ENTREPRENEURSHIP AND A HEALTHCARE SYSTEM IN AFRICA: A THEORETICAL REFLECTION

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ABSTRACT

In a continent that hordes many illnesses and conditions it is shocking that many do not have the means to see a healthcare specialist when they need one desperately. In this discussion, we addressed the situation in which many Africans continue to find themselves when confronting their many ailments. The continent has been deprived from its many natural potent ways of curing diseases and today many who are sick find themselves left to a terrible fate. There is a prospect and possibility to seize and engage in entrepreneurship: Investing in a healthcare system in many countries in the African continent. We broke ground by offering a theoretical model of failed healthcare systems and the creation of *African Healthcare Corps*, a call for the urgency to break out of the current healthcare situation in Africa which is no longer bearable.

Keywords: Entrepreneurship, "*healthcare corps*," fighting diseases, financing healthcare

INTRODUCTION

Africa is reputedly lacking just about everything. From technology, to transportation, education, and housing to name but a few of the bare necessities Africa still lacks. Africans do not even have enough food or so do many say, since images of famished and almost dying kids are all too familiar to everyone who has ever seen Africa on the news. Rarely is Africa discussed in public forums but to mention the Continent for its numerous pathologies and incurable diseases. Nowhere is there a mention of the riches with which the African continent was endowed: Diamond and gold, timber bauxite and oil (Robson, Haugh & Obeng, 2009) are just some of the natural resources with which the continent was gifted. Despite these many natural endowments with which Nature graced the African continent, the latter is in serious need of a structural shift in healthcare reform. Thus, it is a different kind of Africa this theoretical study is depicting: It is a continent ready to take ownership of a tiny but important piece of its destiny: Healthcare. True to many' s suspicion, just about all Africans, especially in Sub-Sahara Africa continue to lack the means to see a healthcare professional when they are faced with an illness of one sort or another. From the simple malaria onset to the deadlier HIV attack, the African is always left to fend for himself, most of the time wondering what is happening to him and where to begin (Dare & Buch, 2005; Rothe, Schlaich, & Thompson, 2013), always in panic mode when struck by a disease of any kind. Adding insult to injury, the population is no longer equipped with natural means of dealing with diseases, because colonization rid these populations with traditional ways of treating all types of infections. This study finds issue with the fact that the continent did have the means to treat its population and lost those means with the advent of colonization which as it caused the population to abandon their natural pharmacopeia did not do enough to replace these traditional means with so-called modern medical treatments.

In other words, before the advent of colonization, and modernism, individuals all through the continent had the knowledge to effectively cure themselves thanks to the use of natural and traditional therapies when they were subject to sickness (Edgerton, 1971). The advent of modernism caused African populations, often through coercion, to abandon their traditional ways of treating ailments without modern medicine delivering on the promise of helping these populations have access to modern ways and resources of treating diseases, the said modern medical ways never really having materialized to a full degree (Baylies, 1996;). If we reframed this notion differently we would state that by forcing the populations in Africa to abandon inexpensive and frankly free, available to all, means to treat ailments without providing an effective replacement to treat diseases, colonial powers exposed African populations to infections and various kinds of sicknesses to which they are subject to this day.

Our contention in this theoretical study is that the various initiatives many well-meaning stakeholders have been bringing to Africa are laudable albeit insufficient and some of these initiatives could even appear to be questionable. In the interest of enabling the populations to benefit from some type of healthcare, for a certainty, Africans would only be willing to pay into a healthcare system of some kind, if it existed and was serving the affected populations. Therefore, there is here an opportunity for one (s) who would like to invest into a sort of African "*Healthcare Corps*," in order to make it possible for Africans to have some recourse when they are sick (Letiche, 2010). Too many Africans lack any sort of system even germane to this today (Dare & Buch, 2005); and for a continent the size of Africa, with a diaspora and natives equipped with the skills, talent, and financial power the sort of which African dispose, there is an opportunity to start thinking of a solution, entrepreneurial as it may be (Frese, & Friedrich, 2002) to a problem that is only causing too many ravages in a continent many increasingly consider to

be one of the richest in the world even if only because of the undisputed rich talent pool with which it is endowed (Robson, Haug, & Obeng, 2009).

From here on under, this study offers to first discuss the pre-colonial healthcare environment in Africa; the second part of this research will focus on the relevance of seriously thinking about a healthcare system in African countries and the entrepreneurial opportunity this presents. To conclude, this discussion with offer some guidance for future studies concentrating on the state of healthcare in Africa.

PURPOSE OF THE STUDY

The purpose of engaging in an endeavor the like of the one through which we are threading is first to contribute to the nascent body of knowledge on entrepreneurship in Africa (Frese, & Friedrich, 2002; Robson, Haug, & Obeng, 2009) but also to draw attention on the lack of a functional healthcare in the continent (Baylies 1996; Dare & Buch, 2005; Pokam & Hall, 2011).

OBJECTIVE OF THE STUDY

The objective of such a discourse bringing awareness about the flagrant dysfunctionality present in African healthcare systems (Baylies, 1996), is in the hope of forcing African populations into effective corrective thought and action, especially towards not only re-adopting their formal natural ways of treating and healing ailments (Challand, 2004), but also to think in ways populations may participate into the creation of healthcare system, a sort of *healthcare corps*, which would aim at addressing the healthcare needs of the most affected segments of the populations: These segments are made up of the individuals who lack a formal healthcare cushion to which to turn in case of sudden illness. Such populations are constituted of various types of individuals: (i) some though working, either have no health coverage as is usually the case in Africa (ii) or only have an inadequate health coverage, which may cover only an

infinitesimal cost of their health expense; (iii) others, many more numerous than the individuals described in the two first categories, are those who have neither employment (iv) nor health coverage; (v) nor even the wherewithal to see a doctor in case of illness. A functional healthcare system or a sort of "*Healthcare Corps*" financed by the wealthiest in the community, voluntary local and international philanthropists and not by the government, could be a beginning of a solution for the healthcare problem in Africa. In that light, an ensuing objective of this study is also to offer a theoretical model capturing the current healthcare crisis in Africa and its resulting consequences.

RESEARCH QUESTION

One may wonder about the reasons for the perennial condition of the dysfunction present in the healthcare systems of countries in Sub-Sahara Africa, and the reasons this condition has never been successfully addressed: In fact, reframing this question would translate into asking oneself how African people all across the continent got to living so long with a system of healthcare that nearly cares for no one and continues to leave many sick and dying, despite the many ways these populations could have adopted several ways aiming at initiating even if only a start of a turn-around vis-à-vis this situation.

In answering this question this conceptual reflection will contribute to the discussion on healthcare in Africa, while adding to this debate by offering a theoretical model crystallizing the phenomenon under review by bringing together its different angles. This study is sure to benefit stakeholders such as governments the like of China, especially, signaling a very opened determination to be involved in the transformation of healthcare systems in Africa (Pokam & Hall, 2011); but also and most importantly, individual investors and constituencies both from the diaspora and other segments of the Western world, willing to invest in lucrative entrepreneurial

initiatives in Africa; last but not least, this reflection aims at striking a debate among Africans about the imperative need to intervene in their respective countries' healthcare, by setting up healthcare systems that care for the populations, thus inducing a reframing of the condition in which Africans find themselves in times of illness.

THE PRE-COLONIAL HEALTHCARE ENVIRONMENT IN AFRICA

Pre-Colonial Africa's Environment

A review of pre-colonial Africa is only the first part of this sub-section, the post-colonial healthcare environment in Africa constituting its second part: The quest to put pre-colonial healthcare in Africa in perspective, requires for one to go back to the origins of African people, as far back as Egypt, and subsequently to the period when Africa was home to hundreds of millions of inhabitants. This includes revisiting in a non-exhaustive manner, a few periods in pre-colonial African times and their signification: (1) The first of these periods is encompasses the history of Africa before the ravages of slavery, at the time the Egyptians pyramids were constructed supposedly by Joseph, before Jesus Christ, as some would have it. (2) The second of these periods refers to the time of the Ethiopian kingdoms still before Jesus Christ; (3) The third period is that of the kingdoms of Sundiata Keita in the thirteenth century of our era; (4) and those of the Fouta Jallon this time, closer to our generation, in the eighteenth century: These different periods are the times when Africa had vibrant civilizations, inferring structural means to cater to these civilizations, such as, for the purpose of our discussion a functional and effective pharmacopeia, but also clear and systematic organizational methods of managing their societies in matters of health and in other areas (Al-Suyūṭī & Nemoy, 1939; Armstrong, 1960; Reisner, 1922). In fact, management theory is reputed to date as far back as from the time the pyramids of Egypt were built, even if only by inference: There simply is no other way to explain the

successful completion of projects of behemoth magnitude the like of the Egyptian pyramids' construction, without the application of rigorous management principles and skillful management practices.

In other words, it was impossible to have achieved projects of such scopes without applying strict management techniques to the conduct of all the intricate tasks that had to be undertaken and completed in successfully completing the construction of the Egyptian pyramids. The Egyptian pyramids are used only for the sake of argument due to their universal appeal and frankly the difficulty inherent to achieving such enterprises, which to the testimony of some, boasted walls as dense as 20-cubit or 10 meters thick, without mentioning the enormous amount of treasures buried in the pyramids, gold being only one of those riches (Al-Suyūṭī & Nemoy, 1939).

By logical inference, it is natural only, to assume that a numerous people of such advanced clarity of thought and insight could not have survived and thrived without an effective way of dealing with illness. A clear indication of the existence of such an organized system is seen in the remnant of traditional medicinal treatments which endured to this day, and which are sometimes applied to cure diseases Western modern medicine can only alleviate, or in some cases, is simply incapable to even tackle. In other terms, even if to their detriment, Africans were convinced to abandon their traditional medicine (Challand, 2004; Manglo & Trinitapoli, 2011) they continued, even if only sparingly and only for some types of ailments to turn to African traditional medicine (Edgerton, 1971; Hill, Hess, Aborigo, & Hodgson, 2014), and this sometimes, in cases where modern orthodox medicine has failed to deliver to its promises and cure the sick person, or in cases where the traditional healer was the patient's only affordable

option or maybe the healer last resort (Offiong, 1999) after modern orthodox medicine showed its limits.

Post-Colonial African Environment: Anecdotal Examples of Effective Traditional Methods of Curing Ailments

Below follow anecdotes of instances in which individual in Africa have often resorted to use traditional medicine, rather than using modern medicine: (1) Imagine a person who just fractured a limb and refused to go the nearby hospital or health care center because this person knew African traditional medicine was capable of literally healing fractured members in a matter of days. Conversely, keep in mind that a fracture treated in an allopathic way using orthodox western medicine would have taken between three to six months to heal, after the person's fractured limb would have been put in a cask. One can see the reason this person was not eager to take the fractured limb to the hospital. (2) Now picture a person who suffers from debilitating chronic migraines, and this person just about exhausted modern ways of treating these migraines; furthermore, this person is aware that upon drinking his or her most potent migraines medicines, the best result would be an easing off of the pain until the next migraines onset which a rebound migraine would follow; this would occur, even as drinking the medicine would result in dire side effects often leaving the person unable to function for several hours after having taken the medicine. At the same time, the person is aware of a plant which when used, stops the onset of migraines immediately and without any side effect to the user: Just imagine to what medicine the migraine sufferer will turn, whenever he has a migraine onset. (3) Lastly, think of the case of a baby who's suffered from diarrhea for a number of days, as the parents continued to take the baby to the best pediatricians, not only because they could afford it, but mainly because as is often has been the case, many Africans, unbeknownst to many outside of the African

community, have been brought to put more faith in modern medicine than they would in traditional medicine (Challand, 2004; Offiong, 1999).

However, as the days go by, the baby's condition rather worsens and the baby starts showing signs of giving way: At that point, the parents have no choice but to rush the nearly dying baby to a traditional healer: This person who happens to be a female natural healer recognizes the disease for what it is and utter a clear diagnostic of the baby's condition. Thereafter, she proceeds to concoct the medication for the disease by mixing up many plants she gathered from her garden, while explaining the nature and role of the harvested plants. Upon administering the concoction to the baby, the nearly dying baby instantaneously shows signs of a complete turnaround. In fact, just a couple of minutes after that intervention, the child recovers and the condition subsides, resulting in a complete cure of the disease.

Whether this transpires from this account or not, the child would not have made it through the simple diarrhea, most likely just a sign of some internal trouble, was it not for the involvement of the natural healer. In this last case, modern medicine failed miserably where it only took a concoction made up of medicinal traditional herbs to heal a nearly dying child in a matter of seconds. The examples hereabove expounded may be anecdotal even as they recoup similar accounts in the literature about the effectiveness of traditional medicine (Beck, 1979; Offiong, 1999). In effect, the literature recognizes that even today, and in increasing numbers, many Africans despite having been discouraged from doing so, turn to and find relief from using traditional medicinal and faith healing means of treating a wealth of ailments from (i) the common cold and (ii) fever; to more serious conditions such as (iii) high blood pressure; (iv) gonorrhea; (v) dementia; (vi) trauma; (vii) leprosy; (viii) lunacy; (ix) snake bites, still very common in some African rural areas; (x) boils; and even chronic diseases, (xi) from the simple

constipation; to more complicated conditions such as (xii) migraines; (xiii) epilepsy; (xiv) infertility, and a host of many other health issues and more and more, rely to Traditional Medicine (xv) even in the treatment of AIDS (Beck, 1979; Feierman, 1985; Fetter, 1993; Offiong, 1999; Kruck, Rockers, Varpilah & Macauley, 2011; Manglos & Trinitapoli, 2011; Schumaker, Jeater & Luedke, 2007). This is the case even if some ridicule African traditional medicine and characterized it as ineffective and thus not worthy to be entertained (Patterson, 1974).

THE RELEVANCE OF SERIOUS REFLECTION ON HEALTHCARE SYSTEMS IN AFRICA

Given this state of affairs, it is appropriate to engage in a serious reflection on African healthcare, especially because the impoverished condition of healthcare in Africa can no longer be ignored (Dare & Buch, 2005). A look at the prevailing Healthcare conditions in Africa hereafter depicted, would persuade many on the importance of serious intervention in the healthcare field, the following list being by no account exhaustive: (1) Alienated from their traditional medicine Africans have been left without a real replacement on which to turn in case of need, depriving them from a Healthcare backbone (Challand, 2004); (2) in other words, the current healthcare system in many African countries can be defined as inadequate at best (Pokam & Hall, 2011) or fragile (Dare & Buch, 2005) and in shamble at worse (Feierman, 1985), as it witnessed rates (*a*) as bad as over 10,084 patients per physician in 2005 to a growth of nearly 15,000 patients per physician only in a matter of four years later, in Cameroon only (Pokam & Hall, 2011); (*b*) and numbers suggesting about 20,000 patients per physician in Ghana; (*c*) or even 100,000 per physician in the same country, in rural regions (Hill et al., 2004); (3) this led to a high infant mortality rate the like of which still exists in Africa only: (*a*) In Ghana, for instance

1 in 66 or 15 out of 1000 babies born die (Hill et al., 2004) before they have reached their first year (Fetter, 1993); (*b*) in 2011 for Liberia, this number, i.e. the infant mortality rate, was between 57-110 out of 1000 compared to 8 out 1000 deaths in the US (Kruk, Rockers, Varpilah & Macauley, 2011); (*c*) some advance the number of 200 deaths per 1000, when applied to the African continent in general (Feierman, 1985).

(4) In fact and said differently, already in 2005, it was still reported that in the Continent, 1 out of 6 kids or 166 out of 1000 still died before they reached the age of 5; (5) while every two minutes, a women died of maternity complications resulting either from pregnancy or occurring at the time of delivery (Dare & Buch, 2005); (6) naturally, one could mention (*a*) the low weight at birth of babies; (*b*) or even malnutrition induced deaths; (*c*) or deaths resulting from a host of health issues, the rates of which are still simply difficult to fathom; (*i*) in the range of 14% in Africa, compared to 7% in Europe for the first, i.e. low weight at birth; (*ii*) and 60% compared to 10% in Europe and even less in the US for the second and third (Baylies, 1996) that is malnutrition induced deaths, and deaths from just an unknown host of health issues; (7) even as simple conditions as Malaria and the common diarrhea, or even measles and tetanus, eradicated completely in the rest of the world, continued and continue to constitute the leading causes of death in Africa (Fierman, 1985); (8) foremost in this list is the AIDS epidemic in Africa (Dare & Buch, 2005; Manglos & Trinitapoli, 2011) which shows no sign of letting up despite the supposedly many programs western countries have been implementing in Africa.

(9) Thus, comes the realization that the healthcare crisis in Africa can no longer be ignored (Dare & Buch, 2005); (10) but also that only Africans will be able to address the healthcare crisis in Africa in an effective way (Fetter, 1993); (11) a notion supported by the World Health Organization which recognized, (*a*) first that the “health for all initiative” just seemed to have

left Africa somewhere South (Baylies, 1996; Fetter, 1993); and thus (*b*) encouraged the use of traditional medicine in effectively fighting diseases in Africa (Schumaker et al., 2007); (13) (*c*) because when empirically tested, African Traditional Medicine was shown to be effective in treating many ailments, in an affordable (Challand, 2004; Feierman, 1985; Fetter, 1993; Hill et al., 2014; Kruk et al., 2011; Offiong, 1999) and also in a natural way, i.e., sometimes simply by using herbal remedies (Beck, 1979; Edgerton, 1971); (12) thus, if one did not see here the rational for an intervention in the African Healthcare system, then at least opportunities for lucrative investments in this sector, in a continent slated to boast high growth percentages only germane to those witnessed in China should entice more than many to invest in an affordable and functional system of Healthcare in the Continent.

OPPORTUNITIES TO INVEST IN HEALTHCARE IN AFRICA

Theory Development

It is necessary to bring the caveat that the suggestions and propositions in this review are supported by theory only at this time and need to be tested in order to be validated: Even so, cognitive theory, one theory used as the backdrop of this reflection can no longer be denied to affect daily happenings: Thus, cognitive evaluation is one of the theory used to test the adequacy and workability of the measures offered in this reflection (Chattergree, 1984; McElroy & DeCarlo, 1999) together with self-determination theory (Deutsher, 1979; Gagné & Decci, 2005; Hennessey, 2000). In other words, our proposition using the tenet of cognitive theory is that as a result of witnessing failing enduring healthcare systems in the Continent, there has to come a time when Africans, would feel empowered enough (Gagné & Decci, 2005) to be in a position to take ownership of their destiny by engaging in the design and implementation of healthcare

systems into which many Africans would be able to buy, and which would serve the needs of African people.

In effect, the ensuing self-determination orientation from witnessing the conditions described above and the resulting intrinsic motivation (Hennessy, 2000) fueled in Africans would be the catalyst for Africans' determination to work at creating functional healthcare systems tailored to satisfy the needs of the people in the Continent (Coleman, 1986; Gagné & Deci, 2005; Satz & Ferejohn, 1994). The drive behind such initiatives besides their prosocial motivation (Coleman, 1986) is the certainty such enterprises would yield rewards both extrinsic, and more important, intrinsic, for all actors involved, beyond anything Africans have yet to have witnessed in matters of healthcare. Understandably, in as much as Self-Determination theory (SDT) may appear to generate a schism between those freely motivated to engage in a course of action as compared to those whose motivation may be more measured, it remains that within the framework of SDT, all actors involved are motivated (Deci, 1971, as quoted in Gagné & Deci, 2005, p. 334).

Motivation is what can and is driving Africans to determine to act in favor of usable and workable healthcare systems in Africa: In other terms, Africans have had it to have undergone many decades of going through the motion of enduring hap-hazard healthcare systems at best which were imposed to the populations, when the populations did not simply have any healthcare at all, the status quo, still, in many African countries (Baylies, 1996; Challand, 2004; Dare and Buch, 2005; Fetter, 1993; Feierman, 1985; Kruk et al., 2011; Macauley, 2011; Manglos & Trinitapoli, 2011; Pokam & Hall, 2011; Schumaker, Jeater & Luedke, 2007; Varpilah & Hill et al., 2014).

Thus, it is only logical to infer that watching the manifestations resulting from such systems even as expounded in the previous sections would act as a spark for action (Coleman, 1986),

motivating many Africans, if not all, both in the Continent, and the Diaspora, to invest in prosocial and economic enterprises showing creativity, resourcefulness and innovation (Hennessey, 2000, in fashioning healthcare systems that would benefit the inhabitants of the Continent, even if doing so does not go without challenges (Gagne & Deci, 2005). In other words, many individuals in the Continent and the Diaspora noticed the state of disarray of Healthcare in Africa and it is for a certainty bound to have elicited a reaction which, easily, can mushroom into a moral obligation to purposefully work at creating something better to allay the populations' sufferings, and frankly at times, the populations' sheer despair. Thus, one could say that cognitive evaluation theory could and should cause Africans in the Continent and the Diaspora to be motivated to intervene in order to propel healthcare in Africa to new heights.

Social and Economic Business Opportunities in the African Healthcare Industry

Therefore, a healthcare system "*à l'Africaine*," [i.e. the African way] of a sort, designed without the unique and ubiquitous western influence, not always effective in treating African populations, would be just what the Continent needs (Coleman, 1986; Deutscher, 1979). Said differently, the creation of "*Healthcare Corps*" throughout the Continent, a consequence of enduring broken healthcare systems, would offer a start of an effective solution to the healthcare problem in Africa. If one tried to crystallize this line of thought on a graph, the resulting propositions would yield the following diagram:

Model of Failed Healthcare systems and the Creation of African Healthcare Corps

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Insert the Model about here:

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This model depicts the progression leading to the impulse to create new healthcare systems in Africa, called here for the sake of this review, "*Healthcare Corps*." (1) The whole system is the consequence of failed healthcare systems in Africa; (2) it is this status quo which created a state of weariness in African populations and quite honestly many observers; (3) this is turn, by inference, could only cause the impulse to create African *Health Corps* better tailored to solve Africans' health issues. Even at the theoretical level, this model implies the following simple propositions:

P1: The consequence of long term failed healthcare in Africa created weariness in African Populations

P1: In turn, this situation caused the impulse to create African Healthcare Corps, explained below.

African Entrepreneurial Healthcare Corps

Definition of Concept

What are these entities, one may ask? Just as was the case with the *Peace Corps* the US founded in 1961 with the aim of advancing the interests of peace between the US and other nations, the *healthcare corps* could be created along that same model. The only difference between these two notions would reside in the fact that while the *peace corps* focused on peace, the *healthcare corps* would implement structures meant to promote health, and these would let all who could, pay into the system. Furthermore, these African *healthcare corps* would portray the following characteristics: (*i*) they would offer coverage to all with no discrimination: In other terms, *healthcare corps* would be built along a model tantamount to the notion of single-payer system *à l'Africaine* [i.e., the African way]. (*ii*) Furthermore, these creative entities would combine coverage for allopathic treatment and African traditional medicine alike; the reason for

instituting this duality resides in the fact that this system and its accompanying behavior has already been gaining traction in many countries in Africa, resulting in the co-existence of western modern and African traditional medicine (Hill et al., 2014), to the dismay of some in the western world (Patterson, 1974; Roux-Kemp, 2012); and this, quite contrary to many in Africa who increasingly believe in the effectiveness and even efficiency of traditional African medicine (Fetter, 1993; Hill et al., 2004). In other terms. African are realizing gradually that abandoning their healthcare to western notions on this area caused them to suffer greatly: Consequently, there is a shift in African's perception, one bringing them to no longer believe African medicine could be reduced to witchcraft only; and thus, considering African ways of healing as being just as effective as western medicine, if not even better in some cases as in the treatment of chronic illness (Feierman, 1985). For this reason, African today would only opt to design a healthcare system integrating the two approaches: modern and traditional African medicine.

Organization of Entrepreneurial Healthcare Corps

The notion of entrepreneurial *healthcare corps* is organized around the idea of "health for all," whose design and implementation could follow the following steps: (1) enroll everyone and give them a health card.; (2) seek funding from sources outside of established governments; i.e. (*i*) through international and local grants; (*ii*) voluntary donations from companies and philanthropists, and (*iii*) sponsorships from various constituents; (3) secure the participation of doctors who would be part of the network, by developing relationships with doctors, hospitals, and medical centers; (4) provide a reduction in health deductions to all those subscribing to the *health corps*; (5) plan to collect contributions to those who can afford to pay; (6) provide a sliding scale for those who have difficulty paying; (7) design a mechanism ensuring healthcare access even to those who cannot afford to pay for their healthcare coverage: The ultimate goal of

these entrepreneurial "*healthcare corps*" would be to do away with the notion of leaving individuals scrambling and to fend for themselves when confronted with illness.

The reason why these *healthcare corps* should be organized along the entrepreneurial model is because it is the right time to invest in entrepreneurship in Africa, whose only hope to emerge from its "lost continent" status is through entrepreneurship (Frese & Friedrich, 2002; Robson Haugh, & Obeng, 2009; Williams & Hovorka, 2013), a growing topic of interest in the literature (Memili, Kaciak, & Ahmed, 2013; Robson et al., 2009). In other words, Africa's economic future is bound to pass through entrepreneurial driven initiatives (Jackson, 2016) both of a social and economic nature (Williams & Hovorka, 2013) if the continent is to develop and evolve from its supposedly dark place to become a continent which controls its economic future (Klingebiel & Stadler, 2017; Robson et al., 2009). What other way, other than to invest in healthcare corps enterprises.

Furthermore, building the *healthcare corps* according to the entrepreneurial models would compel the different stakeholders to follow best practices (Williams & Hovorka, 2013) in designing and implementing these entities. Accordingly, the various health care corps would identify their distinctive competencies, but would also of course, design business plans including such elements as the following: (1) cash budget to determine the amount of funds to raise for a smooth functioning of the entity; (2) an income statement; (3) a balance sheet; and (4) a break-even chart. The purpose of such an exercise is to ensure that these entities would remain viable even as they seek to accomplish the following: (*i*) provide affordable healthcare for all; and (*ii*) make it possible for those willing to opt for African natural medicine to do so; i.e., individuals should be able to choose between natural birth, midwife assisted birth and delivery at a conventional hospital. The objective of such measures would be to achieve the following results:

(1) gradually reduce the number of people left unattended for when confronting illness; (2) achieve better health for all, health being described not only as lack of illness but overall well-being; and (3) ultimately increase the life-span of the populations.

CONCLUSION, IMPLICATIONS, LIMITATIONS AND DIRECTION FOR FUTURE STUDIES

Even as this study breaks new ground by offering a model of Failed Healthcare systems and the Creation of African Healthcare Corps, it remains that no market research was done to validate the propositions herein offered. The suggestions offered in this discussion are grounded on theory whereas a market research would make it possible to ascertain, in an empirical way, the need for the proposed *heath care corps* on which this study focused, while making it possible also to forecast how many would buy into these programs and the fee to charge in order to break-even. Thus, a study of this nature is limited because it lacks an empirical component which would make it possible to test the inferences herein proposed, component which can be explored as a follow-up to this study.

A caveat to keep in mind as one goes through this study is that this review does not aim to demean or take away from western medicine; rather, its aim is to suggest for African populations, just as is true for Chinese populations for instance, there should be more than simply having to resort to modern medicine which is not always there for the populations in Africa when they need it. The reason is that sometimes, these populations cannot even afford western medicine, let alone the fact that western medicine is not always effective at treating the ailments which plague these populations.

At this stage, this discussion added its voice in making salient the critical need to intervene in African healthcare systems because it is the right time to do so. Furthermore, the benefit of

engaging in such a path would be immensurable for all stakeholders involved, both those investing in the proposed healthcare as well as those benefitting from these initiatives. Africa as widely acknowledged now, is poised to become a thriving economy, with the CIA Factbook indicating the average economic growth rate in the Continent nears 4% annually, a rate only compared to China's. Thus, to be sure, there are here golden opportunities to be seized and for those seizing these, the prospect to do financially well and thrive, while also addressing a real need in the continent: The need for functional healthcare systems, herewith termed "*healthcare corps*." To be sure, there will always remain an element of mystery in what and how individuals get to be healed. However, in a continent ravaged by all sorts of diseases, both benign and serious, starting to work at alleviating the conditions of the populations by providing these with some organized and affordable recourse would start taking some of the mystery from the healing equation.

References

Al-Suyūṭī, J., & Nemoy, L. (1939). The Treatise on the Egyptian Pyramids (Tuḥfat al-kirām fī khabar al-ahrām). *Isis, 30*(1), 17-37. Retrieved from http://www.jstor.org.vsu.idm.oclc.org/stable/225578

Armstrong, R. (1960). THE DEVELOPMENT OF KINGDOMS IN NEGRO AFRICA. *Journal of the Historical Society of Nigeria, 2*(1), 27-39. Retrieved from http://www.jstor.org.vsu.idm.oclc.org/stable/41970818

Baylies, C. (1986). The Meaning of Health in Africa. *Review of African Political Economy*, (36), 62-73. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/4005782

Beck, A. (1979). The Traditional Healer in Tanzania. *Issue: A Journal of Opinion, 9*(3), 2-5. doi:10.2307/1166255

C. Rothe, C. Schlaich, S. Thompson. (2013). Healthcare-associated infections in sub-Saharan Africa, *Journal of Hospital Infection, 85,* 257-267.

Challand, S. (2004). Wasting time with people. *BMJ: British Medical Journal, 328*(7455), 1573-1573. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/41708149

Chatterjee, P. (1984). Cognitive Theories and Social Work Practice. *Social Service Review, 58*(1), 63-80. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/30011709

Coleman, J. (1986). Social Theory, Social Research, and a Theory of Action. *American Journal of Sociology, 91*(6), 1309-1335. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/2779798

Dare, L., & Buch, E. (2005). The Future Of Health Care In Africa: Depends On Making Commitments Work In And Outside Africa. *BMJ: British Medical Journal, 331*(7507), 1-2. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/25460047

DE PRINCE POKAM, HILAIRE, and Jonathan Hall. "Chinese Medicine in Cameroon." *China Perspectives*, no. 3 (87) (2011): 51-58. http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/24054711.

Deutscher, I. (1979). Social Theory, Social Programs, and Program Evaluation: A Metatheoretical Note. *The Sociological Quarterly, 20*(3), 309-320. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/4106250

Edgerton, R. (1971). A Traditional African Psychiatrist. *Southwestern Journal of Anthropology, 27*(3), 259-278. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/3629396

Feierman, S. (1985). Struggles for Control: The Social Roots of Health and Healing in Modern Africa. *African Studies Review, 28*(2/3), 73-147. doi:10.2307/524604

Fetter, B. (1993). Health Care in Twentieth Century Africa: Statistics, Theories, and Policies. *Africa Today, 40*(3), 9-23. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/4186918

Frese, M., & Friedrich, C. (2002). From the Editors of the Special Issue on Entrepreneurship in Africa. *Journal Of Developmental Entrepreneurship, 7*(3), v.

Hill, E., Hess, R., Aborigo, R., Adongo, P., Hodgson, A., Engmann, C., & Moyer, C. (2014). "I don't Know Anything about their Culture": The Disconnect between Allopathic and Traditional Maternity Care Providers in Rural Northern Ghana. *African Journal of*

Reproductive Health / La Revue Africaine De La Santé Reproductive, 18(2), 36-45. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/24362165

Jackson, T. (2016). The next degree of entrepreneurship? *African Business*, (426), 84-85.

Klingebiel, R., & Stadler, C. (2017). 3 Things Driving Entrepreneurial Growth in Africa. *Harvard Business Review Digital Articles*, 2-4.

Kruk, M., Rockers, P., Varpilah, S., & Macauley, R. (2011). Which Doctor? Determinants of Utilization of Formal and Informal Health Care in Post conflict Liberia. *Medical Care, 49*(6), 585-591. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/23053766

Le Roux-Kemp, A. (2012). Conventions, customs and beliefs – social determinants and realising the right to health in Malawi and Uganda. *The Comparative and International Law Journal of Southern Africa, 45*(1), 1-17. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/24027176

Letiche, J. M. (2010). Transforming sub-Saharan Africa. *Journal of Policy Modeling, 32*, 163–175.

Manglos, N., & Trinitapoli, J. (2011). The Third Therapeutic System: Faith Healing Strategies in the Context of a Generalized AIDS Epidemic. *Journal of Health and Social Behavior, 52*(1), 107-122. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/23033166

McElroy, J., & DeCarlo, T. (1999). Physical Attractiveness on Cognitive Evaluations of Saleswomen's Performance. *Journal of Marketing Theory and Practice, 7*(1), 84-100. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/40469951

Offiong, D. (1999). Traditional Healers in the Nigerian Health Care Delivery System and the Debate over Integrating Traditional and Scientific Medicine. *Anthropological Quarterly, 72*(3), 118-130. doi:10.2307/3317426

Patterson, K. (1974). Disease and Medicine in African History: A Bibliographical Essay. *History in Africa, 1*, 141-148. doi:10.2307/3171766

Reisner, G. (1922). The Pyramids Of Meroe And The Candaces Of Ethiopia. *Sudan Notes and Records, 5*(4), 173-196. Retrieved from http://www.jstor.org.vsu.idm.oclc.org/stable/41715619

Robson, P. A., Haugh, H. M., & Obeng, B. A. (2009). Entrepreneurship and innovation in Ghana: enterprising Africa. Small Business Economics, 32(3), 331-350. doi:10.1007/s11187-008-9121-2

Schumaker, L., Jeater, D., & Luedke, T. (2007). Introduction. Histories of Healing: Past and Present Medical Practices in Africa and the Diaspora. *Journal of Southern African Studies, 33*(4), 707-714. Retrieved from http://www.jstor.org.ezp-prod1.hul.harvard.edu/stable/25065246

WELSH, D. B., MEMILI, E., KACIAK, E., & AHMED, S. (2013). SUDANESE WOMEN ENTREPRENEURS. *Journal Of Developmental Entrepreneurship*, *18*(2), -1. doi:10.1142/S1084946713500131

WILLIAMS, M., & HOVORKA, A. J. (2013). CONTEXTUALIZING YOUTH ENTREPRENEURSHIP: THE CASE OF BOTSWANA'S YOUNG FARMERS FUND. *Journal Of Developmental Entrepreneurship*, *18*(4), -1. doi:10.1142/S1084946713500222

Model 1: Model of Failed Healthcare systems and the Creation of African Healthcare Corps