



Global Economic Governance Programme

Centre for International Studies | Department for Politics and International Relations



Setting a Developing Country Agenda for Global Health

Preliminary Report of a High-Level Working Group
11-13 May 2008

In 2008 the Global Economic Governance Programme of Oxford University brought together a group of current and former health ministers and senior health officials from developing countries (see Appendix) to discuss gaps and challenges they face in dealing with current global health financing and governance arrangements. This short report summarizes key points emerging from the meeting which highlighted an urgent need to reform international assistance in health.¹

Over the course of the meeting, participants voiced their frustrations with the current state of health assistance. Already, within countries health policy-makers face strong incentives to prioritize clinical care and infectious diseases and to under-fund prevention and wider inter-sectoral health issues such as access for the poor to health services, maternal mortality, tobacco-related illnesses, and carcinoma. Crucially, national health strategies need to aim at stronger health systems. However, far from helping to correct this imbalance, at present, donors are exacerbating and magnifying it.

1. Too many new initiatives: donors need to learn to 'stay the course'

At the international level, a constant deluge of new initiatives, focussing on specific diseases or issues makes it extremely difficult for governments to develop and implement sound national health plans for their countries. As one participant put it:

'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 countries 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.' (Francisco Songane, former Minister of Health, Mozambique)

As 'fashions' take hold in the development community, donors shift attention from one issue to the next without working to build capacity or 'stay the course.' While in certain cases more assistance is provided with a new initiative, such as the Global Fund to Fight HIV/AIDS, TB and Malaria, others such as the International Health Partnership are guilty of creating new strings without providing new sources of money. Too often donors want to 'plant their flag' and take credit for moving health forward. Often the same countries are involved in several such initiatives at any one time.

Solutions?

¹ Note that some of the quotes have been made anonymous in this preliminary report while we await permission from participants to identify their names with the views attributed to them. This document is by no means a consensus statement, but rather a summary of discussions.

Containing donors' enthusiasm for launching new initiatives is difficult but participants noted that a few donors – the Gates Foundation and the Global Fund were mentioned – are beginning to recognize the need to support underlying health systems. In the face of powerful incentives for donors to pursue vertical strategies, one suggestion made was:

'A step forward would be for a percentage of all donor funds going into initiatives, especially vertical programmes, to be earmarked for health systems development' (Srinath Reddy, President, Public Health Foundation of India).

Another solution which improves the possibilities for a national health strategy is pooled or 'basket' funds in Ministries of Health which are seen as creating policy space for the ministry.

Debt relief has also been identified as assisting countries in moving towards self-sufficiency in financing health. As participants commented

"Political will was not enough [...] We needed to make new rules for external debts." (Alfredo Palacio, former President and former Secretary of Health, Ecuador)

'Nigeria finally got debt relief [...] that will not give you money, but what you are setting aside to service your debt every is now available for local spending. So our debt relief saving at the federal level was about 800 million US dollars. [...] In 2006, that money was set aside, but not just set aside, the Ministry of Health was given 21% of that money on top of the regular policy.' (Eyitayo Lambo, former Minister of Health, Nigeria)

In addition, South-South cooperation with the emerging powers, such as between Mozambique and Brazil on HIV/AIDS, was seen as a positive way forward as well as providing an alternative to the traditional donors.

2. National strategies are being weakened by parallel priorities and implementation directed by donors

A deluge of initiatives brings another problem for recipient governments. Too often donors find or direct their own ways of implementing initiatives in-country, thereby distracting from, weakening, and neglecting national health strategies and systems.

The World Bank was cited by several Ministers as a very poor donor, dictating how money is used, how programs should be implemented, and how evaluation and monitoring should be undertaken. This has led some governments to choose not to take World Bank assistance.

'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. The World Bank is offering loans not grants, these are not aligned with national systems and priorities, and it is intrusive.'

More generally, officials stressed that:

'We want to work with them [the donors] not to be told what to do by them.'

Some participants favourably compared the Global Fund to other donors in these regards.

Even assistance which has been explicitly aimed at strengthening local capacity falls prey to the problems of donor over-direction. In some countries, capacity-building assistance directed by donors results in a plethora of workshops which draw key staff members away from the ministries where they are most needed: DFID-funded workshops and seminars in Uganda are one example.

For example, through their hiring of international consultants who provide undesired technical assistance. As participant summarized:

‘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.’ (Mahesh Maskey, Chair, Nepal Health Research Council)

More generally, participants noted how much funding was used for technical assistance which was sometimes unwelcome. As a participant noted,

‘From our assessment, it was only 40% of World Bank aid that has tangible benefit. The other 60% is in the form of technical assistance.’

Solutions?

Participants shared their strategies for negotiating with donors identifying leadership at the country level and a national strategy as essential. One minister 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 problem 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 wanted 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 were looking at the problems facing the country.’

In addition to leadership, a national strategy is necessary. As another Minister noted,

‘We have a program. Whoever wants to help must swim with us in the programme.’ (David Mwakyausa, Minister of Health, Tanzania).

However, sticking to the strategy and strong leadership can be undermined by the fear of donors walking away and moving resources to another country. For heavily donor-dependent countries this is a stark alternative. Reflecting on the refusal of PEPFAR to participate in the national approach agreed to by all other donors, one minister noted,

“We have never put our foot down. We fear. We are cowards.”

Major challenges exist in generating political will needed for multi-sectoral action at country level. As one participant reflected:

‘We have the people. We have doctors and nurses. We are lacking planning. We are not exerting enough influence on our Ministry of Finance and leaders of the country.’

In this area, Ministers of Health and senior advisors need to convince other ministries and sectors of the importance of investing in activities which impact health. Participants noted the paradox that policies that have the most impact in terms of ensuring good health and preventing illness often lie outside the health sector. The domain of Ministries of Health is predominantly treatment, resulting in an under-emphasis on preventive activities at the country level.

In addition to including a wide range of actors, participants remarked on the multi-sectoral nature of health, with one minister suggesting a 'triangle' model for movement on health. The triangle refers to the three key aspects of technical knowledge (information, good evidence-base), social activity (civil society), and political will (involvement of other key ministries such as water and irrigation, trade, transport, finance). Each of these areas is lacking and could use further strengthening.

Several participants reflected that the long-term goal was to achieve self-financing in health so that governments could focus at the national level on improving health instead of looking 'upwards'.

Once governments have the space to set their own policies, participatory multi-stakeholder mechanisms can then be used to ensure that policies reflect the needs of the people. A particularly successful example of a participatory process for setting health priorities is the creation of a National Health Assembly:

'the Thai National Health Assembly brings together citizens from all parts of the country, civil society and parliamentarians to collectively decide on policies' (Mongkol Na Songkhla, former Minister of Health, Thailand)

Similarly, the National Human Rights Commission of India which holds public hearings on the access to health and has been used to hold state officials responsible for ensuring the health of their constituents. This Commission is a critical part of the broader participatory approach in making decisions on public health:

'We require a strong multi-stakeholder participation in priority-setting and decision making, including a strong civil society component. Unless the planning process becomes more broad-based, the priorities may not appropriately reflect the societal needs. This would become especially problematic if governments progressively abdicate their responsibility for stewardship of the health system, with increasing economic liberalisation. Multi-stakeholder participation in the planning process will provide a corrective balance.' (Srinath Reddy, President, Public Health Foundation of India)

3. Too little transparency and information about aid activities: donors must learn to report fully to developing countries

While the challenges discussed above have been recognized before, participants noted that severe lack in donor accountability has resulted in little progress on improving health assistance. Donors seldom report fully on what they are doing.

'Donors talk a lot about transparency and accountability, but they themselves do not practice this.'

All participants concurred that serious problems arose for planning when there is no accurate information provided to the government about the scope of donor activities.

There is a lack of transparency from donors about the quantity of aid flowing into the country and how it has been used. Part of the difficulty is that recent initiatives, such as PEPFAR and the Bill and Melinda Gates Foundation, disburse funds directly to NGOs. This makes it difficult for Ministries to plan their efforts as they do not know which NGOs are already receiving funds, and also the purpose of and region where the funds are being used. In one instance a Minister spoke about finding out - after the fact - that donors were using and paying the same NGOs as the government for providing the same services. In the words of one Minister:

“If they say, ‘we have sent \$100 million dollars,’ you would expect the 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. (David Mwakya, Minister of Health, Tanzania)”

An accounting for that part of aid which remains in donor countries is equally necessary. At the joint review with donors each year, recipient governments have no way to know if, or how much money, has actually reached their country. Donors often accuse developing countries of corruption and mismanagement of funds, yet developing country officials note that funds ‘leak’ at the donor end of the equation.

Country experience highlights that information sharing also needs to also extend into health research. Reflecting on a US National Institutes of Health research programs in country, a participant noted that

‘the Ministry of Health has no idea what the researchers [collaborating in research with the US National Institutes of Health] are doing or why they are interested’

As discussion continued on donor practices, it became clear that the same donors have adopted strategies which vary across countries: in some instances supporting health system development and in others undermining it. While in Tanzania the activities of PEPFAR and the PMI are governed by USAID which sits within the caucus of development partners, in Uganda PEPFAR and the PMI insist on remaining absolutely separate from other donors.

Solutions?

From the discussion among Ministers and officials it became apparent that it would be very useful for recipient countries collectively to evaluate and compare donor activities and practices across different countries. It also became apparent that this sharing of practice and experience does not occur in existing forums.

Participants also discussed ways to move towards greater donor accountability. Participants felt that while the Paris Declaration, and the principles of ownership and support for national development strategies, all take the right steps towards accountability, the problem lies in implementation. For example, participants pointed to the lack of institutions for monitoring donor programmes and practices at both the global and national level. As one minister noted,

‘They [donors] like to monitor activities, but they do not like to be monitored and evaluated’

The recent trend for donor coordination has been happening for years, but continues to lack a genuine respect for country ownership.

‘What is articulated in the International Health Partnership – which is one of the pillars of the global campaign for the health MDGs – is nothing new. The countries have been doing that for years. Some of the countries have gone into a second phase of coordinating mechanisms [...] but donor community is not respecting that. So what we need is a robust response from the country side.’ (Francisco Songane, former Minister of Health, Mozambique)

At the global level, participants noted that organizations such as the World Health Organization have become dependent on donor funds and thus cannot serve to independently monitor donors

‘The major international organizations are being distracted. They are looking for money because they are judged by the way they are mobilising money. They are not guided by what has to be done.’ (Francisco Songane, former Minister of Health, Mozambique)

Srinath Reddy noted that 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, the WHO could not take on such a political task. Participants agreed and noted that the WHO is a bureaucratic institution controlled by certain donor countries. Several participants pointed to the key role of academia in serving as independent evaluators of donors providing information on current practices. However, Francisco Songane commented that even the most reputable universities are heavily dependent on donor funds, and thus cannot be seen to be objective and impartial. Participants noted the challenge of maintaining the independence of researchers and academic institutions in the face of vast concentration of funding from the same donor(s).

In addition to pointing out the need for further information on donor practices, participants alluded to the developing country coalitions in the World Trade Organization and the possibility of similar coalitions in health. Countries could come together to ‘name and shame’ the major violators of the Paris Declaration. Reflecting on the need for a coalition, one participant noted,

“What happens is there is an exploitation of weaknesses 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.’” (Francisco Songane, former Minister of Health, Mozambique)

He suggests that a coalition

‘will give political voice to countries facing the consequences’.

or as Srinath Reddy noted, ‘provide a collective defense to developing countries.’ Mahesh Maskey put forward a possible grouping of the 68 countries failing to meet MDGs four and five. At a minimum, a coalition could be a forum for developing country delegations to consult one other and coordinate before major meetings. It is suggested that civil society needs to bolster the capacity of countries to form coalitions and to advocate for the importance of health, and that health researchers play a critical role in monitoring donor programs and funding.

Monitoring progress on global health goals

A second suggestion related to a partnership with donors to monitor progress was referred to as ‘Donor Maximization Review.’ Donors and recipients could each nominate two representatives to sit on a taskforce, chaired by an academic. One minister noted that this would only work if done by an institution with credibility and if trust existed between donors and recipients.

Setting ethical standards for health assistance

A third suggestion related to the creation of a universal code of conduct on health assistance that is based not just on efficiency, but on ethics. This code may progress best if not attached to a sectoral agenda, and can be taken to the highest levels of the UN. A shortcoming of this suggestion is again the need for mechanisms to ensure implementation.

To proceed with either of these initiatives, further analysis is needed to provide an evidence-base for what kinds of donor assistance are most effective, to provide tracking of grants from commitment to actual impact on-the-ground, to provide information on the quantity of donor financing in-country, and provide further documentation on the case for health.

Appendix 1: Participants

High-Level Working Group Participants:

Mr. Santiago Alcazar, Brazil (Advisor to the Minister of Health for International Affairs)

Prof. Eyitayo Lambo, Nigeria (Former Minister of Health)

Dr. Widjaja Lukito, Indonesia (Advisor to the Minister on Health Public Policy)

Hon. Dr. Stephen Mallinga, Uganda (Minister of Health)

Dr. Mahesh Maskey, Nepal (Chair, Nepal Health Research Council)

Hon. Professor David Mwakyusa, Tanzania (Minister of Health and Social Welfare)

Hon. Minister Charity K. Ngilu, Kenya (Minister of Water & Irrigation; Former Minister of Health)

Dr. Alfredo Palacio, Ecuador (Former President; Former Secretary of Health)

Prof. K. Srinath Reddy, India (President, Public Health Foundation of India)

Dr. Ismail Sallam, Egypt (Former Minister of Health)

Dr. Francisco Songane, Mozambique (Former Minister of Health; Director, The Partnership for Maternal, Newborn and Child Health)

H.E. Dr. Mongkol Na Songkhla, Thailand (Former Minister of Health)

Hon. Dr. Siti Fadilah Supari, Indonesia (Minister of Health)

The Global Economic Governance Programme at the University of Oxford convened the Working Group. *The following were participants from Oxford:*

Rajaie Batniji (Research Associate, Global Economic Governance Programme; Coordinator, High-Level Working Group)

Harold Jaffe (Professor of Public Health; Head of the Department of Public Health)

Devi Sridhar (Post-Doctoral Fellow in Politics, All Souls College; Senior Researcher, Global Economic Governance Programme)

Ngairé Woods (Director, Global Economic Governance Programme; Professor of International Political Economy)

Further updates will be available at www.globaleconomicgovernance.org, along with video of a public panel featuring the Working Group. Please direct queries to the Global Economic Governance Programme.

The Global Economic Governance Programme

University College

Oxford, OX1 4BH

United Kingdom

Tel: +44 (0) 1865 276 639

Fax: +44 (0) 1865 276 659

Email: geg@univ.ox.ac.uk