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The political economy of 'strengthening health services': The view from WHO AFRO, 1951-c.1985

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ABSTRACT

Our contribution to this special issue examines the early history of international striving for universal health care, from the perspective of the World Health Organisation's (WHO's) Regional Office for Africa (AFRO). The aspiration was repeatedly reframed, from 'strengthening health services' in the 1948 constitution of the World Health Organisation (WHO), to 'Health For All' through primary health care (PHC) in the 1970s, to today's articulations of universal coverage and 'health systems strengthening'. We aim to establish how AFRO supported member states in implementing these policies up to the mid-1980s, and with what degree of success. We also compare AFRO's experience to the established historiographical narrative of global health, as over-fixated on vertical interventions, save for the transitory impact of the PHC movement. Using the archives of WHO in Geneva and AFRO in Brazzaville, we first analyse AFRO's influence and capacity through quantitative financial data. The AFRO nations were net recipients of WHO resources, raising questions about their relative autonomy and voice in the organisation. We then examine AFRO's expenditure, showing that though circumscribed by funds with allocated purposes, there was nonetheless a significant proportion committed to services from the early 1960s, specifically capacity for planning and administration and the nursing, maternal and child health workforce. Counter to expectations though, there was no significant boost to these areas, nor to funding PHC projects, in the 1970s/early 1980s, when disease-specific interventions obtained a larger share. Qualitative sources show that despite its slender resources AFRO accomplished much with respect to training, capacity building and supporting innovative service-delivery, while insisting on African policy input into design and implementation. However country level system-wide planning in health was persistently vulnerable, and the bureaucratic capacity of post-colonial states often weak. Thus AFRO's overall impact was decisively bounded by the global structural inequalities in which it operated.

1. Introduction

Our contribution to this special issue examines the early history of international striving for universal health care, from the perspective of the World Health Organisation's (WHO's) Regional Office for Africa (AFRO). In the post-war period the goal of universalism in international policy was repeatedly reframed, from 'strengthening health services' in the WHO's 1948 constitution, to 'Health For All' through primary health care (PHC) promoted by WHO and UNICEF in the 1970s, to recent articulations of universal coverage and 'health systems strengthening' by the World Bank and WHO. In sub-Saharan Africa however, the major problem has been the limited availability of health provision itself, or at least those effective biomedical services from which Westerners already benefitted. In what follows we explore how WHO AFRO attempted to widen access in the late- and post-colonial era. Regional offices were the organisations through which WHO's strategic direction and support were intended to diffuse to members, as well as vehicles for autonomous action. Working principally with economic data, our main aim is to establish what AFRO did to develop health services in its early period to the mid-1980s, and to assess the extent to which its accomplishment reflected WHO's larger goals.

There is already a substantial critical historiography of the WHO which informs our discussion. This argues that it paid too much attention to single disease campaigns on behalf of poor countries, and not enough to building the health services that would empower them directly (Packard, 1997, 2016; Cueto et al., 2019; Birn, 2014). The

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critique turns on the distinction between 'vertical' and 'horizontal' programming (González, 1965). Vertical campaigns were those grounded in technocratic biomedicine that sought to control or eradicate diseases through externally devised approaches (Cueto et al., 2019; Packard, 2011, 2016). Horizontal strategies derived instead from the interwar social medicine tradition and focused on fostering national health systems so that countries could plan and manage their own policies (Cueto, 2004; Gorsky and Sirrs, 2019). The literature argues that this tradition was largely side-lined at WHO's inception, leaving health systems as matters for individual nation states (Gillespie, 2002; Gorsky and Sirrs, 2018). A temporary reversal of this direction, following the 1978 Alma-Ata Declaration and WHO's espousal of PHC has been well-documented (Roemer, 1986; Cueto, 2004; Litsios, 2002, 2004; Birn 2014). In the standard narrative this was rapidly curbed by the international debt crisis, which enforced a return to vertical approaches of 'selective primary health care' based on limited, cost-effective interventions in child health (Newell, 1988). WHO's leadership was then superseded by the World Bank which yoked development lending for health services to structural adjustment conditionalities, resulting in a largely unsuccessful attempt to widen access through pluralistic, private sector development (Stein, 2008; Abbasi, 1999; Packard, 2016; Cueto et al., 2019).

Our enquiry into the activities and achievements of WHO AFRO is framed by this contextual literature, but also offers a means of interrogating its applicability to regional conditions. It therefore contributes to the ongoing project of decentring WHO's history and de-emphasizing Western agency. Recent work shows the extent to which the United Nations organisations consolidated existing patterns of power despite decolonisation (Mazower, 2009; Pearson, 2017). Nonetheless, the WHO's regions were not simply quiescent vehicles for Geneva's directives. For example, the Americas regional office, originally Pan-American Sanitary Bureau (PASB), later Pan-American Health Organisation (PAHO), had by 1947–8 escaped its origins in the 1910s as an instrument of US sanitary hegemony, to represent also the spectrum of Latin American public health (Cueto, 2007). It would not only initiate disease control activities but also promulgate planning methodologies, and lead the push to have health integrated into economic development plans (Pires-Alves and Maio 2015; Gorsky and Sirrs, 2019). Meanwhile the South East Asian Regional Office (SEARO) took a key leadership role when the smallpox eradication campaign lost momentum, advocating for surveillance and containment rather than the overly ambitious goal of universal vaccination (Bhattacharya 2006). Thus, the regions can reveal how the ideals of international health projected by WHO's Executive Board actually played out. Were they indeed constrained by the primacy of vertical interventions as set out in the established historiographical narrative? Or did they allow local creativity to emerge, feed back to Geneva and so shape the direction of world policy?

The article unfolds as follows. In Section 2 we bring into view the place of AFRO within the WHO, then discuss the methodology we have adopted to analyse its activities. Section 3 looks briefly at the existing literature on African health system development during our period. Sections 4, 5 and 6 contain findings. First we present statistical data on AFRO's place within WHO, then on its financing and activity. These provide empirical grounding on its resource base and delineate the extent and broad areas of its 'horizontal' health systems work. Next we draw on qualitative sources to add illustrative examples of these local and national programmes. We conclude by returning to our central question, of what regional action was taken on the ground to improve national health systems and whether this fulfilled WHO's larger aspirations.

2. WHO AFRO: setting, sources and methodology

Founded in 1951, AFRO was the last of the regional offices to be created. There had been extensive internal debate at WHO's inception over whether a centralised structure, with a single headquarters and in-country representatives was preferable to a decentralised model of empowered regional offices. The latter won out, largely because the American member states insisted on the continued existence of the PASB (Hanrieder, 2015). In addition to AFRO and SEARO (1949), the Eastern Mediterranean (1949), Western Pacific (1951) and European (1951) regional offices (EMRO, WPRO, EURO) were also created (Cueto et al., 2019). The initial centre/region contestation has continued throughout WHO's existence, with recurrent centralisation attempts reflecting concerns over waste, and inappropriate expenditure by regional directors currying favour from member states on which they depended for election (Beigbeder, 1997; Hanrieder, 2015).

In our period, the division of functions saw Geneva managing WHO's representative and decision-making mechanism, its technical and advisory services and its expert committees while the regions implemented programmes at country level. These fell under such broad categories as infectious diseases interventions, non-communicable diseases, staffing and public health administration (later 'health systems strengthening'), maternal and child health, nutrition and sanitation. Each had a regional office with an intermediate role in planning, data-gathering and distributing resources to the in-country staff, and in providing a locus for training and decision-making. Most regional funding though went to the field activities at country level, as well as to some 'inter-country' programmes. During the 1970s, to further the Health For All agenda, WHO's Director-General (DG) Halfdan Mahler extended further powers over budgetary allocations, and staff and fellowship appointments, making the regions essentially 'self-reliant in operational terms' (Hanrieder, 2015, 228).

WHO AFRO's constituent nations contained many of the world's poorest, with the somewhat wealthier North (Egypt, Tunisia, Libya, Algeria, Morocco, Sudan) hived off to WHO's EMRO. Late colonial politics was central to its design and early operational logic. Colonial powers, notably the British and French, fought a rear-guard action through the 1940s and early 1950s to keep UN agencies out of scrutinising and policy roles in African colonies, often through collaboration on alternative bespoke agencies designed to demonstrate a rhetorical commitment to colonial stewardship and development, such as the Commission for Technical Cooperation South of the Sahara (known by its francophone acronym CCTA) (Pearson-Patel 2015). These agencies contested the primacy of AFRO in the arena of technical assistance, while AFRO itself was directly controlled by colonial powers and white settler states until the early 1960s, when independent African nations began to exert political pressure (Cueto et al., 2019). The Organisation of African Unity, founded in 1963, emerged as the new arbiter of inter-African cooperation, side-lining colonial era and bilateral models of arranging technical and advisory relations (Havik, 2020).

Whereas the first two Regional Directors, François Daubenton and Francisco Cambournac, had expertise rooted in colonial medicine, and while both vouched for greater attention to Africa's specific health problems, their framing was shaped by late colonial politics. In line with other continental and post-colonial developments, including the founding of the OAU, newly independent African states ensured that from 1964, AFRO health policy development would be driven by an African director, Alfred Comlan Quenum (Cueto et al., 2019: 77–85). While the policy space around health remained diverse and contested, AFRO occupied a key role in translating policy into national settings. It is within this institutional landscape and history then, that the autonomy, budget, and scope of AFRO should be understood.

In approaching the records of AFRO we have followed a standard historical methodology of documentary analysis using archival sources. We selected records from two repositories, WHO's Geneva library, where many key papers are digitised and easily accessible, and AFRO's archive (AFROA) in Congo Brazzaville. The former has recently been subject to a COVID-related archival closure that prevented us from visiting Geneva to collect non-digitised data. This affected our research on AFRO's financial records, limiting our time series to the period before 1981. The latter archive has until recently been underused, and indeed

suffered disruption between 1997 and 2001 during a civil conflict which saw AFRO's temporary relocation to Harare, and the sack and looting of its Brazzaville campus and buildings. Since then, the archive has been well conserved and catalogued, with excellent facilities for reading and recording sources.

Our principal documentary source is the WHO's annual programme and budget estimates. These include tabulations of the organisation's income, expenditure and staffing, from which regional data may be disaggregated. They also contain detailed regional sections with more granular expenditure data. These allowed us to categorise the different fields of activity and distinguish the extent of 'horizontal' health systems work and its changing pattern through time. We obtained a similarly detailed record of the region's income from another source, AFRO's annual reports, where it was recorded between 1966/67 and 1983. This allowed us to break down receipts into those for which funders had specific expenditure requirements, and those which AFRO had latitude to allocate.

We stress that neither of these are entirely tractable sources. There are two difficulties with the programme and budget estimates: each annual book contains financial and staffing data for three current years, but the figures for any given year may change in a subsequent year's publication (whether due to inflation, or the formula for converting national currencies to $US, or to post-estimate changes to allocations); there are also minor changes in the variables recorded (for example sub-categories of expenditure) from year to year, and at two points (1969, 1974) larger changes in the tabular structure, which present challenges for deriving consistent time series. Also, the income figures in the AFRO annual reports use a different taxonomy and do not balance with the expenditure totals given in the WHO budget estimates. We assume this relates to the latter's exclusion of some receipts from sources such as bilateral donors from the main WHO accounts. Hence the quantitative data that follow come with caveats about precision and should be treated as strongly suggestive, not definitive.

To discover finer detail of the in-country expenditure, and then to assess the relationship between regional activity and central goals, we analysed several different qualitative sources. The regional sections of the programme and budget estimates contain summary descriptions of projects and staffing in each of the member countries. Perspectives of the regional director and officials were gleaned from the introductions and relevant sections of the AFRO annual reports. We found a number of documents relating to training fellowships and programmes in AFROA that shed further light. Lastly, we occasionally used specific examples drawn from our work on Nigeria; these should be treated as illustrative not generalisable.

3. African health services development: the key phases

As a final preliminary, we will outline a brief chronology of international policy for health services development in sub-Saharan Africa to provide further context. Birthed in the late-colonial period, AFRO represented member states undergoing different modalities of 'development', alongside the continuing economic exploitation, political repression and social apartheid that accompanied the end of empire (Rodney, 2018; Cooper 2002). In the mid-century, just prior to the wave of independence (roughly 1957 (Ghana) to 1980 (Zimbabwe)) the dimensions of inequality were stark: per capita GDP in 1950 in Africa was $894, against $5018 in Western Europe, and life expectation at birth 48 and 67 years respectively (Maddison, 2010, 32, 441, 603). The high prevalence of infectious and parasitic diseases, sometimes exacerbated by colonial disruptions to traditional farming and diets, lay behind this. 'Tropical' medicine had been introduced to Africa by imperialists as an exogenous practice, initially to protect settlers and colonial servants, with the result that its institutions were not sited according to general population need (Van Dormael 1997). Thus, at independence rural areas were particularly underserved other than by traditional healing. At the same time, developmentalist public health, like the French Pasteurian model of mass screening had begun yielding positive results.

As decolonisation accelerated in the 1950s and 1960s, African health systems development at WHO was primarily associated with 'planning'. With questions of financing and coverage off-limits due to political sensitivity, this was a more neutral administrative realm (Gorsky and Sirrs, 2019). It also suited the late-colonial emphasis on economic planning which sought to bequeath a template for government, bridging the advent of independence (Van Dormael 1997). Thus, in Nigeria for instance, the colonial planning cycle produced a ten-year plan from 1946, a five-year plan from 1957, and post-independence plans covering 1962–1968, 1970–74 and 1975–80, prioritising agricultural and industrial policy (Waterston, 1965: ch.5; Federal Ministry of Health, Nigeria, 1988: 4). Health planning augmented this approach, with its estimates of institutional capacity and labour, and attendant assumptions about human capital. WHO therefore aimed to propagate techniques local bureaucrats might employ. However, African nations typically lacked the statistical capacity for such exercises, so that planning was more broad brush and faced an obvious resource challenge (Hodge, 2015; Jerven, 2016). Moreover, at this stage the region was concentrating primarily on disease control and large vertical programmes, often simply at a pilot project level (Graboyes, 2014: 445).

International policy from the mid-1960s was in principle more conducive to a sustained focus on health services, albeit eradication was the main priority. Independent African nations were increasingly assertive, demanding a new approach to development with better terms of trade for primary exports, lending to support industrialisation and import substitution, and an end to the neo-colonial influence of Western multinationals. The UN accepted this programme in 1974 when it announced the New International Economic Order. Aid and lending also began to encompass social provision in the form of schools and health care – 'basic needs'. Tanzania illustrates the period's initial promise of an African path to development, with its 1967 Arusha Declaration committing the state to a self-reliant, socialist, and pro-rural approach supported by development aid. In the health sphere it halted hospital programmes in favour of expanding rural PHC and piped drinking water, policies partly credited with raising estimated life expectancy from 40 to 52 years, 1967–1979 (Nugent, 2004: 141–153).

By the mid 1970s though, it was clear that the promise remained unfulfilled. Late-colonial strategies for retaining effective political power in Africa had bequeathed state apparatuses poorly equipped for popular sovereignty, which fell all too easily captive to local and expatriate interest groups unmotivated to advance health services. Many independent states also struggled with rapidly growing debt obligations due to tightening international economic conditions, compounded by regional environmental crises such as the Sahelian drought (1968–73). Nonetheless, Africa offered several models that inspired the turn to PHC by the WHO. Niger had piloted the use of trained community health workers and traditional birth attendants, and Tanzania's rural health centres and preventive programmes were exemplars (Newell, 1975). The Pholela and Valley Trust initiatives in South Africa, albeit marginalised by apartheid, were further influences (Digby and Sweet, 2012). Yet the promise of these pioneer models remained unfulfilled as the PHC movement foundered.

Macroeconomic analysis suggests that the era of structural adjustment saw overall increases in public health spending in sub-Saharan Africa, at least from 1985 (Kentikelenis et al., 2015). However, other studies argue that individual debtor countries faced 'enormously destructive social consequences and human costs' (Ferguson, 2006: 71; Pfeiffer and Chapman, 2010). Many African polities still lacked the bureaucratic capacity to translate grandiose policy aspirations into viable welfare programmes and now the limited structures nurtured by harnessing pilot interventions and programme designs were dismantled, in response to onerous conditionalities (Packard, 2016, 259–64). The capability to implement PHC withered, alongside careers and investments in managing public welfare programmes. Structural adjustment failed to reduce debt levels, imposed forms of cost recovery which

impoverished public sector workers, reduced the size of the public payroll and policy implementation capacity, and squeezed the income base for user fees in the new, consumer-driven health sector (Nugent, 2004: 333). By the mid-1980s then, scope for health system development lay not in comprehensive PHC but in the areas now attracting funding, selective PHC and mass child immunization.

4. AFRO within WHO: financial contributions and human resources

Before exploring AFRO's activities we first bring into view the financial relationship between centre and region. Table 1 summarises the proportion of WHO's total income that was expended through AFRO, 1954–81, and the numbers of WHO and AFRO staff, indicating the percentage in the region as a whole, and distinguishing personnel at headquarters from those undertaking field work. AFRO seems to have received between 12% and 15% of WHO's revenue, with the majority of this going to field activities. Likewise, between 70% and 80% of the staffing in the region was active in the field at country level (the blank cells reflect changed reporting). It should also be noted at this stage how small-scale this operation was. Despite rising staffing levels through the sequence, the presence of only some 700 people to steer international health in the 1970–74 period through the whole AFRO region is clearly insubstantial.

Table 1
AFRO expenditure as proportion of WHO spending, and AFRO staffing, 1954–81, quinquennial averages.

	total income WHO $US	*AFRO exp as % WHO total*	*AFRO field exp as % WHO total*	*total posts AFRO*	*AFRO field posts as % of total AFRO posts*
1954–59	28,211,001	*12*	*10*	120	*70*
1960–64	64,553,600	*14*	*13*	406	*83*
1965–69	100,859,538	*14*	*13*	630	*84*
1970–74	183,317,395	*12*	*9*	705	*81*
1975–79	303,695,188	*12*	-	611*	*72**
1980–81	389,668,200	*15*	-	-	-
				* = 1974-78	

Sources: WHO 1954, 1955, 1958, 1961, 1963, 1964, 1967, 1969, 1972, 1974, 1978.

In light of these scarce resources, what degree of autonomy did AFRO actually have to set its agenda and programming? The founding principle had been that all nations would contribute according to their levels of wealth and population, and that each member state would have a vote at the World Health Assembly where policy was agreed. In practice there was a huge disparity of annual contribution assessments (Fig. 1, sources as Table 1). We have summarised the published data by distinguishing a consistent set of 'high payers', whose assessment in the 1950s–1960s exceeded 1% of WHO's total budget, classified as Western High Income (Australia, Belgium, Canada, France, Germany, Italy, Japan, Netherlands, Spain, Sweden, UK); Eastern Bloc High Payers (Poland, USSR, GDR, Ukraine), Other High Payers (China, India, Argentina, Brazil), and the USA alone. These few countries covered some 85% of the budget, with one nation, the USA, meeting about a third in the 1950s, falling to about a quarter in the early 1980s, when its fellow high-income Western nations provided somewhat more than a third. Soviet bloc high-payers contributed about 15–16% and the 'others' a declining proportion of some 12–18% (India's share in particular fell).

How much of the remaining contributions came from Africa? Table 2 reports biennial average percentages of the WHO total, based on the assessments of all African nations during this period. Prior to decolonisation these were few, first comprising Liberia, South Africa, and Rhodesia/Nyasaland of the AFRO nations, joined by Ghana, Nigeria and Sierra Leone from 1958, then rising to 38 separate states by 1981. Most

Table 2
Continental African contributions to WHO budget, 1954/55–1980/81.

	1954/55	1956/57	1958/59	1960/61	1966/67
	%	%	%	%	%
Sub-Saharan	1.17	1.09	0.96	0.96	1.67
Maghreb/Mashriq	0.83	0.75	0.30	0.31	0.35
WHO AFRO	**1.17**	**1.09**	**0.96**	**0.98**	**1.76**
WHO EMRO	0.83	0.75	0.30	0.29	0.26
African Continent	**2.00**	**1.83**	**1.26**	**1.27**	**2.01**
	1968/69	**1970/71**	**1972/73**	**1974/75**	**1980/81**
	%	%	%	%	%
Sub-Saharan	1.77	1.79	1.81	1.53	0.93
Maghreb/Mashriq	0.29	0.26	0.50	0.34	0.33
WHO AFRO	**1.81**	**1.79**	**1.89**	**1.53**	**0.93**
WHO EMRO	0.25	0.26	0.42	0.34	0.33
African Continent	**2.06**	**2.05**	**2.31**	**1.86**	**1.26**

Sources: WHO 1954, 1958, 1963, 1964, 1967, 1972, 1978.

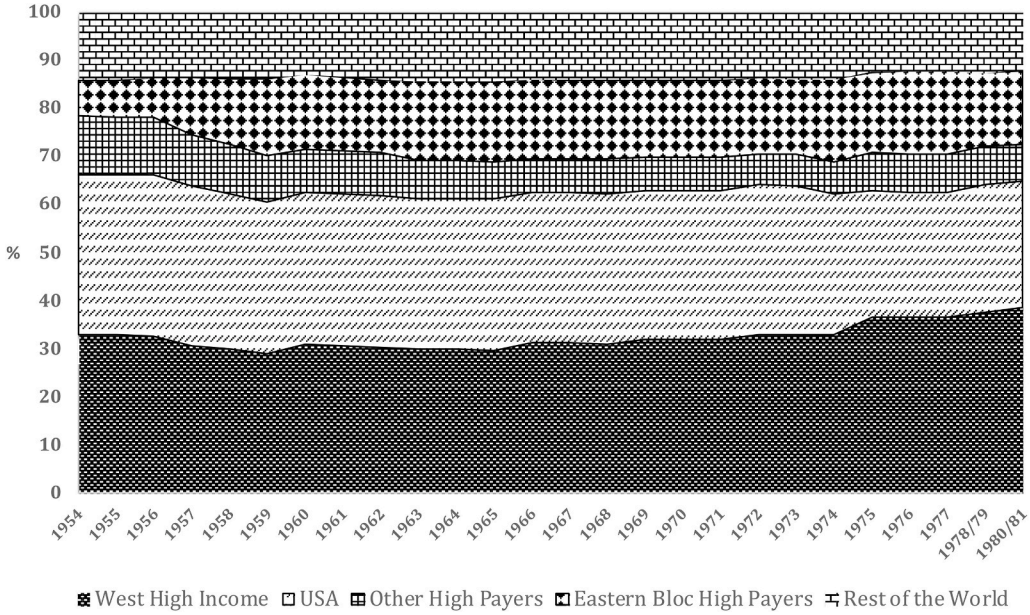

Fig. 1. WHO: Assessed Contributions by Member and Associate Member States 1954–1981, percentage of Regular Budget.

of these (usually excepting Nigeria, Ghana, South Africa and Congo) were assessed at a flat rate rather than the standard formula, in acknowledgment of their low national incomes. Overall, the whole African continent contributed c.2% falling to c.1.25% of WHO's regular income with the AFRO nations comprising between 1.8% and 0.9%. The substantial extent of redistribution is clear. We can speculate that this economically dependent position, coupled with their later arrival as independent states put African members at a disadvantage in strategic policy debates. Further research may establish whether this was the case, or if the Executive Board provided a relatively equitable power balance, as Chorev (2012) suggests.

5. AFRO: trends in income and expenditure goals

Prior to examining AFRO's activities, brief discussion of its income is needed to establish how much autonomy it had in setting regional goals. Receipts came partly from bilateral aid, but predominantly from WHO distributions. Assessed contributions of member states constituted WHO's 'regular budget' over which AFRO had discretion, but various funds from other sources had earmarked purposes. The regular budget was the dominant component of income in the 1950s, before declining to 43% in 1974, then rallying again to 55% by 1981. Its other sources included 'technical assistance' funds (c.30%), like the dedicated 'malaria eradication fund', as well as 'extra-budgetary funds', consisting of for example UNICEF allocations for joint projects, UN funds for population and development, the International Agency for Research on Cancer, and other 'funds in trust' for specific purposes. Thus, resources for focused work on health services and systems were already circumscribed.

What did this mean for AFRO itself? Fig. 2 (sources WHO, 1964, 1968, 1971, 1978, 1979) presents a partial picture of the regional office's income from AFRO's annual reports and its proposed programme budgets, recorded between 1966/67 and 1983. Strict accuracy is uncertain as noted above, since these figures differ from totals given in the WHO budget estimates and use a different taxonomy. About 70% of AFRO's income came from the WHO's regular budget, falling to about 50% from the mid-1970s. The UN Development Programme was initially the main supplementary support, with smaller sums coming from bilateral aid monies, including, in 1973/74 for example, $215,542 for smallpox eradication, $345,318 from DANIDA, and $134,222 from SIDA, respectively the international development agencies of the Danish and Swedish states. From 1973/74 the WHO/World Bank onchocerciasis programme quickly rose to furnish a quarter of AFRO's budget. This was another vertical intervention, against the parasitic disease of river blindness, initially involving environmental spraying against the insect vector, black-flies, and subsequently the distribution of chemotherapies. Motivated by humanitarian and developmentalist perspectives, the initial focus was to be on Dahomey (present-day Benin), Ghana, Cote d'Ivoire, Mali, Niger, Togo and Upper Volta (today Burkina Faso), with the Bank creating a fund and eliciting contributions, then partnering with WHO to run the programme (WBA 1973).

In light of these constraints, Figs. 3 and 4 (sources as Table 1) reveal the scope for health systems work within AFRO's activities, the different graphs reflecting a change of taxonomy from 1974. In Fig. 3 our 'health systems' category encompasses budget lines for nursing, maternal and child health and 'public health administration' (whose composition is described below), on the assumption that these supported permanent service development. The major categories combined under 'communicable diseases' are malaria, smallpox, TB and VD/Yaws, with lesser streams for leprosy, viral, bacterial and parasitic diseases. Also geared to fighting infectious illnesses were the sanitation projects of 'environmental health'. 'Non-communicable diseases' includes dental, occupational and mental health, as well as radiotherapy and nutrition, while 'health promotion' refers to health education and training; 'statistics' is self-explanatory. As expected, in the 1950s programmes to address communicable diseases dominated, particularly yaws. This category then declined to about 20% of the whole by the early 1970s, though environmental sanitation grew commensurately. There was a consistent focus on non-communicable diseases, mostly nutrition projects. Health promotion and statistics were minor categories, the latter to support post-colonial bureaucratic planning.

What about 'health systems' activity? There was significant expansion, sometimes accounting for over half of all spending (eg. 1961–5, 1970). Within this category maternal and child health initially dominated, though nursing and health 'manpower' later rose, suggesting a recategorization of efforts to train and embed skilled personnel. Its other component, 'public health administration', made up about one third of the category in the 1950s, rising to over 80%. Here then was the real core of early health systems strengthening, amounting to about one-third of AFRO's early 1970s field expenditure. Activities went beyond the development of curative services, and were not synonymous with PHC. Examples in the mid-1960s include hospital and rural health services planning (e.g., Kenya, Cameroon, Nigeria, Senegal) installing staff like sanitary engineers (Burundi, Congo Leopoldville [today DRC],

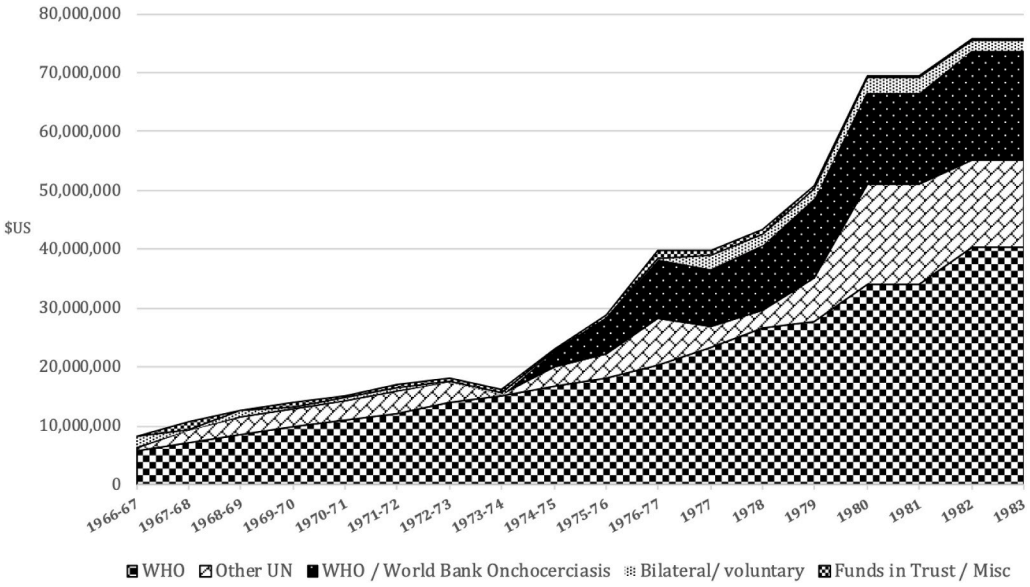

Fig. 2. Composition of income of WHO AFRO, 1966/67-1983.

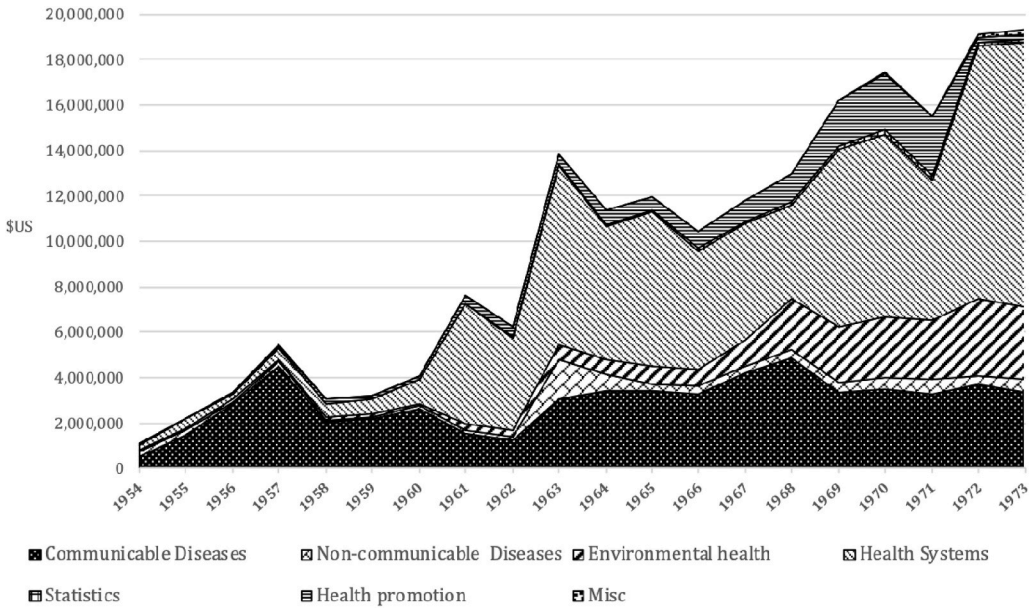

Fig. 3. Composition of field expenditure of WHO AFRO 1954-73.

Senegal), laboratory technicians (Congo Brazzaville), virologists (Nigeria) and nurse educators (Nigeria), as well as more general public health advisers, nurses and managers (WHO, 1964a,b: 102–120). Partly then, it overlaps with broader communicable disease efforts, rather than building patient services *per se*.

Fig. 4 covers the era of the Alma-Ata Declaration, when we might expect to see PHC more to the fore. Surprisingly this was not the case, and indeed the disease programmes, coupled with environmental sanitation, expanded their scale, to about 50% by 1981. Partly this growth reflected the onchocerciasis interventions discussed above. The category 'strengthening of health services' diminished slightly, from a high point of 24% of spending in 1975 to 14% in 1981. This was primarily planning and management costs, with the smaller sub-category 'primary health care' disaggregated from 1978 and amounting by 1981 to $1,691,950 – just 3% of AFRO's entire spend. The staffing activities allocated in Fig. 3 to 'health systems' is here subsumed under 'manpower', which was principally funding for training. Taken together these two categories amounted to 44% of the whole in 1974, falling to 35% in 1981. Of the remainder, the limited 'family health' category included maternal and child health, nutrition and health education, while 'therapeutic substances' alluded to drug programme planning and quality control; statistics were now included in 'health informatics' alongside legal documents and health publications. The key point then, is that *contra* the global health history narrative, there was no spending shift from vertical to horizontal programming. If anything, a movement in the other direction occurred.

Summing up so far, Sections 4 and 5 have established the parameters of the relationship between AFRO and Geneva with respect to building

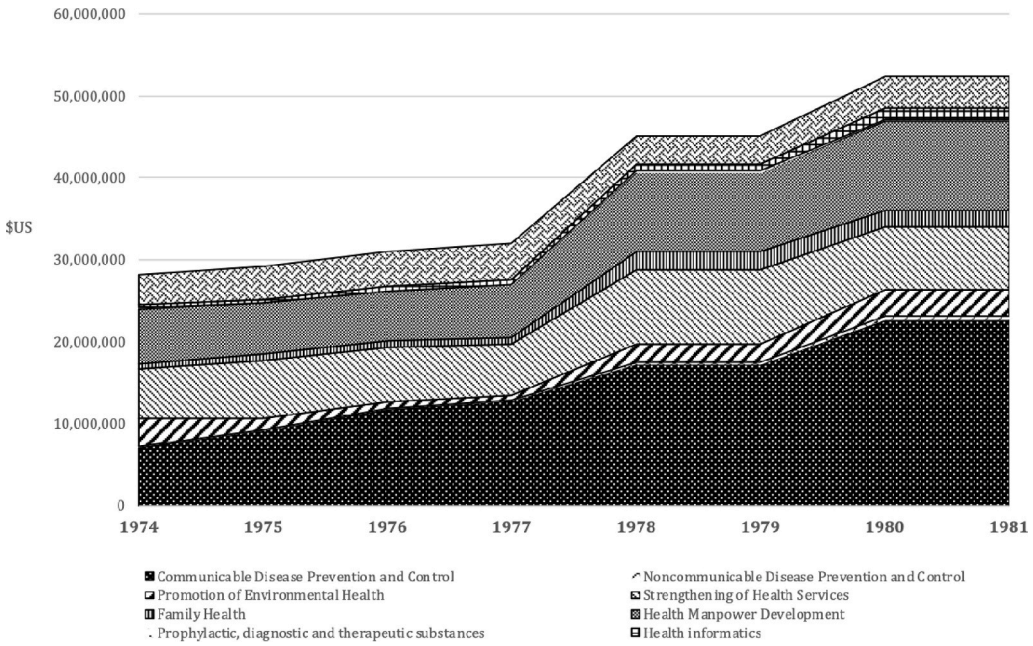

Fig. 4. Composition of expenditure of WHO AFRO 1974-81.

country-level health systems. Notwithstanding the fragile underlying statistical data, several conclusions emerged. AFRO's expenditure before the early 1980s was upwards of 12% of WHO's budget, while the AFRO nations themselves contributed less than 2% of its income. WHO was dominated financially by a small number of rich nations, most notably the USA, and we may therefore hypothesize that this restrained AFRO's independent power. In addition, an increasing proportion was non-discretionary and tied to designated projects. The figures also revealed what a small operation AFRO commanded. Field expenditure by the mid-1970s of $15 million, of which at best $6.5 million went on health systems, with at most some 600 field staff (1973) for all in-country work, was insubstantial in the face of Africa's health challenges. By way of comparison, in 1980, when AFRO's spending (field and head office) was c.$57,500,000, the total expenditure of New York City's Department of Health and Mental Hygiene was $99,053,000 (Independent Budget Office 2021 Independent,). This brings a sobering perspective to any estimation of what the regional offices, and WHO itself, could achieve. Within these limits, there was continuous interest in health systems strengthening, particularly building staff capacity and planning rural or hospital services. However such activity waned somewhat in the 1970s – a pattern unrelated to the chronology of universal PHC's 'rise and fall'.

6. Examples of AFRO's health systems work

Given the considerable gulf between the rhetoric from Geneva and the slender resources at AFRO's disposal, what did the region actually achieve with respect to 'health services strengthening' and then to primary health care? We now turn to qualitative sources for fuller detail of the programmes delivered under the broad headings outlined above. We set these in chronological sequence of the policy phases outlined in Section 3, and discuss the extent to which they can be seen as meeting international goals.

What form did the earliest initiatives take in the 'planning' era of the 1950s and 1960s? One specific AFRO programme was Area Public Health Officers: three regional posts responsible for conferring with 'the health authorities of individual countries on the promotion and co-ordination of health activities.' Another was country-level Public Health Administration programming, albeit only explicitly budgeted for the Union of South Africa (WHO, 1954: 67, 72). These modest steps contrast with extensive programming and staffing in Latin America, South Asia, and the Western Pacific for country-level investments in rural public health, maternal and child health services, and regional expertise in diagnostic support, statistics, and laboratory services (WHO, 1954: 64, 99, 105–06, 224, 259). The dissimilarity probably reflects the colonial status and lack of policy-making agency in sub-Saharan Africa, while the strong emphasis on externally funded vertical disease control programmes also indicates capacity constraints within late-colonial health systems. In Tanzania for example, there were continuities of systemic underfunding of patchwork health services across colonial and postcolonial eras (Jennings, 2015: 2).

By the late 1950s, AFRO's public health administration staffing still lagged behind other regions, despite the establishment in Geneva of a Division of Public Health Services for 'the organisation and strengthening of health services at national and local level' (WHO, 1958: xii-xvii, 34). Limited funds were largely allotted to fellowships, though integrated planning for rural health care in Ghana and Nigeria was also supported (WHO, 1958: 95, 98). As African states began gaining independence and assuming full WHO membership there is some evidence of shifting organizational priorities beyond vertical disease control. WHO now recognised that '[l]ong-range health planning appears in fact essential if a developing country is fully to benefit from the improvements resulting from the mass campaigns' (WHO, 1963: xiii-xix). In terms of practical commitments, technical advisers were placed in a number of countries, though only in Congo, Leopoldville was a concentrated effort made, absorbing some $4.4m, and 229 of the 659 regional and field staff dedicated to health services (WHO, 1963: 99, 234, 244). As independence neared, AFRO was able to launch operations across the continent, and an initial maternal and child health project began in Nsukka, Eastern Nigeria, in 1958. Over the next decade, it trained 700 health workers at supervisory, nursing, and inspector level (WHO AFRO, 1968: 10–11). Meanwhile, USAID funds were made available to five pilot countries – Gabon, Liberia, Mali, Niger, and Sierra Leone – as part of a national health planning programme whose ultimate failure has been discussed elsewhere (Manton and Gorsky, 2018).

AFRO recognised the unsatisfactory terrain in health services, which if improved might undergird more ambitious programming, including the surveillance capacity for disease control implemented elsewhere. Pilot efforts in malaria control demonstrated that the lack of well-articulated national health and sanitary services made broader investment particularly difficult (WHO AFRO, 1968: 12–13). Consequently, AFRO commissioned studies of current provision and budgetary needs to attain complete national coverage in basic health and sanitation across 14 countries and sub-national regions, primarily for malaria pre-eradication and prospectively for tuberculosis control and smallpox eradication (WHO AFRO, 1968: 13–15). Meanwhile, existing WHO/USAID health planning pilots began to yield lessons, demonstrating the difficulty of devising measurable objectives, the problems posed by uncertain aid flows, and the poor integration of health within national plans (WHO AFRO, 1971: 19). While AFRO developed country agreements and a slew of projects with newly independent governments, it faced challenges in reconciling pioneer training and pilot programming efforts with its inability to strengthen health services to underpin broader coverage.

Turning now to the mid-1960s and early 1970s, did the era of 'basic needs' mark a step change? AFRO sources indicate that goodwill and clearsighted appraisals of bureaucratic, training, and funding deficits went unmatched by adequate funding or expertise (WHO, 1964: xiii). National health planning and reorganisation remained stated priorities, and in the estimates for 1966 provision was made in Burundi, Cameroon, Congo (Brazzaville), Guinea, Kenya, Madagascar, Nigeria, Rwanda, Senegal, and Upper Volta (now Burkina Faso) alongside the five pilot countries funded under the USAID programme (WHO, 1964: 101–122). Funds and staffing capacity broadly matched that available in PAHO and WPRO regional budgets, although African programmes and projects operated at a more basic level (setting up services and departments, endowing fellowships, providing advisory services) rather than implementing more long-standing programmes and follow-up work (WHO, 1964: 101–233). Again, this reflected the lack of existing institutional diversity and capacity.

In response, WHO now began to emphasize comprehensive, adaptable long-term health planning (WHO, 1967: xiii-xiv; WHO AFRO, 1964: 17–18). Noting that the original five USAID-funded programmes had lacked inbuilt monitoring and evaluation, a 1969 project in Upper Volta piloted such functions. A new United Nations planning institute in Dakar, Senegal was set up to refine methodologies, in-project adaptation, and consultation processes around health and economic planning. Demonstration and strengthening projects launched in Guinea, Cameroon, Kenya, Lesotho among others, variously integrating maternal and child, environmental, and nutrition services into basic provision (WHO, 1967: 118–140). AFRO also attracted an increasingly large share of the WHO's projected regional operating budget for health services - $10m out of approximately $37m for 1974 (WHO, 1972: 3, 133). This supported programmes across member states (part funded by UNDP), often complemented epidemiological service initiatives. Country-level projects were linked by a comprehensive regional programme of symposia, seminars and courses, and a cohort of consultants-at-large advising on health service and manpower development (WHO, 1967: 133–182). Local priorities and expertise also mattered, as when two Western Nigerian tuberculosis and yaws control projects merged into an epidemiological service (Piotrowicz, 1975: 1).

Despite all this, a consolidated approach to health planning across

the region was still unrealised by the early 1970s. Persisting personnel problems undermined such initiatives, which often relied on unachievable or unrealistic projections of 'health manpower' (WHO, 1972: xv). Improvements to training and flexible experimentation proceeded but remained inadequate to the scale of need.

Coming to the mid-1970s and early-1980s, how did the 'rise and fall' of PHC play out in the region? Creeping gloom pervaded the reports of director Comlan Quenum, notwithstanding the promise of the New International Economic Order that a 'health revolution' might advance 'in the name of justice and equity' (WHO AFRO, 1979: xi). Yet across the continent the backdrop of 'fratricidal wars', an 'escalade of violence' driven by apartheid, the 'world financial and energy crisis' and the 'acute selfishness and resistance to change' of political leaders meant health development was 'in a blocked situation' (WHO AFRO, 1979: ix). Looking to the early 1980s, Quenum deplored the 'wretched living conditions of the rural and peri-urban masses' and inveighed against the 'vertical co-operation' model of Western technical assistance. This 'ill--considered import' fostered 'cultural and technological alienation' rather than the national self-reliance needed to implement PHC (WHO AFRO, 1978: 11–12).

What lay behind this pessimism? As shown above, there was no substantial shift of resources towards services, while vertical disease-focused interventions, like the WHO/World Bank onchocerciasis initiative, gained traction. A new WHO-led Tropical Diseases Research programme also launched in 1976, funded by the Bank, UNICEF and UNDP and run by the Nigerian Adetokunbo Lucas; its budget leapt from $41m, 1978–79, to a projected $78m, 1980–81 (Watts, 2021; WHO, 1978B: 71–77). WHO's leaders might proselytize for 'programmes that reflect the collective decisions of Member States', but achieving the Alma-Ata vision of universal PHC was 'far beyond the capacity of WHO's regular budget', while global financial turbulence and accelerating national indebtedness exacerbated matters (WHO, 1978a,b: xii-xiii).

In these circumstances, AFRO continued with its modest programme of 'country health planning' and management workshops. National plans were developed in Madagascar, Ghana, the Gambia, Mozambique, Upper Volta and Angola, while units were established in Kenya, Uganda, Burundi and Mali to integrate health objectives into national economic plans (WHO AFRO, 1979: 30–31). PHC was promoted through seminars and workshops to 'make the concept … more explicit', while delegates from Botswana, Mozambique, Sierra Leone and Mauritius undertook a study trip to China (WHO AFRO, 1979: 32). Such initiatives probably reached some 300–400 individuals, and their impact is uncertain. Nationally, there were several education schemes for community health workers in the classic PHC mould, as in Dori (Upper Volta) where traditional birth attendants were trained in maternal and child health, and Chad, where support from the European Development Fund supported 525 village health workers. The other recorded AFRO PHC project was a scheme in Lesotho for constructing latrines and wells in primary schools (WHO AFRO, 1979: 33–34).

Beyond this, proper realization of health planning goals remained elusive, for AFRO lacked the consolidated power to implement and fund national policies and programmes, and individual governments might not prioritise these. For example, examining basic health services in Nigeria, WHO's country Medical Officer noted that although malaria control schemes were well integrated into basic health services across most of Nigeria's 12 states, survey funds were patchy in severely affected areas, such as Rivers State. Moreover, there was not yet a Planning Unit within the Federal Ministry of Health, the national Public Health Administrator role was unfilled (Carpenter, 1974: 9–10) and state planning units were *ad hoc* bodies lacking statutory powers (Paik, 1976; Hotobah-During, 1976). WHO's leadership also recognised that its management training approach was flawed, over-emphasizing sophisticated techniques for hospital and vertical disease programme administrators, rather than supporting indigenous development of management education throughout member states (AFROA, 1980: 4, 42–4). Its goal now became building self-reliance in providing management training, modelled on embryonic programmes in Tanzania and Ghana (AFROA, 1980: 39–40).

This new emphasis on self-reliance, or 'greater participation of nationals in the preparation, management, evaluation and continual revision of WHO programmes' (WHO AFRO, 1978: 11), was part ideological shift and part pragmatic recognition of existing state capacity and stakeholder terrain across much of Africa. In Cameroon, for instance, both state and WHO relied on bodies such as the Catholic Relief Services to deliver dispensary care and rural health education. These built on long-term engagement in rural areas, which often evaded national health planners and international policy workers (AFROA, 1981). Similarly, health planning and service delivery in post-Civil War Eastern Nigeria depended on World Food Programme interventions and collaborations with local universities, and both federal and state ministries for economic development (AFROA, 1974). Similar consortia evolved between UN agencies, states and NGOs in emergency settings through the 1970s.

Where did this leave the heady optimism of 'Health For All'? In 1977, Resolution 30.43 of the World Health Assembly had decided that WHO's 'main social target … should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life'. The following year's Alma-Ata Declaration had further resolved that Health For All would be achieved through 'primary health care in communities as part of a comprehensive national health system and in coordination with other sectors' (WHO, 1981: 15–16). From the vantage of AFRO however, these aspirations played out against a backdrop of political instability which undermined their promise. Without additional resources to seed projects, and lacking engagement by national leaders, it could only advance slowly on well-established tracks of training, pilot schemes and exhortation, building on PHC practices already evidenced in Tanzania and elsewhere (see Beaudevin et al., 2023, this issue), drawing as best it could on external aid.

In the succeeding era of structural adjustment and selective PHC, concern grew about the continuing viability of UN agency funding and administrative processes. WHO noted in 1982 the fundamental tension between 'the continued, indeed growing, seriousness of the economic situation of a great number of Member States … [and] the increasing emphasis placed by some Member States on the desirability of containing the budgets of international organisations … or even of reducing them' (WHO, 1983a: 30). Indeed, the centrality of 'Health For All' was criticised by the USA, among others, and maintaining it required considerable administrative gymnastics and financial flexibility from the WHO Directorate General through the 1980s (WHO, 1983b: 138, 163).

Such uncertainty about resource flows for Health For All necessitated continual refinement of feasibility and evaluation mechanisms (WHO, 1983b: 225–226). Organizational attunement was rarely smooth, as in the 1982 effort at WHO's Nigeria country office to adapt the operational relationships of PHC management to Nigeria's federal system. These were halting, due to the complexities of allocation, financial responsibility, existing health system structures and staffing. WHO's National Programme Coordinator noted that reorganisation would be 'a long process', and the implementation of PHC a 'monumental task' (AFROA, 1982). Indeed, it was to be another six years before the publication of the *National Health Policy and Strategy to Achieve Health for All Nigerians*. This document bemoaned a long and continuing history of inefficiency, inadequate coverage, inappropriate service design, lack of useful statistics, and largely weak management (Federal Ministry of Health, Nigeria, 1988: 4–5).

The keynote then, was a sense of resource constraint for health systems work. In 1983, Gabon's Louis Adandé Menest noted a reduction in AFRO's health system infrastructural allocations, which increased difficulties in developing cooperative work on statistical and epidemiological information needed for meeting the Health for All objectives (WHO, 1983b: 132). AFRO became consistently parsimonious in

relation to staff costs and recruitment, while programmes such as Tropical Diseases Research feared a tightening of funds just as past investments in laboratory investigation and applied field research promised to bear impact (WHO, 1983b: 123, 204–205). Its Director, Adetokunbo Lucas, sought its integration with Regional Office capacities, underlining various stratagems through which WHO might enfold extra-budgetary funding lines into regional operations, and indeed, the TDR programme was key to mobilising UNDP and World Bank investment in the broader WHO policy framework through the late 1970s and 1980s (WHO, 1983b: 206–207). The TDR's survival attests to the new set of priorities for international health in the era of selective PHC.

7. Conclusion

This article has explored the prior historical context to today's debates about extending 'health for all' in Africa. It asked how the changing iterations of the WHO's policy goals for health services and systems were translated through its regional arm, AFRO, to drive developments at national level. It also interrogated the familiar critique of international health policy as over-fixated on vertical interventions, save for the transitory impact of the PHC movement. First, we analysed AFRO's influence and capacity using quantitative financial data. The AFRO nations were net recipients of WHO income and resources, raising questions that we could not resolve here about their relative autonomy and voice in WHO's Executive Board. We then tracked patterns of expenditure at AFRO, which, we emphasized, was a comparatively small operation. Already circumscribed by substantial extra-budgetary funds over which WHO lacked discretion, there was nonetheless a reasonable proportion committed from the early 1960s to health systems purposes, specifically, capacity for planning and administration and the nursing, maternal and child health workforce. Counter to expectations though, there was no significant boost to these areas, nor to funding PHC projects, in the Alma-Ata era, when, surprisingly, disease-specific interventions obtained a larger share.

We then examined what AFRO was able to achieve with its slender resources. It confronted the perennial issues of reconciling WHO's shifting funding priorities with mobilising and resourcing national capacities, and of refining programme aims in response to budgetary imperatives driven by international agendas, all the while insisting on African policy input into design and implementation. While health service delivery was ongoing, and internationally-supported programmes proliferated throughout this period, country level system-wide planning in health was persistently vulnerable, despite headline bilateral and UN agency commitments. Despite all it accomplished with respect to training, capacity building and supporting innovative service-delivery, its scale was too small substantively to meet the challenges it faced.

Three caveats need to be entered. First, this necessarily brief account has read AFRO's activities from the headline reports of its spending and programmes, and set this in the context of the strategy laid out by WHO's head office. We have not attempted to broaden that context to consider the influence of funding and initiatives from UNICEF, the Rockefeller Foundation, the World Bank, USAID and others, nor have we considered the part other organisations such as the OAU and CCTA played in shaping decisions. We hope though that the empirical material presented provides a platform for future research which will explore these issues more fully.

The second caveat relates to the ongoing tension between centrists and regionalists within the WHO alluded to in Section 2. Those who favoured the principle of central control consistently worried about devolving responsibility for WHO policy goals to regions. Specifically, DG Halfdan Mahler felt in retrospect that entrusting regional directors to deliver PHC had been a mistake, and that too often 'collective resources' had been treated 'as a blank cheque for pocket money' (quote from Hanrieder, 2015, 228). The bureaucratic reporting in the sources used here does not disclose anything of accountability for the AFRO decisions which kept PHC spending so flat, nor whether these were entirely disinterested.

The third issue is the risk of oversimplification in the vertical/horizontal dichotomy that runs through our assessment. Defenders of selective PHC had argued at the time that this was overdrawn, and that disease interventions or general vaccination programmes could also strengthen health infrastructure (Taylor and Jolly, 1988). More recent research has further interrogated the validity of the dichotomy through specific cases, and shown positive long-term effects on health system capacity were sometimes possible (Keugong et al. 2011). While we cannot retrospectively apply the evaluative frameworks that now exist, we accept that our dichotomous taxonomy was probably more permeable than we imply (Atun et al., 2010).

Overall then, our findings point to a larger, unspoken reality behind the critical literature with which we began. It was not the case that AFRO, nor WHO, neglected horizontal 'health systems strengthening' within its work and financial allocations. It was rather that against the legacy of colonialism its limited means counted for little. At independence, African states largely inherited bureaucracies designed to support and stabilise European imperial-led and capitalised enterprises mostly oriented around security and extraction. This ill-fitting apparatus proved unwieldy and unsuited to indigenous policy development, putting them at an immediate disadvantage in influencing agendas and harnessing UN support. Over the next fifty years, systemic economic and geopolitical shocks compounded relative disadvantage to constrain the developmental African state from consolidating bureaucratic resources around policy-making and planning. Thus while it is important to retrieve the efforts of AFRO's early protagonists of universal health care, we should not lose sight of the fact that their overall impact was decisively bounded by the global structural inequalities in which they operated and by the finite resources at WHO's disposal.

Author contributions

Martin Gorsky: Funding acquisition, Conceptualization, Methodology, Resources, Writing – original draft preparation, Writing- Reviewing and Editing. **John Manton**: Conceptualization, Methodology, Resources, Writing – original draft preparation, Writing- Reviewing and Editing.

Data availability

Most data used are historical documents available in the public domain.

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