Marianne Macaluso

May 11, 2018

Empowering Low and Middle Income Countries Through Foreign Aid and Partnerships

Population health is a complex issue that requires coordinated efforts. While some countries lag behind in population health achievements, others are thriving. To help low- and middle-income countries (LMICs) improve population health, other nations as well as international programs give foreign aid to LMICs. While this foreign aid is provided in an effort to improve important health factors and achieve global health goals, foreign aid has at times contributed to political disruption, resentment among healthcare staff, and decreased government investment in population health (Cailhol et al., 2013; Lu, Cook & Desmond, 2018). In other cases, foreign aid can be used in collaboration with recipient countries to strengthen and empower these societies and set them up for independence (Logie, Rowson & Ndagije, 2014). In this commentary, I use the case of Rwanda as an example of effective use of foreign aid and outline the steps that were taken in Rwanda to achieve improved population health. Using Rwanda as a model, I advocate for foreign aid policies that empower the recipient country by inviting them to have a partnership role in strategizing, developing, and implementing the interventions with a long-term goal of sole ownership of the program by the recipient country.

Rwanda is a small country in East Africa that was nearly destroyed by genocide in 1994 (Schaivone, 2013). An overwhelming majority of Rwandans live in the rural sector (Lu, Cook & Desmond, 2018), with 65% of citizens living below the poverty line (Mutesi, 2017). Despite

these barriers, Rwanda is well-known for its impressive gains over the last two decades in terms of its economy, infrastructure, and population health status (Lu, Cook & Desmond, 2018; Schaivone, 2013). The country serves as an example of a low-income country that has made remarkable strides particularly in meeting or nearly meeting Millennium Development Goals (MDGs) (Abbott, Sapsford & Rwirahira, 2015). So far, Rwanda has met the target for underweight children and is on track to meet other targets such as measles immunization, under-five and maternal mortality, and free antiretroviral therapy for AIDS patients within the suggested time frame. The use of modern contraceptives and providers present at births are also reasonably close to the target values and could be achieved by 2020. Rwanda's successes in population health parameters can in great part be attributed to the partnerships it has created with its donors. (Abbott, Sapsford & Rwirahira, 2015)

The Rwandan Ministry of Health (MOH) has made population health a priority by determining steps to improve health and consistently working towards achieving health goals (Binagwaho et al., 2013). For example, the Rwandan MOH established care for HIV-infected individuals as a priority in the early 2000s and identified improving the specialized health workforce as an important step in decreasing the burden of HIV/AIDS. The Clinton Health Access Initiative partnered with the Rwandan MOH to create the Human Resources for Health Program which aims at improving the health professional education system in Rwanda. This is done by sending physicians from the United States to Rwanda to improve education for specialties and subspecialties within the country. The Human Resources for Health Program also initiated two new master's programs in hospital administration and global health delivery to account for administrative needs in Rwandan hospitals. To encourage professionals to continue working in the public sector, the Human Resources for Health Program also provides necessary

equipment to facilities so that physicians are able to practice the new skills they learn. The program is designed with the long-term goal of Rwanda running the program within its own budget in 2019, after seven years of partnership with the United States. The way this program is designed allows Rwandans to invest in their health and take ownership of the program. (Binagwaho et al., 2013)

In 2005, the Country Coordinating Mechanism (CCM) for Global Fund to Fight Aids, Tuberculosis, and Malaria (GFATM)-funded projects in Rwanda proposed a health insurance scheme that was approved by GFATM, making it one of three Health System Strengthening projects to be approved by them (Kalk, Groos, Karasi & Girrbach, 2009). The goal of the insurance subsidies was to improve access to care for AIDS, tuberculosis, and malaria. Increase in insurance coverage most likely contributed to the increase in health service utilization which also may have contributed to the country's improved health status in relation to the MDGs. (Kalk, Groos, Karasi & Girrbach, 2009) In this case, Rwanda took the initiative to request assistance from foreign aid to accomplish a goal and achieved great success. This shows that the recipient country's government may be the most informed to determine what would most benefit their own country, but often they do not have the funds to achieve those goals without the help of donors. For this reason, it is imperative that donors involve the recipient country's government in interventions to improve that country's health, but it is also crucial that funds to these countries do not cease once the country is seeing improvements in health and infrastructure.

The Rwandan government is also unique in the way that it monitors foreign aid and collaborates with donors to ensure that funds are being spent efficiently (Logie, Rowson & Ndagije, 2014). This indicates the government's commitment to collaboration and shows that it is taking steps towards its goal of ending external aid by 2020 (Logie, Rowson & Ndagije, 2014).

From the perspective of the funder in this case, it is important that this type of collaboration and ownership be encouraged by donors rather than met with resistance (Logie, Rowson & Ndagije, 2014). While strict analysis and distribution of funds in collaboration with the recipient may cause extra work for the donor in the planning stages, it is vital to empowering the recipient country and setting them up for future independence.

Rwanda's achievements in population health demonstrate that in many cases there is a need for foreign aid to jump-start the processes to improve population health problems, but for this aid to be used to full capacity, there needs to be a partnership between the donor and the recipient. Rwanda has been successful at improving its infrastructure and overall burden of disease because of a focused effort that has involved both self-sustaining measures by the country, as well as financial and technical support from outside countries (Binagwaho et al., 2013). It is important to note that while Rwanda has made impressive strides towards improving population health, infrastructure, and economy, that does not exclude it from needing foreign aid (Mutesi, 2017; Logie, Rowson & Ndagije, 2014). Rwanda is still considered a low-income country and still needs the support from donors to achieve additional health goals and continue to improve the country's infrastructure. It is also worth noting that while overall improvements have been made in Rwanda, there tends to be a discrepancy between healthcare in rural areas compared to urban (Lu, Cook & Desmond, 2018), as well as for low compared to high socioeconomic status populations (Tshikuka et al., 2014). The government of Rwanda is focused on improving health outcomes for rural populations and while insurance schemes have improved the socioeconomic gradient of health in Rwanda, more work needs to be done in this area (Lu, Cook & Desmond, 2018).

The President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) are useful examples of global health initiatives (GHIs) that have received mixed reviews due to the negative impacts that have occurred in recipient countries as a result of foreign aid (Cailhol et al., 2013). A five-country study in Sub-Saharan Africa found that these programs have created resentment among staff due to differences in pay between GHI-funded staff and those from the public sector (Cailhol et al., 2013). This unequal pay also created brain-drain, a lack of qualified health professionals working in the public sector due to desires to earn more pay through GHI-funded programs (Cailhol et al., 2013). This demonstrates the problems that can arise when programs do not collaborate adequately with the recipient country to maximize benefits. In cases of unequal pay between the public sector and GHI-funded staff, there ought to be a conversation between the funders and the recipient country about investing in health professionals to maximize benefits.

This is related to the claim that governments tend to invest less in health problems when foreign aid invests in these problems, using that foreign aid as a replacement for allocating funds (Lu, Cook & Desmond, 2018). Interestingly, the opposite has been found in Rwanda, where there was a positive association between foreign aid involvement in rural health centers and government funds being allocated toward those health centers (Lu, Cook & Desmond, 2018). This undermines the claim that foreign aid 'crowds out' government spending. Perhaps what needs to be further evaluated is how the association between foreign aid and government spending is affected when a partnership is created between the donor and the recipient so that the recipient takes ownership of the intervention. My suggestion is that if countries are involved in the development of initiatives that involve foreign aid as well as government planning and spending, this will increase government spending, as was the case in Rwanda. This will be

crucial to improving the long-term health of low- and middle-income countries because it will give these countries a better chance of later being self-sufficient. This can be seen in the case of Rwanda's Human Resources for Health Program, which includes a goal for Rwanda to take full ownership of the program after seven years of partnership with foreign donors (Binagwaho et al., 2013).

In conclusion, the most efficient way to assist LMICs with foreign aid is to collaborate with, rather than attempt to control, these countries. Rwanda exemplifies the ability of LMICs to take initiative, maintain commitments, and determine their own fate when it comes to improving population health parameters. In contrast, programs that have not made strong efforts to collaborate with recipients have contributed to problems that may have otherwise been avoided. I urge foreign aid agencies to consider this when working with countries to improve population health. Empowering these countries today will lead to a better future for all of us tomorrow.

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