Available online at www.asric.org

ASRIC Journal on Social Sciences & Humanities 1 (2020) 107-119

Interrogating Public-Private Partnership in African Healthcare within the Lenses of Capitalist Philanthropy in Nigeria's Primary Health System

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Received 19 December 2019; revised 30 January 2020; accepted 30 January 2020

Abstract

This study examined how partnership between Nigerian government and international private entities shape primary healthcare development in Nigeria. At the global level, partnership in healthcare between the national governments and international private entities takes the form of Global Public Private Partnerships (GPPPs) mostly driven by global capitalist philanthropic foundations whose influence in healthcare funding and agenda-setting has mushroomed, particularly since the adoption of the Millennium Development Goals (MDGs) and subsequently the Sustainable Development Goals (SDGs) which articulated specific healthcare targets to be achieved globally. The study is anchored on the gatekeeper state theory and employed documentary approach to collect secondary data analyzed via qualitative descriptive method. Two key arguments are presented in the study. First, the study argued that weak governance structure of Nigeria's primary healthcare system undermine efficacy of GPPPs in the primary health system. Second, with specific focus on the philanthropic activities of Bill and Melinda Gates Foundations (BMGF) in Nigeria's healthcare, the study argued that the self-serving capitalist interest of philanthropic foundations involved in GPPPs undergird their episodic and disease-specific interventions in primary healthcare. This rather enervates the primary healthcare system and undermine the efficient health service delivery through the primary health system in Nigeria. The Nigerian experience demonstrates that government partnership with international private capitalist entities is weakened by weak national health governance on the one hand, and the capitalist interests of the private entities on the other hand. This situation undermined the attainment of 'health for all in 2000', the attainment of MDGs 4, 5 & 6, and also threatens attainment of health components of the SDGs and Africa's Agenda 2063.

Keywords: public-private partnership; capitalist philanthropy; healthcare; primary health

1. Introduction

Primary healthcare is the basic unit of healthcare which provides basic preventive and curative health services and usually serves as the first contact an individual has with a country's healthcare system. It is the essential healthcare based on practical, scientifically sound and socially acceptable methods and technology, made accessible in the community through full community participation and at a cost that the community and country can afford to maintain at every stage of their development to ensure sustainability

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(World Health Organisation [WHO], 1978, p. 3). Meanwhile, the poor state of public health service delivery in Nigeria particularly, at the primary health level occasioned by the failure of the Nigerian state to finance health services necessitated the search for sustainable alternatives to augment healthcare provisioning in the country. Hence, public private partnership (PPP) in healthcare provisioning has been adopted by the government as one of the sustainable solutions to the inadequacies of Nigeria's health system especially at the primary healthcare level. Public private partnership involves mobilizing private sector resources for government functions and development projects. It involves a long-term relationship between government and private sector in sharing of risks and rewards with private sector agreeing to specified performance level (African Union Commission, 2015, p. 6). At the global level, PPP takes the form of Global Public Private Partnership (GPPP). The GPPP is usually consummated within the context of capitalist philanthropy – a phenomenon that involves the employment of huge sums of private capital and application of capitalist principles by corporate capitalist entities to address social problems so as to remodel the public sector and the entire civil society in the image of the private sector. The overarching objective of capitalist philanthropy is to entrench neoliberal principles through complementarity and reduction of state intervention and responsibilities, devolution of powers to the non-state actors, and accentuating hegemony of the philanthropists over the recipient (Morvaridi, 2016; Thompson, 2014; Morvaridi, 2012).

Three successive global health agenda adopted at three different epochs have shaped the mushrooming of GPPP in primary healthcare in the global South. The first is the 1978 Alma Ata Declaration, the second is the Millennium Development Goals of 2000 which identified eight goals, three of which are health related goals (MDGs 4, 5 & 6) to be achieved by the year 2015. The third is the Sustainable Development Goals (SDGs) adopted in 2015 with a total 17 goals, six of which are health related goals to be achieved by the year 2030. Apparently PPP is an important component of the SDGs given that SDG 17 (Partnerships for the Goals) emphasized the need for partnership between governments, private sector and civil society at the global, regional, national and local level.

The adoption of the MDGs and subsequently, the SDGs has contributed to increasing GPPP orchestrated by various Global Health Initiatives (GHIs) like the Global Alliance for Vaccines and Immunisations (GAVI), proliferation of International Non-Governmental Organisations (INGOs) and capitalist foundations focusing on achieving the health components of these global health agenda. Consequently, the healthcare sector has emerged as a major area of intervention through the GPPP and the biggest recipient of philanthropy globally in the last two decades. Within the health sector, primary healthcare attracts the greatest attention as percentage of total donor commitments for health going to primary health increased from 60% between 1990-98, to 70% between 1999 – 2004, and 80% between 2005 and 2011. In Africa, Nigeria remains a major destination of healthcare philanthropy, receiving about 528 million dollars in health aid in 2012 alone (Shaw, et al., 2015; Stuckler, Basu and McKee, 2011; Beatrice, 1993). However, despite the various GPPPs and huge flow of capitalist philanthropy to the primary health, it remains the weakest link in Nigeria's health system (Tilley-Gyado, et al., 2016).

Since, the adoption of the MDGs and later SDGs, Nigeria has entered into various PPPs to address the crisis at the primary healthcare level. The framework for PPP in Nigeria's health sector is provided by the 2005 National Policy on Public Private Partnership for Health in Nigeria. Meanwhile, the role of GPPPs especially those orchestrated with global philanthropic foundations in the health sector has been eulogized and has been rehearsed as *deus ex machina.* Thus, the proselytization of GPPP as a solution to health challenge in Africa and as a vehicle to sustainable healthcare provisioning requires more scrutiny. Yet, existing scholarship focus too often on Public Private Partnerships (PPPs) between national government and local private entities with little attention paid to the nuances in the outcome of GPPPs between national government and global local private entities in the health sector. These literature largely underreport the capitalist motive that undergird most philanthropic entities involved in such GPPPs. This study therefore intervenes by interrogating the connection GPPPs between the Nigerian state and global private philanthropic foundations in primary healthcare. Against this backdrop, the motivation of this study derives from the abysmal performance of the primary health system despite the avalanche of interventions by capitalist philanthropic foundations through GPPPs. Two key issues are highlighted in

the paper: First, weak governance structure of Nigeria's primary healthcare system engendered by its gatekeeper character undermines the efficacy GPPPs in the primary health system. Secondly, capitalist philanthropic foundations involved in GPPPs are driven by their self-serving capitalist interests which undergird their mode of interventions characterised by episodic and disease-specific interventions in primary healthcare. This enervates the primary healthcare system and undermines efficient health service delivery.

The study argues that Nigeria is a gatekeeper state pursuing the healthcare agenda set by external agents including capitalist philanthropic foundations. This explains its emphasis on PPPs in the healthcare sector and the perfunctory GPPPs it enters into with global philanthropic entities. It demonstrates that capitalist philanthropic interventions through GPPPs in the health system of a gatekeeper state cannot develop the health system to deliver quality health services, given that the health agenda pursued by the capitalist foundations are shaped by their self-serving capitalist interests. The paper is organised into seven main sections. Following the introduction is the conceptual review section which is followed methodology section, the fourth section provides the theoretical perspective on which the argument is anchored. The fifth section presents results and discussion of the study which provided details of evolution of the primary health system in Nigeria, it analyzed how adoption of the MDGs and SDGs contributed to the growth of GPPPs in the health sector, it then examined how health governance structure impacts on GPPPs in the primary health system and how Nigeria's GPPP with Bill and Melinda Gates Foundation (BMGF) affects Nigeria's primary health system. The sixth section presents conclusion of the study and the last section proffers policy recommendations based on findings and discussion in the paper.

2. Conceptual Review

This section provides brief review of the basic concepts used in the study with a view to further clarifying the meaning of the concepts as they have been employed in this study. Health governance specifies how the different components of the health sector are financed by different institutions or layers of government.

2.1 Public Private Partnership

In the health sector, PPP involves coming together of the public sector and the private sector including non-government agencies to augment existing public health system with a view to providing efficient and affordable health for all (Thadani, 2014). Public private partnership in healthcare may take place at various levels. At the national level, it may involve partnership between the state and other local private entities. At the global level, PPP usually takes the form of Global Public Private Partnership (GPPP) and involves partnership between the state and other international private entities such as corporate foundations, International Non-governmental Organizations (INGOs) and the likes (Gideon and Unterhalter, 2017).

2.2 Capitalist Philanthropy

Philanthropy is a multi-faceted concept which implies love for humanity expressed by tangible (money, materials, properties etc) and intangible (time, care, service, expertise, advice etc) giving to promote the cause of humanity and address root causes of challenges facing mankind. Philanthropy targets various aspect man's life – security, economy, healthcare, education etc. (African Grantmakers Network [AGN], 2015; Mottiar, 2015). Agents of philanthropy (or philanthropists) can be formal (foundations, corporate entities, governments, NGOs etc) or informal (individuals, self-help groups, community based associations etc). However, Morvaridi (2012b), notes that main motivation for philanthropy is ideological and political because rich philanthropists are only satisfied to be concerned with poverty in as much as it diverts attention away from their own assets and income and does not threaten the hegemonic structure from which they benefit.

The concept of 'capitalist philanthropy' is used describe the devotion of large amount of private capital by philanthropists for solving social problems using business strategies with the goal of

transforming the public sector in the image of the private capitalist sector in ways that profit the former (Thompson, 2014).

2.3 Neo-liberalism

Neoliberalism is a political economy ideology which specifies minimal state intervention and hegemony of self-regulated market. It emerged in the post-World War II era as an antidote to the threats to capitalism and to provide ideological impetus to the expansionary character of capitalism with a view to re-establishing conditions necessary for capital accumulation and dominance of economic elites (Harvey, 2005). Accordingly, the central thrust of neoliberalism is that the state should exist to maintain institutional frameworks appropriate for liberating individual entrepreneurial freedoms and entrenching strong private property rights, free markets and free trade. Sue (2001) identified neoliberalism as the global factor shaping healthcare reform in various states. According to writer, neoliberalism which is based on the three cardinal principles of individualism, free market via privatization/deregulation and decentralization has brought about a healthcare system which is akin to a market place that marginalizes individuals who cannot purchase healthcare since the state cannot provide healthcare for the citizens.

2.4 Health governance

This has to do with the range of policy making and implementation functions in the health sector carried out by institutions of government in the country. In line with this, USAID (2013), conceptualized health governance as governance undertaken with the objective to protect and promote the health of the people and involves setting strategic direction and objectives; making policies, laws, rules, regulations, or decisions, and raising and deploying resources to accomplish the strategic goals and objectives; and ensuring that the strategic goals and objectives are accomplished. Extending this definition, the World Health Organization (WHO) opined that health governance has to do with overseeing and guiding the health system as a whole, not just the public system, so as to protect the public interest (WHO, 2014). Health governance involves 10 key components which includes: strategic vision, participation and consensus orientation, rule of law, transparency, responsiveness, equity and inclusiveness, effectiveness and efficiency, accountability, intelligence and information, and ethics (Siddiqi et al cited in WHO, 2014, p. 10).

3. Methodology

This study employed case study design which allows for in-depth study of a specific or small number of cases in their real-life context and understanding how the cases influence and influenced by their contexts (Yin, 2009). To this end, the study focused on the PPP between the Nigerian government and the BMGF with particular focus in the primary health level of care. Further, documentary approach was adopted for data collection. Documentary method of data collection is considered appropriate for this study because it is suitable for contextual analysis and is also useful when the task is to glean, illuminate, interpret and extract valuable information from documents to draw inference from the available evidence so as to reach a conclusion (Mogalakwe, 2006). Hence, we relied secondary sources from where relevant data were drawn and analyzed qualitatively to demonstrate the arguments contained in the study.

4. Theoretical Perspective: Explaining capitalist philanthropy in Nigeria's health sector within the context of the gatekeeper state theory

The study is anchored on the gatekeeper state theory which explains how the postcolonial African states have been structured to depend on external agents for articulation and implementation of reform agenda. Coined by Cooper (2002), the basic proposition of the gatekeeper state theory is that colonialism has structured postcolonial African states to depend on external agents for recognition, policy direction and support. Hence, the states serve as 'gates' which are outward oriented and are not interested in building institutions necessary for development nor are they able to provide basic services to the masses.

The gatekeeper state theory underpins the recurring crisis of development in Nigeria's primary health system where there is acute external dependence on external agencies, particularly capitalist philanthropic entities in collaboration with other international donor organizations and INGOs for recognition, policy direction and funding through GPPPs. Apparently, as a gatekeeper state, Nigeria has continued to depend on 'development partners' and global development prescriptions for health policy direction and support, thereby providing opportunities for capitalist philanthropists to shape the healthcare agenda by unilaterally deciding which healthcare programme to implement at any point in time. Through GPPPs, Nigeria has been a destination for healthcare philanthropy implemented under various labels such as performance-based financing (PBF), funded by various international donors through the Health Results Innovation Trust Fund (HRITF). However, the PBF is a health programme designed by academics and professionals from the global North as an innovative approach to improve health sector performance without input from beneficiary countries like Nigeria but adopted in the country because of donor pressure (Paul, et al., 2018).

This theory further underscores how the intensification of neoliberalism and the adoption of global programmes like the MDGs and now the SDGs have accentuated GPPPs in Nigeria thereby deepening the global relations of dependence of Nigeria on capitalist philanthropists for healthcare agenda setting, funding and implementation. This entrenches the gatekeeping role of the Nigerian state in the global political economy. More so, given that the agenda of the capitalist philanthropists in the GPPPs is usually self-serving, they neglect the most pressing problem of the primary health system which is institutional capacity building and basic infrastructure required to strengthen the health system and service delivery. For example, the primary health facilities in Nigeria are used for various routine immunization programmes, yet much of these primary health facilities do not have functional facilities for storage and preservation of the vaccines thereby exposing the vaccines to damage before use.

Empirical studies have demonstrated that much of the donor funded health programmes implemented in developing countries including Nigeria are donor fads disconnected from the existing health system institutions and fails to entrench effective health institution development (Paul, et al., 2018). This explains why even where there are medical supplies, the challenge of infrastructure and medical personnel in the primary health facilities thwart proper administration of the medical supplies to the needy patients. Thus, the relations of global dependency on capitalist philanthropy for healthcare funding has seen growth in fund implemented in ways that undermine Health System Strengthening (HSS) of Nigeria's primary health system. In line with the SDGs, the BMGF prioritise primary healthcare such as immunization, family health with little attention to HSS required to sustainably reposition the primary health system for effective healthcare delivery. Thus, disease-specific and episodic GPPPs between BMGF and the Nigerian government in the health system only enervates the fledgling primary healthcare system in the country.

5. Results and Discussion

5.1 Evolution and dynamics of primary health system in Nigeria

Three factors historically explain the evolution and dynamics of primary health system in Nigeria. First, is the 1978 Alma Ata Declaration, second is the global adoption of the Washington Consensus (WC) and Post Washington Consensus (PWC), and third is the adoption of the MDGs which has been modified as SDGs. The 1978 Alma Ata Declaration was anchored on the philosophy of primary healthcare as a means for actualizing affordable healthcare for all. Obviously, in the spirit of Alma Ata, primary healthcare was conceived as a comprehensive healthcare system anchored on the principle of addressing healthcare problem in developing countries by providing affordable health services to all especially the grassroots people. This philosophy of universal health for all was shaped by the then prevailing Keynesian political economy orthodoxy which stressed on welfarism. However, by mid 1980s, the resurgence of liberalism as couched in the Washington Consensus led to the eclipse of institutions like World Health Organisation (WHO) by the World Bank on health related issues. This began to inflect the philosophy that underpin the primary health, as primary health system and emphasis was placed on

primary health as cost saving health mechanism instead of institution for promoting universal healthcare. Hence, since the 1980s, the World Bank's economic reform programmes have continued to shape the development of primary health in developing countries and has led to deviation from universal health principle on which the Alma Ata model of primary health was anchored to primary health models designed mainly as cost-cutting measures to be adopted by developing countries implementing Structural Adjustment Programmes (SAPs). In line with the neoliberal philosophy of adopting the primary health as a cost-cutting measure, in 1987 the Bamako Initiative was introduced by the United Nations Children Emergency Fund (UNICEF) and WHO, and adopted by African Ministers of Health in Bamako, Mali. The central philosophy guiding the Bamako Initiative was to pass the cost of providing basic health care to users and communities through the primary health mechanism in the face of dwindling government healthcare expenditure occasioned by implementation of SAPs. This philosophy gave impetus to the launching of primary health system in Nigeria for the first time in 1988 through the National Health Policy. Federal government budgetary allocation to health during the SAP period remained among the worse in Nigeria's history, ranging from ₦0.13billion in 1986, ₦ 0.04 billion in 1987, ₦ 0.42 billion in 1988, ₦ 0.58 billion in 1989, ₦ 0.50 billion in 1990 and ₦ 0.62 billion in 1991 (Central Bank of Nigeria [CBN], 2015).

By the beginning of the 21st century, the adoption of the MDGs and later the SDGs (in 2015) saw the enunciation of healthcare goals as global agenda to be actualised through global partnership between states and various stakeholders including philanthropic foundations. The emphasis on global partnership and role of non-state actors in actualization of health agenda of the MDGs and SDGs contributed to the increase in activities of capitalist philanthropic foundations in health system of African countries particularly the primary health system.

5.2 How did MDGs/SDGS engender GPPP in Nigeria's primary healthcare?

The last two decades have seen participation of international organisations, donor agencies, states, and capitalist foundations in articulation, funding and implementation of global health agenda. The MDGs were adopted by 189 United Nations members in 2000 as a global health agenda to be achieved by the year 2015. Hence, the MDGs re-energised the spirit of the Alma Ata Declaration by committing nations to a set of healthcare targets that must be attained by 2015. Three out of the eight MDGs focused on primary health related issues (MDGs 4, 5 & 6). Meanwhile, the MDGs were framed as end products of implementing the Poverty Reduction Strategy Papers (PRSP) articulated by the International Monetary Fund (IMF) and foisted on many African countries as the overarching development strategy of the early twenty-first century (Weber, 2006). The implication of this is that health crisis in the developing countries was framed as a challenge to all including the developed countries and there was need for partnership to mitigate health crisis. The MDGs therefore provided the justificatory marker for capitalist foundations to intervene directly in healthcare systems of African countries or do so in collaboration with other INGOs, donor agencies and Bretton Woods institutions under the guise of GPPPs. This has led to proliferation of new actors and massive resources to the health sector as well as adoption of new strategies to address health problems (Kruk, 2012).

In Nigeria, the National Economic Empowerment and Development Strategy (NEEDS) was articulated and adopted in 2004 as the overarching development framework for actualizing the MDGs and overall development of the country. This was done with the assistance of the Bretton Woods institutions and in line with the basic principles of the PRSPs. The NEEDS identified improving healthcare delivery and development of the health sector, especially the primary health system as critical to overall poverty reduction. The document specifically stated that 'the plan is to improve the system of healthcare delivery, with emphasis on HIV/AIDS and other preventable diseases, such as malaria, tuberculosis and reproductive health-related illness' (Nigerian National Planning Commission [NPC], 2004, p. xi). More so, NEEDS was bandied to development partners including philanthropic foundations as a veritable tool for attaining the MDGs and as a justification for their assistance through philanthropy. Hence, the adoption and articulation of the MDGs into Nigeria's development framework enlarged the space for increased intervention of philanthropic organisations in Nigeria's primary healthcare system.

Similarly, the adoption of the SDGs saw renewed effort to strengthen GPPPs between national governments and global private entities. This is because, just like the MDGs, the SDGs identified health related targets (goals 3 and 6) to be achieved by 2030 and also stressed on need for partnerships between various stakeholders in actualizing the SDGs. Hence, the pursuit of the SDGs has led to intensification of partnership between Nigeria and various international private agencies in the area of healthcare in order to achieve the SDGs by 2030. The increasing philanthropic activities of BMGF in primary healthcare is underscored within this context. Hence, BMGF healthcare philanthropy in Nigeria focus on four key health related issues which include: polio; improving family health; healthcare system strengthening; improving child nutrition. More recently, in 2019, the Foundation pledged a whopping $75million dollars to tackle immunization in the next five years in Nigeria

5.3 Nigeria's Healthcare Governance Structure and GPPPs in Primary Healthcare

Despite the growth of GPPPs in the primary healthcare, the structure of healthcare governance in Nigeria weakens the efficacy of the GPPPs in enhancing healthcare provisioning in the country. Nigeria practices a federal system of government with three levels of government – the federal, state and local governments. There are 774 local governments, 36 states and Abuja as the federal capital territory. The health governance structure also reflects the three tier structure of the federal system with the federal government primarily responsible for tertiary health care, state government responsible for secondary health care, and local government authority responsible for primary health care. The tertiary healthcare has to do with specialized consultative healthcare, focusing mainly on curative care usually for inpatients and those on referral from a primary or secondary health professional, it is also involved in teaching and research. The secondary healthcare is administered by the state government and provided by comprehensive health centres and general hospitals supervised by the State Ministry of Health (SMoH). Other services at the secondary healthcare include curative care, radiological, diagnostic, referral and emergency medical and surgical services. The primary healthcare is the first level of care provided by frontline health workers with focus on services that include antenatal care, childbirth care including health education and promotion, simple laboratory tests and preventive interventions. The local government authority (LGA) is responsible for managing the health service delivery at the primary level (Federal Ministry of Health [FMoH], 2011).

Currently, primary healthcare is considered as the foundation of the country's healthcare system and all the three tiers of government are involved in the governance of primary healthcare. The federal government does so through the Federal Ministry of Health and the National Primary Healthcare Development Agency (NPHCDA) which provides technical and financial support. The state government intervenes through the State Primary Health Care Development Agency (SPHCDA) and State Ministry of Health (SMoH) which provide financial and technical support and also coordinates the activities of primary health facilities in the state. The local government which is the weakest level of government in the country focuses on provision of services, recruitment, retention and deployment of staff. Figure 1 presents illustration of this multi-stakeholder involvement in primary healthcare management in Nigeria.

Obviously, this existence of multiple levels of governance with concurrent and overlapping responsibility for primary health care constitutes a serious challenge for the primary health system especially when it comes to coordinating activities of various donor entities involved in different GPPPs with the three different layers of government in the country.

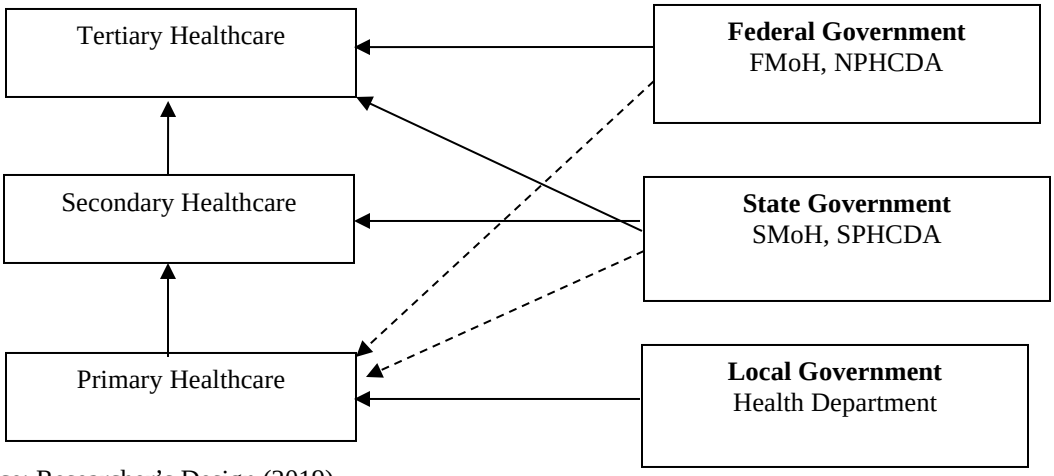
The framework for PPP in Nigeria is provided by the 2005 National Policy on Public Private Partnership for Health in Nigeria. The policy recognizes PPP as a collaborative relationship between government and private sectors including not for profit entities, aimed at harnessing human and material resources for efficient healthcare provisioning for all in Nigeria. The PPP policy framework recognized four key partners in the PPP arrangement to include:

i. The public sector players which include the Executive and Legislative bodies in all the three tiers of government as well as other public institutions including key health parastatals;
ii. The private sector players which include Faith Based Organizations, Non-Governmental Organizations, Philanthropists, Cooperatives and other Civil Society Organizations;

iii. Professional councils and associations;
iv. Consumers of healthcare such as individuals, family and community members (FMoH, 2005).

According to the policy, the partnership could take various forms such as 'public driven partnership' or 'private driven partnership'. Irrespective of the form the partnership takes, the central objective of the PPP should be to attain and sustain the desired level of health development in Nigeria as contained in the MDGs (and later the SDGs) and other national health targets (FMoH, 2005).

Figure 1: Structure of Healthcare Governance in Nigeria



Source: Researcher's Design (2019)

Apparently, the policy framework of PPP in Nigeria empowers the various tiers of government to enter into various PPPs in primary healthcare with different private entities. This engenders multi-dimensional fragmentation characterized by lack of coordination of healthcare projects, agenda and partnership across the states. This explains why Nigeria's primary health system is fragmented in time, scope and space. Fragmented in time because since the establishment of the primary healthcare system over 30 years ago, it has not consistently pursued any specific strategy to achieve the objectives of primary healthcare in the country, rather too many episodic programmes have been pursued as a result of different GPPPs entered into by different layers of government. The primary health system is also fragmented in scope because the range of healthcare services offered in the primary health facilities differ from state to state. Even though the National Primary Healthcare Development Agency (NPHCDA) has articulated a Minimum Service Package (MSP) to be adopted by all primary health facilities across the country, most states have not adopted this MSP. Further, the primary health system is fragmented in space, because various states continue pursue various agenda with different development partners across the country while various levels of government involved in the management of the system usually pursue varying health programmes at same time through the same primary healthcare channel thereby enervating the system. There is therefore absence of coherence and coordination in the primary healthcare system across the country.

This multi-dimensional fragmentation draws from the fact that nature of governance of Nigeria's primary healthcare involves some form of decentralization which allows the three levels of government to implement primary health programmes concurrently. Again, the PPP policy framework allows states to engage in various partnerships with different private entities who may be pursuing different healthcare agenda.

The fragmentation of the primary health system is re-enforced by the GPPPs because most philanthropic organizations have specified goals to which their philanthropic activity is tied. Some of these goals are also time specific and the programmes terminate as soon as the time (and possibly fund) elapse. Again, most private entities directly fund or execute health projects in the locations of interest

with little or no involvement of state agencies. To illustrate this, over the years, different primary healthcare projects were implemented through GPPPs with different donors in different states across Nigeria in a bid to meet up the with the MDGs health related targets. Nigeria partnered with the UK Department for International Development (DfID) to implement the Programme for Reviving Routine Immunization in Northern Nigeria (PRRINN) which was started in late 2006 as a six year project. PRRINN aimed to help address the challenge of eradicating polio and improving coverage of other vaccines in Northern Nigeria. Two years into the programme, the PRRINN programme was modified to include Maternal and Child Health (MNCH). Consequently, the PRRINN-MNCH programme was created in 2008 following additional resource from the Norwegian government and was operational in only four northern states – Jigawa, Katsina, Yobe and Zamfara. Meanwhile, by 2014 another programme - the Nigerian Maternal Newborn and Child Health (MNCH2) - was initiated for implementation in few states selected by the donors. The MNCH2 which was a five-year DFID funded programme aimed at delivering maternal, newborn and child health interventions in six states in Northern Nigeria (Kano, Kaduna, Zamfara, Jigawa, Yobe, Katsina). Much as the MNCH2 was expected to improve on the progress of PRRINN-MNCH, it is important to note that it was limited in scope to only six states out of 36 states in the country. Although the Integrated Maternal and Child Health (IMCH) strategy was adopted by the federal government in 2007 in order to synchronize many MNCH policies and programmes towards meeting the MDGs, the challenge remains that political will of the states is required to invite the FMoH to roll out the IMNCH in the states. As at 2011, only 24 states out of 37 (including the FCT) had started implementing the IMCH strategy (FMoH, 2011).

The foregoing demonstrates that the governance structure of the health system in Nigeria has created a situation where GPPPs entered into by various layers of government mainly reinforce fragmentation of the primary healthcare system in the country. This is evidenced by the fact that much of the primary healthcare programmes implemented through GPPPs are episodic and narrow in terms of their area of coverage. As a result, the primary healthcare system in the country remain a mosaic resulting in lack of uniformity in policies, programmes, processes and outcome. As noted by Kruk (2012) the challenge with flooding under-resourced health systems with disease-specific donor programmes is that local health system can be distorted due to emergence of fragmented decision-making and multiple health agenda which threaten implementation of necessary system-wide health reforms.

5.4 Nigeria's Global Public Private Partnership with Bill and Melinda Gates Foundation

The Bill and Melinda Gates Foundation's endowment mainly comes from Bill Gates' personal fortune and stock in Berkshire Hathaway given to the Foundation as a gift from Hathaway's CEO Warren Buffett, who in 2006 made a pledge to gradually give away all of his Berkshire Hathaway stock to the BMGF. As at 2017, the Foundation had a total asset worth over $51 billion (Bill and Melinda Gates Foundation, 2017).

Table 1: Global Health Grants Awarded by Bill and Melinda Gates Foundation, 2012 - 2019

S/No.	Year	Amount (USD'000)
1	2010	1,485,337
2	2011	1,977,507
3	2012	892,868
4	2013	1,088,000
5	2014	1,114,000
6	2015	1,182,000
7	2016	1,197,000
8	2017	1,267,000
9	2018	1,345,000
10	2019	1,247,205*

*Author's Calculation based on data available on the website as at 12/01/2020

Source: Culled from Bill and Melinda Gates Foundation Website and Annual Reports, 2010 - 2018

The Foundation has 15 guiding principles driven by the interests and passions of the Gates family and the annual letter from Mr. Gates setting out the Foundation's agenda for the year. Currently, BMGF is the largest private philanthropy in global health, with financing greater than the budget of the entire WHO (Stuckler, Basu and McKee, 2011). Table 1 presents grants awarded by BMGF under its global health programmes between 2012 and 2019.

The BMGF philanthropic activities particularly in healthcare funding is influenced by its business interest in pharmaceutical companies. This is underscored by the level of direct and indirect investment of the Foundation in pharmaceutical companies that benefit from its healthcare grants for vaccine production and the number of the Foundation's management committee members who are serving or previously board members of such major pharmaceutical companies. Detailed analysis by Stuckler, Basu and McKee, (2011), has shown that about half of the Foundation's stock holdings are invested in Berkshire Hathaway, which is a conglomerate holding company owning several subsidiary companies, including ownership in leading pharmaceutical companies like GlaxoSmithKline, Johnson & Johnson and Procter & Gamble. This explains why more than 97 per cent of the Foundation's healthcare granted are directed to infectious diseases and a large chunk of the Foundation's financial transfers in global health are invested in programmes developing medical technologies from which some the pharmaceutical companies in which the Foundation is invested benefit. For instance, Johnson & Johnson is reported to have entered a clinical partnership to develop new HIV-prevention technology which it considers a strong, strategic and comprehensive relationship with the BMGF (McCoy, et al. cited in Stuckler, Basu and McKee, 2011). The investment structure and board composition of the BMGF and business interest of the companies in which the Foundation is invested demonstrates that the concentration of the Foundation's philanthropic funding and activities in the health sector is not a *creatio ex nihilo.* Rather, the funding of healthcare is informed by the business interest of the Foundation in pharmaceutical companies. Again, by funding medical technologies and consumable produced by the pharmaceutical companies in which it has business interest, the Foundation provides global competitive advantage for such pharmaceutical companies and thereby increasing the revenue accruable to the BMGF.

It is within the context of the capitalist approach of the BMGF that its GPPP with Nigeria in primary healthcare can be understood. Hence, in line with the overarching capitalist interest of the Foundation, the Foundation's philanthropy in Nigeria prioritised the following core areas which are within the primary healthcare. These focal areas are eradication of polio, improving family health, strengthen healthcare systems, improving Nutrition.

In terms of their philanthropic strategies in Nigeria, BMGF provides funding for multiple stakeholders including international donor agencies working in Nigeria, government at the national and subnational levels, private entities, international non-governmental organisations and domestic agencies to implement multiple sectoral programmes and projects particularly healthcare programmes.

Evidently, enormous fund has spent by the BMGF on primary health through GPPPs in Nigeria. However, the primary health system remains weak measured in terms of available of infrastructure and skilled medical personnel required to deliver healthcare services. It needs to be noted that the health system comprises of organizations, people and actions whose primary intent is to promote, restore or maintain health. It consists of six building blocks identified by WHO to include health services, health workforce, health financing, health information system, leadership and governance, medical products, vaccines & technologies (World Health Organization [WHO], 2007). Accordingly, Health System Strengthening (HSS) is the application of technical knowledge and political will in improving these six health system building blocks and managing their interaction in ways that achieve more equitable and sustained improvements across health services and health outcomes (WHO, 2007). A well-functioning primary healthcare system require 'system-wide' investments to assure effective priority setting; sound management, administrative and financial planning; up-to-date 'health management information systems' for resource tracking; and appropriate regulatory and accountability Mechanisms (Shaw, et al., 2015).

Much of the healthcare projects funded by the BMGF through GPPP in Nigeria are disease-specific focusing on one disease or the other like polio, malaria and other infectious diseases. Hence, aside the poor attention to strengthening the health system through investment in human capacity and

infrastructural development, the implementation of multiple and uncoordinated healthcare projects through various stakeholders fragments and enervates the primary health system.

This fragmented primary health system and lack of uniform healthcare programme across the primary health facilities in the country explains, why the country has continued to experience different episodes of infectious diseases in different locations at different periods. Attempts to address this fragmentation in the primary healthcare programmes through establishment of the Primary Health Care Under One Roof (PHCUOR) in 2005 has not yielded the desired result as different levels of government continue to implement different healthcare projects funded by different or the same donors.

The primary health system as a whole still suffers from inadequate skilled medical personnel as issue of staffing does not receive desired attention in the GPPPs entered into with capitalist philanthropic foundations including the BMGF. In most cases ad hoc personnel are used to implement specific programmes like routine immunization and other disease-specific programmes. Not much attention is being given to enhance the capacity of Community Health Workers (CHEWs) who are regarded as the 'barefoot doctors' necessary for successful implementation of primary healthcare programmes. The importance of the CHEWs in building as sustainable healthcare system cannot be overemphasised.

Again, not much is being done to enhance the management structures of the primary healthcare system. Most of communities do not have well developed healthcare management mechanisms such as the recommended Ward Development Committees (WDC) and the Community/Village Development Committees (CDC), which serve as mechanism for community participation in the management of the primary healthcare. The implication of this is that the communities who are expected to actively participate in the management and ownership of the primary health system in their various locations remain alienated from the system in terms of management and decision making. This alienation of the community may result in resistance to implementation of healthcare programmes. For example, in 2003 some northern states in Nigeria (particularly, Kano, Zamfara and Kaduna) boycotted immunization and parents were called upon by community leaders not to allow their children to be immunised on the ground that the vaccine was contaminated with anti-fertility agents (Jegede, 2007). This boycott could be linked to be general distrust arising from the non-participation of community leaders in the whole process of healthcare management. Such boycott may have been averted if the communities had strong mechanisms for participation in the whole gamut of primary healthcare programmes. Another implication of weak or absence of strong mechanisms for community participation in primary healthcare management and programme implementation is that the communities may not sustain projects initiated and implemented through GPPPs with philanthropic foundations but would perpetually depend on inflow of funding from philanthropic organization. This is because implementation of new healthcare programmes without concomitant strengthening of the healthcare system is likely to yield unsustainable health gains and may even undermine the trust of communities in their health system (Kruk, 2012).

6. Conclusion

The proselytization of PPP as a solution to health challenge in Africa and as a vehicle for sustainable healthcare provisioning requires more scrutiny. Yet, existing scholarship focus more on PPPs between national government and local private entities with little attention paid to the nuances in the outcome of GPPP between national government and global private entities in the health sector. This study has examined the connection GPPP between the Nigerian state and global private philanthropic foundations in primary healthcare with specific focus on the BMGF. The study notes that the intensification of neoliberalism towards the end of the twentieth century with the reformulation of WC into the Post Washington Consensus (PWC) as the dominant neoliberal ideology saw the glorification of PPPs as a basic principle sustainable development.

In healthcare, the framing of primary health issues and the mainstreaming of healthcare in the MDGs and SDGs saw increased intervention by private philanthropic foundations through GPPPs in health systems of national governments. Hence, a lot of GPPPs have been orchestrated between the Nigerian state and various global private philanthropic foundations. However, the weak healthcare governance structure

which allows the three tiers of government to intervene in the primary health system concurrently undermines the GPPPs by predisposing the system to fragmentation and simultaneous implementation of overlapping health programmes. Further, through the GPPPs with various tiers of government, the BMGF prioritised funding of various episodic and disease-specific primary healthcare programmes implemented by multiple stakeholders (federal government, state governments, local governments, INGOs and other development partners). However, while the primary healthcare system was the major healthcare channel used for implementing most of the health related programmes, not much attention was given to infrastructural and human capacity development. Consequently, the primary healthcare system has remained enervated by the multitude of stakeholders implementing healthcare programmes in overlapping manner occasioned by lack of coordination of the programmes. This has continued to undermine efficient healthcare service delivery through the primary health system in Nigeria.

7. Policy Recommendations

In the light of findings and discussion contained in this study, the following policy recommendations are put forward:

i. The Nigerian state should address the governance gap in the health sector by ensuring that all the 36 states of the federation establish the State Primary Healthcare Development Agencies (SPHCDA) while the National Primary Health Care Development Agency (NPHCDA) should be strengthened to coordinate activities of the SPHCDAs across the 36 states particularly in the area of PPP and implementation of donor projects. This will help in actualizing the dreams of the Primary Health Care Under One Roof (PHCUOR).

ii. There should also be revised National Primary Health Care Development Policy at the national level while states should have State Primary Health Care Development Policy in line with the vision of the national policy. These policies will specify the roles of each tier of government and the long term health programme and priorities of the government in the area of primary health care development. This will go a long way in addressing overlap and fragmentation in the primary healthcare system.

iii. International philanthropic organizations and the private sectors willing to assist the government in primary healthcare development through PPP must adopt participatory approach to ensure that the projects are not only needs-based but that the beneficiaries from their healthcare philanthropy are involved in setting the agenda and implementation strategy of the healthcare projects in the countries. This will ensure that PPPs and GPPPs are mutually beneficial and healthcare programmes implemented through such partnerships remain sustainable.

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