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REVIEW ARTICLE

Innovative Strategies to Strengthen Health Service Delivery for Universal Health Coverage in Africa – A Scoping Literature Review

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Abstract

African nations have failed to achieve the mandate of health for all forty years after Alma Ata declaration. To achieve Universal Health Coverage (UHC), government alone are unable to solve the problems of health service delivery such as lack of good infrastructure, poor management, inter-cadre conflicts, lack of skilled birth attendants amongst others. This review assessed the involvement of non-state actors (private sector/philanthropists) in achieving UHC in Africa.

We explored eight databases and search engines using specific search terms. We retrieved and conducted a detailed review of 47 publications comprising published literature and reports focused on private sector/philanthropy involvement in achieving UHC in Africa, and explored the challenges and opportunities. We included both qualitative and quantitative studies published in English.

Inequity and a wide gap exist in countries' health care service delivery due to numerous challenges such as chronic economic instability, bureaucracy, poor healthcare financing, corruption among others. Review of existing literature suggests that as Africa embarks on reforms toward UHC there is a great need for involvement of private sector/philanthropists to support government in addressing challenges facing health care system. The type of involvement revealed were; provision of infrastructure (hospital buildings/facility, good roads), technical support, technological innovations, provision of diagnostic and therapeutic equipment, financial support and other support services.

This scoping review showed that private and philanthropist actors' involvement in healthcare system have huge potentials to improve, restore and maintain health service delivery in African nations. This will accelerate progress towards the achieving UHC by 2030.

Keywords: Private, Philanthropy, Health service delivery, Universal health coverage, Africa

Introduction

The Alma ata declaration of 1978 identified Primary Health Care (PHC) as the key to attainment of the World Health Organisation (WHO) goal of 'Health for All' (1). However, forty years after, this declaration is yet to be fulfilled by most countries of the world especially, the African nations. In 2018, the WHO endorsed the Astana declaration to renew the commitment to strengthen PHC and achieve a Universal Health Coverage (UHC) which is one of the targets of health related Sustainable Development Goals (SDGs) (2). UHC is the bedrock for health-related SDGs to ensure equitable and sustainable health outcomes as well as contributing to other SDGs to ensure an effective health system (3). UHC is defined as all people having access to quality health services without suffering financial hardship associated with paying for care (4). This means all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality, while ensuring that the use of these services does not expose the user to financial distress (5). To achieve UHC, six essential health systems attributes are embraced which are reflected in the health policy objectives across regions. These are; quality, efficiency, equity, accountability, sustainability and resilience (6), summarized into three related objectives: (i) Equity in access to health services - everyone who needs services should get them, not only those who can pay for them; (ii) The quality of health services should be good enough to improve the health of those receiving services; and (iii) People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm (7). The health systems for UHC consists of three pillars which are necessary to improve well-being of the people in African nations; these are service delivery, health financing and governance (8). In Africa, health service delivery is faced with problems of poor management; inter-cadre conflicts; lack of good infrastructure, lack of skilled birth attendants; essential medical commodities and high cost of treatments among others (9). This results in poor utilization of health services with poor health outcomes such as low immunisation coverage, high morbidity and mortality from communicable and Non-Communicable Diseases (NCDs) (9, 10). The government is unable to guarantee availability, accessibility, acceptability, and quality of all health-related services for everyone residing on her territory (11). Pregnant women and children are mostly affected by these challenges as evident by the poor health indicators reported in the WHO African region. This includes, maternal mortality rate of roughly two-thirds (196 000) of global burden, infant mortality rate six times higher than WHO European region (51/1,000 live births), and rising cases of NCDs (12, 13). Research has documented that some African countries, such as Ghana, Kenya, Morocco, Rwanda, South Africa and Senegal are on the path to achieving some aspects of UHC. These countries have provided insurance coverage for the low-income group and improved on access to health care (8, 14, 15). Rwanda and Ghana have progressed the furthest toward achievement of UHC evidenced by improvement in the country's health indices (14). However, the progress of most African nations towards achieving UHC is rather slow (8). In addition, most African countries are yet to adopt the African Union's Abuja declaration of 2001 which was to increase spending on public to at least 15 % of the government's budget (16). Instability in governance, lack of political will, financial constraints are some of the other causes of poor health service delivery, which is one of the WHO health systems building blocks. Health service delivery is confronted with challenges which have de-

prived individuals, families and communities, of the people centered care that PHC offers (2). Undoubtedly, government of many African nations are unable to handle health service delivery, hence the need to shift focus from government as major providers and financiers of healthcare to non-state actors (private/philanthropists) for provision of affordable, accessible and quality healthcare. Also, it is important to strengthen the health service delivery with private/philanthropy participation to bring quick progress towards attainment of UHC by 2030. Philanthropy is a strategic private initiative, established on rebuilding the system and meant for public good. It is an approach for promoting the welfare of others to better humanity especially by generous donation of money to good course (17). The donations aim primarily to promote the economic development, welfare and health of developing countries. In addition, they refer to transactions which could be in cash or kind that originate from foundations' own sources, notably endowment, donations from companies and individuals including High Net Worth Individuals (HNWIs), crowdfunding and legacies, as well as income from royalties, investments (including government securities), dividends and lotteries (18). The private sector plays a vital role in most of the world's health systems. They can be for-profit, not-for-profit, informal, formal, domestic or foreign. Their involvement in health care delivery is usually for a specific goal. The private sector provides a mix of goods and services including: medicines and medical products, infrastructure and support services, direct provision of health services, financial supports, training for the health workforce and information technology (19).

Challenges to appropriate health service delivery

Minimum standards are set on health service delivery in terms of the human resources, infrastructure, medicines and health technologies, as well as the way people are treated when seeking health services (6). However, health service delivery in most African nations have experienced user by-pass basically because of many confronting chronic challenges. Hence, Africans are unable to access affordable and quality healthcare. These are discussed in the following paragraphs according to the six WHO Health Systems building blocks to strengthen health systems.

1) Service delivery

Availability of a well-maintained health infrastructure with conducive consulting rooms, equipped emergency rooms, patient wards, ambulance, on-site laboratory, pharmacy services, and information and communication technology are essential to a proper health service delivery (20). Poor infrastructure and access to health care facilities is a fundamental weakness of health service delivery (21). Majority of health facilities in Africa lack good road access; consist of poor and dilapidated infrastructure which has facilitated medical tourism (9). For instance, in Nigeria, over 5000 people leave the country every month for various forms of treatment abroad and about 1.2 billion USD of Nigerian economy is lost to medical tourism yearly (22) .

2) Health workforce

Overtime, health facilities have been grossly understaffed with staff mix that does not meet the population demand. Africa nations continuously experience shortage of health care workers due to brain drain as a result of poor wages and staff welfare (23). This has resulted in increased workload on the available staff with associated reduced efficiency and effectiveness, long clinic waiting time and poor staff attitude (22). Inter-cadre conflict is another barrier which has rendered the health system unworkable (13). In addition, many

African nations still lack skilled birth attendants who address complications during pregnancy and childbirth, hence the high maternal and neonatal morbidity and mortality rates (24).

3) Access to essential medicines

Another challenge of health service delivery is the recurrent shortages and weak supply chain of quality essential medical commodities, such as drugs and equipment in most health facilities in Africa (23). This results in high cost of treatment which the patients could barely afford. Hence, patients are unable to obtain required medication or treatment as and when due. This unavailability and perceived high cost of care with apparent low quality has contributed to low utilization of health facilities in some African nations like Nigeria (10, 25).

4) Health information systems

Health management information system (HMIS) contributes to the production, analysis, dissemination, use of reliable and timely health information by decision-makers and practitioners at different levels of the health system (26). Unfortunately, the national health information system in African is weak. Implementing HMIS has been difficult because of factors such as poor funding, governance, poor socio-economic conditions, corruption, etc. (27). Most African nations still operate paper-based system of record keeping which is cumbersome, ineffective and often lead to loss of health information.

5) Leadership/governance

Leadership in healthcare system is one of the biggest challenges that hindered expected progress of healthcare interventions in Africa (26). There is poor integration of healthcare programmes due to limited community participation in planning, management and monitoring of health services. The government of most African nations lack the political will in implementing government policy and guidelines; there is poor resource management and corruption (28).

6) *Financing*

Financial barriers to healthcare system remain a prevalent problem in most Africa nations with high rates of Out-Of-Pocket expenditure (OOP), owing to ineffective national health insurance system. A study found that about 40% of Total Healthcare Expenditure (THE) is made up of OOP payments in most African nations. The average THE in African countries was US$ 135 per capita in 2010 compared to US$ 3 150 spent on healthcare in an average high-income country (29). Poor healthcare financing is a recurring problem and seem to be beyond the capability of governments of African nations, hence the need to maximise the involvement of non-state actors in mobilizing resources and providing innovations to support health service delivery towards achieving UHC. This approach has worked in developed countries and some regions in Africa with huge potentials in improving, restoring and maintaining health service delivery and overall improvements in health outcomes of the people (19, 30). This can be further studied and adapted by other African countries. Various studies have explored the benefit of private sector in achieving UHC but few studies have looked into private sector/philanthropist participation in optimizing government activities in the progress towards UHC. In this paper, we reported the findings of a scoping review which synthesized evidence on healthcare challenges in Africa nations, inefficiency of African governments and the possibilities and areas of private sector/philanthropists' involvement in health service delivery on the way to ''achieving UHC in Africa leaving no one behind''.

Methods

This scoping review focused on countries where private actors/philanthropy are involved in health care delivery towards achieving UHC in Africa. We retrieved and conducted a scoping review on 47 publications comprising grey, primary literature and reports. We focused on studies from developed and developing countries, especially African nations. We included both qualitative and quantitative studies published in English. The inclusion criteria were that literature must focus on Private sector/Philanthropy for UHC in WHO regions.

Search strategy and screening

Various databases and search engines were explored such as PubMed, Google, Google Scholar, Directory of Open Access Jounals, Science Direct, Hinari and ResearchGate. Boolean operators were used to make search more specific using strings with combination of terms (Table 1). Titles and abstracts of peer reviewed articles, reports and other grey literatures were retrieved and reviewed. We also searched reference lists of included studies in order to look for additional relevant literature.

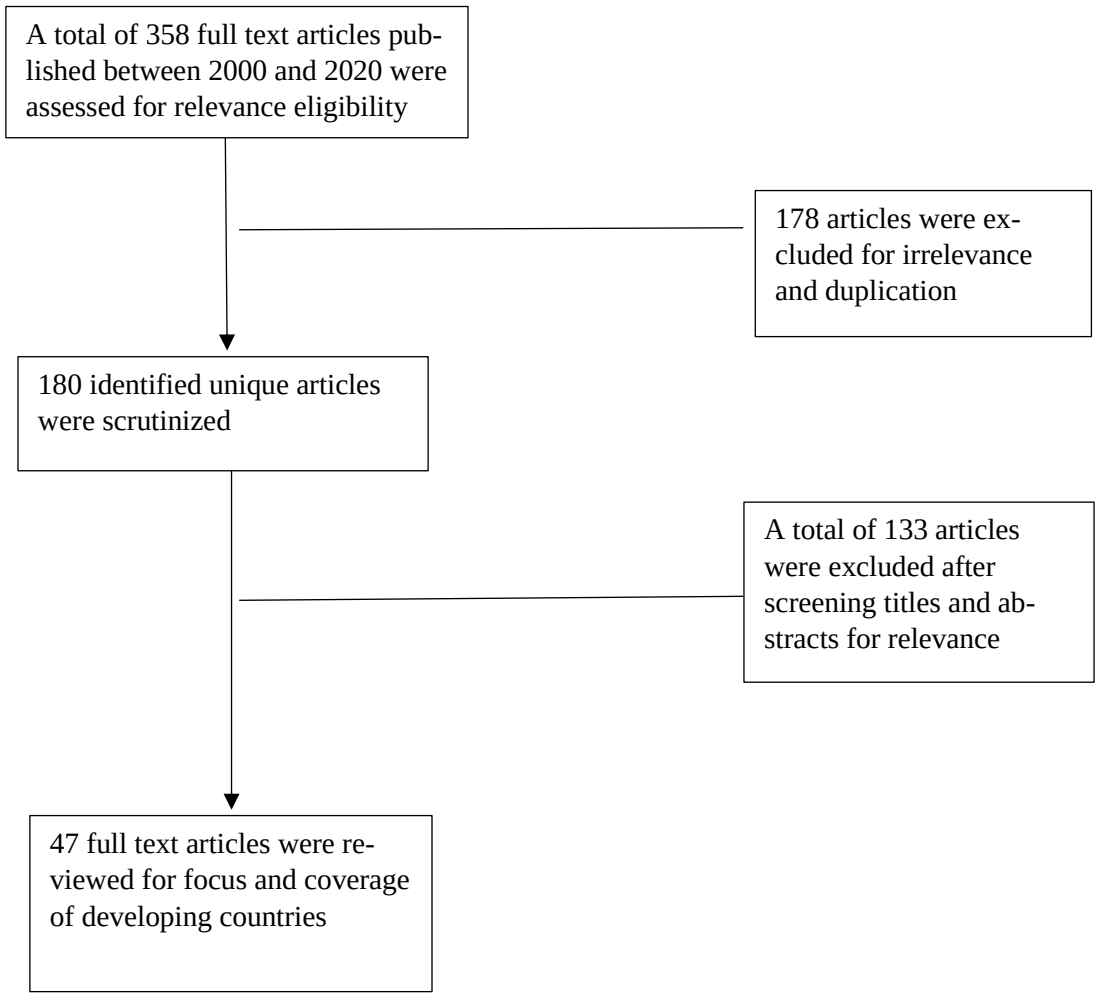
Results and Discussion

From primary searches, 358 published, unpublished and grey literature and reports were retrieved. Other sources included technical reports from Governmental and Non-Governmental Organisations (NGO) news article, online magazine, civil society organizations, and book chapters. After initial screening, 47 matched the inclusion criteria and were reviewed. The flow chart describing this process is shown in Figure 1.

Table1: Literature search terms

1. “private actors” OR “private provider” OR “private sector”
2. philanthropy OR philanthropist OR “philanthropic actors”
3. “Universal Health Coverage”
4. “developing country” OR “low-middle income countries” OR LMIC OR “sub-Sahara Africa”
5. “western pacific region” OR “south east asia” OR “region of Americas” OR “european region” OR “eastern mediterranean region” OR “Africa region”
6. challenge* OR threats AND
7. opportunit* OR benefit*
8. #1 AND #2 AND #3 AND #4 AND #5 AND #6 AND #7

Figure 1: Flow chart showing detailed article extraction and evaluation method



We included articles published from year 2000. These studies employed diverse methodological approaches, using a range of quantitative and qualitative methods. To enable an understanding of this concept of private/philanthropy involvement in health care, we first established the outcome and impacts of poor health service delivery in Africa using the health indices. We also stated the causes of these poor health indicators which result in high morbidity and mortality. Thereafter, we highlighted the challenges service delivery such as inefficiency, bureaucratic bottle necks, economic instability, lack of political will, and other gaps in health service delivery. Subsequently, the definitions of private actors/sector and the types; philanthropy and their activities in health service delivery were discussed. We also highlighted some of the agencies that reinforce this sector, dimensions they take and their mechanism of services alongside corresponding interventions. Studies on involvement of private actors and benefits on health care delivery are well represented in literature for both developed and developing countries. However, the few studies conducted on Philanthropy actors revealed that the aids and grants awarded to nations contributed immensely to the health system growth of such nations. We also found studies that discussed the risks associated with involvement of private actors in health care delivery especially the for-profit private sector. However, the advantages far outweigh the risks which could

actually be controlled by instituting policy and guidelines for the operationalization of private actors. Some of the reviewed literatures are listed in **Table 2.**

Evidence of best practices with private/philanthropist participation in health care delivery

The involvement of non-state actors in health service delivery is not a new phenomenon globally, especially in developed countries where it contributes to the growth and success achieved in their health sector (30). This participation as a comparative advantage, such as infrastructural development, technological innovation, training of healthcare workers, provision of health related services, manufacture of materials and technologies used in health care provision; and financial support which the government can leverage upon (7).

Private sector involvement

Private actors in health care delivery can either be for-profit or not-for-profit organisations. They are important stakeholders in any country's healthcare delivery as they cushion, complement and assist the government in strengthening the healthcare system (31). They are found in situations and communities where governments presence and activities are weak in terms of infrastructure, personnel, finance, commodities and when public facilities are closed or on industrial strike (30). The for-profit private actors such as big corporate hospitals are able to mobilise substantial private financing for expensive medical equipment and technology such as those used in advanced treatments of cancers and cardiovascular diseases (32). The non-for-profit private actors such as Medicines San Frontiers (MSF) known to have more experience and better resources, are quick to mount emergency epidemic and disaster responses compared to the government. In addition, Marie Stopes International, with highly experienced staff who are experts in family planning services work in different countries to ensure regular access to family planning products and commodities (32). Both for-profit and non-profit private actors provide a mix of goods and services including: direct provision of health services, medicines and medical products, financial products, training for the health workforce, information technology, infrastructure and support services (e.g. health facility management) (7). Consequently, most countries operate "mixed health systems", where a mix of public and private providers deliver health-related goods and services (7, 33). Research showed that among 27 high-income countries, 21 have their primary health care delivered by the private sector (33). Grepin in a household survey in 70 low- and middle-income countries, reported that private services provide about 65% of care for childhood illness, but the proportions varied widely by country (34). Between 2007 and 2008, the International Finance Corporation found that in Africa, the private sector already delivered about half of Africa's health products and services (35). This was as a result of the perceived lack of efficiency, quality in the provision of public health care and largely from increased costs with reduced budgets for health care due to the financial crisis experienced during the period. A report by the African Development Bank highlights that Africa's private sector accounts for over 80% of the total production, 65% of total investment, and 70% of total credit to the economy, and employs 90% of the working age population (36). In 2005, of the total health expenditure of $16.7 billion in sub-Saharan Africa, about 50% were captured by private providers (36). It is thus becoming important to engage the non-state actors in enhancing the services of the public sector. In Uganda, the United State Agency for International Development (USAID) secured the private sector's role towards the costs of HIV service delivery through a counter-part funding scheme that enabled for-profit clinics to commence provision of

HIV services in 2009 (37). USAID provided medical equipment and health workforce trainings thereby expanding the national network of HIV treatment sites across Uganda especially in parts of the country where government presence was particularly weak (38). The assessment of private sector activities in Uganda was said to be too important to be ignored in attaining UHC (39).

Table 2: Summary of papers reviewed

Sector	Challenges of health care delivery	Authors that elaborated on interventions
Private	Service delivery (Infrastructure, medical, laboratory services and equipment, technological innovations)	A. Hallo de Wolf and B. Toebes (2016), WHO 2018, D. Montagu and C. Goodman (2016), D. Clarke et al (2019), K. Grepin (2016), International Finance Corporation (2007), M. Baig (2014), R. Brugha and A. Zwi (2002), R. Kumar (2019)
	Health workforce (technical expertise)	USAID (2013) The health initiatives for the private sector (hips) project final evaluation report, D. Montagu and C. Goodman (2016), H. Zakumumpa (2016), Africa Healthcare Federation, 2020
	Finance (financial support)	International Finance Corporation (2007), S. Basu (2012), World Bank (2016) Uganda Private Sector Assessment in Health, M. Baig (2014), S. Pour Doulati et al (2011), O. Olu *et al (2019)*, P. Bakibinga *et al.*, (2014)
	Access to essential medicine (medicines, medical products)	S. Pour Doulati (2011), B. Uzochukwu (2015)
	Health information systems	D. Clarke et al (2019), WHO (2018), R. Kumar (2019)
Philanthropy	Service delivery (infrastructure, medical, laboratory services and equipment)	OECD netFWD. (2019), Africa Healthcare Federation, 2020, S. Basu (2012), B. Uzochukwu (2015), Africa Portal. (2018), University of Ibadan. (2020). *Otunba Tunwase National Paediatric Centre*, P. Bakibinga et al (2014)
	Finance (financial provision/donations)	United Nations. (2019). *Inter-agency Task Force on Financing for DevelopmentOfficial development assistanc*, OECD netFWD. (2019), Africa Portal. (2018), M. Sulek (2009)
	Access to essential medicine (provision of essential medicine)	Alliance Magazine. (2018), University of Ibadan. (2020), F. B. Dennis. (1993)

Research from Southeast Asia, middle east and some African countries have reported rewarding experiences from government and private engagement. Improvement was seen in the areas of infrastructure, laboratory services, equipment and supplies which resulted in affordability and patient satisfaction (40, 41). Better performances in the maternal and child healthcare utilization was observed as a result of improved infrastructure and supplies (15). Evidence from Islands of Cabo Verde showed that private/philanthropist involvement produced positive health outcomes through technological innovations like telemedicine to bridge the gap in human resource and service shortfall (23). Governments of African countries can leverage upon some of these existing services for continuity while the non-state actors continue to execute impactful activities in strategic areas of health service delivery. Private sector participation in health service delivery is not without risks and concerns such as quality of services they provide, pricing among others (42). However, the benefits outweigh the risks which can be managed by all the parties involved with well-established regulations and guidelines. The WHO as a governing body can help to support countries to develop policy guidelines and monitoring tool for managing private/philanthropy and government activities.

Philanthropic involvement

Philanthropy donations aim primarily to promote the economic development, welfare and health of developing countries (18). These donor funding from government could be in form of loans or aids grants from donor countries who contribute a target of 0.7% of their gross national product as Official Development Assistance (ODA) to developing countries (43, 44). Philanthropic actors have contributed enormously to healthcare on various programs to combat diseases as well as deliver health interventions in developing countries. Between 2013 and 2015, international philanthropists contributed USD 12.6 billion to reproductive health as well as to combat AIDS, Tuberculosis and Malaria. The top five foundations that provide 87% of funding in health and reproductive health globally include; Bill & Melinda Gates Foundation BMGF (72%), the Susan Thompson Foundation (5%), the Children's Investment Fund Foundation (4%), Wellcome Trust (3%), and Bloomberg Philanthropies (2%) (18). Evidence showed that philanthropic donation is concentrated in Africa and Asia. According to geographical allocation of giving, the top 25 foundations target India (USD 679 million), Nigeria (USD 511 million), Ethiopia (USD 268 million), Pakistan (USD 208 million) and Mexico (USD 144 million). Between 2013 and 2015, Africa received 24% of philanthropic funds for health and reproductive health, and Asia received 13%. The funding went into reproductive health/family planning for Ethiopia (USD 89 million) and infectious disease for Nigeria (USD 310 million) (18, 45). Most of these foundations channel their funds for health through intermediary organisations such as NGOs, civil society, multilateral organisations, universities and research institutes. Indigenous foundations also contribute to healthcare development in Africa through local foundations, community groups, and wealthy individuals. A formal structure of philanthropy which include foundations and trusts was set up by HNWIs and charitable organisations with distinct objectives relating to African development (46). Well-known foundations by HNWIs include, the Aliko Dangote Foundation in Nigeria, Nicky Oppenheimer Brenthurst Foundation in South Africa, and the Chandaria Foundation in Kenya, while charitable trusts and vehicles that promote philanthropy include the Southern African Trust, and the Ghana-based African Women's Development Fund (46). The performance of private and philanthropy

actors in health care delivery is resourceful in ensuring improvement in the area of quality health care, equity of access and efficiency of services which catalyses government activities and achievement. This can be in the aspect of financial support to increase funds for health to meet up with international standards. In addition, prioritisation of PHC, increasing funding to rural poor especially by redistributing resource allocation between levels of care for preventive and promotive care (30).

Discussion

This scoping review has identified various challenges hindering provision of quality healthcare in African nations, most of which are recurrent and implicated in the slow progress towards attainment of UHC. Government of African nations have failed in their responsibility to provide quality, affordable and accessible healthcare for their citizens. The health system therefore requires support from private sector/philanthropy which have become important sources of health care provision for developing nations. The benefits of private/philanthropy participation in health system delivery are enormous and have helped in delivery of quality healthcare with improvement in health status of the people. Successes reported in the health system of high income countries are as a result of the major contributions of private sector/philanthropy in their health care delivery (18). This invariably contributed to the excellent health system, best quality of life and good health indicators experienced in developed countries. In essence, health care delivery in African nations may not survive without assistance from non-state actors (7, 47). Some African nations have been supported by private sector/philanthropy both from external and within the African nations with health care interventions to combat health problems such as infectious diseases e.g. malaria, HIV/AIDS, tuberculosis; non communicable diseases and reproductive health issues (18, 36, 46). This has contributed immensely to the improvement in healthcare system in the supported nations. It is therefore important for governments of African nations to strategically optimise the involvement of private/ philanthropist actors in mitigating the challenges of health service delivery. This will go a long way to restore, improve and maintain health service delivery of African nations; thereby accelerating the progress towards attainment of UHC by 2030.

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