting robust and sustainable national health-care systems. ■