

Seven Challenges in International Development Assistance for Health¹

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Summary

This paper outlines seven challenges in development assistance for health, which in the current financial context, have become even more important to address. These include the proliferation of initiatives, focusing on specific diseases or issues (1), as well as the lack of attention given to reforming the existing focal health institutions, the WHO and World Bank (2). The lack of accountability of donors and their influence on priority-setting are part of the reason that there is ‘initiavitis’, and resistance to creating a strong UN system (3). Other than absolute quantity of aid, three other challenges linked to donors relate to the quality of aid financing particularly the pragmatic difficulties of financing horizontal interventions (4), the marginal involvement of developing country governments as aid recipients (5), and the heavy reliance on Northern-based organizations as managers of funds (6). The final challenge discussed focuses on two unintended consequences of the recent linking of health and foreign policy for international development assistance (7). The paper then provides three suggestions for ways forward: creating new mechanisms to hold donors to account, developing national plans and strengthening national leadership in health, and South-South collaboration.

Introduction

Over the past twenty years, international development assistance for health has increased, albeit for some diseases more than others (Shiffman 2008). However, the triple crises of food, fuel and finance have raised questions regarding whether aid flows will continue to increase, or even be maintained in the coming future. Health, as well as education, are often the first victims of budget cuts in times of limited funding and competing priorities as they are viewed to be in

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the realm of 'low politics' as opposed to security and military spending which are seen as 'high politics'.

Cuts in overseas development aid will have drastic impact on countries where external funding makes up a significant proportion of national health budgets. Although global health aid accounts for only 0.3% of total expenditures on health globally (6.5% in sub-Saharan Africa) (Sridhar & Batniji 2008), in some countries like the Solomon Islands and Mozambique, for example, 82% and 66% of the national health budgets respectively come from external resources (WHO 2008). WHO estimates that 23 countries have over 30% of their total health expenditures funded by donors.

Given this situation, it is of upmost importance that a strong case continues to be made for development assistance to health and that in the context of a stable, or shrinking, pot, funds are used most effectively to improve the health of those living in low and middle income countries. While the financial crisis has brought much attention to aid quantity and quality, the problems developing countries face are not new. As one former Sub-Saharan African Health Minister noted, 'Insecurity of funding has been something we have been facing for many years now. It is not a new phenomenon.'

This paper outlines seven challenges in development assistance for health, which in the current financial context, have become even more important to address. The purpose of this paper is to provoke debate and discussion. It does not aim to be prescriptive. Only with scrutiny over the perceived or real failings of global health assistance can steps be made to not only make the system more effective, but also to make a stronger case to policy-makers for increased overseas development aid.

Throughout the paper, the theme of country ownership is underlined. On 4 September 2008, the Accra Declaration was agreed upon which emphasized that country ownership over health must be strengthened. While the Accra Declaration, which builds on the 2005 Paris

Declaration, is a major step forward, this paper argues that there are still structural factors that impede country ownership in health.

Challenge 1: The Proliferation of Initiatives and the ‘Dream’ of Coordination

At the international level, there has been a constant deluge of initiatives, focusing on specific diseases or issues, most recently the International Health Partnership (IHP+) and the Campaign for the MDGs. It is estimated that there are more than 40 bilateral donors, 26 UN agencies, 20 global and regional funds, and 90 global health initiatives active at the moment (McCull 2008).

Despite the articulation of a set of principles for more effective and equitable aid delivery, in the form of the Paris and Accra Declarations on Aid Effectiveness, it is disconcerting to note that the current landscape is characterized by fragmentation, lack of coordination and even confusion as a diverse array of well-funded and well-meaning initiatives descend with good intentions on countries in the developing world (Sridhar 2009a). Many of the initiatives lack mechanisms of accountability, transparency and evaluation in the way they operate within countries (Sridhar & Batniji 2008), and tend to focus on short-term results - thus raising a real question about future sustainability. Internal brain drain, as manifested by loss of health workers from the public sector to better funded initiatives and NGOs offering better remuneration, has been highlighted as a particularly serious problem. Although some efforts are ongoing (e.g. in relation to the Global Fund to Fight HIV/AIDS, TB and Malaria which claims that 30% of funding goes towards health worker training and salaries) much more needs to be done on evaluating the impact of multiple initiatives on national health systems.

As ‘fashions’ come and go, donors keep shifting attention from one disease to the next without working to build long-term national capacity. Many of these initiatives are narrowly focused on specific diseases (e.g. HIV/AIDS, malaria and TB) rather than systems-wide strengthening, tend to be ‘top-down’ in nature and are largely driven by donor agendas rather

than the country's own needs and priorities. However ambitious or well intentioned the initiative might be, it becomes difficult in this environment for governments to develop and implement sound national plans for their country. As Francisco Songane, former Minister of Health from Mozambique has noted,

‘We need to reach some sort of stabilisation, because what happens is that countries are being jostled from one initiative to another...We need to reverse the situation and reach the stage where donors can stay the course. It is the moral duty of international community to change their tune and support weak countries and accept developing country leadership. That is a crisis right now- the international community is not accepting developing country leadership’ (GEG 2008).

In non-health sector aid, after many years of debate, there has been recognition of the importance of ownership, as demonstrated by the endorsement of the 2005 Paris Declaration and the 2008 Accra Declaration. Ownership was defined in the Declaration as developing countries exercising ‘effective leadership over their development policies, and strategies’ and coordinating development actions.

Small steps are being made in this direction in global health, but they must be examined critically. For example, the International Health Partnership (IHP+) launched in 2007 by Gordon Brown aims to provide better coordination among donors; focus on improving health systems as a whole; and develop and support countries' own health plans (see Pang et al. 2009). The IHP+ is an attempt to bring 23 countries, 13 organizations and civil society to work together in a partnership to improve health outcomes through a single, harmonized in-country implementation strategy. At the centre of this strategy is the ‘country compact’ where development partners work in the context of existing in-country mechanisms through a single, costed, results-oriented national health plan with the objective of scaling-up effective coverage as a means of achieving the targets set by the health-related MDG's. To date Ethiopia, Mozambique, Nepal, Rwanda and Uganda have signed the country compact and other countries are in the process of doing so. In response to critics that the IHP+ created additional strings

with no new monies, the IHP+ recently launched a High-level Task Force on Innovative International Financing for Health Systems with the UK government, for example, pledging a £500 million contribution.

However, the rhetoric of coordination should be viewed sceptically for two reasons. First, there are concerns that coordination will decrease the policy space of developing countries by shifting the balance of power towards the ‘consortium of donors acting in unison,’ and thus there could be an inherent contradiction in the partnership (Murray, Frenk & Evans 2007). In fact, it has been argued that donor coordination to provide budgetary support has taken donors into the ‘heart of government’ and further reduced the space for countries to set their own priorities (de Renzio 2007). The assumption built into the rhetoric of coordination is that an external body needs to coordinate donors or various institutions. However there is a real case to be made for coordination to be led by national governments, not by external initiatives.

Second, although they might agree in rhetoric or on paper, there is little incentive for various development partners/institutions to coordinate their activities. Even within the UN system, the case of UNAIDS, which was designed to be a coordinating entity among the UN bodies, illustrates how difficult coordination is in practice (see Sridhar et al. 2008). As one senior policy-maker commented, ‘No one wants to be coordinated...the job of being coordinator is the most thankless and ungrateful job.’

While the rhetoric is in place, and the principles are outlined in the Paris and Accra Declarations, action lags far behind. Rather than put countries in the driver’s seat so that investment can be made in long-term priority-setting and planning, donors focus on ‘quick wins’ and measurable returns through vertical programming. The focus on these quick results discourages investment in health systems and indicates the need for a country-led process of priority-setting.

Challenge 2: Overemphasis on ‘New Players’, rather than Reforming and Strengthening Existing Institutions

At present, the global health system can be viewed as a patchwork of donors, UN agencies, governments, civil society organisations, and the private sector.

- (1) The first group of actors is the *multilateral institutions* such as the World Health Organization, UNICEF, UNDP, UNFPA, World Bank, and the indirect effects of the WTO and IMF. The two main multilaterals are the WHO and the World Bank. The WHO was established in 1948 with the objective to aid all peoples in the attainment of the highest possible level of health, broadly conceived. It was created to be the director and coordinator of international health work. It has focused on two activities: providing scientific and technical advice and setting international normative standards. However the World Health Organization’s limited core financial resources results in its dependence to external priorities achieved through extra-budgetary funds from member states and philanthropic organisations (Sridhar 2009a). The World Bank was not created to address health directly, but has a more broad poverty alleviation objective. Since 1980, it has played an increasingly important role in health primarily due to its financial power as a lender, its interaction with Ministries of Finance in developing countries, as well as its reputation for its intellectual prowess (see Sridhar 2008). Member countries can establish trust funds in the Bank with funds earmarked for specific diseases. These funds are essentially a bilateral form of aid channelled through a multilateral institution.
- (2) The second group consists of *national aid agencies*, or bilaterals, such as the U.K. Department for International Development, and the German GTZ. The biggest player here is the U.S. government through its HIV/AIDS, malaria and child survival initiatives. Bilateral aid has increased relative to multilateral aid in the past ten years.

- (3) The third group consists of *non-governmental organisations and networks*, with key players including the People's Health Movement (grassroots network of developing country activists) and Oxfam GB (with field presence throughout the world). This kind of governance has been grouped under the broad category of civil society organisations, or CSOs.
- (4) The fourth group is *private foundations* (e.g. Rockefeller Foundation) with the biggest player the Gates Foundation.
- (5) The fifth group is the *private sector*, and its engagement through public-private partnerships (e.g. Medicines for Malaria, Stop TB Alliance) with the biggest player being the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. The private sector bring expertise on technical norms and standards, bring financial resources, and have proved to be crucial actors in global health (although some have criticized the partnerships for allowing private sector a seat at the table without sufficient checks on commercial interests).

As noted under the section on initiatives, there has been a continuous expansion in the number as well as the type of actors involved. Instead of creating new forums and new initiatives, there is a real case to be made for reforming and strengthening the existing global health institutions, particularly the WHO and the World Bank. While the WHO was created to be the lead health agency, an increasing number of the initiatives referred to above are completely independent to the WHO.

For example, UNAIDS, which is stand-alone, was created from the WHO's Global Programme on HIV/AIDS. Why was HIV/AIDS first taken out of the WHO? As Merson et al. (2008) note, "There was growing concern about the senior leadership of the WHO among donor governments, who reacted to the re-election of Hiroshi Nakajima to a second term of Director-General by decreasing their overall support and voluntary contributions to WHO, calling for organizational reforms, and devising new health-related

initiatives outside the agency's influence or control.' Thus the birth of UNAIDS is intricately linked to the real and perceived failures of WHO.

Even today, when the question is raised whether UNAIDS can become a special programme of the WHO, or whether it can play a larger role in monitoring health financing, the shortcomings of WHO are listed as key reasons why new initiatives need to be created (see Lee 2008 for discussion of shortcomings). These include that: it is perceived to be bureaucratic and inefficient, subject to political pressure from its more powerful Member States, and lacking clear priorities among a multitude of programmes. There is also a perception that the organization has not been able to deal with the challenges posed by globalization and that, as a result, others have stepped into the void. Importantly, it suffers from inadequate resources and the reality that nearly 80% of its budget now come from external donors, rather than from assessed contributions of its Member States, has brought into question WHO's neutrality and independence.

However, as has been articulated by various academics, strong leadership is urgently needed and as the leading international public health agency representing 193 sovereign states, WHO 'is uniquely positioned to provide this leadership by virtue of its role in setting evidence-based norms on technical and policy matters, highlighting best practices that improve health globally, and monitoring and coordinating action to address current and emerging global health threats' (IOM 2008). Instead of examining how the WHO should be reformed, new initiatives are launched that erode WHO's authority as the leader in global health.

Similarly, the World Bank's role in health is often reduced to its role in structural adjustment programmes and user fees (Global Health Watch 2005). However, in the context of the current financial crisis, there is an important role to be played by the Bank given its comparative advantage as 'the lender of last resort'. The World Bank has a particular role to play in shaping health policies through its interaction with government, and in supporting country's

efforts to strengthen health systems (see new strategy at World Bank 2007). In contrast to many of the ‘new players’, the World Bank must lend to governments thus ensuring that the state plays the central role in driving health policy.

It is worth briefly mentioning the Gates Foundation which is now one of the largest players in health. The Gates Foundation has received criticism due its focus on funding scientific research focused on the development of new technologies for preventing infectious disease (Birn 2005). Is this criticism justified? The Foundation’s research investment has been characterized by a focus on the creation and improvement of health interventions, particularly through technology development. This is in line with the Gates Foundation’s desire to develop tools that can ‘change global health for all time’ (Perkin & Foege 2000). The Foundation’s ability to take risks and its freedom from short-term assessments of impact shape its comparative advantage: it is able to invest in long-term scientific research with the expectation that the results will take more time than the other donors can allow. However, despite its articulated objectives to focus on technological innovation, the Gates Foundation has become arguably a ‘gap filler’ funding research and services in global health that other donors cannot or will not fund ranging from advocacy initiatives to vaccine research to university centres to service provision. However, given that it is a private philanthropic foundation, the Gates Foundation should not be looked at to be ‘everything to everyone’, and in this situation, maybe more attention should be paid to reforming the main health multilaterals, the WHO and World Bank, rather than looking to new players to compensate for their shortcomings.

Challenge 3: Donor Influence on Priority-Setting and their Lack of Accountability

The third major challenge is donor influence on priority-setting and their lack of accountability. As noted above, global health aid accounts for only 0.3% of total expenditures on health globally (6.5% in sub-Saharan Africa). Given this small percentage, why is the impact of donors so critical? Many Ministries of Health have become ‘donor dependent,’ with Ministers

from Tanzania, Kenya and Uganda reporting that 40-60% of their budgets come from donors (GEG 2008). Due to this donor dependence, the priorities and services established by national governments, even those operating on private funds, may be vulnerable to the magnified influence of donor priorities. This is true, not only of heavily dependent countries such as Uganda, but also of middle income countries such as India (Qadeer 2000, Sridhar & Gomez 2009) and Brazil (Gomez 2007).

Qadeer (2000) notes that although only roughly 1.6-2% of financing in the health sector in India comes from external funds, this small percentage is distorting national priorities. For example, she notes that from 1990-91 until 1998-99 investments only increased for selected programmes for TB, leprosy and AIDS Control at the expense of the National Malaria Control and Diarrhoeal Diseases Control Programmes. Similarly, Deolalikar et al. (2008) note that external assistance constitutes a sizable share of national disease control programmes for TB, HIV/AIDS and malaria.

The proliferation of initiatives discussed in section one brings other challenges for recipient governments. These include lack of alignment of donors with the national approach, lack of harmonization among donors, and excessive transaction costs on recipient governments. Too often donors have their own ways of implementing initiatives in country thereby distracting from, and weakening, and neglecting national health strategies and systems. As one official from a developing country noted, 'Ideally assistance should be free from political pressures, it should not detract from national plans, it should be grants not loans, it should be properly aligned with national health systems, and donors should not be intrusive'(GEG 2008). The example of the World Bank has been used to demonstrate why governments sometimes choose not to take assistance: 'The World Bank is offering loans, not grants, these are not aligned with national systems and priorities, and it is intrusive', and as another official noted, 'From our assessment, it is only 40% of World Bank aid that has tangible benefit. The other 60% is in the form of technical assistance'(GEG 2008).

Donors tend to over-involve themselves even with assistance which is more broadly aimed at strengthening local capacity. They push ‘technical assistance’ on recipient governments through consultants and training workshops. In terms of consultants, an advisor from Nepal noted, ‘Now, there is a chronic problem of hiring highly paid consultants from outside, and a lot of money goes back to those consultants. So why not use our own consultants, who are national, who are equally competent, who know the country well’(GEG 2008). On the other hand, capacity-building projects can result in numerous workshops and training sessions which draw key staff members away from ministries where they are most needed.

Much of the challenges outlined above, stem from the underlying lack of accountability of donors to recipient governments. Accountability is defined as the relationship ‘in which an individual, group, or other entity makes demands on an agent to report on his/her activities, and has the ability to impose costs on the agent’(Keohane 2003). Accountability can take a number of different forms ranging from supervisory to fiscal, and to peer and public reputational(Grant & Keohane 2005).

For example, the U.S. government disbursements through USAID, PEPFAR and the Malaria Initiative follow a bilateral aid model. The Executive Branch of the government, especially since USAID has been absorbed into the State department, executes the initiatives. The funds are acquired from taxpayers with congressional approval of the budget. Ultimately, the initiatives, and the related agencies within the U.S. government are accountable to Congress, which can be viewed as a distinct and regulatory agent within government which exerts supervisory power. Congress members in turn are accountable to their constituents ranging from individuals to large corporations. Thus there is no direct accountability of U.S. government assistance to recipient governments.

In addition, donors seldom report on their activities, and while they monitor recipients according to good governance indicators, they themselves do not follow this. For example, there

is a lack of transparency about the quantity of aid flowing into a country and how it has been used. Part of the difficulty is that recent initiatives, such as PEPFAR and the Gates Foundation, disburse funds directly to NGOs, thus making it difficult for Ministries to plan their efforts. The Health Minister of Tanzania noted, 'If they say, we have sent \$100 million dollars' you would expect government to be accountable. But the funding is not recorded. We don't know where it goes. Much goes to civil society, and much remains in donor countries'(GEG 2008). Thus, recipient governments have difficulty knowing how much money is actually in their country, and where in the process funds are 'leaking'. Adding to the difficulty in monitoring donors is that the same donors have adopted strategies which vary across countries.

Challenge 4: The Rhetoric of 'Health Systems'

Since the Declaration of Alma-Ata, attention to health systems has waxed and waned. Most recently, in the global health community there has been a shift back towards promoting health systems, or horizontal, interventions. Horizontal interventions are defined as those that strengthen the primary care system, improve health systems service and delivery, and address general non-disease specific problems such as health worker shortages and inadequate skilled birth attendants. However, there are pragmatic difficulties with realizing the rhetoric and financing horizontal interventions. For example, there is a lack of consensus over how financing should penetrate the system, through promoting specific targets that indicate the strength of a health system, such as maternal mortality(Garrett 2007), or through general approaches such as building clinics. In addition it is difficult for donors to accurately monitor and evaluate horizontal interventions since the impact is not easily attributable.

Thus the tension remains between the desire to fund horizontal activities with the reality of financing for vertical interventions such as through the U.S. government and Global Fund. Much of the increase in monies for global health has been directed to address HIV/AIDS, malaria and TB. A recent study of the four major donors in global health noted that in 2005,

funding per death varied widely by disease area, from \$1029.10 for HIV/AIDS to \$3.21 for non-communicable disease(Sridhar & Batniji 2008).

The focus on separate vertical initiatives rather than investing in capacity-building at the national level partially arises from an underlying issue: the global health community does not have good estimates for non disease-specific deaths. For example, information is not available on mortality caused directly or indirectly by lack of access to health systems. The insufficiency of current health metrics, particularly in determining community (as well as national and regional) needs has been widely recognized. It is worth noting the implications of the lack of measurement tools for assessing not only the impact of financing on health systems, but also the impact of financing for preventive public health measures. This leads to considerable uncertainty not only for researchers, but also for donors making decisions on where to invest their funds. With the current measurement system driven by disease-specific causes of death, investing in health systems comes to be seen as a ‘bottomless’ pit as there is not yet a universally accepted proxy for the impact of health systems investment on mortality. Once funds are put into the ‘health systems’ basket, it becomes difficult to track and measure their impact. The imperative for donors to fund programmes that show measurable results in a short-time frame clearly demonstrates that there is little incentive to fund health systems (Sridhar 2008). Only when the incentives are aligned towards funding health systems will real change in resource allocations take place.

Challenge 5: Going around Government

In addition to distribution of funding by disease area, the question of whom donors fund is extremely important. As noted above, there has been a move towards funding non-state actors especially by the newer institutions. For example, the Global Fund’s use of country-coordinating mechanism (CCMs) gives a larger voice to civil society as it is supposed to include a wide range

of actors in a participatory process. The Global Fund reliance on CCMs indicates that the focus of donors has changed from a state-centric approach to financing to a process aimed at increasing the role of non-state actors. PEPFAR, the U.S. government initiative, also reduces the role of the state in the prevention, care and treatment of HIV/AIDS as it predominantly funds faith-based organisations and NGOs. Similarly, the Gates Foundation predominantly works through civil society and private research institutions and essentially bypasses government. This can be viewed as part of the Foundation's strategy to complement government, by engaging in high-risk activities that cannot be pursued by governments. The Avahan service initiative, although partnered with government agencies, is not financed through the Indian government.

Despite its push for increased private sector involvement, the World Bank is the only donor that exclusively funds recipient governments. This is a result of its historical mandate. While legally tied to government, the Bank has focused on creating a policy environment conducive to the private sector (McCoy 2007) through conditionality to strengthen the private sector, direct interaction with the private sector, and a reduction in funding to state-owned enterprises.

The marginal involvement of developing country governments in many global health initiatives raises questions about sustainability. In terms of process, it can be argued that in some cases, bypassing the state is an unsustainable approach. In fact, the civil society report to the WHO Commission on Social Determinants on Health notes that the state is the key actor in development and that government action is the key to collaborative and collective action because governments are ultimately responsible for health of populations: 'Public sector has played a major role in almost all situations where health outcomes have improved significantly' (Civil Society Report to CSDH 2007). Although it might be more difficult in the short-term, strengthening health systems through government might be the most efficient in the long-term. In contrast, in terms of short-term outcome, bypassing government and going straight to

communities can potentially result in more immediate impact. The poor quality and lack of capacity of public institutions can create enormous obstacles to delivering services, especially in countries with poor governance. In pressing situations, when lives could be saved through ARV provision, is there justification to prioritize short-term outcomes over long-term process?

The debate about the role of government in providing health for their populations is being fought, inconsistently and somewhat incoherently, in the health services of low and middle-income countries. In this debate, the U.S. government and Gates Foundation are united in largely bypassing government health programmes (despite PEPFAR's selection of countries based on good governance, and the discussion by the Gates Foundation of transitioning of programmes to government), and the World Bank and Global Fund engage and financially support government programmes, yet may shape them based on international priorities.

Challenge 6: Channelling Funds through Northern Organizations

In addition to aid quantity, and what types of institutions should be funded, a third issue of importance is where, geographically, donors should be funding. As McCoy et al. (2009) discuss, global health is a multi-billion dollar industry and there are clearly competing interests amongst different actors to make use of this funding. The heavy reliance on certain Northern-based organizations raises the question of whether global health financing is organised to suit the interests of particular actors. For example, pharmaceutical companies appear to benefit considerably from global health programmes that emphasise the delivery of medical commodities and treatment (as well as from the positive image created by their participation in public-private partnerships). NGOs, global health research institutions and UN bureaucracies also have an interest in increasing or maintaining their levels of income and thus tend to prefer that funding from major donors flows through them (as managers of funding), rather than directly to developing countries. Further scrutiny is needed on aid flows in global health to assess whether they are being 'captured' by vested interests and used to support inappropriate spending

on the private commercial sector or on a large and costly global health bureaucracy and technocracy based in the North. It is important to look at not just the volumes of money raised, but also how it is spent and who it benefits so as to help ensure that the needs of recipient countries are kept at the forefront (McCoy et al. 2009).

For example, while the World Bank and Global Fund directly fund developing country recipients, the Gates Foundation and PEPFAR have tended to fund northern organizations (Sridhar & Batniji 2008). However, even by the Bank and Global Fund there are certain 'leakages' in the North such as the reliance on consultants, as well as on auditing firms such as Pricewaterhouse Coopers that can assume relatively large parts of the budget.

In global health research, there is no clear consensus among institutions and scholars about where the most effective investments should be made, suggesting that a plurality of approaches may be warranted. Investing in health research based in North America and Western Europe has logical justification. These regions have, arguably, the best capacity to deliver results on a short-time scale, dedicate personnel to new projects and absorb the large financial flows. An alternative geographical distribution of investments, which would favour the global South, may lead to slower success given the dual process of building capacity and conducting research.

Concerns have been raised that research investment should be in institutions in developing rather than developed countries (GEG 2008). Financial flows can enhance and develop the research capacity as well as provide incentives for talented young scientists to remain in-country. Perhaps most significantly, scholars and leaders in the global South are best placed to inform how delivery systems for health interventions can improve.

Challenge 7: Linking Health to National Security/Foreign Policy Interests

The past three years have witnessed the linking of global health and foreign policy (Fidler 2005, 2006, 2009). In 2006, the Ministers of Foreign Affairs of Brazil, France, Indonesia,

Norway, Senegal, South Africa and Thailand issued a joint statement in Oslo highlighting the need to apply a health lens to foreign policy:

‘We believe that health is one of the most important, yet still broadly neglected, long-term foreign policy issues of our time...We believe that health as a foreign policy issue needs a stronger strategic focus on the international agenda. We have therefore agreed to make ‘impact on health’ a point of departure and a defining lens that each of our countries will use to examine key elements of foreign policy and development strategies, and to engage in a dialogue on how to deal with policy options from this perspective’ (Lancet 2007).

There are two unintended consequences of this linking that require further research. First, as Gostin (2008) has noted, ‘Do political leaders acknowledge, and act on, the evidence just presented that global health is in their national interest? The answer may be that States are beginning to understand that responding to health threats outside their borders serves their interests, but their engagement is relatively limited. And the sad truth is that the **coincidence of interests is narrower than activists, and even scholars, have suggested.**’ Gostin makes an important point. While translating health into national security and foreign policy language might attract attention from high levels of government, it is only for a ‘few high-profile problems: AIDS, pandemic influenza and the Indian Ocean tsunami.’ In fact, Gostin notes that national security assessments offer ‘relatively narrow justifications for State action on global health.’ Thus, while health advocates might use the language of foreign policy as instrumental in gaining attention, this attention does not move into less glamorous areas such as health systems, malnutrition and water and sanitation. A review of six country policies in health and foreign policy, Norway, UK, Switzerland, France, Brazil and Thailand, illustrates that many, but not all, strategies tend to be catalysed and supported by concern with surveillance and control of infectious disease (Sridhar 2009b). It remains to be seen whether this concern extends to other areas, since as Gostin (2008) notes, ‘In many respects, States may be correct that true global engagement does not serve their interests.’

Second, while global health advocates have often emphasized the links between health and national security to place health issues on the agenda (Donaldson & Banatvala 2007, IoM 2007), it may be precisely this link to national security that leads states to favour a bilateral funding approach. The move towards bilateral aid has been noted in areas both within health, such as by the U.S. government, and outside health by new donors such as China and India. While multilateral aid has the advantage of shielding allocations from direct foreign policy priorities, bilateral aid is often quicker to disburse.

Suggestion 1: Strengthen Mechanisms to Hold Donors to Account

What are suggestions to address the seven challenges? In the second part of the paper, three ideas are put forward that require further research and analysis. These draw on the suggestions made at a meeting in May 2008 of former and serving health ministers (GEG 2008). First, the global health community must work to strengthen the mechanisms to hold donors to account through ensuring implementation and enforcement of the Paris and Accra Declarations, and through creating a donor accountability forum. The Paris Declaration, as noted above, focused on ownership through the three mechanisms of harmonization (donors adopting the same goals and policies), alignment (donors aligning their goals/policies with those of developing country governments), and coherence (ensuring goals in different issue areas are not contradictory e.g. trade policy or intellectual property policy does not contract health goals). While the Paris Declaration outlines the necessary adjustments donors need to make, its implementation has lagged far behind its acceptance. A key obstacle is that many of those working in public health in middle and low income countries are not aware of the contents of the Paris Declaration, and what donors have agreed to.

The larger issue is that there is basically no institution or forum to monitor donors either at the national and global level. While the WHO might be looked at to fulfil this function, given its dependence on extra-budgetary funding, it cannot be seen to be independent. As Srinath

Reddy has noted, while WHO carries the best imprimatur among international health organizations, its limited budget, lack of mandate for primary research, sparse technical capacity, and its need to derive its mandate from countries, indicate that the WHO could not take on such a political task (GEG 2008). While academia could assume this role, even universities have become heavily dependent on donor funds and thus would not be perceived as objective by recipient governments. Perhaps what is needed is a partnership between donors and recipients to monitor progress, what has been referred to as a 'Donor Maximization Review'(GEG 2008).

Suggestion 2: Develop National Plans and Support National Leadership in Health

Second, countries require adequate policy space to develop national plans and cultivate national leadership in health. One minister has recounted the approach to donors,

'The Ministry of Health was rather being run by our donors, saying what needed to be done. And until I said, 'can we have a health sector strategic plan that we come up with that says who provides, who says exactly what should be done.' We understand the problems better than our partners and also we understand the priorities- where we need to put the resources. We needed first of all to have a meeting with them and tell them where our priorities were and where we want to put resources- available resources. Of course, at that point there was a lot of resistance because that business had gone on for a long time. And they would not put money where we wanted to put money. Until at one point I said, 'you may want to do your business but don't do it in the health sector' and then they came back, 'what do you want us to do.' And I said, let us work out a strategic plan first. And when we provided leadership, we have seen the Ministry of Health and the health sector change dramatically because we are looking at the problems facing the country.'

Similar to this, the Minister of Health of Tanzania has noted, 'We have a program. Whoever wants to help must swim with us in the program'(GEG 2008).

As T.J. John and Franklin White (2003) note, 'Public health in South Asia should not be left to the international community to define; it is primarily the responsibility of the countries themselves to define their priorities. The global agenda should be viewed as complementary at

best, and South Asian countries must build their systems more assertively in accordance with their public health needs and with their own resources'.

At the national level, the difficulty arises from the need to engage with Ministries, such as Finance and Trade, whose primary concern is not necessarily health. For example, if the Ministry of Health approaches the Ministry of Water and Irrigation and requests assistance addressing diarrheal diseases, the Ministry of Water and Irrigation needs to have incentive to allocate some of its budget to diarrheal diseases. These incentives seem to be currently lacking in most cases. Perhaps the paradox of health policy is that the policies that have the most impact in terms of preventing illness often lie outside the traditional health sector. Thus, Ministries of Health predominantly focus on treatment.

Suggestion 3: Study and Learn from South-South Collaboration

Perhaps one of the least explored areas by academics is south-south collaboration, both bilaterally between the emerging powers and low income countries, and plurilaterally through clubs and coalitions. South-south collaboration can provide alternative forums for countries to approach for financial and technical assistance. Anecdotal evidence from Sub-Saharan Africa has noted the success of China's bilateral aid programme in improving infrastructure and providing what governments' request. Similarly, positive news has been reported from the partnership between Brazil and Mozambique on HIV/AIDS(GEG 2008).

In April 2008, India hosted the Africa-India Summit to explore furthering its relations in aid, trade, and to enhance partnership to achieve the MDGs. In February 2009, the Indian Foreign Minister Pranab Mukherjee launched a project to connect 11 African countries with India in providing medical education. The project will provide virtual classes for medical staff, helping around 10,000 African students annually to receive specialised nursing degrees. It will also provide online medical consultations where patients in parts of rural African can seek medical advice from Indian doctors via satellite. If the project is successful, it will be scaled up to

all 53 African countries. Thus there is considerable potential in South-South collaboration in both service provision and research.

In addition, low and middle income countries can work together through coalitions to push forward their collective agenda. In the WTO, developing country coalitions have built and used coalitions to improve their bargaining power. As Patel (2007) describes, this pooling of bargaining resources has improved the technical and lobbying capacity by which developing countries engage in the WTO. These coalitions are highly visible, formalized and coordinated and focus on working within the WTO and existing trading structures to proactively engage in the negotiation process with the purpose of improving outcomes for developing countries. These coalitions are bolstered by civil society. In health, coalitions can serve two purposes. First, they can increase negotiating power directly. Reflecting on the possibility, Francisco Songane has noted, 'What happens is there is an exploitation of weakness in countries. If the donors see that in country A there has strong leadership, and direction on what they should do, they are not going to mess around. They go to another country where they can do things differently, and that country will accept. We need to get a grouping of countries with one voice, that say, 'if you want to deal with us let us be together, and what we have to achieve is the country benefit, not for donors A B or C'(GEG 2008). Second, coalitions can serve as a forum for developing country coalitions to consult one another and coordinate before major meetings of donors and of international institutions. The increasing reliance on meetings at regional forums such as UNASUL (S. America) and ASEAN (Southeast Asian) before WHO negotiations indicates that while coalitions may be less developed or formalized as within the WTO, they are still being used by certain regions and like-minded countries to advance their agenda (Sridhar 2009b).

Conclusion

This paper has outlined the seven challenges in international development assistance for health, and three possible ways forward. Underlying the paper has been the argument that we must get beyond rhetoric to ensure the necessary changes in the global health system are made so that developing countries can assume ownership in policy-making. Attention must be paid to

who gets what, when and how. While there are no simple answers to the questions raised in this paper, space should be created for discussion and exploration of these issues. Only with open dialogue of the possibilities as well as the consequences of the current international development architecture for health can steps be taken to make the system more efficient and make a stronger case to policy-makers to prioritize international development assistance to health in the context of limited funds.

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