# Foreign Aid and Resource-limited Settings

I had recently arrived in Papua New Guinea on an exciting assignment with WHO. At a seminar, queuing for lunch, I started to chat with an Australian consultant behind me. Somehow question of the role of consultants in developing countries came up and I blurt out my opinion that my aim was to train a national as soon as possible and leave. Somewhat surprised at my statement, he responded, so you want to work yourself out of a job. I had no answer but it intrigued me with a realisation that this could be one of the reasons for lack of progress and that we have so much of dependency of foreign aid and experts in resource-limited countries. For some, it seems, sharing and imparting knowledge is threatening!

At the WHO office in PNG, there were a number of consultants fulfilling various roles to support the country. It was noticeable that very few visits were made to the provinces where the work was. During my four years in PNG, the country representative never went on a tour outside Moresby. On one occasion, when I invited him to chair a function in one of the provincial headquarters, he politely declined. On another occasion I needed some assistance in a workshop and asked my Nepali health promotion consultant, if he could join me in my trip to participate in strengthening reproductive health programme. His response was that I was too brave for his likes and that he did not feel safe leaving the headquarters. For me Port Moresby was more dangerous than the interior of the country. However, that was not the reason why I spent more time in provinces, but the work was in the neglected and remote areas where health services were extremely thin and the health centre staff struggled to do their work.

One day I saw a number of toilet seats in the corridor which had just been delivered and were going to be sent to rural PNG health facilities for installation. I asked my American colleague if there was any specific reason for ordering toilet seats rather than toilet squatting slabs, which are easy to keep clean, cheaper and a common method of defecation in most of the PNG, especially in rural areas. There was no response. In a similar situation, in large mining project in Indonesia, thousands of people were resettled and descent housing provided with a toilet, in this case a squatting slab. On my visits to the villages, when I realised that village periphery was littered with human excreta, I asked to see a toilet in a house. To my surprise, the toilet slab was sealed and the room used for storage. In this case it was not acceptable to defecate in 'one's own house'. Shouldn't this required prior discussions with the community, as to the type of toilet and where to construct it? We were conscious of these facts and the type and place of the toilets in resettled communities in Laos were acceptable and used by more than 95% of the households (Health survey findings).

When I first went to Laos and visited a district hospital, I noticed a big machine covered by a drape in one corner of the corridor. On inquiring about it I was told that some time back, a multilateral had donated incubators to every district hospital (DH) in Laos to care for premature new borns, but incubators to this day, have never been used because of lack of manpower and resources (*click on the pictures below*). Provincial hospital was the only place it was put to use. Incubators require 24 hour power and skilled manpower to continuously monitor the premature. The capacity of a DH in Laos is limited to functioning only 9 to 5, with a health worker on call after hours for any emergencies. There is no skilled person who may know anything about how an incubator works. There is no power most of the time. Although 10-15 beds are allocated to the DH, occupancy is very low. I was told that at the time of supply each incubator cost around USD 20,000. There were 12 provincial hospitals and 130 DH in Laos in 2010. The cost of supplying incubators to all the DHs alone would

have run up to USD 2.6 million. According to WPRO report, Laos required USD 12 million for its health expenditure in 2011, with an ability to contribute only 9% of it, rest coming from foreign Aid.**[1]** Did anyone pay any attention to incubator requirement at DH and its usefulness, either at the time or in future? I guess that the money had to be spent before certain time!

Another agency working in our project area supplied Fax-machines, Photocopiers, Safes and other similar office equipment to district hospitals, when our project had already provided these items to the DHs. This was in spite of the fact that we had advised them of this information. To add to this, this international agency was one of the leading monitors of our project.

Choices of equipment chosen by the funding agencies was according to how much and how fast the money can be spent, without giving any thought to the need and utility of the supplies. Cost, maintenance and likely malfunction are rarely considered. To facilitate antenatal care, electronic fetometers were supplied to each DH at a cost of more than USD 200 each, whilst the same function was already being performed by hand held manual aluminium fetoscope costing less than a dollar or the stethoscope costing less than ten dollars, that each clinic has several (*click on pictures below*). Moreover stethoscope or fetoscopes are handy and easily carried on person. We have all seen wall clocks stuck at some distant time because no one bothered to change the battery. Once the electronic fetometer battery is dead so would be the gadget. Even more dangerous could be a weak battery giving low readings.

We were as big culprits as any other in supplying goods. With all good intentions, a four-wheel drive was provided to each one of the DHs in our project area, so that health teams could travel to each village to conduct monthly maternal and child health (MCH) clinics. However, they could never use the vehicle. Somehow, monthly clinics continued to be held using motorcycles. Even though approved rules from the provincial health office were in existence, these vehicles were used by district medical officers for their personal use. Providing a vehicle to DH turned out to be a failure of our strategy. Similar situation was experienced in Strengthening Reproductive Health Services project in PNG. Yet in another non-governmental project in Indonesia, the system worked where there were strict rules for the use of project vehicle and the vehicle was always available for the purpose for which it was intended.

The first thing health center staff learn is to set up an intravenous drip for every patient admitted to the center. Irrespective of the need for an IV line, this takes place in most of the rural hospitals and clinics. Although at times lifesaving, it is costly, unnecessary in many instances and even dangerous if not carried out properly. So much so, the public have got used to expecting it for any illness on admission to a health center or DH. To take it to a limit, some private practitioners add vitamin B complex to the bottle to give it a colour, signifying dramatic power to the infusion. We have seen patients coming to the health center equipped with IV fluids to be infused, because they feel it will strengthen them!

International aid agencies, NGOs and health service providers in this respect are professionals engaged in fooling countries and its people with irresponsible implementation of funds, distributing gadgets, unnecessary treatment and forgetting that health awareness and preventive approaches are more beneficial than these fake actions. Instead of wasting resources, urgent need is to strengthen primary health care and consolidate comprehensive MCH (RMNCHA) through each primary health center.

What it implies:

1. Technology is essential and should be used where it provides essential health service, but the decision for its application should be taken responsibly by both the funding agency and those who approve it. Foreign Aid can be a great blessing but it turns out to be a curse if not spent responsibly;
2. Governance and accountability are two buzzwords we hear daily, it applies equally to both the provider and the recipient;
3. Focus must remain on the people we serve. Community engagement, their agreement and acceptance for the success of any programme is critical. I recently read someone saying that, consultants should themselves be *necessary and significant*, but avoid being *central*;
4. Most of the consultants come from privileged background and it has little to do with the decisions made or hard work put in, because when opportunities appear most people make good use of it;
5. Provision of health is a *service* to individuals and populations, it should not be turned into a *business*. HEALTH should never be used for exploitation of vulnerable people or populations;
6. Funds pour into poor countries, and as the time goes by, dependency on these funds keeps on increasing with little hope for self-sufficiency;
7. For those who are engaged in health service provision, it is a mission. It requires care and compassion. Giving a little, from what we have, can be a great source of satisfaction.

**[1]** WPRO (WHO). The VIIth Five-year Health Sector Development Plan (2011-2015) Lao People's Democratic Republic. Ministry of Health.