Section 1 Paradigms of international policies

Introduction to Section 1

This section outlines the doctrine of international health policies that have prevailed over the past 25 years, acknowledging that implementation has varied a great deal from place to place and over time. Chapter 1 delineates the paradigm of contemporary international health policies. Chapter 2 provides a summary of our concerns about them. This section thus serves as the basis for, and as an introduction to, the main elements of the book.

Section 1
Chapter 1

Paradigms of international policies

Donor led policies: analysis of an underlying doctrine

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Introduction

Many authors advocate integrating vertical programmes into local health facilities in order to achieve reasonable prospects for successful disease control (Bossyns, 1997; Loretti, 1989; Oxfam, 2003; Tulloch, 1999). An editorial in the influential *New England Journal of Medicine* (Mulholland & Adegbola, 2005) on bacterial infections (as a major cause of death among children in Africa), for example, stressed the need for comprehensive, integrated and accessible health services to address health needs and questioned the narrow, disease-based approach that has prevailed to date.

Whilst there is a need for some non-integrated vertical programmes in most countries (Criel et al., 1997), any health policy allocating public health activities and disease-control programmes to Ministry of Health (MoH) structures and general health care to private facilities remains highly problematic since it precludes the integration of disease control with general health care.

Through a review of multilateral aid policies, this chapter examines whether current international aid policies have supported the allocation of health care and disease control to different health facilities rather than integrating them into one. In other words this section will focus on outlining the doctrines informing policy rather than describing their implementation, which will be addressed in later sections. The actual implementation may differ due to specific political, social, geo-strategic, and economic factors. The analysis of the doctrine however is relevant per se, since it will clarify health policies promoted by international organizations, which have influenced national policy design in developing countries for decades (Koivusalo & Ollila, 1998; Ollila et al., 2000). First we examine some historical factors, followed by a more detailed focus upon cases in order to explore the nature and function of the doctrine that has been an underlying feature of international health policies.

To what extent have international aid agencies allocated health care and disease control to different health facilities?

The background

The history of international aid is one of action and reaction: the restoration of an order established in the 1950s – disease control at that time being the core of health policies conceived by industrialized countries mainly for the then colonies – and reconfirmed in the 1990s, as

opposed to the Primary Health Care (PHC) strategy that was advocated in the 1970s. We contend that the allocation of disease control and health care to separate sectors is the result of both this history and an explicit doctrine.

Citizens of most colonies had little political weight and limited access to health care, which had never been viewed as a priority by the colonial powers. These diseases were managed in isolation, as a quick and cheap way of dealing with health problems without having to provide a comprehensive service. During the 1950s and even in the 1960s, policies for disease control in many African countries focused on vertical programmes with a disease-oriented approach. The most important achievement of this approach was the eradication of smallpox in 1979. This success eventually was used as a major argument for continuing with this strategy: Foege et al., for example, suggested organizing health services along the lines of fire brigades, based on epidemiological surveillance and modelled after smallpox control (Foege et al., 1976). This proposal failed to recognize the specificity of health service organizations and underestimated the epidemiological features of smallpox, characterized by very slow transmission. So far, successful disease eradication has not been repeated (the failure of the malaria eradication campaign is a good example), although the burden of poliomyelitis, dracunculiasis, onchocerciasis, and measles was greatly reduced owing to disease-control programmes.

In 1978 a challenging new approach was approved in Alma Ata (World Health Organization, 1978), under the leadership of the World Health Organization (WHO) and its Director-General Halfdan Mahler: PHC promoted comprehensive care and community participation in public services, which echoed the mood of the 1970s and the politics of participatory democracy. This new vision of health promoted community participation to democratize publicly oriented services, with users being called to co-manage health services together with professionals and civil servants. This 'health for all' concept brought WHO several head-on confrontations with multinational companies (for example, on breast milk, essential drugs and substitutes), with the United States even withholding its contribution to the WHO's regular budget in 1985 (Walt, 1993).

This caused a return to the strategies of the 1950s – vertical programmes – at least for developing countries. One year after the Alma Ata conference (1978) Walsh & Warren, from the Rockefeller Foundation, wrote a paper in the *New England Journal of Medicine* to reduce the scope of PHC to the control of four or five diseases, a strategy labelled 'Selective Primary Health Care' (SPHC) (Walsh & Warren, 1979). This was officially promoted by the Rockefeller Foundation and United Nations Children's Fund (UNICEF), which contended that the public sector should be selective in the services it offers and that most health care is better delivered and financed privately. This policy, however, was criticized on the grounds that Comprehensive Primary Health Care (CPHC), including the same disease-control objectives but securing access to health care, incurred the same costs as SPHC (Unger & Killingsworth, 1986). The numerous scientists who had mobilized around the world against this initiative failed to sway US policy. Instead, soon after, the World Bank (WB) followed the United States. Its 1987 report, Financing Health Services in Developing Countries: An Agenda for Reform (World Bank, 1987) (p. 38), began to distinguish between health care and disease control: 'For some types of health care, especially simple curative care, private providers may well be more efficient than the government and offer comparable or better services at lower unit cost,' and 'many health-related services such as information and control of contagious disease are public goods.' The paper argued in favour of greater reliance on private-sector health care provision and the reduction of public involvement in health services delivery. As a United Nations Research Institute for Social Development (UNRISD) report states: 'What is not in doubt

is the scale of the policy pressures over the last two decades from, particularly, multilateral donors to commercialize health care. The WB has been particularly influential in promoting the concept of health care as largely private good, hence deliverable through the market, all the while downplaying the well-understood perverse incentives structures in health care markets' (Mackintosh, 2003) (p. 6).

In 1993, echoing the SPHC policy, the WB report Investing in Health (World Bank, 1993) proposed a basic service package to be provided by public health services, and other curative care by private for-profit providers. The report, WB's most comprehensive document regarding health, viewed health care not as a need, much less as a right, but as a demand, defined by the consumers' ability and willingness to pay (Nair et al., 2006). As observers in developing countries noticed, the Bank's 1993 report opened avenues for private investment in formerly public programmes (Turshen, 1999; World Bank, 1999).

A 1996 WB discussion paper recommended governments not to tie public finance to public provision, 'though that does not necessarily mean eliminating public provision, which will sometimes be the best solution' (Musgrove, 1996) (p. 56). The objective of the paper was to 'minimise deadweight losses from public intervention and leave as much room as possible for private choices.'

The 1997 Strategy Paper for the World Bank Health, Nutrition, and Population Program was even more explicit (Human Development Network, 1993). It stated that 'in low-income countries, where private sector activities often dominate, governments will be encouraged to focus their attention on the provision of: services with large externalities (preventive health services); essential clinical services for the poor; and more effective regulation for the private sector, and to promote greater diversity in service delivery systems by providing funding for civil society and non-governmental providers on a competitive basis, instead of limiting public funds to public facilities' (p. 26). The minimal package for the poor to be provided or mandated by governments would include 'basic immunization, management of sick children, maternal care, family planning, targeted nutrition, school health, communicable disease control' (p. 26). Excluded from the package were family medicine, or patient-centred care with an assessment of social, family, psychological, and somatic factors that may influence the problem and its solution, and 'expensive' hospital care.

In its 1997 report 'The State in a Changing World,' the WB recognized that markets undersupply a range of collective goods, among which public health goods (World Bank & Chibber, 1997). Instead the report favoured the private sector as the provider of choice for individual health care. It focused on programmes that would take a vertical approach to disease control while ignoring the effect of non-specific mortality in deprived groups. The results were expert-decided standardized disease control over context-dependent priority setting by the local community and national MoH, and a failure to support an integrated approach to health services.

The history of competition between the WB and WHO for leadership in international health can be written as the record of neoliberal ideology capturing international policy. Neoliberalism refers to political–economical policies that de-emphasize or reject government intervention in domestic economies, but favour the use of political power to open up foreign nations to entry by multinational corporations. In a broader sense it is used to describe the movement towards using the market to achieve a wide range of social ends that were previously filled by government. Arguments for the effectiveness of this movement follow the neoliberal paradigm that markets perform best in allocating and using resources, even in the field of public health (Armada et al., 2001). It is the story of market values replacing the vision of

medical ethos and humanitarian aid, of industry controlling the scientific community, of free-market philosophy overtaking social and democratic ideals. WHO's third function, advocacy for changes in health policy, which came to the fore with the launch of Health for All in 1977, had been taken over by the Bank while WHO had retreated into its technical and biomedical shell (Godlee, 1994).

The WHO, in its well-known report Health Systems: Improving Performance in 2000, emphasized the increasing demands on health systems and the limits as to what governments can finance (World Health Organization, 2000). It then recommended a 'public process of priority setting to identify the contents of a benefit package available to all, which should reflect local disease priorities and cost-effectiveness' (p. 15). In this way, it implicitly separated disease control and individual curative care. It also reaffirmed the key role of government as stewardship, to 'row less and steer more,' and promoted quality-based competition among providers, together with a combination of public subsidy and regulation for private providers in middle-income countries.

A good example of the powerful influence of the WB on WHO was the 2001 report on Macroeconomics and Health: Investing in Health for Economic Development (Commission on Macroeconomics and Health, 2001). Investing in Health, the subtitle of this Commission's report, echoed the Bank's controversial World Development Report 1993: Investing in Health (World Bank, 1993). The Report on Macroeconomics and Health updated the earlier Rockefeller Foundation campaigns (Commission on Macroeconomics and Health, 2001) against endemic infections, which were deemed necessary to improve labour productivity. It recommended, against criticisms from several sources (Banerji, 2002), a vertical approach to the eradication of specific diseases, rather than encouraging the development of integrated health care systems.

The authors of the report, all of them commissioned by WHO but most having had extensive experience with the WB, International Monetary Fund (IMF) or other multilateral economic organizations (Katz, 2004), argued that investment to improve health was a key strategy towards economic development. This development meant reform: 'streamlining the public sector, privatization, public funding of private services, introduction of market principles based on competition' (Waitzkin, 2003) (p. 523). The proposed system would involve a mix of state and non-state health service providers, with financing guaranteed by the state. 'In this model, the government may own and operate service units, or it may contract for services with for-profit and not-for-profit providers' (Waitzkin, 2003) (p. 524). One of the working papers of the Commission on Macroeconomics and Health (CMH) bluntly stated that in order to make progress in liberalizing health services in the current round of General Agreement on Trade in Services (GATS), more member countries would need to schedule this sector (Chanda, 2001). 'Given privatization trends and greater public–private cooperation in the delivery of health services around the world, often necessitated by declining public sector resources, more countries may be willing to table health services in this round of GATS discussions' (Chanda, 2001) (p. 88).

This formula was accepted without much critical analysis and was seen as a desirable goal in the WHO-funded paper, despite reports of poor results of health sector reform in countries such as Chile and Colombia, which had applied them comprehensively (Holst et al., 2004; Navarro, 2004; Chapters 6 and 8 of Section 3). Trade agreements, in particular the GATS/World Trade Organization (WTO) and the plethora of regional and bilateral treaties (Free Trade Agreement of the Americas, Association of Southeast Asian Nations etc.) since the Doha round, also limited the ability of governments to control markets through regulatory measures (Feedman, 2005). Whilst discussion on Trade Related Intellactual Property Rights (TRIPS) have taken precedence

over those related to trade in services (GATS) and are more visible in the public domain, the underlying threat to public services from GATS could prove to be more pernicious.

The European Union (EU) did not lag behind. A 2002 communication from The Commission to the European Council (p. 14) stated: 'The European Community will work closely with development partners including government, civil society, and the private sector,' 'exploring opportunities to work with the private, not-for-profit and for-profit sectors.' A more active approach would be adopted for 'community work with the private for-profit health sector,' and mechanisms would be sought to 'enhance co-operation with private investors to improve their responsibility for health in developing countries.'

The World Development Report 2004 (p. 215), entitled 'Basic Services for the Poor,' separated 'highly transaction-intensive and individual-oriented clinical services,' requiring individually tailored diagnostics and treatment, from 'population-oriented outreach services; services that can be standardized and include vector control, immunisation or vitamin A supplementation' (World Bank, 2004) (p. 133). These were new ways of denominating and, at the same time, administratively and operationally segregating curative individual medicine and disease-control programmes. The report stated that even governments with limited capacity could provide the latter (or write contracts with public or private entities to provide them, which now opens the door for private sector involvement in disease-control programmes), while the former were best left to private initiative.

The report stressed the public sectors' difficulties in providing clinical services for the poor, though both the long route, which requires the policymaker to monitor the provider, and the short route of direct control of the patient over his provider fail. The first fails because of the complexity of clinical services and the heterogeneity of health needs, which make it difficult to standardize service provision and to monitor performance. The second fails because of the lack of accountability of public providers. It did not mention that the long route is the one that worked in Northern European countries, nor that the short route in private practice may not be so short because of information asymmetry, supplier-induced demand, and the opportunity cost for communities of monitoring health care providers.

The World Development Report (WDR) 2004 recommended private provision of clinical services, except for the few countries with a strong public ethos, pro-poor policies, and enforcements of rules (World Bank, 2004). The Bank maintained its bias against government-provided services, presenting obstacles to improving traditional public services as ample justification for shifting to new institutional arrangements, yet, obstacles to market-based approaches, even if severe, were characterized as challenges that could be met. For instance, according to the WDR, in a situation in which a public sector regulator is not independent from a policy-maker, it justifies the contracting-out of care. However, when the issue is privatization, the absence of regulatory experience (monitoring quality and compliance of private providers) only leads to recommendations for regulatory capacity building.

The last decade: the persistence of 'market deficiencies'

Attempts to remediate market deficiencies and to control diseases have featured in international policies tailored for LMICs during the first decade of the millennium. They ended up in an unprecedented bureaucratic growth while failing to achieve epidemiological objectives. Therefore, some donors reconsidered the value of applying markets without restraint while many others didn't but amended their strategical recommendations.

Global health initiatives and disease-control programmes

Global Health Initiatives are Public–Private Partnerships (PPPs) geared towards the control of diseases in LMICs. They have contributed to a significant increase of aid to the health sector. Development assistance for health was stable at around 5% of total ODA or around USD 3 billion during the beginning of the 1980s and remained virtually unchanged until the end of the 1990s. Since then it has started to grow and has increased from just over USD 6 billion in 1999 to USD 13.4 billion in 2005 and to USD 16.7 billion in 2006 (OECD, 2008). This expansion has to a large extent fed a rapidly increasing number of DSPs, and in particular HIV/AIDS. In 2006 HIV/AIDS (and other sexually transmitted diseases) were already representing about 50% of total health ODA commitments (Piva & Dodd, 2009).

PPPs are at the core of DSPs. They emerged from ventures organized in the mid-1990s through pharmaceutical industry initiatives and have also resulted from increased awareness of the heavy burden caused by some major diseases. In 2007 about 80 PPPs existed world wide, some with relatively small portfolios while others were managing sizeable ones. They have reportedly now increased to over 100. In the Congo alone, for example, in 2008 there were as many as 52 DSPs.

Although the typology is not clear-cut, GHIs may be classified into four main categories: those focusing on research and development, including discovery and development of new therapies; technical assistance/service support, including drug donations; advocacy at national and international levels; and those focusing on financing, including the provision of funds for specific programmes (Carlson, 2004). GHIs are central to the contemporary aid architecture. Their interests span from jobs to capital return, from academic to NGO activities and from trade to consultancy. They vary owing to their choice of disease target and product focus (drugs, vaccines, diagnostics, microbicides, and other health products) (Widdus & White, 2004). The portfolios of the DSPs are thus huge. The funding levels for HIV/AIDS alone approximate or exceed the entirety of the national health budget in several sub-Saharan African countries (Shiffman, 2008).

The rationale of the choice of intervention area has often been based on economic factors and/or a reflection of the fear of industrialized countries' of LDC borne pandemics. Therefore, GHI do not only address large health problems, but also conditions and diseases that cause lesser disease burden. For instance, top killers such as acute respiratory infections and shigellosis, cancers, cardio- and cerebro-vascular diseases have been largely overlooked (Shiffman et al., 2002).

GHI mobilized funds and, admittedly, in some cases took the lead in innovation. A Department for International Development (DFID) report (2004) identified several positive features of GHIs as follows (Caines et al., 2004): 'The R&D Global Health Programme (GHP) components generally appear as a particularly fruitful way to foster research and development for new diagnostics, drugs and vaccines. Some GHPs – such as the Global Alliance for Vaccines and Immunisation, the TB Global Drug Facility and the Green Light Committee for multidrug-resistant TB – have successfully secured commodity price reductions, and fostered both competition and research, though antiretroviral price reductions may stem more from increased competition from generic manufacturers and global pressure than the Accelerating Access Initiative.' However, the same authors continue: 'The more taxing concerns relate to GHP operations at country level.' Concerns that GHPs may weaken LMIC health systems arose as it could be assumed that the clinical activities of DSPs compete with those of general health care for limited system resources, particularly staff time (crowding-out effects) (Aylward et al., 2000; Travis et al., 2004) (see Section 2, Chapter 4). The numerous and often highly paid employees of DSPs have been responsible for a major internal brain-drain, especially in low-income countries (LICs). These concerns

	Maternal mortality	AIDS prevalence	TB mortality	Malaria risk
Latin America	moderate	moderate	low	moderate
Sub-Saharan Africa	very high	high	high	high
South Asia	high	low	moderate	moderate
South-East Asia	high	low	moderate	moderate

Progress sufficient to reach the target if prevailing trends persist

Progress insufficient to reach the target if prevailing trends persist

No progress or deterioration

Figure 1.1. Millennium Development Goals: Progress or deterioration? *Note*: The data for malaria was not available in the 2008 MDG progress chart, the data shown are data from the 2007 MDG progress chart. *Source:* Adapted by authors from MDG progress charts 2007 and 2008 (United Nations). TB, tuberculosis.

are crucial since the large increase in total ODA in health has not delivered the expected outcome – to significantly progress on MDGs (Figure 1.1).

Regulating health care markets in LMICs?

During the past decade, international policies stressed the need for improved regulation. While they assume that existing regulatory arrangements can be significantly improved, there are reasons to believe that this plea could be a straw man argument to justify continued privatization.

As early as 1994, most developing countries already had the basic legislation for regulation but there were difficulties in enforcing such controls (Bennett et al., 1994). Although calls to LMIC States to develop regulation in LMICs were heard since 1993, when the World Development Report addressed a crucial need for strengthening capacity of government to regulate the private sector, progress was either extremely slow or inexistent. This happened even in some middle-income countries (MICs) (see Section 3, Chapters 6 and 8) cited as 'success stories' where the private sector benefited from public subsidies. Enforcement of law and regulations against non-compliant health care providers remained thus usually weak (Matsebula et al., 2005) – because it was perverted by powerful vested interests (Bennet et al., 2005).

Anyway, legal interventions alone would have little influence on the behaviour of for-profit providers (Cassels, 1995) since bureaucratic control, sanctions, and penalties would tend to be ineffective unless there are underlying financial incentives (Ferrinho et al., 2004; La Forgia & Couttolenc, 2008). Unfortunately, financing the private sector and purchasing care for the poor are of limited practicability since LMIC public finances to support private providers has long been constrained by the weight of public services wages. Furthermore, the few countries which managed to release funds for the private sector such as Chile and Colombia did not manage to make it work for public goals (see Section 3).

In fact, and paradoxically, countries with a 'bad' regulatory governance record (e.g., because of insecure property rights and contracts (Qian, 2002) and because their health sector is less open to private initiative than the majority of the others) are those which get the best achievements (Grindle, 2007).

In conclusion, there are many reasons why the Rockefeller Foundation could depict 'non-model countries' (that is the large majority of them) with an 'absence of near-term government capacity for broad stewardship of health markets' and could state that 'Progress toward stewardship of mixed health systems – especially the non-state sector – is a long-term aspiration rather than a short-term goal' (Lagomarsino et al., 2009). However, the Foundation report did not recommend treating as a long-term aspiration the commoditization of health care in LMICs.

Maturing markets and policies

During the past decade, several strategies attempted to remedy some of the deficiencies of health care markets in LMICs. These 'corrective' strategies spanned from market maturation to argumentation meant to explain past setbacks and offer avenues for further privatization. We will examine the concepts of social security under neoliberal health policies, community mutual aid associations, 'diagonal' organization, and strategic purchasing.

Bismarckian health policies were a response to political threats at the end of the nineteenth century posed to the economical establishment by the working class organizations and to the State by the socialist movement (Rimlinger, 1971). At the end of World War II it was again the combined threat of a strong, armed resistence movement led by communist parties and the existence of a powerful Soviet block which led European governments to decently finance health care for the under-priviledged (Pauwels, 2002).

The concepts of social insurance and social protection for LMICs were verbally promoted by international aid agencies and industrialized governments (e.g., Arjona et al., 2001; Bennett et al., 1998). Like in European countries where mutual aid associations (the British 'friendly societies') had flourished without significant State financial support, and where mere solidarity amongst the poor never permitted real improvements in access to care nor reduction in catastrophic health expenditure (de Swaan, 1988), successes in LMICs were expectedly rare. Thus, in French speaking Africa, compulsory insurance systems never contributed for more than 20% of overall health sector financing (Sery & Letourmy, 2006), and with a few exceptions, their coverage rate remained between 3 and 6% of the population (ibid, p 204). Although mutual aid associations were relatively old (Ndiaye, 2006), their members in 11 African French speaking countries represented only 0.58% of the total population of these countries in 2003 (ibid. p 326). Finally, while international organizations had hoped that community associations would compensate for the lack of State regulation and funds, in practice, these associations did not even manage to influence quality of care where they existed (Criel et al., 2006).

As in the nineteenth century, social insurance remains conceived to purchase private health care (de Roodenbeke, 2005). The link appears clearly in the concept of 'diagonal organization' (Sepúlveda, 2006) as labelled to describe the Mexican way of social insurance, the Plan Oportunidades. This organizational pattern was presented as a way to reconcile 'artificial dichotomies … between the vertical approach focusing on specific disease priorities, and the horizontal approach aimed at strengthening the overall structure and functions of the health system' (Frenk, 2006). In practice this benefit package designed for 'the poor' encompassed a series of disease-specific programmes representing by their number a compromise between 'vertical' and Comprehensive Health Care (CHC) supposed to strengthen health systems. Just as vertical is not synonymous of 'disease specific' but rather refers to the type of administration (Section 2, Chapter 4), the administrative costs of organizations managing health funds proved to be as high as those of disease-specific programmes (see transaction costs of the Colombian system, Section 3, Chapter 7).

These facts, together with the frequently observed paradox of increased health insurance coverage and reduced access to health care, lead us to two conclusions. Firstly, the feasibility of developing the social insurance model seems to have found little root in most LMICs. Secondly, the concept of social protection applied to health and often used for the expansion of social insurance appears to be little more then a lure to justify privatization. This is because, in reality, its practice will require a purchaser–provider split as has happened in Colombia and Chile (Section 3, Chapters 7 and 8).

Finally, 'strategic purchasing' is becoming a concept replacing 'contracting out' in neoliberal policies – which was acknowledged to have failed in the vast majority of LMICs (Lagomarsino et al., 2009) – by amplifying the range of purchased care and expanding the array of providers to complex organizations, in spite of manifest regulatory breakdown and government failure to control simple health care delivery in LMICs.

Is an international health policy reorientation in the pipeline?

In 2007, a new type of initiative, the International Health Partnership (IHP), aiming at the coordination of activities among donors and putting the principles of the Paris Declaration 2005 (harmonization of aid programmes) into practical action, appeared as a key element in the global aid architecture. This was intended to tackle the challenges of health systems, and its disintegration through disease-specific programmes – but without explicitly aiming at improving access to comprehensive care. It included some of the most resourceful actors such as the WHO, the WB, the Joint United Nations Programme on HIV and AIDS (UNAIDS), UNICEF, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the European Union (EU) as well as bilateral donors including the United Kingdom (UK), France, Germany, Italy, The Netherlands, and Norway. One aim was to speed up efforts to reach the MDGs by pooling resources, also from DSPs, into one national plan, with one single policy and results framework, one budget, and one monitoring system (the 'four ones'). A pilot study of the aid effectiveness was conducted in several countries between 2003 and 2007, with a budget of more than USD 1 billion. Its preliminary evaluation was completed in 2008. The results were uneven (OECD/DAC 2008). Although the move to coordinate aid initiatives is certainly a welcome one, international health policies continue to remain donor driven to a large extent and are unlikely, in the immediate future, to alter the damage caused by the effects of disease-specific programmes on health systems worldwide. Today multilateral agencies have begun to recognize the contradictions of not considering 'access to health care' as a core MDG and of the negative implications of this upon disease-control achievements (Action for Global Health, 2009; Economic Governance for Health, 2009). In 2003 the Pan American Health Organization (PAHO) began advocating a return to PHC (Macinko et al., 2007; Pan American Health Organization, 2003; Pan American Health Organization; 2005). In 2008 WHO also followed suit, indicating a shift in international policy directions (World Health Organization, 2008, World Health Organization, 2009). However, the way this strategy will unfold and whether it will be devoid of commercial tones is uncertain. As said earlier, there still is a risk, especially in Africa, of viewing the PHC strategy as limited to the introduction of village health workers without any attempt to change the health care system or improve access to health care.

Conclusion

To what extent does international aid have an underlying 'doctrine'? The answer appears to be an undeniable one: the general trend has been the allocation of public health and disease-control