THE ROLE OF GLOBAL HEALTH PARTNERSHIPS IN SHAPING POLICY PRACTICES ON ACCESS TO MEDICATION IN CAMEROON: THEORY, MODELS AND POLICY PRACTICES

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ABSTRACT

This thesis argues that health policy practices on access to medication in Cameroon have been shaped by global health partnerships (GHPs), with the result that the capacity of the state has been undermined and the national health system fragmented, with no resultant reduction in the incidence and burden of malaria and HIV/AIDS. GHPs have played an increasing part in relation to access to medication in a number of developing countries in Africa, defined in terms of potential and actual access to pharmaceuticals and healthcare services. GHPs are supposed to provide a better policy response to the practical problem of access to medication by combining the expertise of UN agencies, the pharmaceutical industry, international civil society organizations, national government and local groups to formulate and implement country-specific policies. Ostensibly, they are able to bridge the gap between medical technology and the public health needs of poor societies. Neither of these claims can be substantiated.

Theoretical approaches to models, embodied knowledge and social constructionism are used to provide a conceptual framework to study the role of GHPs on access to medication. GHPs are conceptualised as 'models' that occupy the intermediate position between theory and policy practices, within which are found three major narratives, based on public health, economistic and human rights approaches to the issue of access to medication. These narratives became embodied within GHPs, and are analysed to show how they shape different elements of policy practices. The operation of GHPs within a

'transcalar network', this 'social space' in which global-national-local linkages are formed and interactions take place is also examined.

Global and national (country-specific) perspectives on the emergence of the GHP as a facilitator of access to medication are identified, and the role of GHPs in determining national health policy and local delivery practices for achieving access to medication for the poor and most vulnerable population is investigated. Two programmes in Cameroon are used as case studies: 1) National Malaria Programme created on Roll Back Malaria partnership guidelines and 2) National HIV/AIDS Programme created on Accelerating Access Initiative and Equitable Access Initiative guidelines respectively.

The empirical evidence from this thesis supports a critical evaluation. GHPs emphasise specific medical intervention programmes, and are effective only in this narrow technical sense. Even though their efforts have not reduced the incidence and burden of malaria and HIV/AIDS, they have legitimised the direct intervention of international agencies, private corporations and civil society organizations at the local level. The GHPs' pursuit of 'quick results' has fragmented the national health system and undermined the role of the state. This thesis suggests that the key to reducing disease burden and improving public health is a strengthened national health system, one that the current GHP model does not offer. Developed to address the supposed failure of African states to ensure access to medication, GHPs have further marginalised the role of the Cameroon state, thereby reducing its capacity to protect and advance the health of its citizens.

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LIST OF ACRONYMS

AAI	Accelerating Access Initiative
ACT	Artemesinin Combination Treatment
ART	Anti-Retroviral Therapy
CCAM	Cameroon Coalition against Malaria
CCM	Country Coordination Mechanism
CDC	Centre for Disease Control
CENAME	National Drug Procurement and Distribution Centre
CSO	Civil Society Organization
CTG	Central Technical Group
DFID	Department for International Development
EAI	Equitable Access Initiative
FAAS	Fight Against Aids and Sexually Transmitted Diseases
Global Fund	Global Fund for Malaria, HIV/AIDS and Tuberculosis
GHP	Global Health Partnership
GMCS	Global Malaria Control Strategy
GPA	Global Programme on AIDS
GPPP	Global Public-Private Partnership
GTZ	German Development Cooperation
IAVI	International AIDS Vaccine Initiative
IMF	International Monetary Fund
INGO	International Non-Governmental Organization
ITN	Insecticide-Treated Mosquito Nets
LSHTM	London School of Hygiene and Tropical Medicine
MAP	Multi-Country AIDS Program
MoH	Ministry of Public Health
MSF	Medecin Sans Frontiere
NSMA	National Social Marketing Association
NSMP	National Social Marketing Programme
NGO	Non-Governmental Organization
NMC	National Malaria Committee
NMP	National Malaria Programme
NAC	National HIV/AIDS Committee
NAP	National HIV/AIDS Programme
OAPI	African Intellectual Property Organisation
PCIME	Integrated Management of Childhood Illness
PHC	Primary Health Care
PTME	Prevention of Mother-to-Child Transmission

PPP	Public-Private Partnerships
PPSC	Provincial Pharmaceutical Supply Centre
PSI	Population Service International
RBM	Roll Back Malaria
SAP	Structural Adjustment Programme
TRIPS	Trade and Related Intellectual Property
UN	United Nations Organization
UNAIDS	United Nations AIDS Programme
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Programme
WTO	World Trade Organization

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CHAPTER 1: INTRODUCTION

1.1 Background

This is a Science and Technology Studies (STS) thesis about embodied knowledge. The case study is the role of global health partnerships (GHPs) on access to medication for malaria and HIV/AIDS in Cameroon. In particular, the thesis investigates how the embodiment of public health, economistic and human rights ideas in GHPs shape policy practices on access to medication in African countries and Cameroon, in particular. GHPs have been created to provide '*universal access*' to medication for the poor in developing countries (Buse and Walt, 2000a; Buse and Harmer, 2007; Caines et al., 2004; Carlson, 2004). As such, they are meant to provide, directly or indirectly, a better public health policy and better national health system to respond to previous policies and systems failures to deal with the rising pandemic of diseases in these countries. To achieve these objectives GHPs combine the expertise of global UN agencies, the pharmaceutical industry, international civil society organizations (CSOs), national governments and local groups in a public-private partnerships (PPPs) to formulate and implement country-specific policies. The often conflicting and competing public health, economistic and human rights ideas from these stakeholders, expressed in international meetings and conventions as narratives (Ngoasong, 2009) obviously shape policy practices.

This thesis argues that the global and country-specific claims on the capacity of GHPs to achieve 'universal' access to medication can be substantiated.

However, the GHP model is inadequate as a justification for policies aimed at correcting the persistent institutional and public challenges facing African countries. Such claims are grounded in the prior assumption that medical technology, whatever the science behind it, can be adapted in a socially useful way to simultaneously increase the commercial interest of the pharmaceutical industry and address the healthcare needs of the world's poorest peoples (Doyle 2004; Chataway and Smith, 2006; Grace, 2006). This thesis is able to demonstrate that the claims for a GHP model, one that can be implemented on a country-specific context, lacks credibility in relation to the overemphasis on the medical model (which assumes a causal relationship between medical technology and health) and the complex dynamics associated with the deployment of specific GHP programmes (strategic interests and actions of GHP partners, the complexities around the type of diseases being targeted and country-specific challenges). This does not undermine the urgent need for the global activism put forward by GHPs to combat disease pandemics in developing countries.

> 'The poor in developing countries are disproportionately affected by global diseases like HIV/AIDS, tuberculosis and pneumonia, as well as tropical diseases such as malaria, sleeping sickness or river blindness. Around 80% of the poor/rich health disparity – measured in avoidable health or disability adjusted life years – probably still arises from infectious diseases, as it did in 1990. If interventions exist to prevent or treat some of these diseases which account for the rich-poor differences in health status, these products are not reaching those who need them. While neither the public nor the private sector alone can eliminate health inequities, focused partnerships involving both sectors have the potential to contribute to their reduction.' [1]

[1] Global Forum for Health Research created the Initiative on Public-Private Partnerships for Health (IPPPH) in 2000 (defunct end of 2004), as a database for global policy responses to disease pandemics (http://www.globalforumhealth.org/en/About/Research-initiatives/IPPPH) (Accessed: 12/10/08).

Initiated by UN-based agencies, GHPs have been formed to deal with the above challenges. Accordingly, medical technology has been suggested by high profile personalities and institutions from all over the world as a panacea. Notable examples abound on malaria and HIV/AIDS, the two diseases studied in this thesis. A joint study by the WHO, LSHTM and Harvard University claims that wider use of insecticide-treated mosquito nets (ITNs) could reduce malaria infection in Africa by half (UN, 2000a). Similarly, the potential for Anti-retroviral therapies (ART) to provide life-sustaining support as a way of containing the incidence (and consequently the burden) of the HIV/AIDS pandemic in hardest hit regions of the world is well documented (Joseph, 2003; UNAIDS/WHO, 2002a). Influential personalities within these institutions do not only use this scientific knowledge about the potential for medical technology to act as a means of improving the livelihoods and life chances of the poor, but also to push for a globally backed strategy (such as those pursued by GHPs) in realising it[2]. They even mobilise world renowned celebrities to help promote and popularise global strategies on access to medication.[3]

In principle, the above claims appear compelling in the context of disease-endemic and poverty-ridden African countries. Despite several decades of international health policy interventions, Africa remains the hardest hit region when talking about the incidence and burden of both communicable and non-communicable diseases. For example by 2000, Africa accounted for about 80%

[2] Bellamy, C. (1999) 'Public, private and civil society' Statement of UNICEF Executive Director to the Harvard International Development Conference on *Sharing Responsibility: public private and civil society,* Cambridge, MA, 16 April; Brundtland, G.H. (2000) Towards a strategic agenda for the WHO secretariat: Statement by the Director General to the Executive Board (105th session, WHO: EB105/2.

[3] E.g. 'Celebrities lend their voices to children's fight against malaria' *WHO New Releases* 22/04/2004 <http://www.who.int/mediacentre/news/releases/2004/pr27/en/index.html> (Accessed: 01/06/09).

of 300-500 million world-wide cases of malaria detected annually (WHO, 2000; Feachem et al., 2002:5) and by 2004, 90% of an estimated one million world-wide malaria deaths (mostly children younger than 5 years were reported in Africa (Shetty, 2004: 319)[4]. Similarly, HIV/AIDS has hit hardest in Africa with about 29.4 million people living with the disease by 2002 (UNAIDS/WHO, 2002a:6). These examples illustrate the fact that access to medication is undoubtedly one of the greatest development challenges in Africa. Governments continue to struggle to implement a national health system needed to adequately deliver pharmaceutical and healthcare delivery while public health measures are challenged by traditional medicine, self-help treatments, alternative healings and the inability of the poor households to pay the costs of treatment (Essomba, Bryant & Bodart, 1993; WHO, 2002).

Increased awareness of these health crises has led to the development of innovative measures by a number of agencies to facilitate access to medication, and has brought some of the key actors together. Clearly, this new kind of approach put forward by GHPs is evidence of failures of previous policy efforts, but also when other factors such as the rising disease pandemics, prices of patent protected drugs, poverty and the challenges posed by globalization (Dodgson, Lee, & Drager, 2002; Piachaud, 2005) come into play. The severe lack of reliable access to medication for the 'poorest people' (WHO, 2005: 48), demonstrates the failure of African governments to build proper health systems capable of ensuring pharmaceutical and healthcare delivery on a sustainable

[4] For progress in the global fight against malaria see WHO/UNICEF (2005a) *World Malaria Report* <http://www.rollbackmalaria.org/wmr2005/html/introduction.htm> (Accessed: 21/01/07).

basis.[5] Thus, to achieve 'universal access' to medication in Africa many factors need to be considered by GHPs. Most notable are the nature of the health problem (which is related to public health), the resource constraints (which are rooted in economics) and the very nature of GHPs at global, national and local levels (which is related to institutional reforms).

Malaria and HIV/AIDS are typical disease areas to illustrate the nature of the above challenges. Having survived over 4000 years of human history,[6] malaria continues to be described as a disease of poverty caused by high annual entomological inoculation rates (EIR), tropical location of countries, population growth and movements, poor housing conditions, drug resistance and insufficient capacity of the health care system to deliver anti-malarial interventions (Gallup and Sachs, 2001; Feachem et al, 2002). While it was successfully eradicated in Europe and North Africa by the 1960s, it continues to take the lives of 700,000 African children annually and costing the continent $3-12 billions each year (UN, 2000a): 'Malaria is taking costly bites out of Africa ... It is feasting on the health and development of African children and draining the life out of African economies.'[7]

As a sexually transmitted disease, HIV/AIDS, despite being a more recent case, also poses daunting societal and resource constraints. First detected in 1981, HIV/AIDS quickly became a global pandemic with statistics showing up to 10

[5] Statistical evidence from various editions of the *Human Development Reports* is often cited by proponents of GHPs to demonstrate the lack of access to medication in Africa.
[6] More history on malaria: <http://www.cdc.gov/malaria/history/index.htm> (Accessed: 15/01/07)
[7] Former WHO Executive Director Dr. David Navarro speaking during the launching of the Africa summit to Roll Back Malaria in Abuja, Nigeria (UN, 2000a).

million people infected in 1990 (UNAIDS, 2000) and 38 million by the end of 2003 (UNAIDS, 2004:190). By 2002, the total number of deaths caused by HIV/AIDS had exceeded 20 million with Africa being the hardest hit region (UNAIDS, 2002: 5). Highly active ARTs that went into circulation in 1996 promised life-sustaining support for people infected by the disease. With US$8-10 average per capita spending on health for least developed countries (Dodd and Cassels, 2006:383) way below $10.000-15.000 for ART treatment in 1996 (Joseph, 2003:428), African countries struggled to contain the rising incidence and associated socio-economic burden of HIV/AIDS.

Apart from the above public health and economic challenges, the debate around the spread of HIV/AIDS in the face of high treatment costs in the late 1990s put the recognition of human rights as an essential element of public health policy on the global agenda, a concept that was only made implicit previously (Mann, 1999). The advocacy efforts of influential personalities such as former WHO Director Jonathan Mann (Fee and Parry, 2008), the rise of international civil society activism in response to economic globalization in the pharmaceutical industry and political activism by African leaders (Hill, 2006: 156-157)[8] made it even more urgent that a new kind of global approach to policy practices was needed to deal with the HIV/AIDS pandemic.

From the above perspectives, proponents claim that GHPs can help developing countries such as those in Africa to improve access to diagnosis and treatment and to develop better scientific and institutional mechanisms for the detection

[8] ACP-UP (2000) 'Treatment for all ... Now!' Global Manifesto, Durban, South Africa <http://www.actupny.org/reports/durban-access.html> (Accessed: 21/09/08).

and management of epidemics such as HIV/AIDS and malaria. They recognise that 'treatment is technically feasible in every part of the world'[9] as long as there is political will and 'sustainability of drug financing' (WHO, 2002a: 9). Apart from mobilising political will and funding, GHPs are also needed to create a national health system capable of distributing medicines and care facilities as well as delivering general healthcare services (Holms, 2001) irrespective of the abilities of governments and households to pay.[10] The PPP approach, haven worked in previous international campaigns such as the Mectizan Donation Programme, is being adopted by GHPs to address other disease areas (Etya'ale, 1998; Peters and Philips, 2004).

Despite the optimism about the role of GHPs as a panacea to the problem of access to medication in developing countries, technical studies commissioned by UN agencies and their affiliated academic institutions point to many controversial issues: the co-option of the values of African partners by UN agencies; overemphasis on reconciling the interest of UN-based agencies and private corporations; neglect of interfaces between institutions and structures of national vis-à-vis global health governance and the potential for GHPs to fragment or overwhelm Africa's national health systems.[11] These issues point our attention to the need to clarify some of these global controversies by exploring the practical ways in which medical technologies (such as deployed

[9] Statement by Dr Peter Piot, Executive Director, Joint United Nations Programme on AIDS during the International AIDS Conference in Barcelona, July 2002 (WHO, 2002:9)
[10] WHO/UNICEF (2003) *Africa Malaria Report*; WHO, Geneva; WHO (2002) 'Scaling up the response to infectious diseases: A way out of poverty' Ch 3:42-60, Geneva, Switzerland. <http://www.who.int/infectious-disease-report/2002/pdfversion/Ch2HealthServices.pdf> (Accessed: 21/10/07)
[11] Details of a combination of the issues raised here can be found in the following GHP studies: Frost and Reich 1998, Kickbusch & Quick 1998, Holm 2001, Buse 2004a, Caines and Lush 2004, Nishter 2004, Richter 2004a, 2004b, Piachaud 2005.

by GHPs) can be linked to the specific needs of the poor in developing countries through a country-specific empirical study.

GHP evaluations focus on statistical data that attempt to prove that global targets are met in the context of disease-endemic countries. More recently precise claims about 'localising' GHPs by applying programmes to meet country-specific needs are beginning to emerge. It marks a potential departure from the dominant terms of the debate, which initially revolved around global statistics, global policy documents in various regions of the world. Most GHPs are increasingly claiming to target global policies to the treatment of diseases in African country-context (WEF, 2005; Martens, 2007) and funding of R&D for Africa's diseases (Grace 2006). Yet, there remain some unanswered questions about the feasibility of GHPs solving the medical and healthcare needs of the poor in African countries, beyond the narrow objective of access to medicines, especially integrating GHP programmes as part of the national health systems (Carlson, 2004; Caines and Lush, 2004; Caines et al., 2004).

Apart from the issues above, Buse and Walt (2000b) had already identified two major challenges to be addressed for GHPs to claim country-specific achievements. First, it is not clear if GHPs have in fact succeeded in targeting resources at health problems and opportunities to strengthen existing infrastructures (such as the national health system). Second, the extent to which GHPs involve the national government (such as the Ministry of Health officials) in creating and implementing programmes and activities remains debatable. These claims, often reported in policy documents and technical

reports of GHPs (or individual GHP partners), need to be investigate through theoretically-informed country-specific empirical studies.

What we see from the discussion above is a problem of health development in the context of globalization, the interplay of GHPs and established bodies of thoughts (for example public health, economics and human rights) in both understanding and shaping institutions and local practices on access to medication. In many ways, each of these bodies of thoughts is relevant for achieving access to medication. In public health, ideas shape efforts to define the causes of diseases and their remedies as well as the process of developing preventive health policy (Tesh, 1988). In economics, ideas are powerful political weapons used by decision makers to shape the direction of the economy (Blyth, 2002) with implications for public health. Furthermore, it is no longer surprising to hear about the unavoidable significance of human rights ideas in the conceptualisation of health policy and practice (Mann et al., 1999).

Nevertheless what appears to be crucial in the case of GHPs is the interplay of ideas (or forms of knowledge) from public health, economics and human rights in relating to access to medication (e.g. Ngoasong, 2009). This is where the notion of embodied knowledge found in STS (MacKinzie, 2006) becomes useful for understanding the role of GHPs on access to medication. An STS approach involves analysing the link between technology and policy by side-stepping into established bodies of thoughts to uncover the scientific and technical expertise and the non-technical communications that are contributing to the production of context-sensitive knowledge (Gibbons, 2000: 162).

The technology, in this case of GHPs is the medically-based interventions and the dominance of the medical model promoted by the main global partners. The policy is the PPP approach that exists at global, national and local levels for ensuring that this technology is able to facilitate access to medication. In this case, GHPs breach the gap between technology and the public health needs of society. The concept of 'access to medication' used by GHPs appears therefore to represent the combination of the simultaneous pursuit of collective activism (or global citizenship) and good medical technology/science. If GHPs can achieve access to medication for the poorest segment of the global society, then proponents would have a powerful case for the implementation of this 'global model' in all countries of the world.

1.2 Objectives and Research Questions

The above optimism, questions and controversies reveal that the relationship between GHPs and access to medication is an interesting one. They all point to country-specific needs in relation to access to medication, the broader political economy of healthcare and the respective roles played by global (multilateral and bilateral organizations, MNCs, INGOs) and local (government, public and private sectors, civil society) actors in shaping the prospects of GHPs to facilitate access to medication in specific African countries. One question that begs to be explored in this debate is: what exactly is 'access to medication' and how best can GHPs deliver it in the context of the poor in Africa? In other words, how does the emergence of GHPs relate to the meanings ascribed to, and the country-specific barriers to 'access to medication'? Answering the above questions provide the basis for assessing the case for GHPs solving the

country-specific policy and institutional challenges relating to access to medication in African countries.

The aim of this thesis is therefore to investigate the role of GHPs in determining policy and local practices on access to medication in Cameroon.

The validity of claims that by providing access to medication for the poor implies GHP can deal with disease pandemic in African countries is interrogated through a set of inter-related investigations. First the underlying assumptions about the role of GHPs in Africa are analysed, which includes the global, national and local perspective on the emergence of GHPs as a new kind of model on access to medication. Second, the interplay of different constructions of 'access to medication' by the wide range of actors involved in GHPs is explored to better understand how the GHP model relates to the nature of the health problem. Both investigations are pursued within the analytical framework of models and the notion of embodied knowledge. Two case studies on GHPs for malaria and HIV/AIDS treatment and control in Cameroon respectively provide the setting for these investigations, leading to a comparative insight (one country with multiple disease areas in which GHPs are actively involved). The findings, in conjunction with the data from the case studies, provide the basis for an appropriate and well-informed consideration of the feasibility of GHPs solving the pharmaceutical and healthcare needs of the poor in African countries.

The specific research questions for this thesis are based on previous research on the conceptualization of 'GHP' and 'access to medication' and the relationship between the two terms. Although PPP appears to be the core term (Buse and Walt, 2000a: 550), Buse and Harmer (2007) propose the term GHPs to signify the shift away from geopolitical or historical relations towards more selective partner-recipient commitments, longer time horizons, responsiveness to recipient priorities and equality. This definition is relevant in this research because it best captures the involvement of non-state actors (NGOs, foundations, community groups), private industry, multilateral and bilateral agencies, and governments. GHPs can be categorised under three broad headings: policy-oriented organizations (Caines et al., 2004), institutionalised forms of organization (Buse and Harmer, 2007) and organizational ventures (Kaul, 2006).

Ngoasong (2009) identifies three narrative strategies used to relate to access to medication: public health (WHO/UNICEF), economistic (WTO/IMF/World Bank) and human rights (UNDHR) narratives respectively. The formation of GHPs is an attempt to pursue a global strategy on access to medication by integrating these narratives. Accordingly, the nature of demand and supply sides of access to medication (problem-oriented, patient-oriented, demand-oriented) and the necessary levels of commitment expected at global, national and local levels need to be understood in the context of these narratives, as well as the multi-stakeholder nature of GHPs. This involves investigating how the narrative strategies of GHPs partners are aligned and integrated with those of national governments and local communities as well as the opportunities for

continued dialogue to coordinate the efforts of global, national and local actors in providing access to medication for the poor.

The specific research questions that this thesis will answer are:

1. How best can the role of GHPs in facilitating access to medication be understood?
2. How does the global perspective on the emergence of GHPs relate to the history of the political economy of health development in Cameroon?
3. What effects do global-national-local linkages have on the effectiveness of GHP programmes?
4. What are the challenges of all the above for the future role of GHPs?

Access to medication is defined in this thesis in terms of potential access (the presence of healthcare) and realized access (the actual use of health services) (Andersen, 1995). Potential access include the availability and accessibility of healthcare taken into account the infrastructure needed to reduce the rural–urban differential and the time to reach a health facility for the poorest persons. Realised access is related to quality and acceptability of public health measures (preventive and curative) in relation to traditional medicine, self-help treatments, alternative healings and the costs of treatment (Essomba et al., WHO, 2002; 2005).

Despite the working definition of access above, it is ultimately the ways in which various GHP partners' conceptualised 'access' (whether potential or

actual) that determines the ways in which GHPs grapple to meets their target objectives. In order to investigate these questions the next section presents a brief description and justification of the theoretical and methodological framework and the choice of Cameroon as the setting for empirical case study analysis. The structure of the constituent chapters is then presented, giving brief overviews of their contents.

1.3 Framework and Methodology

The discussion on the emergence, conceptualisations and typologies of GHPs reveals different manifestations of public health, economics and human rights narratives by key actors and institutions whose existence directly or indirectly implicate the creation of GHP models. Buse and Walt (2000a: 551) illustrates this in terms of ideological shifts informed by changes in economic philosophy and socio-political orthodoxy in UN-based agencies. This suggests that each narrative represents a form of knowledge; each emerged from previous theoretical models and later expressed in international meetings for incorporated into GHP programmes. The notion of transcalar networks is used to conceptualise the 'social spaces' through which global, national and local interactions take place in a GHP context[12]. The three narratives play important roles both in the construction of access to medication in GHPs and the constitution of transcalar networks (global-national-local linkages) through which different GHP partners contribute to policy making and implementation.

[12] The notion of transcalar network for policy transfer and implementation is developed further in Chapter 2 as a better conceptualisation of interactions between global, national and local GHP partners. It is preferred to transnational networks used to study international health policy transfers (e.g. Reich 1995, Walt et al. 2004) as it better reflects the contemporary era of globalization (Castells 2000, Compagnon 2008)

This thesis therefore builds on the theoretical literature on models and the notion of embodied knowledge to provide a conceptual framework on which these claims can be examined in more detail. Specifically, the framework illustrates the basis on which the three narratives on access to medication are embodied in GHPs, and how the emergent GHP model in turn shapes policy practices on access to medication. The study of GHPs as models is relevant in two ways. Firstly, it highlights where to look for answers to questions on GHPs that are not captured by the development studies literature. This is achieved by unpacking the systematic forms of knowledge (MacKenzie, 2006) deployed in (medical) technology and with their social infrastructure (Callon, 1991). Secondly, it reveals the extent to which the models link theory and practice, and the opportunities they offer to introduce new practice elements in the models to better reflect practice settings (Cartwright, 1983; Morgan and Morrison, 1999). Accordingly, the thesis conceptualises GHPs as 'models' that occupy the intermediate position between theory and policy practices and analyses how the public health, economistic and human rights narratives embodied within the GHP model shape different elements of policy practices on access to medication.

The analytical tool is social constructivism, a social science perspective that can be used for understanding global institutions (Boas and McNeil, 2004), but which so far has received limited attention in the case of GHPs. Within this approach narrative policy analysis (NPA) has been selected as the method of empirical analysis. NPA relies on 'the explanatory power of story' (Kaplan,

1986), 'drama' and 'historical narratives' in understanding 'big decisions' (Krieger, 1986; Doron, 1986; Roe, 1989; Feldman et al., 2004). Accordingly, it allows us to conduct a content and context analysis of the 'range of complex characteristics and distinctive narratives' surrounding the contexts within which GHPs grapple with meeting targets for successful healthcare delivery in Africa (Ngoasong, 2009:950). This involves a systematic reading and analysis of secondary literature (policy documents, technical reports, books, and journal and magazine articles) and qualitative interviews with representatives of selected global, national and local partners of two GHP programmes in Cameroon:

I. **The National Malaria Programme** created after Cameroon endorsed the WHO/UNICEF-led Roll Back Malaria partnership (RBM). The RBM puts forward a public health narrative that 'aims to help African families create a mosquito-free zone in the home'[13] by creating a tri-sectoral network (global, regional and local levels) to strengthen national health systems to reduce malaria mortality by half by 2010 (WHO 2000a; WHO/UNICEF, 2005). The functional focus of the RBM is advocacy coordination (Buse, 2004a:227). It seeks to harmonise or bring strategic consistency to the approaches of various actors to single diseases, as well as to raise the profile of the disease on the health policy agenda (Buse and Walt, 2000b:702).

II. **The National HIV/AIDS Programme** created after Cameroon endorsed two GHPs: 1) Accelerating Access Initiative (AAI) launched

[13] RBM Campaign Manager Dr. Awash Teklehaimanot (UN, 2000a)

in May 2000 by five UN agencies and five pharmaceutical companies[14] to facilitate access to patent-protected HIV/AIDS medication through discounted pricing (UNAIDS/WHO, 2002); 2.) Equitable Access Initiative (EAI), a human rights model promoted by Medecin Sans Frontiere (MSF) to facilitate access to generic treatment in poor countries through generic competition (MSF, 2002). The functional focus of the AAI is to broker price discounts for patent-protected drugs through negotiations between developing country governments and pharmaceutical companies (Buse 2004a:227) while the EAI performs the same function, but with generic manufacturers.

In terms of potential access, both RBM and AAI attempt to empower governments to emphasise health system strengthening through political commitment and capacity development (Caines et al. 2004, Carlson 2004, Buse and Harmer 2007:261). The choice of Cameroon is very instructive. Apart from its rich colonial, political economy and cultural-ethnic diversity (Kofele-Kale, 1986; DeLancey and Mokeba, 1990; 2000), Cameroon has always been one of the first African countries to endorse international/global initiatives and therefore presents a rich historical context in which the emergence and impacts of GHPs in Africa can be understood. The choice of GHPs from two disease areas is also very significant, malaria with a long history of failed eradication campaigns on the one hand and HIV/AIDS (with a shorter history) as one of the most popularised global pandemic. The two case studies from Cameroon

[14] (WHO, UNICEF, UNPF, World Bank, UNAIDS) and (Boehringer Ingelheim; Bristol Myers Squibb; F. Hoffman-LaRoche; GlaxoSmithKline; Merck and Co., Inc; Pfizer); Abbott and Gilead joined the initiative two year later).

therefore allows for a nuanced analysis of the country-specific role of GHPs in shaping polices on access to medication.

1.4 Organization of Thesis Chapters

The second chapter develops in detail the conceptual framework that will be used to study GHPs in this thesis. It begins with a more detailed overview of the reasons why GHPs have proved to be controversial despite their popularity, why the needs of the poor initially seem cogent with regards to the situation of Africa's poor and the importance of the way access to medication is constructed in the study of GHPs. It then justifies the use of theoretical literature on models by reviewing its interpretations and ramifications in the philosophy of science, management science and social sciences. The notion of embodied knowledge is justified as a suitable theoretical framework for the study of models. This approach has already been used to analyse the relationship between models and policy practices in socio-technical systems (Callon, 1991; King and Kraemer, 1992) and global financial markets (MacKenzie, 2006). However, a review of theoretical approaches to the study of global institutions reveals that, it has not been applied in a social policy arena, such as those in which GHPs operate. A social constructivist approach (Boas and McNeil, 2004), notably NPA (Ngoasong, 2009) is shown to be consistent with the theoretical literature on models and provides a useful framework for analysing the transcalar networks through which GHPs shape policy practices on access to medication.

The third chapter explains the social constructionist qualitative case study methodology to the study of GHP programmes. The critical assessment of the links between the range of complex characteristics and distinctive narratives constitutive of GHP programmes begins with a re-examination of the agenda of researching transcalar networks. It then follows Kaplan (1986), Krieger (1986), Roe (1989), Feldman et al., (2004) and Ngoasong (2009) to develop a methodology for the identification and study of the relevant contextual features in the policy processes and structures enacted by GHPs in Cameroon. This methodology is developed to study the implicit and explicit forces, which constitute transcalar networks (global-national-local linkages) constituting GHP programmes.

Chapter four presents the link between public health, economistic and human rights narratives on access to medication including the key actors and institutions who initiated them. In particular, the chapter presents the global perspective on the emergence of GHPs. It begins by investigating the theoretical origin of development models from which each of the public health, economistic, and human rights narratives emerged from the early 1900s and how they came to play important roles in GHPs from the late 1990s. It then describes how each of these narratives are embodied in RBM, AAI and EAI (three GHP models studied in this thesis).

Chapter five presents the historical and contextual background of the case studies by exploring the emergence of GHP programmes in Cameroon. It aims to extrapolate the main history of state building, the most important actors and

institutions and the context in which GHP models come to play an important role on access to medication. What emerges is that GHP programmes represent the embodiment of competing development models that were previously implemented in Cameroon during the colonial and post-colonial periods. The historical context presents for analysis of how donor-recipient commitments (North-South divide) and the centrality of the state (pre-GHP era) have been replaced by public-private partnerships that tend to bypass the state to better serve the local communities (GHP era). This blurring of the boundaries of North-South relationships is crucial in determining the role of specific GHP programmes on access to medication.

Chapter Six presents the first case study findings and analysis on the National Malaria Programme in Cameroon. It applies the theoretical framework developed in chapter two to answer the research questions. Following the same approach, Chapter Seven presents the second case study findings and analysis on the National HIV/AIDS Programme in Cameroon. Finally, conclusions, policy implications and the theoretical contributions of this research are presented in Chapter Eight.

CHAPTER 2: UNDERSTANDING THE DEVELOPING ROLE OF GLOBAL HEALTH PARTNERSHIPS: A REVIEW OF THE KEY LITERATURE

2.1 Introduction

The objective of this chapter is to develop a conceptual framework for studying the role of GHPs in determining policy practices on access to medication. The chapter argues that the theoretical literature on models and the notion of embodied knowledge found in STS can be combined with social constructionist international relations theory when studying GHPs. Accordingly, the theoretical framework developed conceptualises GHPs as models that occupy the intermediate position between theory and policy practices. To develop such a theoretical framework the chapter reviews four key sets of literature each of which make a contribution to the generation of an effective conceptualisation and analysis of the role of GHPs on access to medication.

The first section reviews the literature on the definitions and meanings of GHPs and access to medication. It identifies the key actors in global health and their respective narrative strategies in relating to access to medication. The reason why the notion of GHPs has proved to be controversial despite being highly popular with UN agencies is evident from the fact that the definitions and typologies of GHPs do not explicitly define access to medication (and

consequently the best policy measures to achieve it). However, a review of the historical context in which GHPs emerge in Africa suggests that access to medication is a historical construct that enables GHPs (through UN agencies) to introduce policy issues on a global and national level. The historical contexts describes GHPs as an attempt to integrate three previously conflicting constructs (or narratives) on access to medication – public health, human rights and economistic. More importantly, it reveals why the needs of the poor initially seem cogent with regards to the situation of Africa's poor and the importance of the way access to medication is constructed in the study of GHPs.

The second section reviews the literature on the relationship between theory, models and policy practices from science, social science and STS perspectives respectively. It argues that the notion of embodied knowledge is useful for explaining the sociology of knowledge embedded in GHPs. While this approach has mostly been applied to socio-technical systems, recent applications in more social policy settings suggests that it can successfully be applied to a global health policy domain such as the study of GHPs and access to medication. A case is therefore made for GHPs to be conceptualised as models that mediate between theory and practice as a way of understanding their emergence and their role in shaping policy practices.

The third set of literature focuses on the theoretical approaches to the study of global institutions (Boas and McNeil, 2004), with emphasis on those relevant for the study of GHPs. The analysis suggests that a social constructivist

approach, which so far has received very limited attention in the study of GHPs, is more suitable than liberal/neo-liberal perspectives (which to date dominate the literature and interpretations), realist and neo-Gramscian theories in international development. In view of this social constructivist perspective, the notion of transcalar network is introduced as a way of conceptualising the 'social space' through which global, national and local interactions take place within a GHP context while narrative policy analysis (NPA) is presented as the method of analysing these interactions. An STS perspective on the role of models in policy practices is consistent with a constructivist approach (the social construction of technology) and provides a useful framework for investigating the role of GHP models in access to medication.

The fourth section explains further the choice of transcalar networks and NPA for conceptualising and analysing GHPs as models. Firstly, theoretical concepts from policy transfer (Dolowitz and Marsh 2000), multi-level governance (Marks 1993, Marsh 1998), and the 'politics of scale' (Brenner 2001) are used to conceptualise the policy transfer process in GHPs as taking place within *transcalar networks* (global-national-local linkages). Unlike rational planning approaches proposed by liberal interventionists (Dodgson et al., 2002), GHPs rely on negotiating and integrating competing narratives, advocacy and sometimes activism in formulating global policies (Ngoasong, 2009) that are transferred to developing countries. NPA then becomes useful for uncovering the key policy agendas that often remain hidden (mostly implicit) in global and national policy documents and technical reports.

Finally, the theoretical framework for studying the role of GHPs on access to medication is presented. Conceptualising GHPs as models that mediate between theory and practice enables us to better understand the ways in which GHPs are able to develop a global language and a single global strategy that is supposed to be used to shape national health policy and local delivery practices on access to medication in poor countries. The competing and conflicting narratives on access to medication and the strategic objectives of GHPs partners represent manifestations of forms of knowledge within GHPs leading to the creation of GHP models. These manifestations in turn explain why there are specific GHPs for specific diseases areas, why certain GHP 'models' are favoured in specific countries and contexts, the factors perceived to have driven African countries to embrace GHPs and the impact of GHP on access to medication.

2.2 GHPs and Access to Medication – Definition of Key Terms

Since the late 1990s, GHPs have being formed to provide a global collective response to the problem of access to medication in developing countries. Understanding what GHPs are is useful in understanding how they are modelled and how they are expected to shape policies on access to medication to achieve their target objectives. This section presents the different ways in which GHPs have been defined and their relationship to the meaning of access to medication in the context of African countries.

2.2.1 Definition and typologies of GHPs

Most studies on GHPs have focused on defining what a GHP means, discussing how they can be conceptualised and examining their impact on access to medication. In the presence of confusion over a generic definition of the term GHP, Utting and Zammit (2006, iv) over-state the case with their claim that the term GHP has become an *'infinitely elastic concept'*. Typical of the various definitions is the use of terms such as partnership, public-private, global and trans-national or cross-border.

Partnership appears to be the core term. Pearson (1969) used *partnership* to signify the relationship between donors (e.g. WHO, World Bank) and recipient countries (poor and disease-endemic countries), based on reciprocal rights and obligations and the establishment of clear objectives that are beneficial to both parties. Later conceptualisations focus on broader 'development' partnerships (World Bank 1998) that stress the need to include the ethical principles of 'beneficence, non-maleficence, autonomy and equity' (WHO 1999:4). This perspective calls for the need for partnerships to lead to public health gains, improve health and healthcare, respect the autonomy of all stakeholders and distribute benefits to those who need them most.

In a study of post-1990 partnerships, Buse and Walt (2000a: 550) propose the term global public-private partnerships (GPPPs) for health development. It refers to 'a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a

shared health-creating goal on the basis of a mutually agreed division of labour.'

From the above definition, Buse and Harmer (2007) propose the term global health partnerships (GHPs) to signify the shift away from geopolitical or historical relations towards more selective partner-recipient commitments, longer time horizons, responsiveness to recipient priorities and equality. This definition is relevant in this research because it best captures the involvement of non-state actors (NGOs, foundations, community groups), private industry, multilateral and bilateral agencies, and governments. Consistent with the above definitions of GHPs, there are three broad categories or typologies of GHPs: policy-oriented organizations (Caines et al., 2004), institutionalised forms of organization (Buse and Harmer, 2007) and organizational ventures (Kaul, 2006).

GHPs as policy-oriented organizations

Caines et al., (2004) provide a comprehensive study on GHPs as policy-oriented organizations that pursue a combination of four objectives. 1) 'product discovery and development of new diagnostics, drugs and vaccines'; 2) 'support improved service access, may provide discounted or donated drugs, and give technical assistance'; 3) 'raise the profile of the disease and advocate for increased international and/or national response, and resource mobilization' and 4) 'provides funds for specific disease programs'. This descriptive, policy-oriented conceptualisation illustrates that GHPs can be categorised within more than one typology. Buse and Harmer (2007: 260) note that approximately 80-100 GHPs created in the last two decades fit into this policy-oriented typology.

They argue that better criteria for evaluating GHPs should focus on broad composition and the presence of actors from all sectors in board-level decision-making processes, an approach they use to reduce the number of GHPs to 23.

GHPs as institutional relations

According to Buse and Harmer (2007), GHPs are institutional forms of organization through which private actors participate in the strategic level decision-making in the public's interest. They identify three sub categories of GHPs: 1) *Elite Committee models* where relative equality of partners ensures negotiations lead to consensus (citing the Accelerating Access Initiative as a typical example); 2) *NGO Model* emphasises delegation and resource transfer (such as the work of international NGOs and community organizations); 3) *Quasi-public authority model* is one where a hybrid organization with both public and private characteristics is created by public sector institutions (citing both the AAI and the RBM as having these attributes). The notion of 'hybrid' is useful in this categorization because it reveals the multi-stakeholder character of GHPs as captured in the definition of GHPs by Buse and Harmer above.

GHPs as organizational venture

Kaul (2006) proposes a comprehensive typology that can be used to classify GHPs as organizational ventures, that is, a purposeful or industrious undertaking that requires readiness and boldness. In this typology he distinguishes between *domestic* and *global* PPPs, showing the latter to be more effective for leveraging resources for infrastructure developments such as

'construction and operation of airports, hospitals, roads' in relation to the largely state-centric models of the World War II era (Kaul, 2006:219). Through a study of 100 GPPPs, he presents 'three venture classes and seven functional types' of partnerships (business ventures, double-bottom line ventures and social ventures), designed to provide a working analytical model through which partnerships can be examined and conceptualised (p. 223). Within this typology the social venture class and two functional types (Type 5 and Type 6) are particularly applicable to GHPs since they capture issues that are related to the policy-oriented typologies of Caines et al., (2004) and Buse and Harmer (2007) discussed above. The social venture class refers to global partnerships (such as GHPs) that are 'oriented toward public service' (p. 235).

From the definitions and typologies above, the definition of GHPs as 'relatively institutionalised initiatives, established to address global health problems, in which public and for-profit private sector organisations have a voice in collective decision making' (Buse and Harmer 2007:259) appears suitable for capturing the global context of the types of challenges they are created to face. GHPs can be product-based (e.g. drug donation programmes), product development-based (such as vaccine development) or issue/systems based (harmonise approaches of different actors) (Buse and Walt, 2000b). All the studies reviewed above make reference to the following specific functions of GHPs in relation to access to medication:

- *Access to pharmaceutical products for the poor:* GHPs provide pharmaceutical corporations with the enhanced corporate legitimacy of UN-based agencies to penetrate commercially unattractive health

markets; and funding for pharmaceutical innovations (leading to the availability of drugs, supplies, training services and disease management). The development of vaccines by IAVI (Chatawaya and Smith, 2006) and drug donation programmes and bulk purchase of ARTs by AAI are much cited examples).

- *Access to a strengthened national health system:* GHPs can better integrate programmes and activities into the national health system to 'improve effectiveness and ensure impact and sustainability' (Bruce and Harmer, 2007). RBM is a much cited example (WHO/UNICEF 2003; WHO 2006)
- *Advocacy for political commitment and resource mobilization:* GHPs promote priority programmes and empower governments to put more emphasis on health system strengthening through capacity development (Caines et al., 2004; Carlson et al, 2004; Buse and Harmer 2007: 261).
- *GHPs are 'issue-specific' and designed for quick results:* This objective of GHPs relates to the challenges involved in attempts to align global policies to implementing countries' priorities, systems and procedures and to align with development aid (Carlson, et al., 2004; Buse and Harmer, 2007).

Most of the above studies reveal that for GHPs to be effective, the interests of global, national and local stakeholders with both shared and competing interests must be taken into consideration when designing global policies. All the studies reviewed call for country-specific studies to test and assess the above claims. Despite the comprehensive analysis of the history of health partnerships studied and the impact of GHPs, neither of them defines 'access to

medication' nor discusses explicitly where the emphasis on access should be placed. The next section explains the meaning of access to medication in the context of the emergence of GHPs in Africa.

2.2.2 What is Access to Medication in the context of GHPs?

This section describes the historical context in which GHPs emerge in Africa and identifes key actors and their respective narrative strategies on access to medication.[15] This is seen as a first step towards identifying the origin of the different forms of knowledge through which GHPs shape health policies and local delivery practices. In this respect, Ngoasong (2009) conceptualises 'access to medication' as a construct that has been used in the policy literature. This can be seen in the traditional contrast between potential (the presence of healthcare measured as availability and accessibility) and actual or realised (the actual use of health services as measured in quality and acceptability/affordable) access to medication (Andersen, 1995).

As a historical construct, access to medication has been defined implicitly in the policy literature on Africa using narratives and counter-narratives. Table 1 below, reveals the main actors and their narrative strategies around access to medication in different historical periods in Africa's colonial and post-colonial history.

[15] This section is adapted from my recent article: Ngoasong, M.Z. (2009) The Emergence of Global Health Partnerships as Facilitators of Access to Medication in Africa: a narrative policy analysis. *Social Science & Medicine* 68(5): 949-956. The article uses NPA to analyse the historical context in which different narratives on access to medication emerged leading to the creation of specific GHPs, with RBM and AAI as case studies.

Table 1. The historical context of access to medication in Africa

Conventional time line	<1950	1950-70s	1970s - 1990s	>1990s
Scope of Policy	Colonial	National vs. International	National vs. International	National vs. Global
Development Policy	Colonialism (Dictatorship)	Government (Planning)	Government (Privatisation & Regulation)	Governance (Global Health Partnerships)
Policy Maker	Colonial Master	The States and Colonial Masters	States & International Organizations	State & Non-State Actors
Health Policy Goal	Curative & Preventive	Curative & Preventive	Medical & Non-medical interventions	Access to medication

Source: Adapted from Ngoasong (2009)

Unlike the former colonial masters and transnational/multinational corporations with a long historical presence, the role of international organizations became more influential from the 1970s when national health policy goals in Africa were largely influenced by the WHO and UNICEF, while development policy was the domain of the IMF and the World Bank. Other UN agencies (WTO, UNAIDS and Global Fund) and stakeholders such as international CSOs and foundations emerged in the 1990s. These stakeholders agree on the goal of access to medication: 'every human being should have access to treatment irrespective of ability to pay' (Ngoasong, 2009:950). However, they differ on how this should be achieved. Those differences are systemic, and point to three emerging narratives on access to medication – public health, human rights and economistic narratives respectively.

The public health narrative is rooted in the 1978 WHO/UNICEF-led Primary Health Care (PHC) model that emphasises medical (curative) and non-medical

(preventive) determinants of health. The economistic narrative is rooted in the WTO-led TRIPS Agreements (affordability and accessibility of patent-protected medicines) and the IMF/World Bank-led neo-liberal market models (privatisation and liberalization of public utilities including healthcare) promoted in many developing countries. Finally, the human rights narratives are rooted on the Universal Declaration of Human Rights (UNDHR), later taken up by CSOs to challenge the economistic narrative. The article argues that the formation of GHPs is an attempt to integrate these narratives and stakeholders to address the following challenges:

> Government and market failures to provide public goods to the poorest and most vulnerable people ... Widespread bureaucracy, infighting and inefficiencies among multi-lateral and bilateral agencies and the need to foster collaboration with the private industry ... An 'unavoidable necessity' in harnessing the resources to address global health issues and the challenges posed by globalization. (pp: 952)

The discussion contrasting economistic, public health and human rights narratives on access to medication is especially significant because it suggests that full access to medication in the moral sense (potential and actual) has never existed in practice in Africa. The article illustrates this argument using two case studies on RBM and AAI. It emphasises that the need for an enabling environment for GHP programmes, the importance of 'potential' rather than 'actual access' to medication, and the problem of privileging the prices of drugs over the quality of care are three issues that make the emergence of GHPs as controversial and worth exploring further. All of these issues need to be taken into consideration to better understand the effectiveness of GHPs in achieving access to medication.

On the basis of the above categorization of GHPs and the historical context in which they emerged in Africa, it can be seen that the relationship between GHPs and access to medication is a complex one. There is confusion over the nature of demand and supply sides of access to medication (is it problem-oriented, patient-oriented or demand-oriented?) and their relationships; the necessary levels of commitment expected at community, country and global levels; and the strong position of pharmaceutical companies vis-à-vis civil society activism. What does emerge is that a mix of colonial, post-colonial, international and global health agenda created in the context of western ideologies were forced onto African countries. For example, it has been suggested that the strategic interest of UN and other bilateral agencies override those of developing country governments during GHP-related consultations (Holm, 2001; Caines and Lush, 2004; Nishtar, 2004). There are also claims that the monopoly of power of pharmaceutical companies puts national governments in a disadvantaged position when negotiating drug prices and supply arrangements (Buse 2004a). A study of the narrative strategies of GHP partners, such as those studied in this thesis, needs to be understood in these contexts – how they potentially influence global-national-local interactions in formulating and implementing policies.

Nevertheless, the narrative strategies of GHP partners in relating to access to medication direct our attention to the need to explore, theoretically and empirically, the role of GHPs as facilitators of access to medication in this thesis. This involves investigating the setting in which important dialogues, negotiations and learning among public, private and civil society organizations

at all levels take place, as well as the opportunities for continuing dialogue, collaboration and negotiation to coordinate the efforts of global, national and local actors in providing access to medication for the poor. This will include an exploration of how the narrative strategies of GHPs partners are aligned and integrated with those of national governments and local communities, and the impact this has on ultimately determining the potential of GHPs to achieve country-specific objectives. It is this notion of alignment and integration of economistic, public health and human rights narratives that provide the basis for conceptualising and studying GHPs as models that mediate between theory and policy practices. To establish the conceptual framework, the next section reviews the literature on the interplay of theory, models and policy practices as relevant to the context of GHPs.

2.3 Theory, Models and Practice

At first glance, neither GHPs nor access to medication are in the realm of theory. Access to medication is a specific problem, requiring an effective remedial practice. GHPs have emerged as a way of dealing with both the presenting problem and organisational and stakeholder challenges to develop and implement such a practice. As such, GHPs offer a new an interesting model of mixed-stakeholder intervention, a model that is devised to be practical both in terms of its intent and the context within which it operates. However, the GHP model is animated by more than practical considerations. This model is also informed by theoretical traditions, the range of which reflects the nature and history of the various stakeholders contributing to the GHP approach. Accordingly, it is necessary to discuss the nature of a model, in

order to understand the impact of differing theoretical perspectives on the GHP model and the interplay between theory and practice. Finally, to understand this model is a prerequisite to developing the most appropriate way of analysing it.

2.3.1 Traditional Conceptualisation of Models

Within philosophy, science or the social sciences there is no generally agreed theoretical and practical definition of a 'model' (Fetzer, 1999; Johnson-Laird and Byrne, 1999; Morgan and Morrison, 1999; Morton and Suárez, 2001). However, by understanding the general notion of what a model is it becomes easier to examine the theoretical foundations under which models are developed as well as the relationship between models and policy practices. Although no one perspective captures a generalised use of 'model', what matters here is the intent to do so in the context of the interdisciplinary approach to this research.

Studies on models are usually traced to the 1960s. During this period, the process of rebuilding theory, theory change and scientific discovery motivated scholars within the philosophy of science to study models and model use (Hesse, 1966; Bailer-Jones 1999:31; 2003). The earliest writers conceptualised models as analogies and metaphors that shaped scientific reasoning. For example, Hesse (1966) used analogies to demonstrate that models play a creative role in science. Models, to her, are analogies on which a new theory is conceived from a pre-existing theory. However, she claims that although the properties that characterise the model are analogies of a pre-existing structure, the new theory is not identical with those of the model (Hesse 1966:8). In this

case, models shape developments in theory while analogies distinguish between new and old theories.

Other studies on models emphasise 'manipulability' and 'workability' by creating typologies of models to account for the variety of models in science. Much cited are Black's (1962:220) *scale models,* which, he claims, help us to reproduce selected features of 'original' three-dimensional models in physics. Achinstein's (1968) *representational model is* another example. He argues that 'Instead of investigating an object directly, the engineer may construct a representation of it, which can be studied more readily" (1968:209). In these cases a model is defined as a representation of reality in ways that embody theoretical principles.

More recently, scholarly work on models identifies two commonalities among the studies on models in the 19960s: the emphasis on the sciences (such as mathematics, physics, chemistry and computer sciences); and the treatment of models as either abstract or physical entities. As *abstract entities,* models are direct or indirect representations of the thoughts and ideas of people (Suppe 1977; Giere, 1999). This means that once a theory is formulated, it is used to develop a model, such that the model in turn becomes an interpretation (based on empirical analysis) within which the theory can be considered to be true or false (Giere, 1999; 2004). As *physical entities,* models are real world objects that have an imperfect isomorphic relation to another object (Suppe, 1977). These studies explain how models are predominantly used in practice, for

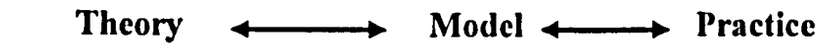
example, as instruments of instruction and as platforms for further empirical investigation.

The objective of this research is not to define or prove the relationship between theory, model and practice, but to investigate how models are developed and how they affect practice. Van Fraassen (1980:64) claims that although early scholars on models (including those cited above) were originally motivated by considerations of the role of models in practice, they ended up overemphasising different aspects of the development of models of science. In terms of practice, Cartwright (1983) investigates the relationship between the theoretical principles of physics and the phenomenological laws that they tried to capture (amid the messiness and complexity of data): 'the route from the theory to reality is from theory to model, and then from model to the phenomenological law' (p. 4). The development of models, he argues, is a pragmatic activity involving adjustments that are based on the objective to be achieved rather than the literal suitability of such adjustments.

Morgan and Morrison (1999) draw on the ideas of earlier works (Cartwright, 1983; Nagel, 1961; Hesse, 1966) to conceptualise *models as mediators*. They claim that this scientific conceptualisation of models does not aim to distinguish between a model and a theory, but provides the foundation on which the role of models in practice (or world as they put it) can enable such a distinction (Morgan and Morrison, 1999:12). They stress the epistemic importance of building and manipulating models as a way of mediating between theory and practice in two ways. On the one hand, a model can be

autonomous from theory and practice where it is the product of attempting to integrate both. On the other hand, a model can be an *instrument* whose representative nature provides the tools with which the relationship between theory and practice can be better understood.

Figure 1. The relationship between theory, model and practice



The above literature review provides three interesting insights about models and their roles in practice. Firstly, models link theory and practice by occupying a middle space between them (see Figure 1. above). Secondly, a model may offer the opportunity to manipulate or introduce new elements to better explain why and how the elements are connected to different theoretical and practical settings, as well as illustrate the circumstances under which they may be considered as autonomous. Thirdly, a two-way causation may exist in cases where models take their representative cues from both theory and practice in similar ways although there may be an overlap in the practicality of the direction of causation.

2.3.2 The place of models within disciplinary traditions

The use of 'disciplinary traditions' to review studies on models in this section is justified on the basis of the preference for an interdisciplinary STS approach to this thesis. As mentioned in the introduction, this approach allows us to side step into other disciplines to understand not only knowledge production but the interplay of different forms of knowledge. In this context, there is distinction between the place of models in science and social science disciplinary

traditions in which the latter is shown to be more attractive for analysing GHPs. Within the social science disciplines (for example STS, development studies, international relations, sociology, globalization policies) reference is made to key aspects of some social science approaches on the basis of a critique of positivism. The framework developed in this chapter therefore side-steps into these disciplines to capture the complex social realities necessary for understanding GHPs in a non-positivist way. This explains why the analysis draws on some apects of an STS approach and some aspects of the discipline of international relations (namely, its social constructivist variant).

The role of models in policy practices (policy formulation and implementation) was already a subject of intense debate in the 1960s, the same period when the study of models became popular. However, the object of study was not the relationship between theory, model and practice that was emphasised by scholars in the philosophy and practice of science reviewed above. Scholars in management sciences emphasised the extent to which models can be trusted in decision-making (the practice domain). A much cited proponent is Herbert Simon's bounded rationality approach to the study of models in management sciences. Simon and colleagues developed and studied computer models of decision-making, which they claim provide the '*correct answer*' that decision makers need to achieve policy objectives (Simon, 1960:40-43; 1991; Newell and Simon, 1963; 1972). Counter arguments emerged from the 1970s in science (Greenberger et al., 1976; Brewer and Shubik, 1979) and management science (Radnor, et al., 1970; Fromm, et al, 1975; Schultz and Sleven, 1975; House and McLeod, 1977), questioning why some models lead to more

successful policy outcomes than others (if Simon's claims were realistic). These opponents point to implementation issues as the principal challenge.

Dantzig (1979:10) identifies the complexity involved in the implementation of models (as against the material foundation of models) as the answer to the question of why some models perform better than others. He claims that as 'politicians and the public demand simple answers to complex issues, the search goes on to find ways of expressing policies in simple terms', and concludes that models do not provide for this dynamic flexibility. Exploring this complexity, he defines a model as 'a black box ... it is possible, however, to observe the various inputs into it or outputs from it' (p.11). He distinguishes between three types of models: 1) a model of *ignorance* (one whose inner workings are a mystery or not known); 2) a *linear* model (one whose inner workings are exogenous or assumed to be known), and 3) a model of *alternative processes* (one whose inner workings is known and can be adjusted).

Studies such as those of Dantzig (1979) provide a basis for questioning the rationalist assumption of science and management sciences on the role of models. King and Kraemer (1992) take on this argument by claiming that the problem of why some models perform better than others lies in the overlapping treatment of models (whether implicitly or explicitly) as either science or non-science. They distinguish between scientific models (such as Geographic Information Systems) and social science models (such as macro-econometric simulations) in terms of their acceptability in a policy process. They argue that

the policy relevance of scientific models as 'the truth' that is 'always right' (p.10) has been moot, as the word 'science' has become something of a euphemism when considered from a social science perspective. Thus the findings of social science are dismissed on the basis that its 'modelling' is unscientific. However, this judgement betrays not only an uncritically positivist perspective, but appears uninformed about all other approaches to the generation of social scientific knowledge.

This points out attention to the general preference for a methodology that is social constructivist in other to be able to investigate and account for allegedly 'correct' or 'scientific' beliefs in the same way as 'incorrect' or 'unscientific' beliefs. Studies in the 'Sociology of Knowledge' become very relevant in this context. In a review of realities and relationships within social constructionism in relation to pioneering works by Barry Barnes (1974) and David Bloor (1976), Gergen (1995:43) presents the case for a social constructionist perspective as follows:

> '...virtually all scientific accounts are determined by social interests – political, economic, professional, and so on. In effect to remove the social from the scientific would leave nothing left over to count as knowledge'

The above comparisons between scientific and social science models are very relevant in the context of the social construction of technology in STS, the approach in which models are studied in this research. STS scholars have recently began to treat technologies as models; however, rather than treat it as a *'black box'* model, the social shaping approaches within STS study view technology as an 'engine of enquiry' (MacKinzie, 2006). Technology shapes

human perception of the world; it does not completely replace human abilities (Mackenzie and Wajcman, 1987; 1999). In addition, those developing new technologies in turn impose their own human limitations upon society (Latour, 1999). Thus, as models, technology mediates theory (creators of technology) and practice (effects on society).

The above interaction between technology and society takes place in what STS scholars call socio-technical systems. MacKinzie (2006) defines socio-technical systems involving hybrid networks of social institutions as models that embody different forms of knowledge. He argues that the best way to understand the nature and functions of models created by such a network is to unpack the forms of knowledge, examine how they are embodied in models and how the models in turn shape policy practices. For example, the choices made by designers and users of technology (not the technology) determine whether *access* to that technology can be achieved (Dutton, 1992). Once access to technology becomes feasible, a broad range of processes in which people and institutions constantly interact shapes the impacts of that technology on society (Danzinger and Andersen, 2002). Thus, a model cannot simply be an '*answer machine*' that provides policy makers with the '*truth*' about a given situation (King and Kraemer, 1992:7), as scientific and management literature predicted. It is instead the multitude of interactions among actors who develop and/or implement models that determines the ultimate outcomes tied to models.

It is this notion of embodied knowledge that suggests an STS perspective on the social studies of models can successfully be applied to the study of GHPs.

Although STS approaches have mainly been used to analyse things that are technical, the argument made here is that they can also be used in a social and public policy arena such as GHPs. Within GHPs people and institutions constantly interact in a hybrid network in the same way as they do within socio-technical systems. GHPs also consist of hybrid networks involving multiple interactions among those actors who create GHP models and those who use the models to formulate and implement policies on access to medication. Furthermore, hybrid networks such as GHPs have been characterised as 'social technologies' (models) that serve as brokers and integrators (model as mediators) between creators (theory) and users (policy practices) of medical technology (Chataway, et al., 2007). The next section explores the role of models in shaping policy practices.

2.2.3 The role of models on policy making and implementation

This section reviews empirical studies on the relationship between theory, models and policy practices, especially those with a global dimension. It explains why and how a specific model might be selected for implementation in a given policy context.

Dantzig (1979) investigates the role of models in determining global energy policies that were being implemented in the US. He classifies global models under models of *'alternative processes'* because of their use of a mixture of approaches and great variety of detail. He argues that one of the key reasons why global models became popular in the late 1970s stems from not only 'their prophecies of worldwide shortages of food and energy' (p.6) but their ability to

address these challenges. In such contexts, 'various groups who may be opposed to change because they feel that their vital interests will suffer' (p.10) had to cooperate for the common good. Here, model developers such as Danzig, apart from their academic pursuit, are very aware of the need to develop consistent programs of action that are advantageous to society. He suggests that the role of models can be studied by examining how policy makers (directly or indirectly) use the model to determine what changes are necessary or to reach a consensus on what actions should be carried out and how. Here, a process of consensual decision-making links a model to policy practices.

King and Kraemer (1992) carried out a comparative study on the role of models in policy making, focusing on the use of similar econometric models of Geographic Information Systems by the German and American governments. They studied the nature of the models, their implementation and the way the models are actually used in the policy process. They found that models are 'effective weapons in ideological, partisan, and bureaucratic warfare over fundamental issues of public policy' (p.5). The extent of using a model depends on the effectiveness of the model in 'the political battles over what kinds of economic and domestic policy should be followed' (p.5). Models, to them, serve as a key focus of negotiation and are 'boundary objects' that bring people from different social domains together. From this context a study of models needs to consider the issues on Table 2 below.

Table 2. The role of models in shaping policy practices

Model as political weapon	The use of model in policy practices
To clarify issues in a debate or to define common ground	To decide which variables are included vs. excluded, exogenous vs. endogenous, weighted vs. unweighted as the basis of a political discourse
To enforce a discipline of analysis and discourse	Enables partners to adhere to technical realities needed to be addressed to formulate a better policy
Powerful form of advice on what to do and not to do	To identify positive/negative aspects of policy (or make decisions) likely to achieve acceptable outcomes

Source: Review of King and Kraemer (1992)

As already mentioned, although studies on models have focused on socio-technical systems (such as those above), recent studies are beginning to extend it to the social policy arena. Pianta and Rimm-Kaufman (2006) investigate the role of models on policy practices by comparing inputs and outputs (as well as their linkages) of models of early childhood development. They argue that, despite apparent inadequacies, a wide range of (national) policy and practice (local implementation) initiatives draw on models in fundamental ways. At the national level, the model is reflected in one of the more contentious and legislative decisions related to accountability in early childhood development. At the local levels, the model is reflected in the many discussions between parents and teachers. They distinguish between models that focus on and regulate around 'outputs' and those that focus on 'inputs' and suggest that a successful model is one that attends to the diverse sets of inputs needed to inform policy and the ways in which those inputs are linked together at any given time.

Thus, the impact of a model depends on the extent to which the model emphasises the organization of assets within an objective, how this organization emerges, and how it operates to support policy effectiveness over time. They caution that the success of a model depends on the current state of knowledge (not the context in which the model was formulated) since the complexity of the models often pose challenges to implementation.

In all of the above accounts of the selection and use of models, forms of knowledge and specific data – whether technical or social - have been crucial. It is this dependence that makes the notion of embodied knowledge that is relevant for the study of the role of models. Using the above notion, MacKenzie (2006) claims that the study of models is a potential contribution because it enables the researcher to treat both technical and non-technical objects (such as markets) in the same way as physical technologies. To substantiate this claim, he unpacks the 'black box' of financial markets by exploring how financial models created from economic theories of markets shape the practices and outcomes in the global stock exchange markets. He discusses how the publication of landmark research papers on options theory in finance (the models) in 1973 coincided with the creation of the Chicago Board Options Exchange (for the practice of those models) as a reflected of an ongoing transformation in the study of finance (theory and models) and the corresponding influence on markets. In this case four variables are critical in investigating the relationship between models and practice: ideas (theories behind models), tools (major research universities), access to technology (such as computers) and data (which became increasingly abundant in the stock

exchange markets). Understanding the relationship among these variables involves exploring the ways in which they are embedded in cultures, politics and networks of personal interconnections, what MacKenzie (2006) refers to as unpacking 'the systematic forms of knowledge' deployed in technology (in his case financial markets).

The above discussions on the theoretical literature on models and the notion of embodied knowledge suggests that models can be located and studied where developments in theory paralleled or preceded developments in policy practices (or the other way round) (MacKenzie, 2006) and the opportunities that the models provide for the inclusion of additional elements in the future to better reflect practice settings (Cartwright, 1983; Morgan and Morrison, 1999). Such an approach to the study of models in a social policy setting is, for example, relevant in the field of development studies, where it is important for understanding the role of global institutions (such as GHPs) in shaping policy practices. It enables us to understand the alignment of the technical and the social, as well as human and non-human interests through several options (e.g. Callon, 1991). The study of the emergence of GHPs by Ngoasong (2009) mentioned earlier suggested that the interplay of different narratives (as forms of knowledge) and institutions in different periods of Africa's history provides an explanation of the emergence of GHPs from the late 1990s. In order to develop a framework for conceptualising and studying GHPs as models, the next section explores theoretical approaches to the study of GHPs to better understand the basis on which they can be conceptualised and studied as models.

2.3 Approaches to the Study of GHPs and Access to Medication

2.3.1 Liberal and neo-liberal approaches to the study of GHPs

Most studies on global partnerships that use the typologies discussed above are based on liberal and neo-liberal theories in development studies and in international relations. Within the broad literature, the emphasis has been on the functional and operational demand for partnerships such as GHPs as governance solutions in an era of globalization. From a functional demand perspective, the advantages of globalization arguably outweigh the disadvantages across African countries, but create governance gaps at global and national levels (Reinicke and Deng 2000; Zacher, 1999). At the national level, governance gaps are specified in terms of capacity to provide public goods such as healthcare. Various editions of the *Human Development Reports* (pointing to the lack of reliable access to medicines for the poorest people), WHO/UNICEF (on weak health systems) and IMF/World Bank reports (poor development indicators) are cited as evidence of governance failures (e.g. WHO, 2005: 48). In this context, GHPs have been created to fill governance gaps by leveraging the resources and interests of different sectors at global and national levels (Reinicke and Deng, 2000), offering cost effective opportunities for coalition building (Grant and Keohane, 2005; Slaughter 2004) and breaking complex issues into smaller, more manageable sub-components on which actors are more likely to agree upon (Reinicke and Deng, 2000).

There is a general assumption that governance gaps exist in state-centred systems in developing countries, gaps that can only be resolved through the hybrid network on which GHPs are structured. Liberal interventionists argue that the inability of countries such as those in Africa to implement effective health governance solutions and the growing capacity or pressure from trans-national public and private organizations force them to share responsibility for healthcare with global institutions (Mathews, 1987). In this context, state and non-state actors voluntarily agree to undertake specific functions in health governance (Dodgson, et al., 2002) and so 'share risks, responsibilities, resources, competencies and benefits' (Nelson 2002: 47).

In globalization studies on the role of global institutions (such as GHPs), *transcalar coalitions* (global-national-local linkages) are used to legitimise the intervention of an array of non-state actors in a given country's internal affairs in order to facilitate access to medication: 'when a local environmental NGO, forest indigenous dwellers, international NGOs and the World Bank join efforts, using both sticks and carrots, an African country's government cannot convincingly claim that it fell victim to an imperialist plot!' (Compagnon, 2008: 15). In the case of GHPs, there is so much talk of 'scaling up' access to medication in terms of space (from the local to a larger scale), time (short-term vs. longer-term) and 'sustainability' through 'mainstreaming' (to incorporate the specific country context) in 'weak states' in Africa, while terms such as 'inter-governmental', 'multi-actor' and 'public-private' are used in explaining global governance and country operational mechanisms (Dodgson et al., 2002; Caines et al, 2004; Buse and Harmer, 2007; Carlson, 2004).

Other studies on GHPs have used liberal and neo-liberal approaches to study the emergence and impact of civil society organizations and other non-state actors in influencing (through advocacy efforts) national government and bilateral and multilateral agencies to take specific actions to facilitate access to medication. One powerful method of influence is advocacy. Abbott and Snidal (2006) argue that non-state actors have the power to influence agenda setting, negotiation or other forms of rule-making, implementation, monitoring and evaluation as well as enforce procedures. Abbott (2007) sees this approach as a reinvention of liberalism as a positive theory that seeks to explain major outcomes in international politics. He claims that positive liberalism directs analysts to focus on particular actors, causal factors, and political arenas. In this case, the major actors in world politics are not states, but individuals (such as civil society organizations, interest groups and other non-state actors) assumed to be either rational (or egoistic) or motivated by values and norms, to pursue their interests in domestic politics. Neo-liberals such as Moravcsik (1997) see liberalism in this context as a "bottom up" theory in which the preferences and policies of governments are being influenced by societal actors. According to Abbott (2007:3), 'by opening the "black box" of the state, liberalism renders areas ruled out by other international relations approaches integral to the study of international relations'.

Traditional liberal theories such as the liberal-internationalist approaches are highly normative. They overemphasise the role of the state and place the analytical weight on the nature and application of the state political economy

policy. Neo-liberals and positivists alike presuppose that states are the key actors in international relations even though they discuss the increasing importance of non-state actors and intergovernmental organizations. Most empirical studies that use these approaches limit the activities of non-state actors to domestic politics without emphasising their influence on multilateral and bilateral agencies and multinational corporations through public activism at international conferences and other forums (Abbott, 2007). As demonstrated in the next section, these approaches also fail to capture the full controversies surrounding the role of GHPs on access to medication, such as the importance of the historical contexts as well as the competing and conflicting narratives on access to medication explained earlier.

2.3.2 Social constructivism and the study of GHPs

Boas and McNeill (2004) review the shortcomings of development studies in relation to global institutions and suggest the creation of an alternate analytical framework from realist theory, the neo-Gramscian school of thought or social constructivism. Both realist and neo-Gramscian approaches are not suitable for the study of GHPs, as defined in the introduction chapter of this thesis, because both represent weak analytical frameworks for conceptualising global institutions. For example, realists over-rely on state sovereignty and argue that the emphasis must still be placed on the state because it is the state that has power, and must ratify international organizations (Abbott, 2007). Neo-Gramscian theory is unable to explain change mechanisms by over-emphasising the political element of development. Although it does politicise the processes of power relations, by arguing that ideas and theories of development are 'always for someone and for some purpose' (Cox, 1995:31;

Cox and Sinclair, 1996), it does not offer a convincing account of how agency can bring about structural or processural change. On the other hand, constructivism, an approach drawn from social theory, has emerged as an attractive alternative to realist, liberal and neo-Marxist theories for analysing GHPs. It highlights the specific source(s) where causes and effects can be located (Boas and McNeill, 2004) and is better able to develop explanations of the actions of both states and at non-states actors in international development (Hopf, 1998; 2002; Wendt, 1992; 1999).

Studies on GHPs would benefit from an effective alternative framework to the dominant liberal and neo-liberal theories. Most GHPs claim to target global policies on the treatment of diseases in a country-context and on funding of R&D for developing country diseases. Yet as pointed out in chapter one, the literature on the impact of GHPs points to many unanswered questions: whether the values of the weaker partners (such as those in Africa) are co-opted by the more powerful ones (UN agencies and their affiliated private partners and international); is reconciling the interest of UN-based agencies and private corporations overemphasised; why is scant attention paid to interfaces between institutions and structures of national vis-à-vis global health governance; is the capacity and fragmentation of national health systems overwhelmed (Hancock, 1998; Bellamy, 1999; Holm, 2001; Caines and Lush, 2004; Nishtar, 2004; Buse, 2004a). In such cases, they may contribute to a form of developing country dependency on UN-based agencies and their internationally affiliated partners (Richter, 2004a; 2004b), rather than serving the needs of the poor.

Where the nature of the above challenges and complexities has been documented, it is suggested that alternative governance strategies should be explored. Even liberal interventionists such as Dodgson et al., (2002), despite over-emphasising the role of the state, directs attention to the urgency of re-examining global health to uncover the implicit (often taken-for-granted) conceptual challenges in the face of incongruous global public-private relationships. In addition, the observation that collaborations in GHPs lead to national health *'systems change'* necessitates the establishment of parameters for theoretical and practical terms in relation to country-context and sustainability (Lewis, 2005: 131).

Social constructivist approaches related to GHPs avoid the problems of realist state-centrism and the lack of a focus on the role of agency in social processes implicit in neo-Gramscianism by using a range of methods to examine decision-making and power relations. The focus of most GHPs focus on a narrowly defined role (Buse 2004a) implies that their role in a liberal interventionist context would vary from one GHP to another (or one country to another) and with varying implications for access to medication. This also depends on the conceptualisation of the determinants of access to medication by partners to GHPs, an issue that is hardly made explicit in most of the conceptualisations of GHP. Constructivist approaches attempt to address these issues using methods such as framing (Odell and Sell, 2003; Sell, 2004; Sell and Prakash, 2004) and NPA (Feldman et al., 2004; McBeth et al., 2007; Ngoasong, 2009). Framing and narrative analyses enables specific issues to be

considered as crucial rather than other issues of equal importance when formulating and implementing policies. They are therefore relevant analytical tools for understanding how GHPs shape policy practices.

For example, Sell and Prakash (2004) illustrate how a shift in framing from concerns about patent protections for specialists pharmaceutical innovations to one of a global challenge to reduce mortality is critical in understanding the sudden importance of Paragraph 6 of the TRIPS agreement. Kanner (2004) elaborates on the importance of framing by showing how one actor in a bargaining situation can alter the frame for a second actor and thus successfully alter the frame (and outcome) for future negotiations. This is similar to the types of negotiations that take place within GHPs, espacially between participating pharmaceutical companies and developing country governments on drug procurement and supply arrangements. In this case, Ngoasong (2009) proposes NPA as a relevant analytical framework. He shows how the formation of GHPs was an attempt to define access to medication globally by integrating public health, economistic and human rights narratives on access to medication each of which is capable of altering the way global actors frame issues within GHPs in response to other actors.

Thus, it can be shown that these competing and conflicting narratives have the potential to shape the types of policies formulated by GHPs, policies that are meant to be transferred to developing countries to shape national health policy and local delivery practices on access to medication. The next section builds on the social constructivst perspective further by conceptualising the 'social

spaces' through which GHP policies are formulated, transferred and implemented what can be termed transcalar networks.

2.3.3 Transcalar network for policy transfer and implementation

So far we have portrayed the GHP model as new because it is different from previous international models of health interventions. The discussions presented earlier on the nature of GHPs suggest that global health policy has effectively replaced international health policy. While international health policy agendas in the 1980s and 90s had clear organizational homes, such as WHO and UNICEF (Reich, 1995; Walt, 2001), global health policy agendas do not necessarily have organizational homes as most GHPs are not accountable to any institutional authority (Buse 2004a; Buse and Harmer, 2007). This calls for the need to reconceptualise the nature of the network through which GHP policies are transferred (from global to national) and how they are implemented (from national to local). In this thesis, the term *transcalar networks* will be used to conceptualise the 'social space' in which policies are transferred and implemented in a GHP context. This conceptualisation is further justified below using concepts from policy transfer, multi-level governance, and the notion of the 'politics of scale' found in globalization studies.

There is a general concurrence that policy transfer takes plays through informal networks of public and private actors who have distinctive but interdependent interests, and who are striving to solve similar problems (Marsh 1998). In this context, policy transfer has been defined as 'the process by which knowledge about policies, administrative arrangements, institutions and ideas in one

political system is used in the development of policies, arrangements, institutions and ideas in another political system' (Dolowitz and Marsh 2000:5). Multi-level governance, 'a system of continuous negotiation among nested governments at several territorial tiers' (Marks 1993:392), reveals how this transfer process has transformed the role of the state towards new strategies of co-ordination in the face of accountability challenges and the increased participation of non-state actors (Bache and Flinders 2004:197). This transformation further supports the argument that a social constructivist approach is preferred to the liberal interventionist perspective when analysing GHPs. Policy networks enable actors to 'play the boundary' of national and international, public and private, formal and informal, market and bureaucracy, state and non-state, legal and illegal in shaping policy practices (Stone 2003:43, Sikkink 2005:152).

Apart from the above boundary problem, Bache and Taylor (2003:283) refer to country-specific challenges and partners' strategic interests as 'policy resistance strategies' that may hinder the effectiveness of policy transfer and implementation – the same factors described by Ngoasong (2009) as crucial for understanding GHPs in Africa. The notion of 'the politics of scale' (Brenner 1999, 2001) then becomes useful to expose areas where policy transfer clashes with policy resistance strategies. Unlike traditional transnational policy networks built around government ministries (e.g. Reich 1995, McCormick 2001, Walt et al. 2004), we now have GHP programmes in which the state (through various ministries) no longer has this centralised bureaucratic authority (Dodgson et al. 2002, Abbott 2007). National GHP programmes have

been created in which representatives of public health (WHO, UNICEF, and ministries of health), donor agencies (Global Fund, World Bank and private foundations) and CSOs at global, national and local levels sit around the same table to formulate and implement country-led health policies.

The term *'transcalar network'* is used to describe this new type of global-national-local linkage. The existence of *networks* indicates levels of institutionalised authority (McCormick 2001) and their *transcalar* character reveals the existence of social spaces through which global, national and local actors interact (Brenner 1999, 2001). In several writings, Castells (1996, 1997, 1998, 2000) demonstrates that globalization has transformed the 'social space' found in traditional network studies from a 'space of spaces' to a 'space of flows'. Castells (1996: 412) defined the space of flows as 'the material organization of time-sharing social practices that work through flows (e.g global-national-local linkages). By flows I understand purposeful, repetitive, programmable sequences of exchange and interaction between physically disjointed positions held by social actors in the economic, political, and symbolic structures of society'.

This transformation is evident in the GHP context. For example, while GHPs recognise the autonomy of the State, the failures of 'weak states' in Africa (Dodgson et al. 2002) suggest that GHPs use CSOs and donors to by-pass the bureaucratic structures of the State to produce 'quick results' (Caines et al. 2004, Buse and Harmer 2007). This transcalar characteristic of contemporary global institutions has been shown, in the case of forest exploitation, to

constrain national politicians' capacity for corrupt practices while ensuring policies are implemented effectively (Compagnon 2008). The fact that key GHP partners (e.g. World Bank) put good governance as major conditions for funding, as well as channel funds directly to non-state actors (CREDES 2004, World Bank, 2007) suggest that the role of GHPs also needs to be understood in terms of whether they have such underlying objective. If local none-state actors are also deeply penetrated by neo-patrimonial tendencies (Compagnon 2008), they may become another form of local policy resistance.

The notion of transcalar network enables us to better describe the 'social space' in which public health, economistic and human rights narratives (and the associated actors) are negotiated, as well as the nature of global-national-local linkages in a GHP context. Understanding the ways in which public health, economistic and human rights narratives (and the associated actors) are connected and the consequent effect on the types of specific GHPs deployed to formulate policies on access to medication for a given developing country is the basis for a more incisive approach to studying the role of GHPs on access to medication. Thus, conceptualising GHPs as models that occupy the intermediate position between theory and policy practices and using NPA as a method of analysing the ways in which GHPs perform this integrating role becomes a potentially fruitful theoretical framework for understanding the role of GHPs as facilitators of access to medication. The next section provides a more detailed justification of NPA as suitable analytical framework for studying the embodiment of knowledge GHP programmes on access to

medication (and consequently, the role of knowledge in shaping policy practices).

2.3.4 Narrative policy analysis as a framework for analysing the role of GHPs

As discussed earlier, one of the key characteristics of GHPs is that they are policy-oriented institutions. They formulate global policies that are meant to be applied on a country-specific basis. This points our attention to the ways in which policy makers in a GHP context formulate policies at the global level, how they transfer policies to the national level and how they are translated into specific programmes at the local levels. Policy makers can approach this difficult task in a number of ways. One method is policy analysis, described positively as 'the choice of the best policy among a set of alternatives with the aid of reason and evidence' (MacRae, 1980:74). However, Quade (1975) had already argued that most immediate social goals are usually the result of opportunities offered by newly discovered or perceived choices rather than a source. This undermines the possibility of such a rational or linear policy transfer process suggested by MacRae. NPA, the application of narratives that takes social values and historical contexts into consideration, has emerged as an effective way of dealing with these problems.

Thomas Kaplan (1986) provides a useful starting point for discussing the relevance of the NPA approach. He argues against writers who emphasize a priori criteria for policy analysis, emphasising that rational planning (the approach suggested by most liberal interventionists theorists mentioned earlier) can only take place when one establishes clear criteria at the very outset. As an

alternative, Kaplan proposes informal narratives or 'the explanatory power of stories' (p.768) as an equally rational approach. Along a similar line, Krieger (1986) advocates the explanatory power of dramatic or historical narratives in understanding *'big decisions'* as choices that are seen as discontinuous, abrupt, and unique. According to Doron (1986), neither Kaplan nor Krieger reject the rational and scientific aim of policy analysis; they simply used NPA as a means of clarifying policy issues in especially complex situations.

From the above context, later studies that employ NPA emphasize semiotic and rhetorical issues for interpreting policy narrative strategies (e.g. Roe 1989; Feldman et al., 2004; McBeth et al., 2007). These features of NPA have also been applied in STS. For example, actor network theory approaches apply versions of NPA which focused on following the views (or narratives) of specific actors across complex socio-technical actor networks over time (Bowden, 1995). Through 'snowball effects' (Bijker, 1995:270), the relevant system and actors are identified, and by 'following the actors' (Latour and Woolgar, 1986), the ways in which their narrative strategies become embodied within models thereby shaping policy practices can be better understood.

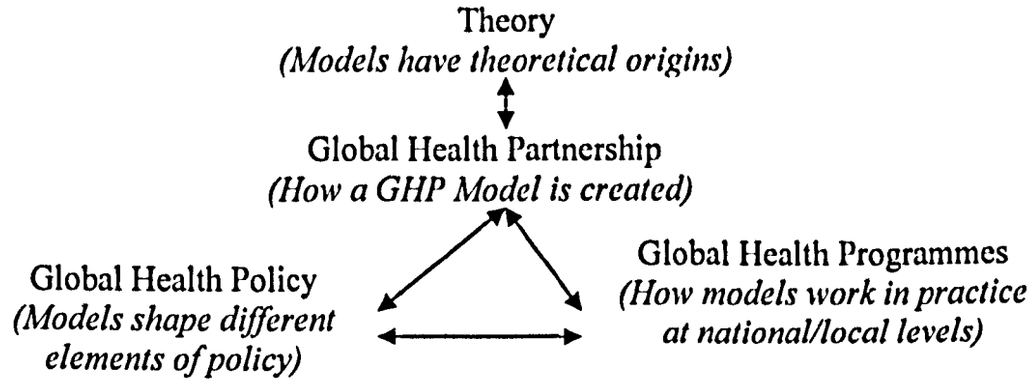
In the presence of policy questions with controversial law-like explanations, NPA is useful to describe change over time and to uncover the hidden assumptions that are implicit in policy documents (Kaplan, 1986). NPA uses narratives such as characters, contents, plots, colourful language, and metaphors (McBeth et al., 2007) to explain the occurrence of and the linkages between events in an attempt to select and justify desirable courses of action

(Zilber, 2007). As Ngoasong (2009:950) demonstrates, 'it is this capacity to address a range of complex characteristics and distinctive narratives that suggest the NPA can successfully be applied to the issue of access to medication'. NPA is suitable for distinguishing between public health, economistic and human rights narratives within specific GHP programmes as well as the ways in which they are meant to shape different elements of the GHP model. Thus, NPA has already shown itself capable of being applied in the domains of STS, policy studies, international relations and development studies including the GHP contexts. It therefore provides a relevant methodological tool for analysing the role of the GHP model on access to medication. The next section presents the theoretical framework for this thesis.

2.4 A Conceptual Framework to Study GHPs as Models

This chapter has demonstrated that the theoretical literature on models and the notion of embodied knowledge as applied within some STS research, when combined with social constructionist international relations, provides a suitable framework for analysing the role of GHPs on access to medication. In particular, the first contribution of this chapter is that a constructivist perspective on the relationship between theory, model and policy practices forms an interesting area of investigation that can be applied to the case of GHPs. A parallel argument is that socio-technical systems are hybrids of social institutions that embody different forms of knowledge. This can be applied to the case of a global social policy system in which GHPs operate. This combination of approaches and methods is best suited to achieving the goal of this thesis – an investigation into the role of GHPs in determining policy and local practices on access to medication.

Figure 2 How a GHP model mediates between theory and policy practices



As presented on Figure 2 below, this thesis therefore conceptualises a GHP as a model, operating in the space between theory and practice, and affected by both. The theories behind the public health, economistic and human rights narratives provide the basis on which GHP partners' interests and ideologies are built and consequently the basis on which GHP policies are negotiated and adopted for transfer to practice settings by stakeholders with very different interests.

The second contribution of the chapter is the realisation that NPA is an appropriate analytical tool, given the STS perspective on the role of models, the social constructionists approach in international relations on policy analysis and the transcalar networks within which GHP programmes operate. It is useful for exploring how public health (WHO/UNICEF), economistic (WTO/IMF/World Bank) and human rights (UN/International CSOs) narratives on access to medication emerged at a global level, how they became embodied within specific GHPs and how they shape national health policies and local practices on access to medication. This is relevant in the case of GHPs because the policy framework is not simply imposed through any

international legal instruments or rational planning framework. Like most global institutions, the policy framework is 'constructed through social interactions that include both formal negotiations and informal deliberation' (Compagnon, 2008:15). The notion of transcalar network enables us to capture the global-national-local linkages that characterise such social interactions, and therefore the role of actors and their narratives in shaping policy practices. Each GHP model has different frameworks and capacities to shape different aspects of policy formulation and implementation at national and local levels.

The domination of liberal and neo-liberal theories in the study of GHPs could imply that they play a leading role in determining the nature of GHPs. However, these theories have significant limitations when considering the impact of GHP programmes. There is need to evaluate the nature of specific GHPs in terms of how they are aligned and integrated with country-specific contexts to better appreciate their potential to promote country-specific access to medication. The theoretical framework developed in this research provides an attractive alternative way of achieving this. Extending the notion of embodied knowledge into governance, international relations and development studies for analysing GHPs is very instructive. It is somewhat surprising that it has not been done previously. GHPs put forward a moral claim for 'universal access' to medication to protect the interest of the poor. The key challenge in unpacking the GHP model is therefore to understand how the competing and conflicting narratives of access to medication are negotiated at global and national levels and how the combination of these are translated into specific programmes and activities at the local level. This is what makes the

'knowledge approach' relevant in this thesis, particularly the possibility it creates to adopt concepts from globalization and development studies into an interdisciplinary framework to understand the role of GHPs on access to medication.

The above framework is applied to the global (Chapter Four) and national (Chapter Five) perspectives on the emergence of GHPs as facilitators of access to medication. It is then applied to two empirical case studies on the role of two GHP programmes on access to medication in Cameroon in Chapter Six and Chapter Seven respectively. Before going into these chapters, the next chapter presents the research methodology used in this thesis.

CHAPTER 3: RESEARCH DESIGN AND METHODS

3.1 Introduction

This chapter explains the methodology used to study the role of GHP models in shaping policy practices on access to medication. Siverman (2001) demonstrates that when conducting empirical research there must be a set of explanatory concepts (Theory), a testable proposition (Hypothesis), a general approach to studying research topics (Methodology) and a specific research technique (Method). This thesis uses a similar guideline. The purpose, according to the introduction, is to understand how GHPs grapple with meeting targets for successful healthcare delivery in Cameroon, with specific reference to access to medication. The theoretical approach combines STS and social constructionist IR, in a NPA research technique. This involves studying and analysing the multitude of interactions between theory, models and policy practices and the ways in which such interactions produce intended and unintended outcomes.

The traditional philosophical views see models as determining and containing social structures (Nagel, 1961; Hesse, 1966; Cartwright, 1983) or as socially constructed (Morrison and Morgan (1999). Still others (King and Kramer, 1992) have interpreted the development and deployment of models as subject to the changes by users as well as a constraint on users' choices and actions. More recent views (MacKenzie, 2006) go on to give historical texture to the descriptive accounts of the cross-contextual interaction among creators and users of models in the structures and processes of globalization. This thesis

follows MacKinzie (2006) in studying the interplay of theory, models and policy practices and Ngoasong (2009) in applying interpretive NPA research methodology (Kaplan, 1986; Feldman et al., 2004) to study the role of GHPs as facilitators of access to medication in Cameroon.

Using the above discussion as a point of departure, this chapter begins by re-examining the agenda of researching transcalar networks using NPA methodology, including a justification of the unit and levels of analysis. It then describes the methods and techniques used in conducting the empirical research. Finally, the limitations of the study are presented followed by a brief chapter conclusion.

3.2 Re-examining the Agenda of Researching Transcalar Networks

GHPs attempt to link global and national actors and coordination mechanisms to address country-specific barriers to access to medication. As such the global-national-local linkages within which such multi-actor or multi-stakeholder interactions take play is similar to those of what is termed in globalization studies as transcalar coalitions operating within a nation state (Compagnon, 2008). In this liberal interventionist construction, the object of study is the nation state. Transnational actors build coalitions of state and non-state actors around government ministries thereby constraining the capacity of the state authorities to practice rent-seeking behaviour and corruption. In this thesis a

more socially constructed conceptualization that replaces the term coalition with network is used.

As pointed out in chapter two, due to the hybrid and interwoven character of the network of actors within GHP settings, the nation state of Cameroon represents a limiting analytical category to understand the nature of the links between the various actors involved in the deployment of GHP programmes. Therefore, understanding the institutional interactions requires us to move beyond state-centrism as the main object of investigation and to analyse its networking with a set of comingled interests (Brenner 1999) interacting within the global-national-local space, defined as transcalar networks. Each GHP model is animated by several transcalar networks of PPPs at global, national and local levels. The object of analysis is therefore the GHP model while the unit of analysis is transcalar networks.

The frequent absence of discussions on policy and development issues in the STS literature is worthy of mention. Jasanoff (1999) suggested a way of integrating STS and public policy studies together to conduct empirical research, explain findings and make policy proposals. In her case, a combination of the SCOT theory (Social Construction of Technology) and policy studies was used to offer fresh potential for answering questions about development. This suggests that any theory's applicability must first be tested through case studies and it is always possible that inconsistencies and contradictions will be exposed. This chapter provides the methodological framework from which the theoretical framework developed in chapter two can

be shown to contribute to the study of GHPs by offering new insights for answering questions about globalization and development.

The object of analysis, the GHP model, is consistent with the objectives and research questions of this thesis (Yin 1994). The data collected enables us to capture aspects of the network properties and its governance. In this sense, individual GHP partners are not the object of study since they represent separate institutions. Such institutions do not always predict, perceive or determine individual or network level interactions (Coleman 1990; Powell and DiMaggio 1991). It is the hybrid nature of the network (Oliver and Ebers, 1998) within which the GHP model operates and the transcalar characteristics (Companogn, 2008) that determine such interactions and therefore form the focus of analysis in GHP settings. In a comprehensive review of theoretical and empirical studies relating to the nature of networks, Oliver and Ebers (1998) argue that networks can be clustered around four themes: contingent decision-making (nodes in a network), social network relations (social linking), inter-organizational power/control (nodes and the links) and inter-organizational governance structures (nodes and the links).

The scope of this thesis does not allow us to attempt to situate GHPs within any of the above clusters. As mentioned in chapter two, in the contemporary era of globalization, Castells (2000) describes a network as a 'space of flows'. Hargittai and Centeno (2001:1550) describe the daunting challenge in trying to quantify global-national-local linkages in contemporary global networks as follows:

> 'Under the previous system of international contact different parts of the world might be connected to relatively few others. Now the number of paths between different people and locations has exploded. This implies that changes in the form and frequency of flows between two points may have reverberations in unexpected paths far removed from them. Whereas previously we might have spoken of a world on which a variety of lines were drawn we now need to think of the globe as enmeshed in a web.'

The above quotation justifies the qualitative approach used to study networks in this thesis, one that does not measure the links and nodes among global, national and local actors in GHPs. The aim is simply to study how forms of knowledge (or narratives) are embodied in GHP models and how the interplay of the knowledge and the actors involve shape global, national and local practices. This approach suggests that the infrastructures within which GHP programmes operate are formed by boundaries and institutions contra-posed to the historical rules and structures of agency that once defined such space. For instance, the interplay of different forms of knowledge within GHPs affect the ways in which power is mobilised, which in turn influences the emergent structures of coordination and control of such knowledge. The emergent nature of specific GHP programmes obviously exhibit considerable variation, while the structures of transcalar networks supported by the GHP model become the scene of new conflicts over their governance.

At one level of interest there are the interactions taken place in networks of multinational agencies in the UN, international development agencies (western nations), international CSOs and private multinational corporations and their roles, functions and responsibilities (GHPs at a global level). At another level is the relationship between this western-dominated global network and the local implementing GHP agencies, the rules and methods governing such

interactions and their relevance for carrying out the proposed reforms, plans and general initiatives (GHPs at country level). Finally, there is the relationship between the local implementing agencies, the local implementing bodies and specific global partners which are local in character and generally part of either the government of the country of interest or a global GHP partner (transcalar networks).

There are parallels, opposites, compliments and competing narratives on access to medication within and between all these scales. Governing the various aspects of policy transfer and implementation in such circumstances is obviously challenging, especially, reconciling between commercial and developmental objectives. However, the governance of such networks is not the subject of study in this dissertation. The focus here is to identify the public health, economistic and human rights narratives on access to medication that operate across these scales, how they become embodied in specific GHP programmes and their role in shaping different elements of global and national health policies as well as local delivery practices on access to medication. This is of interest here because; little is understood about the creation, interaction and maintenance of the web-like structures of actors and narratives that animate the GHP model and how such a model grapples with the challenges for achieving specific targets relating to access to medication.

In this context a state-centric system of decision-making is different from that put forward by GHPs in terms of PPPs (National Programme Committees). Similarly, the network of actors, relations and resources at various levels of

interactions is hard to quantify. These forces are in many ways defining the contexts qualitatively, through an indication of willingness and readiness to participate, submitting policy proposals, showcasing best practice and forming strategic alliances within the global and national structures that define the organization of political, economic, demographic and cultural activities in Cameroon. Therefore, by examining such structures, the nature of the GHP model can be better understood. It also becomes possible to make an assessment about the network of forces and events that give texture to the descriptive accounts in specific GHP and related programme documents. This will be achieved by looking for patterns in the roles that various elements comprising the networks, but preceding the intended outcomes of the overall initiative display and analysing how they are connected to and dependent upon other contexts and the broader national and global dynamics.

Finally, this thesis has not studied in greater detail the role of specific actors and inter-organizational interaction within GHPs. Covering the details of what specific actors are doing and how they link to every other actors through a qualitative approach is not realistic given the time and resources devoted to this thesis, and the number of global, national and local organizations that make up each GHP programme. As described later, the focus of analysis at the local level emphasized two provinces in the country each of which represents contrasting political, economic and socio-cultural characteristics of Cameroon as a whole. However, every attempt was made to capture inter-organizational interaction in areas where such interactions enable us to understand to the role of the GHP model in shaping specific areas of policy formulation and implementation.

3.3. Research Strategy

3.3.1 Justification of qualitative research method

As mentioned earlier, narrative policy analysis, the analytical framework adopted to study GHPs as model, is consistent with actor-network theory approach popular among STS practitioners, which focused on following the views of specific actors across socio-technical networks over time. In the field of STS, Bowden (1995:64-64) provides a dual meaning of method: 'various strategies for data collection and analysis' and 'the method of explanation for data that have been collected'. While the latter refers to general and prescriptive rules, he stresses that the former refers to traditional disciplinary approaches that are already dominantly used in STS (participant observation, ethno-methodological research, analysis of historical documents, and textual analysis). In particular, Bowden argues that because of the multidisciplinary and interdisciplinary nature of topics being investigated each 'researcher uses the methods and techniques of his or her particular academic discipline to study some aspect of science or technology' (Bowden, 1995:67). It is on the basis of this second meaning of research method that suggest NPA is a relevant method of analysis in this thesis since the theoretical framework developed in chapter two is interdisciplinary.

Following Murphy and Dingwall's (2003) argument that the empirical methods should be chosen on the basis that they are appropriate for the nature of the investigation, this research employs a qualitative approach. This allows for a more interpretive analysis of social knowledge and encompasses a range of philosophical underpinnings (Kvale, 1996). A qualitative approach enabled this

research to explain and understand in detail the complexities surrounding the creation of GHP models for specific diseases and their deployment to facilitate access to medication for the poor in Cameroon. The in-built flexibility present in the qualitative approach permitted the constant refining of the research, leading to context and content analyses.

In a social (public) policy context such as those in which GHPs operate, qualitative research is known to adopt a wide range of research methods (Silverman, 2001). Silverman points to the historical, political and contextual characteristics involve in the transformation of issues into researchable problems. On the basis of the historical and contextual nature of diseases (such a malaria with a long history of failed eradication efforts and HIV/AIDS which is more recent) and the history of health interventions (colonial, international and global eras) it was decided that this research should primarily use more than one case study. It was also decided that both documentary and interview data would be collected and analysed.

This thesis seeks to investigate the GHP model as it is deployed in an African country, specifically the prospects of facilitating access to medication for the poor. It was decided at an early stage that case studies would be used to compare GHPs in one country, one in which GHPs are meant to strengthen the national health system as a whole and another one where GHPs are meant to achieve a narrow objective within the national health system. Case studies have been variously criticised for their lack of generalisability (Hamel, Dufour & Fortin, 1993; Yin, 1994), however they are still employed as a crucial method

in social scientific studies (Stake, 1994). Analysing the historical emergence of GHPs at global and local levels through case studies is particularly important because of 'the contribution of the historical method in dealing with the 'dead' past – that is, when no relevant persons are alive to report, even retrospectively, what occurred and when an investigator must rely on primary documents, secondary documents, and cultural and physical artifacts as the main sources of evidence (Yin, 2003:7). Historical analysis is important for understanding the structural framework on which contemporary events are based. This thesis therefore emphasises in-depth historical assessments of the role of the GHP model in relation to previous models of health interventions and health policy reforms.

Two case studies are therefore used in this research to enable us to make comparable (and not necessarily generalisable) claims on the role GHPs in shaping policy practices on access to medication. The use of case studies is to aid empirical analysis and the two case studies were chosen in order to investigate empirical claims on GHPs achieving their target objectives in the context of disease-endemic countries and also to obtain comparative outcomes for the research. The National malaria and HIV/AIDS programmes in Cameroon were the final selection case studies, as they provide a comparison of GHPs with different strategic objectives (the malaria programme focusing on health system strengthening and the HIV/AIDS programme focusing on drug procurement and local distribution) in a single country (Cameroon).

When chosen the specific country and case studies for this research, both practical and theoretical considerations were taken into account. Practically it was imperative that it was feasible to collect data from the given country. The issues of language, political stability and safety were important factors. It was decided that Cameroon provides an interesting case study as it presents in a nutshell the political economy trajectory of Africa as elaborated in chapter five. English and French are the official languages and being a Cameroonian, this allowed me to personally conduct interviews and analyse interviews and documentary data from a wide range of local, national and international organizations without the need for a translator. It was also important that the case study country is stable politically, so that fieldwork could be carried out. In addition, Cameroon has always endorsed international health initiatives and many GHPs are already very active in the country. This allows for a more in-depth analysis of the deployment and implementation of GHP programmes in an African country context.

Practically, it was feasible for fieldwork to be carried out in Cameroon. In Cameroon, many different local languages co-exist but English and French are the official languages and all actors interviewed were fluent in either English and/or French. Despite a few cases of instability that are easily contained by the government, Cameroon has a history of political stability and arguably enjoys a stable democracy. The issue of safety was not particularly important with regards to Cameroon, as it is not known to be one of the highest crime rates in Africa. However, when conducting fieldwork in Cameroon measures

were taken to ensure my personal safety (e.g. interviewing during the day time, taking trusted transport to interview locations).

In principle the choice of case study should add something new to existing literature. Despite a long history of eradication, treatment and control campaigns, malaria is still one of the common causes of deaths in Cameroon. The HIV/AIDS, a more recent pandemic, has attracted substantial funding and mobilization; however, incidence and burden of the disease continues to rise. More so, for both disease areas, little theoretically backed empirically research has been done on GHPs in Cameroon beyond case studies to inform policy documents, compile technical reports or evaluation of specific programme by various GHP partners. This research therefore adds new knowledge to the scattered and arguably limited empirical literature on this subject area in Cameroon. Although there is a vast amount literature on GHPs in African countries, by using the 'knowledge approach' to unpack the network of actors and institutions involved in GHP programmes in Cameroon, this thesis offers new insights on GHP issues in both Cameroon and other African countries and can therefore contribute to existing knowledge.

3.3.2 Interviews

While there is no standard approach for qualitative research, interviews were used as the primary means of data collection in this research, complemented by documentary analysis. According to Silverman (2001:18) an interview study 'highlights the advantages of qualitative research in offering the apparently 'deeper' picture than the variable-based correlations of quantitative studies.' Apart from allowing an exploration of the variables in a much more

exploratory fashion, interviews provide a means of generating data for this research that could not be obtained only from documents or web based searches. In this context, Murphy and Dingwall (2003:93) state that qualitative interviews: 'Allows researchers to explore the ways in which informants themselves define the experience and practice that are the focus of the research .... They open up the possibility of challenging the researcher's preconceptions about what is important or significant.'

In line with the above perspectives, semi-structured interview were adopted throughout this research. Semi-structured interviews provide a level of flexibility that allows interviewees to discuss GHPs and focus on themes of particular importance to them, without hindrance from the interviewer. The aim was to create an environment conducive for a purposeful conversation (Burgess, 1984) where interviewees were able to freely express their views. It was also decided that with the consent of interviewees, interviews would be recorded so that transcripts could remain as faithful to what interviewees said as possible. As the recorder is quite inconspicuous, this allows for a more conversational style interview as opposed to an interrogation that closely follows a script.

In cases where consent was not given, detailed notes would be taken both during and after the interviews. It was recognised that this method did have its limitations, as one could become distracted with note taking and not devote full attention to the interviewees and their responses. Also it is not possible to record all the information given during the interview via this method and the

possibility of omitting important details is increased. However, in the absence of consent, this was the method deemed most suitable for recording interview data.

Many writers point the limitations of using interview data for academic inquiry: 'The limitations of such data are related to the fact that such accounts were consciously and deliberately produced for the purpose' (Prior, 2001:573). The accounts given during interviews can represent what interviewees think they should say as opposed to what actually happened. This does not present a major problem for this research as it was always kept in mind that the interviews represented a reflection of interviewees' perspectives on the role of GHPs in access to medication and it was these perspectives that were of interest. This is why interviews were essential for this research. They represented narratives that are not directly observed by the researcher (the interviewer), and therefore there was a potential gap between what was said and the actual situation. In order to overcome this, the documentary and observational data collected were used as complementary sources.

A log book was kept detailing the day's events, including target dates or schedules of interviews and other planned meetings, the interview location, behaviour of interviewee(s), references to be consulted in specific locations during the fieldwork, notes taken during informal interviews and interactions, general thoughts on the interview as well as all observations made during the fieldwork. This enabled me to reflect on the whole interview process and not carry over any thoughts or feelings on previous interviews. It also enabled me

to collect relevant data from certain employees (such as research and administrative assistants, information and documentation officers) working in the organizations or institutions that I visited. Such data are obviously useful as a way of corroborating those from interviews and technical reports.

3.3.3 Sampling, Approach and Access

This thesis is about the embodiment of knowledge (expressed as narratives) in GHP models and how this shapes global, national and local policy practices. At such it was important to select relevant actors from each of these levels for interview. Two classic STS methods of data collection were employed, namely, 'snowball effects' (Bijker, 1995) and 'following the actors' (Latour and Woolgar, 1986). According to the former, researchers are supposed to 'roll a snowball' to identify and engage a preliminary set of relevant social groups, ask them to identify relevant groups and in this way eventually build up a group of informants. In terms of the latter, the researcher is expected to 'follow the actors' to listen to what they say, observe what they do and recreate a picture of the construction process. During the fieldwork for this research, a manageable number of snowballs were rolled and a sufficient number of actors were selected for interview. However, the plan to follow the actors and observe what they did was not possible due to the limited time and resources available for the entire fieldwork. In addition, GHPs do not hold meetings frequently, implying that the objective was to contact selected participant on a mutually accepted time for an interview.

The notion that GHP models shape health policies and local delivery practices guided the researcher as to which groups represent the key with regards to

GHPs and therefore where to 'roll a snowball'. These were the initiators of GHP models (senior board members of specific GHPs and their affiliated international partners), national policy makers (Ministry of Public Health) and local policy implementers (provincial and district centres and parallel initiatives). This leads to a wider selection of stakeholders including local public, private and civil society groups. Practically these key actors were identified mainly from GHP literature through web-based searches and informal contacts established in Cameroon.

Feasibility studies for this research were carried out between February and April 2007 through informal telephone contacts. As this research was not fully funded, it was decided that only one fieldwork trip would be carried out, that is, to conduct interviews for the empirical research. It was therefore more convenient to conduct feasibility studies through telephone interviews. This did not pose any problem as the researcher is a Cameroonian born and bread in Cameroon and was therefore knowledgeable enough on who to contact at an initial stage. The feasibility study was useful to assess what was happening on the ground with regards to access to medication in Cameroon, as there was little written on this subject in Cameroon through web-based sources.

At the level of Cameroon, it was decided that the research will focus on two provinces, namely, the Centre Province and the North West Province respectively. The Centre Province is located in the French-speaking region of Cameroon. Apart from hosting Yaoundé, the capital of Cameroon, all the country offices of GHP programmes, international private and civil society

GHP partners and UN agencies are located in the Centre Province. The province is also arguably the most developed in the country in terms of infrastructural development and high levels of economic activity. It hosts the country's single University Teaching Hospital, one of two Central Hospitals in the country and well developed private, religious and civil society run hospitals and pharmacies. On the other hand, the North West Provinces is located in the English-speaking region of Cameroon. With its capital city of Bamenda, it is arguably the least developed in the country. The main economic activity for a large majority of the population is subsistence agriculture. Traditional culture dominates political and social organizations. Unlike the centre province, its most advanced health unit is the Provincial Hospital with public, private, religious and civil society health units and pharmacies scattered all over the provinces. These contrasting provinces were selected because they provide the broad view of GHP processes in terms of the much talked about concentration of programmes in cities and urban areas and the need for decentralization to better serve the needs of the poor in rural villages.

After a series of informal discussions with specific persons in these two regions, two persons, one from the Centre and North West Provinces respectively, were selected to act as informants for this research. They were selected primarily because of their local knowledge about key actors and organizations taking part in GHP-related activities and personal affiliations with the researcher. The informant for the Centre Province is a senior medical practitioner at the Yaoundé Central Hospital while the informant for the North West Province is senior medical practitioner at the Bamenda Provincial

Hospital. Both persons graduated in the University Teaching Hospital in Yaoundé and have over five years experience working on issues related to malaria and HIV/AIDS in these respective regions. It was interesting to realise that they did not only know the national policy makers, medical practitioners, public and civil society representatives of the two GHP programmes studied in this research; most of them were either former workplace colleagues or former school mates. These informants are also trusted to be able to voluntarily help the researcher to avoid the lengthy process of requesting permission to conduct interviews.

Through the informants, snowballing was used to access interviewees. In the Cameroonian cultural context it is acceptable to go directly to any given address and ask to speak to a representative of an organization. However, in case where the researcher is not very affiliated with the organizations or persons to be interviewed, or where due to technical difficulties in contacting prospective interviewees at the local levels (for example poor communication networks) it is useful to make use of a local contact persons to assist in getting to interviewees as soon as possible. This proved a successful method during the fieldwork for this thesis. The two informants were very useful in collecting phone numbers, email addresses and other contact details of potential interviewees that are otherwise not accessible in programme files and documents (and therefore hard to access through a formal process). Due to political reasons, certain government officials (such as those in the government ministries and ministerial departments) are sometimes less interested in granting interviews even with formal consent. These local informants also play

a key role in connecting me to specific persons within such departments who are then able to pass over my request to the person that I have selected for an interview.

At the global level, interviewees included specific persons within UN agencies, western development agencies, pharmaceutical companies, international CSOs and foundations who represent these organizations in the GHPs studied (RBM, AAI and EAI). At the national level, interviewees were selected from within the Ministry of Public Health and National Malaria and HIV/AIDS Programme Secretariat respectively. At the local level, interviewees were sought from Provinical and District Delegations for Public Health, Provincial and District Units of the malaria and HIV/AIDS programmes. At each levels, the selection was done to reflect the public-private nature of GHP programmes (public, private and civil society groups were included in the selection).

Thus through the formal and informal processes above, all the organizations contacted willingly gave me the details of relevant people to speak to and the snowballing technique was of importance in this respect. There was a huge secondary literature on GHPs in Cameroon (mostly presented as technical reports and programme evaluations) in the secretariat of specific GHP programme offices as well as local initiatives affiliated with GHP programmes. Although the year 2000 was the year of GHPs, there was little capacity for its research and regulation. Internet searches to identify key groups presented a problem in Cameroon.

A feasibility study to identify the interviewees at the global level was not necessary as it was possible to ascertain that GHPs were a highly debated issue in African countries as can be seen from a reading of GHP literature available online (accessed through university libraries in the UK). However, some INGOs and foundations either do not have websites (or have websites that are hardly updated) and their details were not readily available in published documents. The informants were quite useful in directing me where to go (in cases where they cannot travel to get the relevant contacts) to access the persons or organizations sought. This was especially very useful when arranging interviews in urban and rural areas of the selected provinces.

Potential interviewees were initially approached with a letter which was faxed, emailed (if an email address was available) or presented directly (through the two informants), giving details on my research and why I would like to speak to them. The email approach worked best for those persons who work in international organizations or at the national level of GHPs. In case of no replies, contact was sought through the telephone. This strategy had a far greater success rate as once I spoke to either the individuals or organizations personally; I was assured that they would be willing to speak to me. It was rather difficult to arrange exact interview dates and times whilst in the UK for the research, due to the 'laid-back' approach to timetabling and scheduling prevalent in Cameroonian culture.[16] Although I was a little anxious about access and the availability of interviewees prior to my research trip, this proved not to be a problem as access was never denied and, due to the flexibility of

[16] When I contacted the organization I was reassured that it was not necessary to arrange a meeting and that I could turn up and speak to them at any time.

interviewees' timetables, availability was not a problem. Again in many cases, the two informants had established how flexible certain interviewees would be with respect to timetables during the period of the research.

The groups at the global level were identified mainly through web-based searches. This proved a useful method for the fieldwork, as websites were regularly available and fully updated. In order to engage with some pharmaceutical companies I contacted prominent persons known to promote corporate social responsibility (where the right person to interview could not be identified in GHP documents and other sources) and was able to arrange interviews with the relevant persons through them. In these cases interviewees were mainly approached via emails with a reference to the person through whom contact has been sought. In all other cases, interviewees were mainly approached via emails and the majority of interviews were arranged this way including specific date, time and location (telephone interviews).

Access was more of an issue at the global level than at the national and local levels. GHPs and access to medication is a highly controversial issue in many developing countries and this had ramifications for this research. Some organizations were concerned as to the agenda of this research although all the organizations noted that the Information Sheet and Consent Form clearly explained the funding of the research as well as the underlying motivation behind it. However, while the organizations were assured that this research was purely academic and without any ulterior motives, the interviewees recruited expressed concerns as to the wider implications of their responses. At the

national and local levels all participants were willing to participate even if an authorisation to carryout fieldwork in Cameroon issued by the Department of Research at the MoH was not presented.

There were some unsuccessful attempts at obtaining interviews from some international private organizations. In the case of one pharmaceutical company, two persons who had been recommended as most suitable for an interview never accepted to participate. One of them had left the position since six months and opted as not being in a position to participate. The other person said 'Unfortunately, I am not in a position to answer to your interview due to the nature of my job'. For a similar reason, a sample of the themes and possible interview questions were sent to three pharmaceutical companies before they accepted to participate. It appears, on the basis of the interviews, their concerns centred around the possibility of releasing internal information on bilateral negotiations they have with each developing country on drug prices/quality and supply arrangements that are independent of the GHPs to which they belong.

There was an unsuccessful attempt at obtaining interviews from the French Cooperation, considered as one of the most important global partners (especially in terms of funding and governance guidelines). Both its offices in France and Cameroon were approached for an interview. However, they were unable to arrange a suitable date and time for an interview and were not able to contribute to this research through this method. However, there are several interviews given by the French Cooperation in Cameroon in their website that were suitable for the purpose of this research. All other international

organizations that were approached happily accepted to participate in the interview.

3.3.4 Interview Process

The main fieldwork for this research was carried out in December 2007 in Cameroon and between January and February 2008 in the UK (telephone interviews). Thus approximately three months in total was spent conducting fieldwork. Before setting out to Cameroon an interview schedule was prepared, detailing questions to be asked. A number of draft and amendments were made before the final interview schedules were reached. There were three types of interview schedules, one devoted to analysing the nature of the national health system (pharmaceutical and healthcare delivery) in general and two devoted to the national malaria and HIV/AIDS programmes respectively (see Appendix).

The interview schedule on the national health system was devoted to the historical context of the national health system and the emergence of GHPs in Cameroon. It was specifically targeted at those interviewees who do not have any direct responsibility in national GHP programmes. This included the Division of Healthcare Organization and Health Technology within the MoH, Provincial and District Delegations of Public Health and selected public, private and civil society health and pharmacy units. The questions were designed around the following themes:

- Description of the structure of the national health system
- The process of pharmaceutical and health care delivery
- Barriers to access to medication (potential vs. actual access)

- Awareness of the impact of GHP programmes (overlapping programmes)

The interview schedules for the national malaria and HIV/AIDS programmes were similar to each other, the only difference being specific issues related to disease areas. In addition, during the course of interviews references were made to the questions on the interview schedule designed for non-GHP partners (described above). In general, the interviews were designed in relation to the following broad themes:

- Barriers to access to medication and the creation of national GHP programmes
- The nature of GHP programmes vis-à-vis country-specific context
- The role of each partner vis-à-vis other partners (policy making and implementation)
- Impact or outcome of GHP programmes, challenges and future prospects

The interview schedules were variable at the global, national and local levels to reflect the different status of GHP across these scales. For example, questions about bilateral negotiations between developing country governments and individual pharmaceutical companies were not deemed to be relevant for interviewees at provincial units whose tasks are limited to coordinating programmes and activities within the province. The interview schedule was used as more of guidance than a rigid framework and attention was paid to the interviewees' responses. In addition, interview questions were tailored to each individual's response. Indeed, in some interviews it was not necessary to ask

the majority of the questions in the interview schedule, as the interviewees covered most of the topics without prompting.

Twenty-six interviews were conducted throughout the fieldwork. They varied in length from approximately fourteen minutes to fifty-six minutes. Seven of the interviews were conducted by telephone (most with global partners) while the rest were face-to-face interviews. As explored later in the case studies, some of the interviewees spoke as representative of more than one GHP partner. For example, the national disease committees consist of representatives at global, national and local level. Therefore some interviewees, in addition to being members of the national committee, also hold positions of responsibility in specific GHP programme or activity at global, national or local level. In this case it was ascertained that a total of thirty-four interviews were conducted for this research. The interviews took place in a range of locations including governmental offices, university laboratories, cafes, interviewees' home and telephone. Much care was taken to ensure that telephone interviews took place at locations that were tailored to suit the interviewees. Brief notes were taken during and after the interviews (highlighting key points) and more detailed field notes were taken after the interviews, which typically included observational notes. These were noted in the log book

3.3.5 Ethics and Consent

Although the interviews for this research did not require ethical approval through an ethics committee, the issues of ethics and consent were of great importance. The ethical guidelines of both the University of Nottingham and

the national ethical framework for conducting research in Cameroon respectively were used throughout this research. Nottingham University's six key principles on ethical guidelines[17] are as follows:

I. That the ethical basis and design of research projects are ethically sound and have received the approval of the relevant ethics committee(s) and all relevant statutory regulatory authorities before they commence.

II. The safety of all involved in the research process, ensuring that the research is carried out in accordance with health and safety policies and legislative requirements;

III. Ensuring that research is conducted in a suitable working environment with appropriate equipment and facilities;

IV. The probity of the financial management of all research projects, and for seeking to provide the optimum value for the public or private funders who have invested in them including effective project management to agreed project plans and appropriate quality standards, as well as the timely delivery of any scheduled tangible outcomes;

V. Management of research data in accordance with the Data Protection Act 1998 and any other legal provisions, conditions and guidelines that may apply to the handling of personal information;

VI. Undertaking professional development appropriate to the research

The national ethical framework for conducting fieldwork in Cameroon requires a set of documents to be submitted to the Research Ethics Officer of the

[17] The University's Research Ethics Review Checklist (http://www.nottingham.ac.uk/rso/local/research-strategy-andpolicy/code_of_conduct.pdf) is complied by the Institute for Science and Society Code of Research Conduct:<https://www.nottingham.ac.uk/shared/shared_iss/documents/ISS_Research_Code_of_ConductV3_Oct08.pdf> (Last accessed: 10/02/09)

relevant Ministry to which the research is most related. After receiving the documents, a clearance is issued in the form of an authorization to conduct research in Cameroon. In the case of this research, this involved submitting the following documents for approval by the Ethics Officer in the Ministry of Public Health prior to the start of fieldwork:

I. An undertaken from the head of the department or institute in which the research is being carried out declaring the status of the institution, modalities for dissemination and valorisation of results and that ethical clearances have been approved by the institution.
II. Personal undertaken by the principal investigator in respect of fieldwork research in Cameroon declaring full costs of fieldwork, sources of funding, relevant external ethical guidelines and modalities for dissimilating findings prior to the start of fieldwork.
III. Presentation by principal investigators a CV (that he/she is qualified to undertake the research), research proposal, information sheet and consent form.

The above ethics framework emphasises the use of judgement, discretion, accountability and integrity and these principles were followed throughout the research. Prior to the interview, the objective of this research were made explicit to the interviewees, in that this thesis seeks to investigate impact of GHPs on access to medication in Cameroon. They were informed that the findings of this research would be available in the public domain in the form of an academic thesis and possibly in scientific journals. They were also assured that any comments made would be suitably anonymised in order to protect

their confidentiality and that all data would be destroyed once the thesis had been competed (this was done in line with the University of Nottingham's research ethics framework).

All interviews gave their written (face-to-face interviews) and verbal (telephone interviews) consent for their interviews to be used in this way. Although the above ethics guidelines state that consent is typically given in written form it was judged not to be practically suitable for telephone interviews as well as that verbal consent was able to fulfil the primary objective of 'conducting research openly and without deception'.[18] Consent for the interviews to be recorded was also asked prior to the interview. All the interviewees accepted. Once the interview was over, interviewees were given my contact details and asked to contact me if they have any further queries regarding this research. The confidentiality of interviewees was ensured by treating quotes and comments as anonymous.

3.3.6 Documents

During the interviews, some of the interviewees provided me with documentary data, usually in the form of annual reports, technical reports, programme evaluations, organizational literature, and government documents and, in some cases, academic literature (usually written by the interviewee or a member of the organization). For example, during the interview at the secretariat of the National Malaria Programme, the Provincial Delegation for Public Health (for both Centre and North West Provinces) I was granted access

[18] ESRC Research Ethics Framework :24 <http://www.esrcsocietytoday.ac.uk/ESRCInfoCentre/Images/ESRC_Re_Ethics_Frame_tcm6-11291.pdf> (Accessed: 10/02/09)

to the documentation department. The relevant information officers in each of these offices were available to show me around and have informal chats with me on any questions or issues that I raised. These informal discussions (noted in my logbook) provided valuable data that enabled me to corroborate interview data and get more insights about specific issues on GHP programmes. These documents lie between observational data and individual data and can provide evidence as to how people or organizations would like to project themselves and their experiences (Murphy and Dingwall, 2003). These documents were used as complementary sources and often aided understanding of the interviews. However, these documents were not formally analysed.

3.4 Analysis of Data

This section will detail the process used to analyse data in this thesis. How one regards the status of an interview data is important in how one analyses it. One of the difficulties of describing this process is that it was very much an ongoing process that was present, both formally and informally, throughout the writing of the thesis and had no precise beginning or end. However, this section will detail the formal methods used to analyse data.

Interviews can be analysed as 'straightforward reports on another reality or whether they merely report upon, or express their own structures' (Silverman, 2001:111). This thesis regarded the accounts given by interviewees as their own personal reflections on the role GHPs on access to medication as opposed to an objective depiction of GHPs. The interpretation of the data took this into account as well as the social context of the interviews, including the behaviour of the interviewee (noted in field notes), as this impacted the data gathered.

As already mentioned the analytical method used in this thesis is NPA. It focuses on rhetorical issues as applied to content analysis of texts, or a close reading of interview transcripts (Silverman 2003) to understand the stories (or narratives) people tell with very detailed quotation from texts and interviews (e.g. Roe, 1989; McBeth et al., 2007). For this reason, the interviews were transformed into data through transcription. The interviews were transcribed verbatim (although those conducted in French were translated into English) and although key notes of context (e.g. when someone left or entered the room) were also detailed, minute linguistic details such as false starts were not documented as it was deemed that the impact of these on the research analysis was minimal.

It was therefore decided that the use of computer assisted qualitative data analysis (CAQDAS) was not suitable for this research. Some authors have stated the limitations of CAQDAS as stifling qualitative creativity, limiting interpretations, distorting and weakening data (Becker, 1993; Kelle, 1995; Richards and Richards, 1998; Roberts and Wilson, 2002). It was also decided that computer software package (such as NVivo) were irrelevant as they have not previously been used for NPA related studies. In addition, it was also thought that the use of such software could potentially limit the reflexivity of analysis and therefore not allow for an in-depth review and detailed quotation of the interview data. Therefore a manual approach to data analysis was adopted.

The first step of data analysis involved reading the transcribed interviews and field note, without any note taking or writing on the scripts. This was in order to familiarise myself with the actual scripts. After this first stage of familiarisation interview scripts and field notes were read again, noting prevalent and interesting themes that would be used as the basis for the second stage of data analysis.

A second stage of analysis was inspired by coding practises. Bryman (2001:392) describes coding as a process of 'reviewing transcripts and/or field notes and given labels (names) to component parts that seem to be of potential theoretical significance and/or that appear to the particularly salient within the social worlds being studied'. At this stage scripts were read several times so that labels could be ascribed to emergent themes within the data. Practically, this was done by assigning themes to a particular colour and manually highlighting relevant parts of the data that corresponded to particular themes with the assigned colour. For example, red equalled governance issues, yellow equalled transcalar network issues and blue equalled discussions on access to medication. By this time most of the script was highlighted and, indeed, I was so familiar with the scripts that I committed to memory large sections.

The next stage of data analysis involved constructing a skeletal thematic structure. This structure was based on the themes of the data analysis but also related to the research questions and theoretical framework that shaped the thesis. In line with Coffee and Atkinson (1996:30) this involved expanding and teasing out data in order to formulate more levels of interpretation.

The broad themes that emerged from the data were:

- the formal and informal mechanisms through different narrative strategies on access to medication were negotiated when formulating and implementing policies
- the interpretation of policies and practices on global, national and local levels
- the types of cooperation existing among and between actors that lead to the formulation of policies and the design of programmes and activities at local levels
- the role of key institutions in coordinating and directing different levels of policy formulation and implementation

Documents were also analyzed in order to understand how the current status of GHP programmes relates to the historical and contextual characteristic of the emergence and role of GHPs in facilitating access to medication. This was also relevant because many of these documents were used to create the interviews especially in terms of the hierarchy of global, national and local processes.

The above themes provided the basis and structure of the subsequent data chapters. Each theme relates to a particular research question that the thesis sought to answer. The theoretical framework adopted in this thesis was also used to analyse the data. The construction of access to medication and the role of actors in formulating and implementing policies guided the classification of the themes that had emerged from the field work. These two perspectives proved to be extremely useful analytical tools as they anchored the data

theoretically and this enabled deeper more complex levels of interpretation which would not have otherwise occurred.

3.5 Critical Reflections

So far in this chapter I have detailed the methods used to conduct this thesis and the rational behind them. In this section I shall discuss some of the unanticipated and somewhat unexpected elements of the research process. I shall also outline some of the limitations of this research and propose ways in which this research could be improved.

3.5.1 The Role of Identity

It has been shown that, 'conscious subjectivity' of researchers has replaced the 'value-free objectivity' of traditional research and that this does not only increase honesty, but also helps to break down the power relationship between researcher and researched (Cotterill and Letherby, 1993:72).

One of the main findings, particularly from the national level was how much my identity impacted the research. The first thing I realised when doing research in Cameroon was the impact of the colonial legacy, which seems to infiltrate all aspects of Cameroonian society. Although it did not exert a significant effect on my project it shaped how interviewees viewed me as a Cameroonian on the one hand, and as someone coming from the UK (where my research study is based) on the other. It was quite amusing to see people wanting to speak in English simply because I was an English-speaking Cameroonian coming from Britain for research. In particular, when I arrived

for one interview at the MoH, the secretary was quick to politely refer me to another office (instead of her boss) saying 'that is where English-speaking persons are located'. In another office located in the English-speaking region, a French-speaking director, on entering his office, immediately apologised for his insufficient English proficiency and requested to have the interview in French to enable more detailed discussions. In a few cases, an interviewee would start to speak in English and suddenly switches to French (and vice versa) while in others it was mutually decided that I ask my questions in English for the interviewee to respond in French.

The concept of a 'native' was quite useful to most of the national and local interviewees. Some interviewees spoke in the vernacular when welcoming me to their offices and many were very happy when I did understand what they were saying. It was quite an interesting experience because it made me very aware of my cultural background and how this can shape the way in which people, in particular interviewees respond to me. It also facilitated the whole interview processes as many interviewees even invited me for refreshments after the interview (or at a later convenient time).

According to Arendell (1997:343) 'conscious subjectivity' takes into account issues as identity, race and cultural background. Researchers bring to the research process cultural, social and historical 'baggage' which effects the interaction between researchers and researched'. Although Arendell focused on the impact on a woman interviewing a man (in which case my research displays the opposite) awareness of these issues can enrich the research

process, as it enables reflexivity on the part of the researcher. It is obvious that my identity did impact my research findings in ways that allowed me to subject the research itself to investigation and also my role within it. Such an additional self-reflexivity adds another level of analysis that would not be possible if issues such as identity were not taken into account.

The role of my identity and the part it played in how the interviewees responded to me could be seen to present a form of bias in my research, which could challenge the reliability of the findings. However, it is recognised in all social scientific research it is not possible to exactly replicate social settings, even with the same person/people conducting the research (LeCompte and Goetz, 1982). This phenomenon is not unique to my research and does not pose a challenge to the findings as this does not affect the validity of the research as there is a direct link between my observations and the analysis of the data.

3.5.2 Limitations of Study

On reflection more public, private and civil society organizations could have been included in this research. Although many local partners were contacted (especially representatives from patient groups) they were only interviewed informally to compliment the data collected from documents and formal interviews. It would be more representative to include more of these local partners as they would have given a deeper insight to GHPs from their local perspective and perhaps add new levels of complexity on the role of GHP in Cameroon (for example, the extent to which policy issues agreed at the global and national level are translated into programmes and activities at the local levels).

One of the main areas of improvement was the lack of inclusion of the local civil society partners in this research. The people included in the research where identified as key stakeholders, but arguments could be made for the inclusion of local people. However, ordinary people who would be/are affected by GHP policy discuss and make sense of GHP would have been an interesting topic to investigate. Although this would have broadened the research focus, it would have provided useful insights as to the how these people make sense of GHP issues since GHPs are meant to address the needs of the poor. In addition a systematic study of the role of supporting ministries and the public, private (for-profit) and religious health units in GHP processes was also not given serious consideration. At the end of the fieldwork, it became obvious that the multiple providers of healthcare in Cameroon play a crucial role and have a significant impact in determining the chances of success of the GHPs. This is because, many of these non-state partners run parallel HIV/AIDS and malaria initiatives independently of national GHP programme committees.

As pointed out in chapter two, existing studies on GHPs have usually taken institutional structures as given, rather than in a process of change. In this thesis, the role of the nation-state is related to its surrounding global and local dynamics as a way of developing new categories and analytical strategies for the study of what happens within the borders of a nation and the construction of its social, economic and industrial space. Such an approach does not only reveal the challenges facing global, national and local partners within GHP programmes, but provides the possibility for proposals to incorporate their

competing interests. In such a multi-range or multi-level analysis of policy choices, Sahay and Walsham (1997) illustrate that the use of metaphors (e.g. narrative strategies) can influence specific choices over time. Similarly, Lind (1991) point to the potential for new types of risks arising because differences in the context of global, national and local development policy.

Accordingly, the object of analysis in this thesis is not a single organization or inter-organization relations, but the multiple interactions, dependencies and interdependencies of UN agencies, government ministries, development agencies and other local (public, private and civil society) organizations involved in the process of policy making and implementation. Ultimately, the study is not restricted solely to the national country setting, but also to events outside the direct control of Cameroon and in relation to events happening in the surrounding region and the global context as well. This places the case studies of GHPs for HIV/AIDS and malaria in Cameroon in a position of special interest with respect to similar initiatives in other African countries.

3.6 Conclusions

This thesis aims to investigate the impact of GHPs on access to medication in Cameroon. This chapter has outlined the rationale behind the research design and methods used to carry out the investigation. It agues that the key challenge in unpacking the GHP model is to understand how the competing and conflicting narratives of access to medication are negotiated at global and national levels and how the combination of these are translated into specific programmes and activities at the local level. This is what makes the NPA a

suitable method for analyzing the GHP model in Cameroon. Documentary analysis, case studies and semi-structured interviews have been used in this study in order to conduct a social scientific project that analysis how GHPs grapple with the issue of access to medication in Cameroon. Ethics and consent have been considered and how these were managed was discussed. Finally this chapter critically reflects upon the research process as a whole and the limitations and unexpected findings of this research have been detailed.

CHAPTER 4: A GLOBAL PERSPECTIVE THE EMERGENCE OF GHPS

4.1 Introduction

The main objective of this chapter is to present the global perspective on the emergence of GHPs as a new kind of global model for securing access to medication in developing countries. As mentioned earlier, the emergence of GHPs reflects the challenges facing medicine and healthcare in developing a global language and a global strategy that can help to improve the health of the poorest people in the world. As such, GHPs attempt to achieve access to medication by integrating previously competing and conflicting narrative strategies on where the emphasis on access to medication should be placed, namely, public health (WHO and UNICEF), economistic (WTO, IMF and World Bank) and human rights (UN and International Civil Society Organizations) respectively. This chapter identifies and explains the role of theory in shaping these narratives and consequently how the narratives became embodied in GHP models on access to medication for malaria and HIV/AIDS. It therefore sheds new light on how GHPs are modelled to formulate global policies that are meant to be implemented on a country-by-country basis.

The key argument here is that each GHP represent the embodiment of elements (forms of knowledge) from previous public health, economic and human rights models into a GHP 'models' on access to medication. To substantiate this argument, this chapter applies the theoretical framework developed in this thesis, especially, to conceptualise GHPs as models that mediate between

theory and practice as a better way of understanding their role on access to medication. In this case, models (Morrison and Morgan, 1999; King and Kraemer, 1992:7) can be located and studied where developments in theory paralleled or preceded developments in policy practices related to the models (MacKenzie, 2006). The focus of most GHPs on a narrowly defined role (Buse 2004a) suggests that modelling their role as liberal/neo-liberal interventionists have done (Dodgson et al., 2002) may not fit country-specific context. In addition, the conceptualisation of the determinants/narrative of access to medication by partners to GHPs is hardly made explicit in most study of GHPs. NPA (Kaplan, 1986) therefore becomes a useful analytical framework for making explicit certain issues that are only implicit in GHP policy documents, technical reports and the wider development studies literature on access to medication (Ngoasong, 2009).

Thus, to better understand how GHPs are modelled, this chapter conceptualises them as the embodiment of parallel development models previously promoted by Western nations and UN agencies respectively in developing countries. This implies that although GHPs are of a practical nature, they are implicitly theory informed and this is how they should be studied. Economistic and public health models created in Europe and North America first found their way into developing countries through colonial routes. Later on modified versions of the models were endorsed at international meetings convened by UN agencies and deployed to developing countries for implemention. From the late 1990s, GHPs began to integrate elements of these models into a global model on access to medication.

After exploring the role of theories in shaping the three narratives (forms of knowledge) embodied in GHP models, the potential role of GHP models in shaping local practices (national GHP programmes) are discussed. The next section of this chapter presents the public health narrative on access to medication. It is rooted in behavioural and change models that became embodied in variants of the Primary Health Care (PHC) model promoted by the WHO and UNICEF. Next the economistic narrative, rooted in theories of technological change and economic growth that dominate liberal and neo-liberal market models promoted by IMF, World Bank and WTO is presented. This is followed by a discussion of the rise of a human rights narrative on access to medication. Though rooted in human rights theories, this narrative was implicit in both economic and public health models but later taken up more seriously by UN agencies due to rising incidence and burden of diseases such as HIV/AIDS and malaria and activism by international CSOs.

After exploring the role of theories in shaping the three narratives (forms of knowledge) above, the ways in which they are embodied in GHP models as well as the potential role of GHP models in shaping local practices (national GHP programmes) are discussed using three case studies: WHO/UNICEF-led RBM with a public health emphasis, UNAIDS-led AAI with an economistic emphasis and the MSF-led EAI with a human rights emphasis. Finally the overlapping nature of the three models in relation to country-specific implementation challenges is discussed.

4.2 The Public Health Narrative of Access to Medication

This section provides a description of how theoretical models of public health, developed decades ago, contributed to the emergence of a public health narrative on access to medication in GHPs. The field of public health does not have its own traditional theories. Theories were often adapted from the social and behavioural sciences and applied to epidemiology and the biological sciences (Kreuter and Skinner, 2000) to inform public health policies. Thus the terms *theoretical concepts, theoretical models or frameworks* are often used interchangeably to refer to theories of public health. This also allows theorists to continue to use new social science research to refine, adapt and integrate existing theories (Caplan 1993; Rawson 1992). As discussed below, although global health policy is generic or of a practical nature, they are implicitly theory-informed.

4.2.1 The relationship between public health models and policy practices

The period 1910-1950 is often described as the 'golden age' of scientific, techno-medicine in public health. Following the Flexner Report (1910)[19], the medical profession was institutionalised in universities and research institutes across the US and Europe in relation to changing socio-economic conditions. A growing middle class demand for health care supported a substantial growth in medical centres offering individually focused fee-for-service specialist medicine, what became known as the medical model (Turner, 1995). By 1950, significant developments in micro-biology had heralded a 'New Public Health'

[19] Flexner, A. (1910) 'Medical Education in the United States and Canada' *Bulletin Number Four (The Flexner Report)*. New York: The Carnegie Foundation for the Advancement of Teaching.

as practitioners appeared to fully embrace the medical model rather the environment or 'social' model (Draper, 1991). However, as discussed below, 1950 proved to be a turning point, largely due to the popularity of social theory (psychology and behavioural sciences) in introducing a focus on lifestyles and health behaviour into public health settings.

Armstrong (1988) explains the above shift in terms of the institutionalization of the medical profession and the changing clinical practice that undermines more traditional oppositions between health and illness. This is very much reflected in the numerous theoretical models developed within public health from 1950s. There are 'explanatory theories' (Table 3) on the causes of public health problems and 'change theories' (Table 4) on the development of public health intervention/evaluation programmes. The former emphasise individual and interpersonal levels (cognitive-behaviour theories) and while the latter focus on the community or society as a whole (frameworks for implementing multi-dimensional approaches to promote healthy behaviours) respectively. The development of these models was largely dependent on the health settings and the professional background of those who developed them.

Explanatory theoretical models explore behaviour caused by intra- and interpersonal factors, including attitudes, beliefs, motivation, historical context, past experience, and skills (Table 3). The context of health care during the early 1950s encouraged an emphasis on disease prevention rather than treatment. The theoretical models were also characterised by some degree of

mathematisation, risk analysis and cartographic representations to give a material foundation to the models.

Table 3. Key individual and interpersonal theoretical public health models

Model	Originators	Theory	Purpose of model
Health Belief Model[1]	Rosenstock, Kegel, Hochbaum (1950s)	Behavioural Science/Psychology	Predicts preventive health behaviour in USA
Stages of Change Model[2]	Prochaska J.O & DiClemente C.C. (1970s)	Behavioural Science	Explain smokers' decision to give up smoking habits
Planned Behaviour; Reasoned Action[3]	Fishbein & Ajzen (1970s/1980s)	Social Psychology	Behavioural intention as a determinant of behaviour
Precaution Adoption Process Model[4]	Weinstein (1980s).	Social Psychology	Explain path from health awareness to health action

Source: [1]Rosenstock (1974); [2]Prochaska & DiClemente (1983); [3]Fishbein & Ajzen (1975); [4]Weinstein (1988)

Change theoretical models (Table 4), were largely motivated by social networks, social support and systems theory. Saul Alinsky and Jan Rothman were very influential. They challenged the structural/individual level models in the face of '*the war on poverty in the sixties*' in the USA and Europe, a process that led to concepts such as community organization, community participation and community development to be widely applied national and international from the 1960s (Tones and Tilford, 2001:398). Midgley et al., (1986:20) illustrate the role of these community activisits as follows: 'Instead of seeking to help deprived communities to improve their social and environmental circumstances, the new community work activists urged that people take direct political action to demand changes and improvements.' The writings and

campaigns of community activists provided the basis for the development of tools and methods for evaluating community-level health promotion efforts (Fetterman et al., 1996; Fawcett et al., 2000).

Table 4. Key community (change) models of public health

Model	Originators	Theory (Background)	Purpose of model
Community Action[1]	Saul Alinsky (1940s-1970s)	Social activism	To mobilize and organize grass roots campaigners in Chicago
Community Organizing[2]	Jack Rothman (1960s-1970s)	Social and community planning; social action	How a community function, change and mobilize community members

Source: [1]Alinsky (1946; 1971); [2]Rothman (1968; 2001)

The structural/individual models (Table 3), having emerged from publicly funded university project and programmes, were more important in policy making than the community models (Table 4). They helped policy makers to interpret field conditions and guided their decisions about intervention strategies. Once intervention strategies were decided the theories behind the models again played an important role in formulating models of implementation. Much cited examples include s*ocial marketing* programmes that voluntary behaviour change (Alcalay and Bell, 2000) for health benefit (such as condom users or cigarette smokers) (Andreason, 1995). Similarly, *PRECEDE-PROCEED* enable researchers to identify and implement outcome-based intervention strategies in public health (Green and Kreuter, 1999).

At the international level, health policy practices did not necessarily follow the theory-informed rational planning process described above. Policy making

often took place during international conferences and meetings and involved negotiations among conflicting and competing narratives offered by diverse stakeholders with an interest in the policy process (Ngoasong, 2009). The acceptance of a model depended on a combination of negotiated interrelated factors which determined the specific policy proposal that might be adopted. This was sometimes done without any consideration to country or context-specificities. This further justifies the argument in this research, that the best way to study global models is by studying how different elements of theoretical models come to play a role in the formulation of a model.

4.2.2 From international health to global health – How models shaped a public health narrative on access to medication

The debate around the best model to adopt internationally since the 1950s focuses on whether substantial improvements in the health of a community are dependent on medical (access to medicines) or non-medical (access to healthcare but also food, sanitation and other socio-economic needs) intervention (McKeown, 1979; McKinlay and McKinlay, 1977). The WHO was created in 1945 as a specialised agency in charge of international health policy formulation and implementation. It defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[20] The role of the models described above in the policy practices of the WHO first became explicit in the 1978 Alma Ata Declaration, the first of

[20] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) effective on 7 April 1948.

its kind to be fully embraced by developed and developing countries (WHO, 1978).

The Lalonde Field Model of 1974 was very influential in committing WHO member countries to the principles of the Primary Health Care (PHC) model adopted at Alma Ata. The report was presented by Marc LaLonde, a former Canadian Minister of Health. It used behavioural/explanatory theory-based evidence to put forward the claim that improvements within the environment (a structuralist approach) and in behaviour (a lifestyle approach) should be the main objective of public health (preventive measures). According to Hanckock (1985:10):

> '(The Lalonde Field Model was) the first modern government document in the western world to acknowledge that our emphasis upon a biomedical health care system is wrong, and that we need to look beyond the traditional health care (sick care) system if we wish to improve the health of the public. The Lalonde report was followed by similar reports in Britain, Sweden, USA & elsewhere'.

In the Alma Ata Declaration, PHC was defined as 'essential health care based on a practical, scientifically sound and socially acceptable method, made universally acceptable to individuals and their families in the community through their full participation and at a cost country and community can afford at each stage of development in the spirit of self reliance and determination'.[21] Apart from embracing the provisions of the LaLonde model, the PHC also incorporated a commitment to community participation and inter-sectoral action, a commitment which has been explicitly emphasised in subsequent reorientations of the PHC system (Table 5). In particular, the Jakarta

[21] WHO (1978) Primary Health Care: Report on the International Conference on Primary Health Care, Alma Ata, 6-12 September. Geneva: WHO/UNICEF

Declaration states 'participation is essential to sustain efforts. People have to be at the centre of health promotion action and decision-making processes for them to be effective'[22].

Table 5. Importance of community models at WHO/UNICEF-led meetings

Date	*Theme of meeting*	*Narratives on participation*
1978	Alma-Ata Declaration: The Primary Health Care	*Participatory approach* adopted as core of the Primary Health Care system
1987	Bamako Initiative: Re-orientation of Primary Healthcare in Africa	Community participation in co-financing and co-management of drug supplies
1986	Ottawa Charter for Health Promotion	*Empowerment and Equity* in health policy practices at global, national & local levels
1988	Adelaide Recommendation on Health Public Policy	*Equity* in all areas of health policy making and implementation
1991	Sundsvall Statement: Supportive Environment for Health	*Community empowerment* and *community participation* in democratic health promotion
1997	Jakarta Declaration	*Participation is essential to sustain efforts*
2000	Bridging the Equity Gap (Mexico Conference)	*Improved interactions between all players* in bridging the equity gap in health programmes
2005	Bangkok Charter for Health Promotion	Key focus on *communities and civil society* as a requirement for good corporate practice.

Source: Author's processing of WHO/UNICEF-led meetings

At first glance, it is not clear why the community model became so important at the international stage given that, unlike the behavioural models, they were less institutionalised and received limited public funding. MacDougall (2007:955) claims that: 'internal political and economic forces are as important

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<http://www.who.int/healthpromotion/conferences/previous/jakarta/declaration/en/index1.html > (Accessed: 21/04/09)

as international trends in determining healthcare policy initiatives'. He offers the following as part of the explanation for this trend:

> 'In the 1970s all the English-speaking developed nations were facing deficits as curative costs rose. Adopting health promotion policies permitted them to shift responsibility back to local governments and individuals while limiting their expenditures. Health and community activists, however, used this concept to broaden their focus to include the social, economic and political determinants of health and thus reinvented public health discourse and practice for the 21st century.'

Unsurprisingly, therefore, the PHC model implicitly offered a new vision of health promotion that aims to combine both individual and community level approaches. It also addresses the structural determinants of health. This is what made it so attractive – it combined everything, including the socio-economic determinants of health. Health promotion is what held everything together (Tones and Tilford, 2001).

Participation is defined not in terms of a single community-level model, but in terms of achieving a level playing field between both approaches and taking into account conflicting interest of partners in developed and developing countries. Future models of public health such as PATCH[23] that emerged from the international meetings on Table 5 above combined both approaches (see for example Haglund et al., 1996). This meant that, although countries endorsed the PHC model and its subsequent variants, in reality, national health systems consisted of discrete disease control programmes and activities that were hierarchically organised (Gish, 1992) based on specific or a combination of individual, interpersonal and community models described above (Beaglehole and Bonita, 1997: 124). These models had long been exported to developing

[23] For details on PATCH (Planned Approach to Community Health) see Kreuter (1992)

countries through colonial routes even before the PHC was launched. A former WHO Director General noted as follows:

> 'Repeatedly ... I was forced to keep a prudent silence when high-level officials from a given government would tell me with pride that they had a specific "office" or a "national program" for primary care, or that they had primary care activities only in the most peripheral health centres' [24]

Thus, the public health narrative on access to medication, as put forward by the PHC system, focused on balancing preventive and curative measures through community compliance (what the medical experts say) and community participation (communities provide funding and help with preventive activities such as hygiene and sanitation programmes). The strategy for implementation was to be determined by member countries.

The discussion above reveals how traditional theoretical models found their way into the public health arena of countries all over the world and ultimately became objects of 'international' enquiry. Starting with Alma Ata, the WHO (and UNICEF) began to give certain models more legitimacy over others, serving as a major export route for models around the world through international policies endorsed by member countries. Subsequently, the Ottawa Charter argued that 'health promotion can only make sense as a 'global' phenomenon'.[25] Since then, health policies promoted by international organizations have come under increasing scrutiny in terms of their applicability in different countries of the world. Whitelaw, McKeown & Williams (1997:480) define 'global models of health promotion' as

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[24] Tejada de Rivero, D.A. (2003) 'Alma-Ata Revisited: Perspectives in Health Magazine' *The Magazine of the Pan American Health Organization* 8(2): <http://www.paho.org/English/dd/pin/Number17_article1_4.htm> Accessed: 25/01/2008. .

[25] WHO (1986) The Ottawa Charter for Health Promotion, *Health Promotion,* 1(4): i-v.

'perspectives which focus on simple additions of different health promotion activities, approaches, agents and/or levels of intervention to facilitate health promotion.' They distinguish between models that focus on the 'determinants of health' (conceptual relevance of traditional public health models) and those that emphasise 'health promotion practice' (range of interventions envisaged by creators of models). They argue that both types of models present a 'holistic' view of 'wholeness' of health, one that encompass the entirety of either health determination or health promotion action.

Such a holistic global view is captured in the WHO report on Macroeconomics and Health (WHO, 2001). It provides a framework for defining the extent of consensus in the global health community about the values and approaches that should underpin efforts to improve the health of all people. It also reveals the WHO's conflicting position on public health, that is, a strong emphasis on public health as an instrument of broader economic development, rather than the individual and community orientation at the core of the PHC model. Thus, to understand the role of the public health narrative in policy practices, the next section examines the case of malaria in historical perspective.

4.2.3 Illustrating the public health narrative – the case of malaria eradication campaigns

Malaria is a mosquito-borne disease that has survived human history. It is currently endemic in 130 countries and as explained in the introduction is one of the major causes of death in Africa and Asia, espacially infants and pregnant mothers. It is described as a disease of poverty caused by high annual entomological inoculation rates (EIR), tropical location of countries,

population growth and movements, poor housing conditions, drug resistance and poor health care (Gallup and Sachs, 2001). As discussed in this section, these factors cut across the public health models discussed above.

The shift from a strict reliance on the 'medical model' to those emphasising preventive activities (promoting rural to urban migration, improved housing, indoor spraying insecticides and draining of swampland) led to malaria being eradicated from most of Europe and North America by the early 1950s (Farley, 2004; de Zulueta, 1994). Based on the eradication 'success stories', an emphasis on disease prevention formed the basis for the first ever WHO-led Malaria Eradication Programme (1954-1965) implemented in the developing world (Nájera, 2001; Mabaso et al., 2004; Rosenberg 2004). The programme's model was built around a strategy that included draining swamps, infrastructure development and socio-economic changes. While projects proved successful in some African countries (Mabaso et al., 2004), others were largely ineffective and left in the hands of governments (Greenwood and Mutabingwa, 2002).

In 1992, the WHO attributed the country-specific programmes that failed to growing drug resistance, economic shocks that reduced governments' health spending, insufficient and sustained donor funding, and lack of community participation (Sachs and Malaney, 2002; WHO 1993), factors which reflect the combination of elements from both individual and community level models. It then launched a Global Strategy for Malaria Control (GSMC) in response to these challenges (WHO 1993). The GSMC provided Special Funds for

Accelerated Implementation of Malaria Control in African countries focusing on the use of insecticide and anti-malarial drugs. However, from the early 1990s, empirical evidence began to emerge stating that adherence to treatment, country-specificities (the need to focus on behavioural models) rather than the use of insecticide and the generosity of donors (El Geddal, 1985; de Zulueta, 1994) were the major causes of failures (Najera et al., 1998).

The above contrasting evidence coincided with the resurgence of malaria in many developing countries in late 1980s and became the focus of intense international debate about where the emphasis on malaria treatment and control should be placed. The debate was spearheaded by numerous international initiatives launched in the late 1990s, such as 1997 Multilateral Initiative on Malaria (MIM),[26] 1997 Medicines for Malaria Venture (MMV)[27] and Harvard Malaria Initiative (1997)[28] and the Wellcome trust report (1999).[29] These efforts culminated in the Roll Back Malaria Partnership in 1998[30] a global model for access to medication for malaria. As will be discussed later, the public health narrative was challenged by the economistic and human rights narrative and ultimately broadened the nature of the RBM model from being limited to a public health only debate.

[26] There are two reports explaining the role of MIM: 'Final Report: International Conference on Malaria in Africa: Challenges and Opportunities for Cooperation' (1997) and 'Progress on Priority: Support a Malaria Conference in Africa' (1999) http://www.mimalaria.org/eng/historyandevolution.asp (Accessed: 06/08/07)
[27] See MMV website: http://www.mmv.org/rubrique.php3?id_rubrique=11 (Accessed: 06/08/07)
[28] See HMI website: http://www.hsph.harvard.edu/research/hmi/about-hmi/ (Accessed: 06/08/07).
[29] The full report is available at: http://www.wellcome.ac.uk/publications (Accessed: 06/08/07).
[30] See RBM website: http://www.rollbackmalaria.org/rbmmandate.html (Accessed: 06/08/07).

In the late 1990s, the public health model increasingly clashed with an econoministic (the WTO-led TRIPS Agreement, the IMF/World Bank market policies) and human rights (civil society activism) models. Before exploring the nature of this clash as reflected in GHP models, the next two sections examine the emergence of the economistic and human rights narratives respectively.

4.3 Economistic Narrative on Access to Medication

The economistic narrative on access to medication was put forward by the WTO under the banner of the TRIPS Agreement, itself rooted in developments in economic theory. An economistic narrative defines access to medication in terms of the interrelationships among patent protection, drug prices, poverty, economic growth and pharmaceutical R&D. Liberal and neo-liberal economic theories provided the IMF and the World Bank with models of free markets that were promoted in many developing countries.

As discussed in this section, by advocating patent protection, TRIPS came into conflict with free market principles (privatization and liberalization) and consequently became the subject of intense international enquiry (from GAAT to the WTO). This is because the introduction of TRIPS was a new kind of protectionist regime in international trade, one that did not exist before on such a global scale. TRIPS internationalised a certain type of neo-liberal regime of public health within international trade agreements. Thus, multilateral agencies translated theoretical models into international trade agreements; and so onwards into GHPs. This section explores this process. It discusses the theories

of technology and economic growth behind this market-oriented strategy and explores their contribution to the formulation of GHP models of access to medication.

4.3.1 Theories of Technology and Economic Growth

Traditional economic theory postulates a linear relationship between technology and society (economic growth). The Solow (1956) and Swan (1956) theories of economic growth were the most influential since the two World Wars. Both theorists argue that the rate of technological change exclusively determines the long-run growth rate of the economy, and ultimately the wellbeing of society. Technological change in turn is 'exogenous', that is, a '*black box*' or '*deus ex machine*' that operates outside the realm of economics. In this case, a government's economic policy cannot alter long run economic growth, as this depends on progress in the sciences and engineering. After three decades of dominance, mainstream economists conceded that such a linear relationship no longer makes sense.

In the early 1980s, Roomer (1986; 1990) and Lucas (1988) extended the traditional growth models above focusing on interaction rather than causation between economics and technology (technological change as 'endogenous'), what became known as New Growth Theory. Here, technological progress is a form of capital accumulation. Unlike physical and human knowledge embodied in machines and people respectively, new growth theories argue that technological knowledge is embodied in savings (future R&D expenditures). This makes economic growth a private activity since an economy can become rich in the same way as individuals (given a rationality assumption).

Government's economic policy action is therefore needed to stimulate R&D through incentives to save. This argument, as explained later, formed the basis for public and private investments in pharmaceutical R&D.

More recently, Schumpeterian economists have extended the endogenous growth models by exploring explicitly who gains from technological progress, who loses, how the gains and losses depend on social arrangements, and how such arrangements affect society's willingness and ability to create and cope with technological change (e.g. Aghion and Howitt 1998, Porter, 1990). In terms of the notion of embodied knowledge, the framework for this research, it is the multitude of interactions among actors involved with inputs, technological processes and outputs that ultimately determines the relationship between technology and economic growth (or societal wellbeing).

This above view of economic theories obviously sheds new light on a number of important policy issues that theory affects, and ultimately justifies the link between theory, models and policy practices. The liberal and neo-liberal economic arguments above are invoked in empirical studies to advice on the policies and views of governments on the international stage. They are also used to develop studies that inform corporate strategy of multinational firms as well as providing them with the tools to influence international trade negotiations. Their effects are illustrated below in the areas of competition in the pharmaceutical industry, trade agreements and ultimately the inclusion of an economistic narrative on access to medication in GHP models.

4.3.2 Free markets and intellectual property rights protection

The free market doctrine put forward by the liberal and neo-liberal economic theories above largely inform the debate on the protection of Intellectual Property Rights (IPRs). Despite substantial increase in international trade, investment and migration since the 1960s, the laws of countries continue to differ, thereby creating tension in international economic relations. The TRIPS Agreement, one of the outcomes of the Uruguay Round (1986-94) of international trade talks is arguably the first major international attempt at resolving this tension[31]. GATT set out to establish an international legal framework with similar IPRs around the world. Traditionally, three diverse conceptualisations of IPRs and their protection were put forward: natural rights (moral rights to one's own mental creation), public rights (the non-rivalry nature of inventions) and utilitarian rights (non-excludability in the absence of legal protection). Various individuals and institutions translated these in terms of economic/commercial, political or human rights. The TRIPS treats IPRs as economic or commercial rights (Article 7 of TRIPS).[32] Neo-liberal economic theory played a crucial role in this treatment.

The TRIPS agreement was a challenge to the liberal market models of the 1950s that saw technological progress 'through discovery and invention that is purported to be separate from the natural workings of the economy'

[31] 'UNDERSTANDING THE WTO: BASICS - The GATT years: from Havana to Marrakesh', WTO website: <http://www.wto.org/english/thewto_e/whatis_e/tif_e/fact4_e.htm> (Accessed: 13/02/09)

[32] WTO Factsheet: 'Philosophy: TRIPS attempts to strike a balance' *TRIPS and Pharmaceutical Patents* <http://www.wto.org/english/tratop_e/TRIPS_e/factsheet_pharm01_e.htm> (Accessed: 17/07/08)

(Fagerberg, 2000:302) as the only source of economic growth. Events leading to the TRIPS agreements (the GATT agreement and successive Uruguay Rounds of international trade talks from the 1970s to 1994) paralleled the shift from the traditional exogenous to endogenous (new) growth theories described earlier. The conceptualization of technology as an inherent part of economic structures was taken up by international trade economists who studied how trade, foreign investment and IPRs are related to the process of development (e.g. Bhagwati, 1987; Helpman and Krugman, 1985; Helpman, 1993). In a detailed study of the key literature, Bhagwati (1987:551-2) argues that mainstream economic 'theory of trade and welfare provides the underpinnings for the general principles that underlie GATT'. The general consensus argument here is that, if technology is endogenous, then the economic/commercial interests of pharmaceutical inventions and innovation should be patent-protected, thereby justifying the TRIPS agreement.

The political influence of economic theories is also implicit in its evolution (Fagerberg, 2000), as well as consistent with technological and institutional change. For example, the most important argument supporting TRIPS is the well-known R&D model in growth theories of the 1980s. According to the WTO, through IPR protection, 'inventors and creators ... can expect to earn some future benefits from their creativity. This encourages new inventions, such as new drugs, whose development costs can sometimes be extremely high, so private rights also bring social benefits'.[33]

[33] WTO Factsheet: 'Philosophy: TRIPS attempts to strike a balance' *TRIPS and Pharmaceutical Patents* <http://www.wto.org/english/tratop_e/TRIPS_e/factsheet_pharm01_e.htm> (Accessed: 17/07/08)

Even the advent of economic liberalization that dominated trade and investments from the 1990s did not stop the WTO and its affiliated partners from continually defending patent-protection by capitalising on theory-informed evidence in negotiating the way forward. Both multilateral and bilateral development agencies in western countries depend on the academic literature on the relationship between trade and development by teams of economists to inform their policy on the international state (Globkom, 2002; Nordström, 2000). Thus, Maskus' (2000) justification of patent protection in the face of globalization and economic liberalization is widely cited by the WTO and the United Nations (UN). Consequently, it can be argued that economic growth theory played a substantive and substantial role in the formulation of patent protection laws.

4.3.3 A medicine market monopoly as an instrument of corporate influence

Economic theories provide pharmaceutical companies with the tools to establish a medicine market monopoly. Pharmaceutical corporations in turn use this monopoly power to influence the decisions of their national governments and ultimately those of multilateral organizations (such as WTO). For example, in a study of the monopoly market for HIV/AIDS drugs, Schulz (2002) demonstrates how pharmaceutical companies employ economic calculations to establish a monopoly power. They then use this power to progressively withhold medicines in order to maximise their profits. According to him, this process creates an 'economic death row', a point at which, because of the monopoly people cannot afford medicines and will eventually die. In addition, the people willing to buy the withheld quantity cannot do so because of high

prices. In the case of HIV/AIDS medicines, while developed countries such as Norway (fewer incidence of HIV/AIDS and huge government funding support) may never reach the economic death row, African countries such as South Africa (millions of HIV/AIDS cases with limited government funding support) were within it by 1999 (Hill, 2006:156-157).

Thus, from the 1990s when the patented commodity became ARTs for HIV/AIDS treatment, customers who could not access the medicines died much faster with widespread consequences. Poor countries found themselves in a difficult trade-off situation due to the monopoly power of pharmaceutical firms (Maskus, 2000:161). The free market policies promoted by the IMF and World Bank meant that they had to give up most forms of trade protection and become exposed to the monopoly pharmaceutical companies. The negative effect of economic globalization is that it reduces aggregate economic welfare through rising prices that both individuals and governments could not afford.

Although developing countries like India, Brazil and South Africa exposed the limits of IPR protraction by resisting international IPR regimes in the 1990s, most IPRs were owned by firms in developed countries. After successfully creating a medicine market monopoly, western pharmaceutical companies use their corporate influence at international trade talks to push developing countries to respect international agreements (such as TRIPS). Although the talks are usually negotiated by national governments in relation to domestic and international interests, corporate interests have been shown in several

instances to dominate. In a documentary series, *'War By Other Means'*, Woods (2007) describes the influence of corporations in international trade talks:

> 'Politicians have very limited technical capacity ... private markets and multinational corporations understand the real dynamics of the global market. ... They help politicians to define their country's interests. ... But they have their own interests as well. ... So they become the most powerful players'.

Partly because of the above reasons, Woods explains, the outcome of trade talks 'depends on rules decided in tough negotiations behind closed doors'. Dearborf (2004:5) has also demonstrated that while economic theory is reassuring about the effects of the profit motive when it drives behaviour in the marketplace; there is no trust in its effects in the political arena. In the case of the TRIPS Agreement, he states: 'A group of very large corporations especially in the pharmaceutical industry were, as I understand it, the initiators of the push for TRIPs in these negotiations, and they played an active role in moving the negotiations along'. According to him, pharmaceutical companies initially aimed to defend their IPRs by preventing countries like India from importing unlicensed generic drugs western countries. Once this was achieved, they 'pushed to have the international trading system override the decision that many developing countries had made, that the 'short-term' health of their populations was more important than the profits of the big drug companies' (p.5).

Although it was generally acceptable that a patent system creates monopolistic markets, global projections based on neo-liberal economic models were used to tout western pharmaceutical innovations as the panacea to health problems of the 21st century. Pharmaceutical companies made this

explicit on their websites, claiming to hold the key to access to medicines in least developed countries. For example, GlaxoSmithKline (2002) stated as follows:

> 'We support intellectual property protection because it stimulates and fundamentally underpins the continued research and development of new and better medicines, including those for diseases prevalent in the developing world.'

Publishing statements such as the above became the obvious choice for the pharmaceutical industry in the western world. From the late 1990s, the industry had come under serious international scrutiny by developing countries and international CSOs. Trullen and Stevenson (2006) analyse the historical narrative of events in seven western pharmaceutical companies in relation to several 'years of accusations of being socially irresponsible in dealing with the HIV/AIDS virus in Africa' (p.178). Their analyses reveal that pharmaceutical companies 'respond in strategic ways to institutional pressure that stems from social scandals' (p.178). Specifically, pharmaceutical companies began to claim that corporate social responsibility (CSR) trumps corporate strategy (CS). By the end of 1999, many pharmaceutical companies changed their mission statements from one based on CS (advertising and other marketing strategies to increase sales vis-à-vis pharmaceutical R&D) to one focused on CSR (discounted drug pricing and philanthropic drug donation programmes).

Unsurprising, therefore, most global programmes on drug donation and discounted drug pricing are typically initiated by pharmaceutical companies (Buse and Walt 2000a:700). The 1997 court case between the South African

government and 39 western pharmaceutical companies is a classic example (Hill, 2006:156-157). The South African government authorised the importation of generic drugs for HIV/AIDS in defiance of TRIPS. The government, supported by interest groups, NGOs, celebrities and other developing countries put forward the argument that medicine for HIV/AIDS ought to be treated as human rights. On the other hand, pharmaceutical companies focused on the economic narratives and the fact that South Africa defied the TRIPS Agreement. As a result of the human rights narrative, the outcome of the case went in favour of the South African government.

This South African case, among others, ushered in a wave of negotiations among UN agencies, western development agencies, pharmaceutical companies, civil society groups and developing country governments in an attempt to achieve 'universal' access to medication through discounted drug pricing. These negotiations formed the basis for certain GHP 'models' on access to medication emphasising the economistic, rather than public health and human rights approaches. This is explored later in this chapter in the case of the AAI initiative launched by UN agencies and western pharmaceutical companies to provide discounted patent-protected drugs in developing countries. The next section explores the human rights narrative to access to medication.

4.4 The Human Rights Narrative on Access to Medication

The human rights narrative on access to medication does not have a strong connection to theories of economic growth and international trade, as does the

economic narrative discussed above. The concept of human rights does not also have a strong theoretical connection to the behavioural and change models of public health discussed earlier in this chapter. Rather, the human rights to health reflect a broader, societal approach to the complex problem of well-being. Since being crystallized in the Universal Declaration of Human Rights in 1948, human rights concepts, meaning, content and process only became widely understood by health care professionals and academics from the 1990s as an essential framework for promoting and protecting health. In *Human Rights and Health* Jonathan Mann and co-authors (Mann et al., (1999: 7) claim that one cannot explicitly establish a relationship between human rights theories and the introduction of human rights principles and concepts in health policy discussions:

> 'Health and rights have rarely been linked in an explicitly manner. With few exceptions, notably involving access to healthcare, discussions about health has not included human rights considerations. Similarly except when obvious damage to health is the primary manifestation of a human rights abuse, such as with torture, health perspectives have been generally absent from human rights discourse. Explanations for the dearth of communication between the fields of health and human rights include different philosophical perspectives, vocabularies, professional recruitment and training, societal roles, and method of work'

Nevertheless, there must be a big theoretical literature on the rise of human rights that can be linked to public health (e.g. Toebes, 1999). However, the scope of this chapter does not allow for exploring such literature. Thus, instead of discussing human rights theories as in the previous sections, the focus here is on the evolution of different forms of knowledge (expressed in the forms described in the above quotation) through which human rights ideas come to play a significant role in shaping GHP models. Human rights ideas emerged from two successive and sometimes interwoven movements: 1) The implicit

adoption of human rights principles by international organizations (e.g. WHO and UNICEF) in public health agendas that are subsequently ratified as law by national governments; 2.) The rise of civil society activism (groups of individuals and NGOs) using human rights language and concepts to influence national and global policy, as well as inspire and energise their own health related activities. These two movements are discussed below.

4.4.1 The emergence of the concept of health as human rights

The concept of health as human rights was formally developed in the aftermath of World War II and crystallized in the Universal Declaration of Human Rights in April 1948. The WHO, created in the same year, was charged with its implementation. The declaration explicitly defines the right to health as the right to the 'enjoyment of the highest attainable standard of health.' Although considered as the first international legal document, the human rights requirement only appears in the WHO's preamble (Nielsen, 2001:14). It was adopted as a result of Brazil's concerns that medicine ought to be treated as 'one of the pillars of peace' (Toebes, 1999:15). This is evidence of how an event with no direct links to theories played an important role in introducing human rights concepts in health policy debates. Health as human rights was given a similarly less explicit role in determining policy practices in the PHC model adopted at Alma Ata.

Although health as human rights was given a similarly less explicit role in determining policy practices in the PHC model adopted at Alma Ata, certain events in the 1980s illustrate the emergence of a human rights narrative internationally. The debate on access to medicines became global in the early

1980s with the rapid growth of unregulated international trade in medicine (WHO, 2004). Using this pretext the WHO put forward a narrative on access to essential medicines from the mid 1980s that was considered by international NGOs as promoting the rise of liberalism at the international level (the economistic narrative). Individual countries began to establish their own drug regulatory regime in the face of accusations from CSOs (such as Health Action International and Médecins Sans Frontières) that the big pharmaceutical companies were (indirectly) dumping medicines in developing countries through the WHO (Redfield, 2008). Developing countries such as Bangladesh even attempted to establish their own White List of Essential Medicines claiming to be defending the rights of their citizens, a move that attracted threats of law suits (from pharmaceutical companies) and sanctions (e.g. from the United States) (Loue, 2006).

The evidence above further illustrates that elements of human rights already existed in national programmes to facilitate access to medication for several decades, though with little connection to human rights theorists. Much of the role of human rights depended on the advocacy of CSOs. However, the advent of the HIV/AIDS pandemic in the 1990s, the statistics on the incidence and burden of the HIV/AIDS, the fact that it has no cure, and the emergence of expensive life-sustaining drugs that were well beyond the reach of least developed countries, questions were being asked whether and to what extent access to medication is guaranteed by public health, international trade agreements and human rights treaties. Within the UN agencies, much of the

role of human rights depended on the advocacy of key persons who supported the human rights perspective.

In this context, Fee and Parry (2008:1) provide detailed illustrations on how Jonathan Mann 'developed his theory of human rights and health' thereby promoting the human rights narrative on access to medication within the UN. First as a public health epidemiologist, Mann perceptively demonstrated that the HIV/AIDS epidemic is the first global epidemic and therefore touches the core of the Universal Declaration of Human Rights (the ethics of public health to provide the conditions under which humans can flourish). Subsequently, as the first director of the WHO's Global Programme on AIDS, Mann pushed for a human rights approach as a necessary response to the fact that the social determinants of health (essential components of variants of the PHC model in 1990s) had become too economistic. Accordingly to Fee and Parry (2008) Mann's vision for a human rights model emphasises all the social factors (social marginalization, demographic, socioeconomic and racial inequality) that influence health and well-being, as articulated in the original PHC model of 1978.

In addition to the advocacy campaigns of world renown UN authorities such as Jonathan Mann, the devastating burden and incidence of the HIV/AIDS in the late 1990s also led international CSOs, research and academic institutions, as well as UN agencies (just as the WHO was doing in the early 1990s through Mann) concede that the TRIPS Agreement touches on human rights standards that guarantee the accessibility of medication by enabling pharmaceutical

companies to demand higher prices – and thus hamper access to medication. This debate is summarised below.

4.4.2 Access to medication as human rights

The evidence from the economistic narrative of access to medication provided enormous data and evidence that were later used to crystallise a human rights narrative as an opposing strategy to the economistic narrative. The TRIPS agreement is assumed to stimulate both economic growth and R&D aimed at illnesses in poor and vulnerable populations (Maskus, 2000). However, as early as 1996, there were international calls for a change in the legal framework of TRIPS to accommodate human resources and infrastructure development in poor countries (UNCTAD, 1996: 23-26), a call which relates to Mann's human rights concerns. Similarly, many scholars published evidence contradicting the TRIPS argument[34]. Yet the WTO and its affiliated partners were reluctant to change the rules until the emergence of HIV/AIDS and subsequent international advocacy.

Multilateral organizations, led by UNAIDS (2000a: 11), initially described HIV/AIDS as *'only a health problem'* and identified inadequate healthcare infrastructure, scepticism within the global health community, and the costs of chronic therapy as major barriers to access (UNAIDS, 2002). Similarly, pharmaceutical companies defended both their pricing policies and the patent system stating that social, political, and infrastructural barriers, not drug prices, impede access (as demonstrated, for example, in the case of South Africa mentioned earlier). Advocates from both UN agencies, private industry and

[34] For a review of the major arguments see Sakakibara and Branstetter (2001)

CSO expressed admiration for breakthroughs in pharmaceutical innovation and the supporting role of the pharmaceutical industry in public health interventions: the development of drugs that can treat both HIV/AIDS and other opportunistic infections that kill people with HIV/AIDS (MSF, 2003; WHO, 2002a: 8). Another shared theme was the difficulty of living up to the rising pandemic of HIV/AIDS and its devastating consequences at all levels, an awareness which led to the global recognition unanimously acknowledged that 'treatment is technically feasible in every part of the world' (WHO, 2002a: 9).

Nevertheless, the general outcry that least developed countries would not be able to cope with the rising number of HIV/AIDS cases, high cost of treatment and given the devastating nature of the disease, the right to health was taken up in numerous economic, public health and legal instruments. The most significantly legal document to take up the right to health was the International Covenant on Economic, Social and Cultural Rights (ICESCR)[35] established long before TRIPS. It protects access to medicines as an integral part of the right to health (contained in article 12) under international law. Access to medication is currently defined as the 'right to the highest attainable standard of physical and mental health' (General Comment No. 14, ICESCR, 2000, para. 6). It has four determinants: (a.) the availability of the medication in sufficient quantity, (b.) the accessibility of the treatment to everybody, (c.) the

[35] In 1985 the ICESCR as set up as a committee (E/RES/1985/17 of 28 May 1985) to help the Commission of Economic, Social and Cultural Rights in motoring and implementation. Specific issues related to access to medication are documented in two legal documents: *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: Follow-up to the day of general discussion on article 15.1 (c),* (26/11/2001) and *Human Rights and Intellectual Property: Statement by the Committee on Economic, Social and Cultural Rights,* Doc.E/C.12/2001/15 (14/12/2001).

acceptability of the treatment with respect to the culture and ethics of the individual and (d.) an appropriate quality of the medication.

The GC No. 14 para.12 includes only *'essential drugs'* within the scope of the right. The WHO endorses this and maintains a regularly updated list of essential drugs that all countries should use (WHO, 2003). However, member states are not bound to the list, as the WHO state that: 'exactly which medicines are regarded as essential remains a national responsibility'[36]. This list also attempts to put an end to the long running debate about access to essential medicines promoted by WHO in the mid 1980s (e.g Bangladesh White List of Essential Medicines and drug dumping in the Third World mentioned earlier).

Being the hardest hit region of the world, African leaders also came out strongly on the role of human rights. In the Ouagadougou Commitment of May 2000, African leaders unanimously declared that while 'health constitutes a right and a foundation for socio-economic development'; the HIV/AIDS epidemic is a major 'public health, development and security problem for Africa.'[37] Such a collective political activism and the relaxation of the TRIPS Agreement translated into the WHO's drug lists provide African countries the possibilities to legitimately procure drugs from both patent-protected and generic manufacturers in the fight against diseases such as HIV/AIDS. This is an example of how the economistic, public health and human rights narratives

[36] 'Essential Medicines': http://www.who.int/topics/essential_medicines/en/ (Accessed: 30/06/09)
[37] ACP-UP (2000) 'Treatment for all ... Now!' Global Manifesto, Durban, South Africa <http://www.actupny.org/reports/durban-access.html> (Accessed: 21/09/08).

and the actors who initiated them increasingly became interwoven and integrated into a global political activism to ensure access to medication for the poorest people in the world.

4.4.3 The role of civil society activism in the popularity of the human rights narrative

As already discussed in the case of Health Action International and the Bangladesh drug list, international CSO and activist groups have played a significant role in promoting the human rights narrative on access to medication. This section illustrates further, the global perspective on the role of CSO movements in the debate on access to medication. CSOs and activist groups can rightly be credited for putting a human rights narrative into the economistic agenda of the WTO and the public health agenda of the WHO. Some notable CSOs include Treatment Action Campaign, Oxfam International, Health GAP, CPTech, Health Action International, Act UP and MSF. The human rights narrative is built around the argument that if pharmaceutical companies cannot reduce prices to the level that the poorest person in the world can afford, copying patented medicines should be legitimate to save the life of the poor. In relation to the emergence of GHPs, CSOs use statistics from pharmaceutical companies, WTO and the World Bank to question the arguments that the TRIPS agreement stimulates drug R&D thereby providing medicines to the poor.

One of the most notable is MSF (2002)[38]. MSF uses statistics from pharmaceutical companies, WTO and the World Bank to question the arguments that the TRIPS agreement stimulates drug R&D. It established a series of findings that contradicted the main economistic arguments, namely, global development costs of new drugs ($30-$160 million) are far less than global R&D expenditure ($70-$90 billion); the big pharmaceutical companies spend more on marketing, administration and executive salaries than on R&D; most essential drugs marketed by private companies were originally discovered with public funding (including six AIDS drugs); the pharmaceutical industry is one of the most profitable in the world; and developing countries make up a small part of drug industry revenue (Africa accounts for about 1% of global drug market) (MSF, 2002).

The WHO, having initially favoured patent protection, also concluded that IPRs offer little incentive for R&D on developing country diseases, because of insignificant markets (WHO, 2001:77). The Commission on Intellectual Property Rights (CIPR) stated that they 'do not think that the globalisation of IPR protection will make a significant contribution ... to the treatment of diseases that particularly affect developing countries' (CIPR, 2002: 39). The UN, the World Bank and MSF jointly claim that pharmaceutical companies have little interest in poor countries because it they are not profitable enough even in the case of neglected diseases (MSF, 2003:5).

[38] Notable examples of international CSOs and their campaign slogans include: *Access to Essential Medicines Campaign* (Medecins Sans Frontieres); *Cut the Cost Campaign* (Oxfam International), Oxfam Briefing Paper 15, 2002; Oxfam (2002) Generic Competition, Price and Access to Medicines, Oxfam Briefing Paper No. 26, Oxfam, Oxford; *Health Care and Intellectual Property Campaign* (CPTech) and *Treatment Action Campaign* (TAC), Act UP.

CSO activism also led to a relaxation of the TRIPS Agreement as seen in the inclusion of the CSOs mentioned above in the Doha Round of trade talks launched from 2001. The talks have now shifted the emphasis to more consideration of the interest of the poor in developing countries. The Doha declaration (WTO, 2001: Para.4) on public health states as follow:

> 'We affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all. ... In this connection, we reaffirm the right of WTO members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose'

Two measures seem relevant in the HIV/AIDS case, namely parallel imports and compulsory licensing. Paragraph 5(b) of the Doha declaration specifies that each member has 'the freedom to determine the grounds upon which such licences are granted'. The same paragraph clearly identifies 'public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency' (WTO, 2001). *Parallel imports* are relevant if a drug manufacturer provides drugs at a lower price. However, international NGOs have continually challenged the TRIPS agreement. For example, a joint statement by MSF and Oxfam criticise the WTO's agreement on patent-protected medicine as follows:

> 'The burdensome system being put in place does nothing to ensure that generic production will happen in the future. Rather, developing countries will have little alternative to the high prices and long-term monopolies of brand-name pharmaceutical companies.'[39]

[39] *MSF and Oxfam say WTO drugs deal is 'flawed'* In European Public Health Alliance, Available Online: <http://www.epha.org/a/623> (Accessed: 13/05/09)

This meant that the implementation of TRIPS would no longer restrain the supply of generic copies of patented pharmaceuticals. Although the human rights narrative serves to challenge the economistic narrative, attempts at arriving at a point of agreement has always proved impossible. Numerous international meetings have brought opposing parties together. The outcome is that different global models are being promoted, emphasising a combination of different aspects of the three narratives discussed above. The above distinctive human rights narrative formed the basis for the creation of the *Equitable Access Initiative (EAI),* a GHP launched by MSF at the end of 2000 (MSF 2002, 2002a, 2003). The next section explores two types of GHP models – the first focuses on strengthening the health system in developing countries (RBM), and the other focuses on access to pharmaceuticals (AAI and EAI).

4.5 GHPs for Health System Functioning – Roll Back Malaria Partnerships

The WHO, World Bank, UNICEF and their partner organizations launched the RBM in November 1998 to half global malaria deaths by 2010 and again by 2015.[40] As a global PPP the RBM combines the expertise of pharmaceutical companies (such as MMV, MIM, and Novartis), the field experience of the public sector (WHO, UNICEF and national governments and civil society organizations), donor support from UN agencies (such as the World Bank and the Global Fund) and private foundations (such as Bill and Melinda Gates Foundation). The global RBM network now includes malaria-endemic countries and about 90 bilateral, non-governmental and private sector

[40] See the website of Roll Back Malaria: http//www.rollbackmalaria.org/

organizations seen as 'core' partners due to their active involvement in adding expertise, infrastructure and funds into the partnership.

As mentioned earlier, the RBM promotes a global response to previously failed attempts at malaria eradication. The historical narrative leading the launching of the RBM reveals the interplay of economistic, public health and human rights narratives on access to medication. Consultations on strategies to reduce the rising incidence and burden of malaria intensified between 1990 and 2000 spearheaded by several regional and international initiatives to address specific issues relating to the treatment of malaria (MIM, MMV, HMI). The main focus of these consultations was on the extent to which the public health models (a combination of medical and preventive strategies) promoted by the WHO was responsible for suppressing short-term malaria cases and achieving long-term control over malaria epidemics. The public health model (as defined by the PHC) included measures to reduce infected vector populations feeding on humans through house spraying with residual insecticides, antimalarial drug treatment and surveillance (Nabarro and Tayler 1998).

Unsurprisingly, the global context of RBM when it was launched in 1998 is a tri-sectoral network (to operate on a global, regional and local level respectively) to address the complexity of the root causes of malaria transmission through four core technical strategies: 1) improved and prompt access to effective treatment; 2) increased use of insecticide-treated nets (ITNs) and other locally appropriate means of vector control; 3) early detection and response; 4) and improved prevention and treatment of malaria in pregnant

women (WHO/UNICEF 2005a: xi). It also emphasises malaria R&D and evidence-based action and impacts to help African countries to achieve their national malaria targets.

The RBM was launched on the pretext that malaria has become a global public health crisis requiring a public health (not private) intervention. In this context it attempts to link the causes and consequences of the *'malaria problem'* to the social, cultural, political and economic fabric of developing countries and mobilizes a broad-based and comprehensive effort to address the complexity of the root causes of disease transmission (WHO/UNICEF 2005: xi). Haven established such a global framework, the WHO and UNICEF alongside their affiliated international partners then invite malaria-endemic developing countries to join the initiative. Empirical evidence from across the world are presented as 'lessons learnt', 'best practices' or 'evidenced-based' to encourage countries to endorse the RBM. In the case of Africa, the WHO and UNICEF sponsored the famous Abuja Submit to Roll Back Malaria in Africa (WHO, 2000a). The summit concluded that previous malaria eradication campaigns in Africa failed because they were *fragmented and uncoordinated* (not because they did not address the determinants of health). Subsequently, the narratives did not immediately shift to addressing coordination mechanisms. Instead it went along the lines of an economistic narrative on access to medication.

Specifically, evidence was gathered and presented to demonstrate the potential effectiveness of medical intervention in malaria treatment and control (WHO, 1993; WHO/UNICEF, 2003; Mabaso et al., 2004; Rosenberg, 2004). For

example, a Cochrane review (Lengeler, 2004) shows the potential of ITNs to prevent children from being infected by malaria. While these were considered as 'success stories', studies that seriously negate this narratives, for example those showing that adherence to treatment and control by households and country/region-specific strategies were the causes of failure were hardly taken seriously (Najera et al., 2004). In response to human rights concerns from NGOs and civil society organizations who argued that patents prevent affordability of medicines for poor households, the WHO stated that the pharmaceutical industry was open for negotiated discounted drug prices (Nabarro, 1998), a claim rooted in economistic approaches to access to medication. The economistic narrative then became more important, leading the WHO and the UNICEF, backed by the World Bank and advanced countries, to demonstrate the feasibility of generating funding to ensure a 30-fold increase in the availability and affordability of drugs between 2000-2005 (WHO/UNICEF, 2003a). Here again we see how UN agencies continue to promote the narrative strategies on access to medication which they had initiated decades earlier.

More than 50 African leaders endorsed the RBM under the Abuja Declaration (WHO 2000a) by pledging to reduce malaria deaths in Africa by 60% by 2010. They were convinced by UN agencies that anti-malarial such as chloroquine can treat malaria, ITNs for malaria prevention would be available and that donors will fund the programme. In response, the African leaders made a commitment to clarify the strategy to achieve the Abuja targets at country levels which included addressing the human rights needs of the poor in terms

of decentralisation of services to reach rural areas and integrating civil society participation in policy making and implementation. This is the main narrative on which RBM programmes emerged in Africa. Addressing the public health needs of African countries through health system functioning was seen as the responsibility of national governments with only technical and funding assistance from GHPs. It also implied that instead of public health terminologies, such as public health or health promotion, the term access to medication became widely used. Access to medication was defined at the global level in terms of affordability of drugs (drug procurement and supply arrangements) instead of the broader public health conceptualisation defined in chapter two in terms of potential and actual access to medication.

A few years after the launching of the RBM and implementation in many developing countries, a human rights argument was put forward by civil society organizations and research institutes to challenge the economistic (and narrow public health) narrative. Specifically, the WHO was criticised for promoting drugs like chloroquine and sulfadoxine-pyrimethanine despite knowing for several years that they were ineffective (Attaran et al; 2004). The same article supported ACTs as a more effective alternative. Similarly, Médecins Sans Frontières had already advocated a change from Chiloquin to ACTs during a malaria epidemic in Ethiopia (MSF, 2004). Both Attaran et al (2004) and MSF (2004) argued that providing drugs that are known to be ineffective to poor people (who have no way of knowing the quality of drugs they are taking) is somewhat against the right to health. The timing of these counter-narratives are very interesting as the WHO and the Global Fund to

Fight AIDS, Tuberculosis and Malaria quickly changed to ACTs in 2004 (ACTs is today the core of malaria treatment in Africa), arguably to avoid further criticisms. While the *Lancet* article is often cited in the RBM website, most recent *Africa Malaria Reports* discuss the WHO's reluctance to quickly embrace the ACT in relation to the fact that African countries did not have the health system to deal with the change.

To join the RBM, there was no eligibility criterion. Countries simply had to attend an international or regional summit (such as that held in Abuja in the case of African countries) and endorse agreements or declarations reached. Thus, the nature and success of any RBM programme at country level does not depend only on the country-specific mobilization and the generosity of donors. It also depends on the narrative strategies used by RBM partners, counter-narratives put forward by opponents in relation to previous narrative strategies. More recently, The WHO is increasingly recognising issues not made explicit at the launching of the RBM including determinants of health factors such as (emphasis added) 'dwellings that offer protection against mosquitoes (and) transportation to a health facility capable of treating the disease' (WHO/UNICEF, 2003:20). This is an example of the limited emphasis on potential access to medication during the launching of RBM.

The RBM's use of terms and phrases such as 'Africans cannot afford', 'poorest Africans' is reflected in its policy of heavy subsidization of drugs. This implicitly undermines an economistic narrative (e.g. the World Bank's cost recovery programme) that would emphasise long-term sustainability in the

absence of donor funding (as is increasingly becoming the case). The market for ITNs and ACTs involves negotiations between selected pharmaceutical companies and donors (large foundations, UNICEF and the Global Fund) on the basis of prices rather than quality, thereby contradicting a competitive healthcare market model that emphasises quality of products. These issues clearly qualify the RBM as a new kind of global model whose origins can be traced to theoretical developments in public health, economics and human rights, but also, one that attempts to reconcile the conflicting and competing interests of actors in global health into the RBM model as a way of facilitating access to medication for malaria treatment and control. The role of such a model in shaping policy practices at country level is the subject of the National Malaria Programme in Cameroon presented in Chapter six.

4.6 GHP Models for Access to Pharmaceuticals for HIV/AIDS Treatment and Control

The narratives and counter-narratives discussed in earlier in this chapter were vital in the creation of two (co-existing) global models for facilitating access to pharmaceuticals for HIV/AIDS treatment and control. One is an industry-led *Accelerating Access Initiative (AAI).* In this system, UNAIDS and WHO help countries to develop HIV/AIDS plans and then play a facilitator role between countries and companies to negotiate discounted prices. Companies set the rules and offer different levels of discounts to HIV/AIDS-endemic countries selected on the basis of clearly established eligibility requirements. The second is the 'Equitable Access' model. In this system, policies are implemented to

ensure that the price of a drug is fair, equitable and affordable, both to individuals and the health systems that serve them irrespective of whether the medicines are patent-protected or not. Thus, while the AAI is informed by an economistic narrative on access to medication, the Equitable Access is largely informed by a human rights narrative. However, as discussed in the following sections, it is the interplay of public health, human rights and economistic narratives that ultimately shaped the development of both models.

4.6.1 The UNAIDS-led Accelerating Access Initiative

The AAI was formed in May 2000 by five pharmaceutical companies and five UN organizations [41] with a principal objective 'to make HIV/AIDS drugs more affordable and accessible in developing countries and to improve technical collaboration in the development of national programme capacities to deliver care, treatment and support' (UNAIDS/WHO, 2002:4). The alarming global statistics on HIV/AIDS and the high cost of medicines protected under TRIPS vis-à-vis the resource capacity of developing countries (economistic narratives) are regularly cited as the main reasons behind the creation of the AAI.[42] These factors meant that both a global effort and a global language were needed to fight the disease. The AAI does not have separate legal status; it's activities are coordinated by the Secretariat of UNAIDS in Geneva, Switzerland.

The global activism for access to medication, defined in the context of the right to health (human rights narrative) also played a major role in the launching of

[41] (WHO, UNICEF, UNPF, World Bank, UNAIDS) and (Boehringer Ingelheim; Bristol Myers Squibb; F. Hoffman-LaRoche; GlaxoSmithKline; Merck and Co., Inc; Pfizer with Abbott and Gilead joining later).

[42] Sub-Saharan Africa accounted for 70% of people with HIV/AIDS in the year when AAI was created (UNAIDS/WHO, 2000:5).

the AAI. As mentioned early, by 2000 UN agencies, international CSOs and developing countries recognised that high drug prices preventing the poor from access treatment for HIV/AIDS touches on human rights. Accordingly, the AAI was established on the pretext that reductions in drug prices are in part a solution to such abuses to the right to health. This was particularly important for African countries. It is not surprising, therefore, that the AAI was launched as a globally-backed country-led PPP to achieve '*Universal Access*' to life-sustaining support especially in the hardest hit regions of the world. Since its formation, several other organizations from the public and private sector have joined the partnership. By mid-2003, out of 84 countries that had expressed an interest in joining AAI, 50 had developed national plans and concluded drug procurement arrangements (Sturchio 2004).

As set out in the Statement of Intent (UNAIDS/WHO, 2002: Annex 1, p. 19), three expected benefits of the initiative for developing countries, particularly that Sub Saharan Africa[43] are to:

- Accelerate sustained access to and increased use of 'appropriate, good quality interventions';
- Strive to reach significantly greater numbers of people in need through 'new alliances involving committed governments, private industry, the UN system, development assistance agencies, non-governmental organizations and people living with HIV/AIDS'; and to

[43] 70% of HIV/AIDS patients lived in Sub-Saharan Africa by launch of AAI (UNAIDS/WHO, 2000:5).

- Implement the programme 'in ways that respond to the specific needs and requests of individual countries, with respect for human rights, equity, transparency and accountability'.

To guide the AAI in its efforts to effectively address the AIDS epidemic, members set out to create 'new alliances involving committed governments, private industry, the UN system, development assistance agencies, non-governmental organizations and people living with HIV/AIDS' (UNAIDS/WHO, 2002: Annex 1, p.19). The six working principles established as a framework for implementing the AAI reveal the co-existence of the three narratives on access to medication:

1. 'Unequivocal' and sustained political commitment of national governments involved in the initiative;
2. Building a 'Strengthened national capacity' in the developing countries, including well-designed strategies and a strong infrastructure, both essential to the delivery of care and treatment;
3. 'Engagement of all sectors of national society and the global community' in facilitating access to treatment;
4. Development of 'efficient, reliable and secure distribution systems' to ensure that medicines reach the people for whom they are intended;
5. Acquire 'significant additional funding from national and international sources', at a level commensurate with the epidemic's challenges; and
6. 'Continued investment in research and development by the pharmaceutical industry' to meet the challenges of the epidemic today and tomorrow.

The partners and network taxonomy of the AAI also reflected the three narratives on access to medication. As a global PPP, the AAI was structured in three working groups – country support, communication and procurement working groups respectively. The first is the country support working group comprising UNAIDS Secretariat, UNICEF, WHO and individual countries with each of the five pharmaceutical companies. This means that each country is expected to participate in five independent working groups (only one pharmaceutical company in each group). The second is the communications group comprising of all partners to the AAI while the third, the procurement group consists of the UNAIDS Secretariat, UNFPA, UNICEF and WHO. Thus, while each country is allowed full autonomy in its negotiations with partner pharmaceutical companies, the communication and procurement groups help with advice and technical support to facilitate bilateral agreements on drug prices and supply arrangements (the economistic view). This multi-actor representation was meant to ensure that dialogues and negotiations are fairly conducted and that the public health and human rights interest of the poor in accessing treatment and care are given the right considerations in the face of the dominant economistic narrative.

With respect to the working principles of the AAI, the economistic narrative dominated. The main strategic orientation is negotiated (differential) discounted drug pricing. First, a national plan detailing healthcare and pharmaceutical needs for each country is developed with technical assistance from the UN system (WHO, UNAIDS, UNICEF). Dialogue processes are then concluded with individual pharmaceutical companies on drug procurement and

supply agreements (UNAIDS/WHO, 2002:5-6). Bilateral discussions on pricing take place between national governments and individual pharmaceutical companies independently of UN agencies, a measure which reveals the strong position of pharmaceutical companies. Funding to pay for medication comes primarily from the countries themselves through local mobilization, grants and donor support from the World Bank, Global Fund and occasionally from other affiliated international partners.

Despite the apparently overemphasis on prices and supply arrangements, the public health narratives are also important. This is evident from development of national plans in relation to the specific eligibility criteria set by the AAI on which HIV/AIDS endemic countries could join the initiative: be a 'high HIV/AIDS burden' (WHO, 2005a:1), one of the 'hardest hit regions of the world,' have a relevant health infrastructure and 'adequate' health system 'to handle the complicated HIV/AIDS medicines' (UNAIDS/WHO, 2002). As international public health advocates, the WHO and UNICEF through country support and working groups provide technical assistance to the Ministry of Health in prospective participating countries to enable them to develop robust national plans that meet these requirements. This includes for example, specifying how existing weaknesses within the national health system (that would constraint HIV/AIDS treatment and control) are being (or have been addressed to facilitate local distribution of ARTs as well as treatment and care facilities throughout the country (especially in poorest communities).

It is important to note that the elements of the public health models that emphasise HIV/AIDS prevention appear to be ignored by the AAI. For example, the AAI model measures the impact on access to medication in terms of number of persons receiving ARV treatment directly or indirectly provided by AAI partners, significant reduction in drug prices (UNAIDS/WHO, 2005), effective functional or problem-solving strategies (negotiating lower drug prices), governance arrangements and accountability (Sturchio 2004; Buse and Harmer, 2007). As will be discussed in the case study in chapter seven, following agreement on drug prices and supply arrangements, transcalar networks then became useful as a way of ensuring that the AAI's goal of 'Accelerating Access' through global HIV/AIDS programmes and activities at national and local levels can be achieved.

4.6.2 MSF-led Equitable Access Initiative

MSF is the architect of the Equitable Access Initiative (EAI). To demonstrate that access to medication for HIV/AIDS is a human rights issue, MSF attacked the AAI for being too economistic and in turn used its own published field experiences as a non-profit medical organization to demonstrate the feasibility of a human rights approach (MSF 2002, 2002a:4, 2002b). Specifically, MSF (2002a:6) stated that:

> 'Not only is it medically unethical to deny people living with HIV/AIDS existing treatments, it is also ineffective to separate prevention and treatment interventions: access to treatment creates conditions that improve the effectiveness of prevention programmes.'

According to MSF, 'countries are treating more people using generic versions of some first-line regimens than they would use AAI discounted drugs (MSF, 2002a:4-7). Thus while the AAI emphasises patent-protected medicines

produced by western pharmaceutical companies, MSF favoured generic medicines produced in developing countries such as India.

There are two features of the equitable access model: justification of the need for price reduction (Equitable Pricing) and the means of achieving equitable access (Generic Competition). In terms of the former, MSF argues that price reductions are needed, 'where policies are implemented to ensure that the price of a drug is fair, equitable and affordable, both to individuals and the health systems that serve them' (MSF, 2002a:10). The main objective is to ensure that the poorest individuals can access medicines irrespective of their ability to pay. To achieve this objective, MSF lobbies with developing countries and UN agencies to encourage drug procurement from the lowest cost reliable supplier and for technical assistance from the WHO and UNICEF to emphasise pre-qualification of medicines, bulk purchasing and assistance in overcoming patent barriers to access more affordable medicines. MSF (2002a:10) argues that generic competition is 'the most effective means of lowering drug prices. During the last two years, originator companies have often responded to generic competition'.

There are three measures that are used to support equitable pricing

- The use of the WHO's prequalification system for developing countries that do not have strong regulatory authorities to facilitate the ability of poor countries to pursue the best offers on the world market.
- Enhance existing regional and local production and procurement capacity through voluntary licensing with originator companies (or

compulsory licensing if they choose not to cooperate) and technology transfer.

- Reduce prices by pooled procurement at regional level – Aggregating demand and organising purchases through global/regional procurement.

After establishing the above global framework, the next step in the EAI is to invite developing countries to join the initiative. Just as in the case of the AAI, HIV/AIDS endemic countries voluntarily endorse the equitable access model. In April 2001, MSF organized a conference of the Ministers of Health and Commerce of the OAPI in Yaoundé, the capital of Cameroon, on the question of patents and access to treatment within the framework of the Bangui Accords (MSF, 2002b). During the conference, MSF challenged the AAI model of 'Accelerating Access' by lecturing the delegates on its alternative 'Equitable Access' which ensured that even the poorest individuals could afford ART. In disregard of their previous positions (as signatories to the TRIPS Agreement), most of the participating countries ratified the revised Bangui Accord which allowed countries to import generic drugs in defiance of the TRIPS Agreement without any accompanying sanctions from the WTO. In this way, CSOs such as MSF claim to be global partners most concerned about the right to health for the poorest and most vulnerable people in developing countries.

By endorsing the equitable access model, countries such as those within the OAIPI, are able show an 'Equitable Access' concept to the WTO as a justification of the fact that although they are officially committed to respect intellectual property laws such as the TRIPS agreement, they will continue to

import generic drugs still under patents on grounds that the poorest people in the world still could not afford ARTs at the price agreed through the AAI model. This position could not be ignored by the WTO (as a result of the relaxation of certain provisions of the TRIPS agreement discussed earlier) for countries classified by the World Bank's Debt Relief Program as least developed in the world.

The efforts of CSOs such as MSF are seen not only as an attempt to render the TRIPS argument irrelevant as a major barrier to access to medication for HIV/AIDS, but also to promote the concept of health as human rights. Such contributions are recognised at the Doha Round of international trade talks (WTO, 2001). In particular, it is seen as a breakthrough in the international debate about the impact of civil society participation and the benefits of emphasising the poorest people in the world (as against the economistic interests of pharmaceutical companies) in the TRIPS Agreement on access to medicines.

4.7 Discussion and Conclusion

This chapter illustrates the role of theories in the creation of development models and how forms of knowledge from these models, expressed as narrative strategies on access to medication, became embodied in GHPs. Accordingly, the GHP model can be defined as the embodiment of development models previously promoted by UN agencies. The public health narrative is rooted in social theory, while the economistic narrative is rooted in liberal and neo-liberal economic theories. The analysis illustrates that national and

international public health institutions (WHO and UNICEF) became associated with a public health narrative; economic development, trade organizations (IMF, World Bank, WTO) and pharmaceutical companies with an economistic narrative, while CSOs pushed for a global recognition of a human rights narrative on access to medication. These actors and narratives are global, implying that their embodiment in a GHP gives rise to 'global models' on access to medication. The actors and narratives are also integrated into a hybrid network that defines the structure of a GHP. Studies on specific GHPs are needed to better understand the relationships among these actors and the ways in which the different narratives embodied in a GHP model shape various aspects of policy practices at global, national and local levels in Cameroon.

This chapter also reveals the usefulness of the conceptual framework developed in chapter two in understanding the embodying of models in three GHPs, namely, RBM, AAI and EAI. They all have characteristics of transcalar networks (global-national-linkages), that is, the social spaces through which narratives get onto national and international policy agendas. There is a strong relationship between social actors and the narratives (forms of knowledge) they produce, as seen in the ways that the narratives became embodied within specific GHPs. This suggests that some GHP partners are influenced by the narratives put forward by other partners. For example, in the AAI model, the economistic interest of pharmaceutical companies dominate more, while in the EAI, the human rights interests of the poorest people in the world who cannot afford medicines tend to dominate. It is also possible that although GHPs represent the integration of three narratives into a global model, national

disease control programmes created through GHPs tend to be dominated by these global networks in partnership with particular traditional public, private and local CSOs. Thus, to understand the impact of GHPs at country levels, it is important to study the role of each narrative in shaping national and local policy practices through specific GHP programmes and activities.

The social constructivist approach has also been useful. What emerges is that it the framing of issues through narratives (not a globally backed evidenced-based analysis), that largely determine why a specific GHP model should be adopted for facilitating access to medication for a specific disease. For example, in both the AAI and the EAI, access to medication is framed in terms of affordability and available of discounted patent-protected and equity pricing of generic medicines respectively. Accordingly, the initiators of both models claim victory over the global fight against HIV/AIDS. MSF states that 'the injection of generic competition into the global ARV market has catalysed a dramatic drop in drug prices. As a result, medical, academic, and political leaders are now beginning to tackle other barriers to treatment'[44]. According to the WHO (2002b:6), reductions in drug prices are largely due to 'the work of hundreds of individuals and activists in non governmental organisations (NGOs), governments, UN agencies and the private sector ... and we are now in a position to consider scaling up access in resource limited settings'.

The practical steps to reduce prices reveal how the importance of a public health narrative (quality of care) is undermined by the three GHP models. In

[44] MSF Access Website (2003) <http://www.accessmed-msf.org/campaign/faq.shtm> (Accessed: 25/05/07).

trying to reduce prices and increase access to medication, all three GHPs focus on changing the nature/content of medicines. The emphasis was on drug resistance, identified as a major barrier to access in the early years of GHP experiences. To avoid drug-resistance HIV strains, in the case of the AAI, the WHO relaxed its guidelines on simplified standardised regimens and laboratory monitoring making the ART more available (WHO, 2002b). Similarly, Indian drug manufacturer Cipla, a major supplier of generic medicines in MSF's programmes, launched a once-a-day cocktail to make treatment much feasible in poor countries (MSF, 2003). The same procedure was adopted by the RBM when it recommended the use of ACTs for malaria treatment (WHO, 2004b)[45]. As one would expect from a public health narrative, the emphasis was not placed on the reasons for a lack of adherence to treatment or prevention strategies. In the three GHP models studied in the chapter, scaling up access has focused on multilateral and bilateral agencies providing funding to pharmaceutical companies to finance drug R&D and consequently enable price reductions (WHO, 2001:56; WHO, 2002b:2) so that the poorest people (the human rights narrative) in the world can afford the drugs.

The political story on GHPs and access to medication is that they emerged from the need to correct governance gaps resulting from 'failed states' (government and market failures) in which weakened national health systems are unable to facilitate access to medication for rising number of poor patients

[45] For more on the change from previous anti-malaria drugs to ACTs see: Rational Pharmaceutical Management Plus Program. 2005. Changing Malaria Treatment Policy to Artemisinin-Based Combinations: An Implementation Guide. Submitted to the U.S. Agency for International Development bythe Rational Pharmaceutical Management Plus Program. Arlington, VA: Management Sciences for Health

(Dodgson et al., 2002; Buse and Harmer, 2007). Econometric data commissioned by UN agencies (and their affiliated private corporations)[46] and international CSOs[47] are used to show that the consumption of medicines is sensitive to price as well as suggesting price reductions as a way of increasing the demand for treatment with relatively modest investment in infrastructure (see also Borrell and Watal, 2002:5; Grace 2004:10-12). This serves to contradict the strong public health emphasis promoted by the WHO and UNICEF in the RBM, especially the need for a strengthened national health system.

This chapter finds that the way pharmaceutical companies have a strict economistic narrative which they impose on the arrangements in the TRIPS agreement and the way international CSOs use a human rights models to challenge them largely determines the overemphasis on the prices, the medicines, drug procurement and supply arrangements as against health system strengthening and preventive behavioural changes (related to disease prevention). The WHO defines access in terms of public health: 'guidance on the rational selection and use of drugs ... improved affordability and sustainability of drug financing and by accessible, appropriate and competent health services' (WHO, 2002:9). The RBM recognises this and calls on national governments to do more to address weakness in their national health system. However, the AAI and the EAI models more or less assume that such a

[46] For example in 2000 the AAI contracted McKinsey & Company to produce econometric data on the capacity for administering ARV therapy in Uganda that can be used to project scaling-up of access over time (Fine, Hazelwood, Hughes and Sulcas (2001)

[47] Joint Statement by Oxfam/TAC/CPT/MSF/Health GAP: 'Patents Do Matter in Africa According To NGOs' (17/10/2001): <http://www.accessmedmsf.org/prod/publications.asp?scntid=171020011428553&contenttype> (Accessed: 17/11/08)

health system exists. MSF (2002) argues that 'the necessary infrastructure exists to provide antiretroviral therapy today' while UNAIDS claims there is no 'single place in the world where the real reason AIDS treatment is unavailable is that the health infrastructure has exhausted its capacity to deliver it (WHO, 2002:9).

The discussion above suggests that the human rights narrative is more rhetorical and less practical at the global level. First of all, human rights were only made implicit in the PHC model, specifically targeting community (civil society participation) in health policy making and implementation. However, at the global level, policy issues seem to be negotiated in a corporatist way. Developing country governments are less represented in key GHP meetings while the monopoly power of pharmaceutical companies undermines their negotiating strength (Buse, 2004a). Unlike the RBM, both AAI and EAI do not see infrastructure development through a strengthened primary health care system that emphasises both medical and non-medical determinants of health (as the public health and human rights narratives would suggest) as a major barrier to access to medication. This obviously has serious implications for GHPs, namely, the extent to which they can achieve their country-specific goals. It would be interesting to study the ways in which the global narratives embodied within GHP models play on the issue of weak health systems and community participation in specific developing countries to better understand their role as facilitators of access to medication.

Finally, the global perspective on the emergence GHP models is characterised by competing and conflicting narratives and this obviously affects the ways actors participate at the global, national and local levels. For example, in developing countries where the AAI and EAI models have been implemented simultaneously, it is not clear which one plays a more practical role. Brazil, Thailand and Cameroon are being cited as countries that 'have taken advantage of several strategies simultaneously, including local production, importation of generics and forceful negotiations with proprietary companies to bring prices down' (MSF, 2002a: 7). UNAIDS/WHO (2002:11) also makes reference to Cameroon (among several African countries) for successfully allocating funds to subsidize access to ARVs to people who are unable to afford the drugs' and 'converting part of their debt relief proceeds into a fund for care and treatment'. Similarly, although the RBM claims to emphasise health system strengthening, national RBM programmes overlap with the health structures under the Ministry of Health (created on the basis of the PHC model) (Ngoasong, 2009). The two empirical case studies in this thesis are meant to understand the impact of GHP models in shaping health policies and local delivery practices for national GHP programmes created to facilitate access to medication for malaria and HIV/AIDS respectively.

CHAPTER 5: THE HISTORICAL CONTEXT OF GHPS IN CAMEROON

5.1 Introduction

This chapter presents the country-specific perspective on the emergence of GHP programmes as a new kind of global model on access to medication. It aims to extrapolate the key contextual characteristics that make the Cameroonian efforts to deploy GHP programmes an interesting and challenging object of analysis. The theoretical framework developed in Chapter Two suggested that understanding the role of models in shaping policy practices involve identifying instances where developments in the creation of models parallel or complement instances where new policies are introduced. From this perspective, this chapter identifies and discusses the 'trigger events' and the 'windows of opportunities' (Kingdom 1984; Birkland 1998) through which key policy issues (such as narratives or forms of knowledge embodied in models) get onto national policy agendas and how they shape policy practices in different periods in Cameroon's colonial and post-colonial history. This includes the main history of state building, the most important actors and institutions and the context in which GHP models come to play an important role on access to medication. Historically, the government has acted autonomously - through the adoption of various western models - to create a national health system that was subsequently transformed through the development of GHP programmes.

Models of health development created in Europe were exported to developing countries through colonial routes, multilateral organizations and more recently GHPs. Analysis of these historical processes reveal how western ideologies embodied within development models has been portrayed as superior, leading colonial masters to undermine indigenous knowledge when formulating policies that would shape local practices. This is reflected in the complexity and character of the barriers to access to medication. The barriers and the corresponding failed attempts at resolving them give rise to 'trigger events' that necessitate the endorsement of GHPs from the late 1990s. GHPs in turn create 'windows of opportunities' enabling the government to develop globally-backed national GHP programmes as a panacea to previous programmes that did not work. Each GHP model targets a specific disease, policy or health system failures and each is being deployed to Cameroon as a panacea to previous models that did not work.

This chapter argues that National GHP Programmes in Cameroon represent a new kind of global model that attempts to blur the boundaries of North-South relationships by creating transcalar networks with global-national-local linkages. Instead of reporting directly to the colonial authority (Germany, France and Britain respectively) or to the state (independent and post-independent eras), accountability over policy practices shifted to National Disease Control Committee. Within each committee, public, private and civil society actors from global, national and local levels with competing interests sit around the same table to formulate and implement policy. This new kind of participation gives absolute political control to no single stakeholder, not even

the state. This is the basis on which GHPs are meant to shape national health policy and local practices in Cameroon (and most African countries) for diseases such as HIV/AIDS, malaria and tuberculosis.

The remainder of this chapter is organized as follows: the next section presents an overview of how colonial masters (Germans, French and British respectively) and later the IMF/World Bank-led liberal and neo-liberal models shaped Cameroon's political economy and laid the foundation for an economistic narrative on access to medication. It then describes how colonial medical models became embodied in variants of the WHO/UNICEF-led primary health care (PHC) model that emphasized a public health (with an implicit human rights) narrative on access to medication. A combination of these models and country-specific challenges created a fragmented national health system that could not be sustained. This laid the foundation for the emergence of GHP models in Cameroon. Illustrative examples on the expected challenges to be faced by national GHP programmes on HIV/AIDS and malaria are highlighted in the conclusion.

5.2 The History of the Political Economy of Development

Located around the Gulf of Guinea in the South West of Africa, Cameroon is a developing market economy with an estimated population of 16.6 million on a surface area of 475,402 Sq. km (Ako et al. 2006). It is often referred to as 'Africa in miniature' or 'the Africa continent in microcosm' because of its rich colonial history, and physical, socio-cultural, economic and demographic diversity (Kofele-Kale, 1986; DeLancey and Mokeba, 1990). These

endowments make it one of the few countries in Africa that is self-sufficient in food production (EIU, 2002) and puts in a nutshell the colonial and political trajectory of Africa. From slave trade and migration to a German colony (1884-1922), split into two (British and French) League of Nations mandates (1922-1945) and United Nations trust territories (1946-1960, unification to a federal republic (1961-1972), a centralised system of government (1972-1990) and a multi-party system that is now trying to reshape itself into a decentralized state system. Kofele-Kale (1986) describes Cameroon as a society divided along ethnic regional lines (with more than 200 different African ethnic groups), dominated by Muslims in the north and Christianity in the south and west; and opposition between French and English-speaking peoples based on the country's colonial history.

Despite such a rich traditional and ethnic diversity, exogenous factors (colonial and neo-colonial) are largely responsible for the creation of a 'nation-state' in Cameroon, one that governs the public sphere and supports its socio-cultural diversity. Colonial rule introduced political and socio-economic changes and policies, the consequences of which are deeply rooted in the political struggle for independence (1945-1961) and developments (such as infrastructure, industrialization in agriculture, medical services and education) since that time. Colonialism also introduced new languages (French and English) and enforced new customs (such as Christianity). The former colonial masters (France, Germany and Britain) eventually acted directly (due to their colonial interests) and indirectly (through their influences in international and global institutions) as major routes through which GHP models found their way into Cameroon.

This historical process is divided into phases and discussed in terms of the impact of the colonial, post-colonial and globalization eras in Cameroon.

5.2.1 The Creation of a Nation State in Cameroon

Most historical accounts[48] hold that Portuguese merchants and missionaries first explored Cameroon through the south western coast establishing temporary slave trade routes in the 1450s. The name Cameroon originated from Portuguese navigator, Fernao Do Po when in 1472 he named the River Wouri, 'Rio dos Camaroes' (river of prawns), a name subsequently translated by successive European colonial expeditions in Cameroon: Camaroes (Portuguese), Kamerun (German), Cameroon (English) and Cameroun (French)[49]. The northern part was an important Muslim slave trade network dominated by Islamist Jihadists. When slave trade was abolished in the mid-19th century, the London Baptist Missionary Society (around 1845) and later the Basel Mission from Germany (from 1884) established a presence and continues to play a role in Cameroonian Christian life. Their worship centres and educational programmes were later taken up by Catholic and Protestant Churches respectively. The Portuguese and missionary arrivals were followed by over seven decades of colonial rule starting with Germany and later Britain and France.

The colonial models of political development were militarist, bureaucratic and highly centralised. Despite the apparent difference in the models deployed by Germany, France and Britain, they all shared a common similarity in the sense

[48] See Le Vine and Roger (1974); DeLancey and DeLancey (2000); Ngoh (1987) for a detailed history of Cameroon.
[49] For the purpose of this thesis the English version Cameroon is used throughout this chapter.

that they were meant to achieve multiple objectives (political, economic, health and socio-cultural) simultaneously. Accordingly, most of the colonial administrators performed several tasks simultaneously. For example, Gustav Nachtigal the driving force towards the establishment a German colonial model in Cameroon was an explorer, a medical doctor, imperial consul and commissioner for Germany's interests in West Africa. Thus, instead of trying to describe the exact nature and representation of the models, this section focuses on key elements of the models that contributed to the creation of a nation state in Cameroon.

On 14th July 1884, Gustav Nachtigal negotiated a protectorate treaty with the local chiefs and Cameroon became a German colony under The General Act of 26 February 1885 at the Berlin Conference (Schnee, 2007). Germany's colonial model emphasised the development of an agricultural economy with absolute political authority from the Reichstag in Berlin. Although the goal was to produce goods to be exported to Europe, the model implicitly portrayed agriculture as the engine of economic development. Embodied in the model was a system of *compulsory manual labour* and *punitive sanctions* (on those who defaulted). When the Germans lost World War I, Cameroon was partitioned between France and Britain as two League of Nations Mandates (1922-1945) and later became UN Trust Territories after World War II (1945-1961).

France gained over 80% of the geographical space, and ruled from Yaoundé (the present day Capital) as French Cameroons. Embodied in the French

colonial model in Cameroon was a strategy deploying *assimilation* (French language, legal and educational systems) and *indigenous politics* (French judicial and policing system while tolerating traditional legal practice) (Mbaku, 2005). Traditional rulers often travelled to France for conferences and exhibitions, and under this regime Cameroon quickly became a self-sufficient and thriving civilization. The newly educated Cameroonian elite began to express a new Cameroon identity and forge the vision of a new society. They served in the Christian missions as catechists, pastors/priests and for the colonial government as junior-level civil servants. Britain gained only 20% of Cameroon and deployed a model of *indirect rule* in which the region was split into two and administered as provinces of Nigeria (ruled from Lagos).

Colonialism also divided Cameroonian society between those 'elite' groups trained to promote colonial interests and those who opposed them by emphasizing traditional community values and customs. This is evident in the fierce local resistance to colonial rule (Mbaku, 2005). For example, Rudolph Douala Manga Bell was trained in German law by the German colonial administration and made king of Duala in 1910. He went on to challenge German ownership of land in Cameroon after realising that both international (The General Act of 26 February 1885) and national (in Germany) laws on land ownership had prohibited the ownership of land by many Germans in Cameroon. His legal protest to the German Reichstag was rejected, and his continued activism led to his execution by colonial authorities in 1913 for treason. Other prominent Cameroonian intellectuals directly or indirectly persecuted for political activism include Martin-Paul Samba of the Bulu

(assassinated by the German authorities) and Sultan Njoya of the Bamoun (exiled to die in Yaounde by France) (Mbaku, 2005). The German system of compulsory labour as well as successive and dreadful punitive raids following resistance and rebellion dislocated social life and seriously reduced population growth (Caldwell, 1985: 483).

Another evidence of local resistance to colonial models can be found in the struggle for independence from colonial rule. In 1946, a French-backed Representative Assembly of Cameroun (ARCAM) was created and its leaders (Paul Ajoulat and A. Douala Manga Bell) were assimilated as elected deputies of the French National Assembly. In 1945, an anti-colonial Marxist party, the *Union des syndicats confédérés du Cameroun* (UPC), had been created to fight for unification and independence from France. Activism was supported by trade-unionists in the cities and by local settlers in rural areas, expressed through non-violent rallies, demonstrations and boycotts. However, the punitive sanctions on arrested protested led to a guerrilla war between the rebellion and the French Fourth Republic. The rebellion was crushed and in 1956 the ARCAM was approved by France as an autonomous Legislative Assembly of Cameroun (ALCM). Similar types of protests took place in British Cameroons; however, the indirect rule of the British meant that there was limited violence.

French Cameroon was finally granted independence (backed by the UN) on January 1, 1960 with Ahmadou Ahidjo as president. In a UN-led plebiscite in February 1961, the Muslim-majority North of British Cameroon opted for

union with Nigeria while Southern Cameroon reunited with French Cameroon to form a Federal Republic of Cameroon on 1/10/1961. On 20/05/1972 a referendum transformed the federation into the United Republic of Cameroon. When Paul Biya replaced Ahidjo as president in 1982, the country became the Republic of Cameroon although it remained a centralised and sovereign one-party state. However, in 1990, international pressures led the government to introduce multi-party politics.

Thus, the Berlin Conference of 1884, the First World War (leading to the League of Nations) and the Second World War (leading to the United Nations) can be seen as trigger events that allowed the deployment of colonial models to Cameroon and led to the transfer of political authority from indigenous Cameroonians to colonial masters. The Second World War also created a window of opportunity as it enabled opponents of the colonial model to begin a struggle for independence. Colonial models disintegrated Cameroonian society between those 'elite' groups trained to impose western ideologies and those who opposed them by emphasizing traditional values and customs. In addition, to achieve their colonial interests, Germany, France and Britain used different models to shape the political economy of Cameroon in ways that restricted the political liberty of indigenous Cameroonians.

5.2.2 Development of state institutions: a system of government

The attainment of independence, backed by the United Nations, created a window of opportunity, for the government to start acting autonomously (though with some indirect influence from the former colonial masters).

However, the manifestations of the colonial models described above continued to be reflected in policy and local practices. The Presidency remains the most important institution. The President, vested by Presidential Decree with executive authority, appoints the Prime Minister, judges, executes and ratifies all laws, commands the armed forces and issues orders to hold elections. Decisions taken in courts and at cabinet meetings are issued in his name. The Cabinet of Ministers is led by the Prime Minister (appointed by the President). In turn, the Cabinet is responsible to the president through the prime minister in matters of general policy and legislation.

The cultural and ethnic diversity of Cameroon mentioned earlier implies that no one ethnic group is large enough to exert a dominating influence in Cameroon. Thus, the totality of colonial models were largely embraced: English and French as official languages; different provinces (or educational institutions) use the British and/or French model of education; internationally, Cameroon is a member of both the Common Wealth of Nations (British) and the Francophonie (French); the legal system is built on civil law (France) although in the English-Speaking provinces elements of the common law (British) still exist. With 25% of Cameroon being Muslims (most of whom are French-speaking), political power is implicitly shared among the French, British and Muslims. The President has always come from the French region while the posts of Prime Minister and Chairman of the National Assembly are often rotated between the Muslim and the English-Speaking peoples respectively. This distribution of portfolios is inherent in all structures of government at national and local levels.

Models based on western ideologies also provided the basis on which policy and local practices are mediated and enforced. As first President, Ahidjo set out to established a re-enforced presidency (LeVine, 1997), one that was capable of crushing the Gaullist model of the rebellious UPC party and one that would give him greater control over British Southern Cameroons. Backed by France, he diverted substantial public resources to create several security institutions (such as Brigades Mistes Mobile and Service De Documentation – SEDOC) as tools to maintain political stability. As a result, 'many bureaucrats sacrificed professionalism and efficiency for security' (Mbaku, 2004:143), and local and sectional loyalties became paramount under a highly centralized government. Since 1990 when Paul Biya introduced multi-party politics, the nature and role of the state never changed. The ruling elites, instead of questioning the suitability of colonial systems of democracy and government in local politics, continued to suppress the local chiefs, neglecting developments in rural communities (Rowlands and Warnier 1988:120). Although multipartism allowed the leaders of many ethnic groups to make more open political commitments, their scope for influence remained ceremonial.

The discussions above reveal how western ideologies embodied in colonial models became superior to traditional customs and values in the development and functioning of the state in Cameroon. The manifestations of this cut across all levels of society and can be seen in the ways in which the different sectors of government are organized and how they function. The next section explores how the colonial models directly (during the colonial era) and indirectly

(through their influence in international organizations) shaped economic development in Cameroon.

5.3 How Models Shaped Economic Development Policies

Economic development in Cameroon is a product of colonial, planned liberalism and neo-liberal market models respectively. Accordingly, the nature of North-South relationship has shifted from direct political influence (the colonial era) through donor-recipient commitments (independent era) to public-private partnerships (globalization era). The economic elements embodied in colonial models transformed an 'informal trade-by-barter system in pre-colonial Cameroon into a centralized market economy that was subsequently transformed through various international models of economic development. This process is described below.

5.3.1 The legacy of colonial models on economic development

The abolition of slave trade in the 14th century had enabled indigenous Cameroonians to trade domestic goods (e.g. palm oil) for foreign goods (e.g. guns, gunpowder, scarlet uniforms and hats) with European traders. The early German explorers exchanged these products for land with local Cameroonian Chiefs. In 1874 German merchants inaugurated the first scheduled passenger and freight service between Hamburg and Douala (Washausen, 1968:68) and expanded agricultural plantation operations on the acquired land, under the protection of the Reich. A few years later Chancellor Otto von Bismarck began to use the 'chartered companies' to govern the region (Washausen, 1968:116;

Haupt, 1984:57) thereby replacing the pursuit of private profit with direct political control over economic activities.

The first German Administration (1895-1906) created Trans-National Corporations (TNCs) producing crops (such as cocoa, coffee, banana, latex, plantain) and expanding infrastructural development (roads and rail lines). Through 'a harsh and unpopular system of forced labour' (DeLancey and DeLancey, 2000:125) the Germans depicted Cameroonians as idle people unable to perform any productive work beyond manual labour, thereby reducing them to manual labourers in TNCs (Ngoasong, 2007:96). The notion of partnerships is embodied in the German model, with chattered companies (private partner) running the plantations, Cameroonians (manual labourers) and German administrators (public partner). This model had mutually positive economic impacts in terms of infrastructural development, job creation and economic growth. By 1911 the total volume of trade between Germany and Cameroon exceeded 50 million gold marks (Haupt, 1984:64).

The notion of partnership between public and the private sectors was also embodied in the colonial models of Britain and French, specifically for economistic reasons. Despite setting out to destroy Germany's political legacy, France and Britain allowed German administrators to run the agricultural plantations. In May 1922 the British Parliament (cited in Schnee, 2007:151) lauded the German plantations as follows:

> 'As a whole they are wonderful examples of industry based on solid scientific knowledge. ... Apart from the regular employment afforded, the natives have been taught discipline and have come to realise what can be achieved by industry. ... Large numbers who returned to their

villages take up cocoa or other cultivation on their own account, thus increasing the general prosperity of the country'

France also benefited from the services of the Germans to expand infrastructural development beyond the TNCs (such as to develop electricity and water supply, broaden medical services and to establish educational establishments/schools) (Michel, 2007). These achievements supported by a centrally regulated partnership laid the basis for the creation of an independent Cameroon capable of sustaining an expanding market economy.

5.3.2 Planned liberalism and economic development practices

At independence, TNCs were perceived as inherently malevolent due to their dominant influence on internal policy practices, exploitation of domestic resources (by colonial powers and and merchants of TNCs) and the use of forced (or lowly paid) labour. To consolidate his power as an autonomous president Ahidjo launched a policy of *Balanced Development.* This involved nationalising foreign corporations and introducing maximum state ownership in the public and private sectors. To gain international recognition as a sovereign state he endorsed the World Bank-proposed *Planned Liberalism* model, a series of *Five-Year Development Plans* (starting from 1961). This rationalist model requires policy makers to rely on evidence-based policy analysis to shape economic development programmes. During the Second Five-Year Development Plan (1966-1971), all major foreign-owned companies were transformed into State Owned Enterprises (SOEs). Regulation, ownership and management decisions were decided by the Presidency through a *parastatal class* of senior public managers (van de Walle, 1994:157).

Planned liberalism enabled political stability based on a set of undemocratic institutions that regulated socio-political interactions and provided a semblance of peaceful conflict resolution. The president used dictatorial powers to 'bribe competitive elites, co-opt politically dominant ethno-regional elites, neutralize others, force some into exile, and imprison many individuals who dared to oppose his dictatorial policies' (Mbaku, 2004:155). Such an approach to state expansion enabled the government 'to cement a 'hegemonic alliance,' incorporating the country's emerging elite into the state apparatus' (van de Walle, 1994:155). Thus, the state used the elites of ethnic groups and senior managers of SOEs as instruments to maintaining political equilibrium in the distribution of jobs, wealth, income, power and privilege at the national level. These elites in turn used their positions to maintain political equilibrium at regional and local levels.

With extraordinary economic growth rates, this complex undemocratic set up raised no concerns. By 1980, success in agriculture (mostly cocoa and coffee exports) and the development of oil in the 1970s had stimulated extraordinary economic growth rates, making Cameroon one of the twenty safest countries in the world for investments (Ndongko, 1986), one of the few in Africa that was self-sufficient in food and energy production (DeLancey and Mokeba, 1990) and a model of political and economic stability in the world (Mbaku, 2004:154).

In 1982, Ahidjo resigned and appointed his Prime Minister Paul Biya, as the next president. Mr Biya, who is in power to date, used the media as a tool to

negate the legacy of his predecessor and to consolidate his own power. The regime change can be seen as another trigger event. For the first time the national media began to expose the extent of bribery and corruption that was embodied in Cameroon's political economy under Ahidjo. The media also credited the vast development projects in the country as the work of the former colonial masters. This even prompted the former president to attempt a failed coup d'état in 1984. The brief power struggle 'weakened the new president and made it difficult for him to take appropriate policies to reduce the state sector and prevent its continued expansion' (Mbaku, 2004:158). Apart from this, Biya's spending decisions were very similar to those of Ahidjo's. By mid-1986 'public spending had reached unsustainable levels and a fiscal crisis was inevitable' (Ibid). The regime of Mr. Biya eventually plunged the economy into crisis.

In 1987 Cameroon officially announced its worst economic crisis since its existence as a sovereign nation. Blaming external factors, Mr Biya announced that 'all our export commodities fell at the same time' (DeLancey and DeLancey, 2000:104). He was referring to the sudden collapse in the world market prices of primary exports (such as cocoa, coffee and oil) in the early 1980s. The exact causes of the crisis remain debatable, yet reflect the interaction between western models and local practices: the failure of the state to detect and resolve the crisis at an early stage, uncontrolled expansion of corrupt public banks, inefficient SOEs that over-stretched the public treasury and increased external debts beyond manageable levels (Mbaku, 2004). Between 1985 and 1987, Cameroon's proposed adjustment programs stalled

after former colonial masters (mostly France and Germany) and the USA (creators of the World Bank-led liberal model) rejected the government's plea for financial assistance (see van de Walle, 1994:158). These powerful nations offered to provide funds conditional on Cameroon endorsing the IMF-sponsored Structural Adjustment Programme (SAP).

Thus, international actors moved from one failed model to another with limited attention to country-specific policy contexts and practices. In a press release announcing the SAPs for Cameroon, the IMF confirmed the narrative put forward by the President of Cameroon, pointing to 'declining prices for the country's major export commodities, weakened terms of trade and significant increase in overall fiscal deficit (Mabaku, 2004:160) as the causes of the economic crisis. The next section explores the role the SAPs in shaping the political economy of Cameroon.

5.3.3 Neo-liberal model of development – Structural Adjustment Programmes

SAP was launched by the IMF in the mid-1980s to bail out poor countries from the financial crisis caused by a collapse of primary export prices. In Cameroon, it consisted of guaranteed multilateral (IMF/World Bank) and bilateral (France and Germany) loans and aid along with specific conditions on spending for the period 1988-1995. The broad goals of the SAPs include: increase public revenues through privatisation and efficient management of SOEs; currency devaluation to reduce real exchange rate and stimulate exports; credit and fiscal contraction; and liberalize trade to stimulate competition (van de Walle, 1994; IMF, 1995). Through the SAPs, the IMF and the government of Cameroon

reached agreements on major and additional financial resources to achieve these objectives[50]. Two most significant agreements include[51]:

- 19/09/1988: Financial rescue package of 115.525 millions US$ to stimulate macroeconomic performance through privatisation of SOEs that dominate the industrial sector as well as liberalisation of trade in cocoa, coffee and timber.
- 17/09/1995: Financial package of 1010 millions US$ to continue to expand the structural reforms agreed in 19988 as a means to achieving pre-determined targets: 3% real GDP growth, 5% reduction in inflation, reduce current account deficit to 1% of GDP

In addition to the financial assistance from the IMF, the former colonial masters (France and Germany) immediately invited Cameroonian policy makers to the Paris Club and approved additional bilateral financial aid as well as rescheduling the country's outstanding debts (van de Walle, 1994:159-160).

Economic calculations are often employed to evaluate the impact of SAPs (such as income-related indicators: economic growth rates, terms of trade and debt servicing). In the case of Cameroon, instead of reducing external debts to manageable levels, debts increased substantially, more than 50% of people lived below the poverty line in 1996 (Ngufor, 1999) and government spending deficit increased to 464 billion FCFA (Ofeh and Njong, 2006). Yet the World Bank maintained that SAPs were working. Since 'more time' was needed for interventions to translate into positive macroeconomic performance, the IMF and the World Bank rejected calls for SAPs to be abandoned. Even the 1997

[50] The full text of IMF (1995), a series of country reports, is available on the web site beginning with Staff Country Report no. 97/101

[51] For detailed statistical illustrations and terms of the SAPs see Mbaku (2004:158-159).

IMF-sponsored Enhanced Structural Adjustment Facility (ESAF), meant to address the failures of previous SAPs, did not improve the much needed statistical evidence on success.[52]

Opponents of SAPs claim that 'scarce resources which could have been used to increase spending on such areas as health care, primary and secondary education, HIV/AIDS medication, and to purchase essential inputs for domestic industry, are being squandered on debt service' (Mbaku, 2004:164). More importantly, the SAPs neither identified corruption as a major cause of the crisis in Cameroon nor emphasised measures to fight it as a condition for financial aid. For example, more than 50% of imports into Cameroon during 1988-1990 evaded taxes through corruption in the customs department (van de Walle, 1994:159). Because the SAPs served 'primarily as instruments of global trade that benefits mostly the OECD countries, the main contributors to these agencies' (Mbaku, 2004:163), loans and aids were continuously supplied to increase the dependency of countries like Cameroon on western industrial markets (Danaher, 1994) despite continued policy failures.

Thus, a combination of external and internal pressures forced Cameroon to adopt the liberal and neo-liberal models, rather than a proper evidence-based search for solutions to the country's persistent problems. The models created a 'democratic culture characterised by rent-seeking behaviour' that promoted a vibrant black market and reinforcement tribalism (Baye, 2003:12). All facets of society were hit by the crisis resulting in an increase in poverty, high rates of

[52] Statistical evidence of poor performance of the SAPs can be seen through a simple comparison of figures presented in successive World Bank reports on the SAPs performance in Cameroon (see Van de Walle 1994, Mbaku 2004, 2005).

infant mortality, low levels of literacy, a reduction in life expectancy and limited access to medical facilities (Baye, 1998). Development models also led to the creation of bad leadership and defective institutions (elite-driven, top-down, non-participatory constitutionalism backed by former colonial masters) that were later transformed by multilateral organizations (IMF and World Bank) with serious implications for national policy and local practices.

5.3.4 The consequences of neo-liberalism: globalization era

The discussion above reveals that the neo-liberal model was substantially economistic in Cameroon. The manifestations of the model transformed the Cameroonian state from a centrally planned economy to a free market economy. Within a decade of launching the SAPs, the number of major privatized firms in Cameroon reached 44 (World Bank, 2000) and 58 new affiliates of multinational enterprises were established between 1992 and 2001, while inflows of foreign investments reached 75 million dollars (EIU, 2002). Since the early 1990s the literature on economic development in Cameroon is loaded with terms such as 'decentralization', 'deconcentration', 'devolution', 'privatization', 'contracting out', 'public-private partnership' used interchangeably to describe public and private sector programmes and activities. Such a fragmented system obvious represents an erosion of the political accountability that existed in the colonial era, but that liberal and neo-liberal models never asked for from successive governments of Cameroon.

In the wake of the failed SAPs and the consequences that followed, bilateral and multilateral organizations came out more strongly on the issue of weak governance in Cameroon. In a detailed country study, the World Bank reports

that throughout the 1990s, economic and social development in Cameroon was hindered by the heavy burden of the external debt, balance of payment deficits, structural rigidities, high production costs and weak governance (World Bank, 2000: App B), challenges that the SAPs – imposed through the World Bank - were meant to solve. This gives credibility to the arguments by critics that the SAPs never created the governance structure necessary to regulate the market economy they sought to create.

Having acknowledged this, multilateral agencies began to face a crisis of confidence in the capacity of the state to function effectively. They equated market failures with state failures and began to promote community-level (participatory development) models (World Bank, 1996) that involved bypassing the state to work directly with civil society organizations (CSOs) in programmes of poverty alleviation and sustainable development as a means of correcting democratic deficits within the state. This involved limiting the role of the state to policy making and working directly with local CSOs in policy implementation. Introducing community participation has led to the proliferation of CSOs (e.g. INGOs and NGOs) whose work are described as new ways of filling governance gaps in state institutions (Tafah and Asondoh 2000). CSOs can help multilateral agencies to achieve quick results; however, they also have the incentive to practice rent-seeking behaviour in Cameroon, acting as 'brokers' who effectively confiscate the value-added from development projects (Baye, 2003).

The role of local CSOs became for formal in 2000, when the World Bank's Heavily Indebted Country Initiative (HIPC) was launched, another trigger event that further transformed the nature and functioning of the state. It came into effect in mid-2000, making available $86 million per year for public spending in areas such as healthcare (MoH, 2000). This is because the initiative embodied elements of community-level models with the aim of correcting governance failures. The initiative required the creation of a Country Coordinating Mechanism (CCM) – consisting of representatives of the public and private sectors, CSOs and donor agencies – to formulate and implementing.[53] Although preliminary evidence on the impact of the debt initiative reveals mixed results (Baye, 2003; UNCTAD, 2002), studies on specific sectors of the economy are hard to find. As discussed later, this new kind of participatory approach to governance had a direct impact on the development of the health sector. Thus while the liberal model gave absolute political power over national policy to the government, neo-liberal model eroded this power by creating a fragmented free market economy. The conditions under which resources were meant to be spent by the CCM were intended to ensure that the deployment of GHP models places special emphasis on good governance and the fight against corruption.

The CCM, a multi-stakeholder PPP approach, is capable of blurring the North-South divide in the sense that it replaces the state as the central political apparatus for deciding policy. This means that multilateral and bilateral development agencies would no longer give development funding directly to

[53] CREDES (2004) 'Country Coordinating Mechanism: Case Study Documentation – Cameroon, Report prepared for the Global Fund ATM and Financed by the French Ministry of Foreign Affairs, CREDES, France.

the government (donor-recipient commitments); they would provide funds through the CCM. This type of model has been adopted by GHPs to facilitate access to medication as discussed in the next sections.

5.4 The Historical Context of GHP and Access to Medication

In this section, the historical context in which GHP models emerged in Cameroon is presented, focusing on the key actors and their role in introducing different forms of knowledge (economistic, public health and human rights) into GHP programmes in Cameroon. In many ways the colonial, liberal and neo-liberal models discussed earlier shaped health institutions, policies and local practices in Cameroon. Although the state had autonomy as policy maker (after independence), the structure and content of health policies were largely influenced by western development models (Table 6). Similarly, the WHO/UNICEF-led international health policies were affected by the neo-liberal market models. By integrating international and national partners and their strategic interests, the notion of PPP embodied in GHPs transformed Cameroon's health policy from government to governance. Accordingly, the interests of global, national and local partners became integrated in a multi-stakeholder partnership. The conflicting and competing narratives of different actors during different conventional time-lines shaped the construction of access to medication and necessitated the endorsement of GHP models for specific diseases by the government of Cameroon.

Table 6 The historical context of access to medication in Cameroon

Conventional time-line	1884 – 1961	1961- 78	1978 -1998	>1998
Scope of Policy	Colonial	National vs. Colonial	International	Global
Development Policy	Colonialism (Dictatorship)	Government (Planning)	Government (Privatisation & Regulation)	Governance (Public-private partnerships)
Policy Maker	Germany, France, Britain	The State	State (Ministry of Health)	National Disease Committees
Health Policy Goal	Curative & Preventive	Curative & Preventive	Medical vs. Non-medical	Access to medication

Source: Author's analysis of published materials

5.4.1 The legacy of colonial medical models

During the colonial era, Germany and later France and Britain played the role of the State, complemented by religious missionaries. Traditional healers already had well-established practices based on the customs and tradition of their society. On the other hand, both the colonial masters and Christian missions focused on selective identification and treatment of diseases.

Colonialism in Cameroon coincided with the 'golden age' of techno-medicine in Europe and North America (1910-1950) described in chapter four. The medical profession had become increasingly institutionalised emphasising a combination of evidence-based preventive and curative measures in dealing with health problems. As a result of this science-based approach, colonial medical models contradicted both an evangelical narrative put forward by Christian missionaries and traditional healing practices that were based on the customs and traditions of Cameroonian society. This was evident in the speciality of hospitals, such as those for tropical diseases such as malaria and sleeping sickness.

Embodied within the colonial medical models was an emphasis on selective identification and treatment of diseases to protect the colonial citizens and to preserve the labour force needed to work in the agricultural plantation. In 1911, Ludwig Kalz, Chief German physician in Cameroon, stressed that the 'colonial economy should make the Negroes' strong arms subject to its purposes, hygiene should preserve their strength and increase their number' (Schlich, 2001:59). Several hospitals including centres specializing in tropical diseases (such as malaria) were established, based on a combination of preventive and curative models.

The eradication of sleeping sickness is a classic example (Haas, 2002). Having graduated as a medical doctor and with specialized training in tropical medicine, Dr. Eugene Jamot led a French colonial hygiene group to Cameroon in 1910. In partnership with a similar German group, Jamot identified the tsetse fly as the cause of sleeping sickness. Using treatment models applied during the construction of the Panama Canal (lessons learnt from other countries), his team eradicated the tsetse fly, and therefore the disease, in Cameroon. He became director of health policy formulation and implementation in French West Africa. The 'golden age' of techno-medicine in Europe was consequently prominent in Cameroon. In the interwar years, France encouraged the training of indigenous medical personnel to be able to deal with public health issues with limited supervision. French medical and military doctors emphasised a unity of method and the homogeneity of teams (Patton, 1996).

The colonial models came into conflict with indigenous healing practices, which were already struggling to cope with an evangelical narrative put forward by Christian missionaries. Initially, Christian missions responded to the high mortality rate of their missionaries through direct medical measures. Later on, in an attempt to legitimise their activities, they began to complement the colonial agenda (especially in rural areas) through miraculous healings based on faith, prayers and medicines. Historically, traditional healers in Cameroon served as 'priests, magicians, spiritual and political leaders' using divine powers transferable through ancestral generations (Njoh, 2006:156). Traditional medicine typically views sickness as the failure of complex social and spiritual relationships, and based their prescriptions on both human and supernatural interactions. While colonial medical models attempted to restore physical health, traditional models re-established social and emotional equilibrium based on traditional community values and norms.

Achieving a convergence of the three medical cultures above was impossible. It is often argued that the colonial masters never sought to decisively destroy traditional medical practices (Njoh, 2006). However, they clashed violently when it came to political authority. The militarist rule of the Germans and the French breached the strong link between traditional healing and public authority that was embodied in Cameroonian society, while the British intervened where traditional healing posed a direct and significant threat to colonial rule (Maynard, 2004). Christian missions used indigenous peoples they had trained (as catechists, priests and pastors) as tools to label traditional healing systems as antithetical. Since independence, although traditional

medicine is not formerly recognised nationally and internationally the practice has survived due to the failure of colonial and neo-liberal models to create a national health system capable of providing sustained and affordable healthcare (see for example, WHO, 1990).

5.4.2 From Colonial Health to International Health: WHO & UNICEF

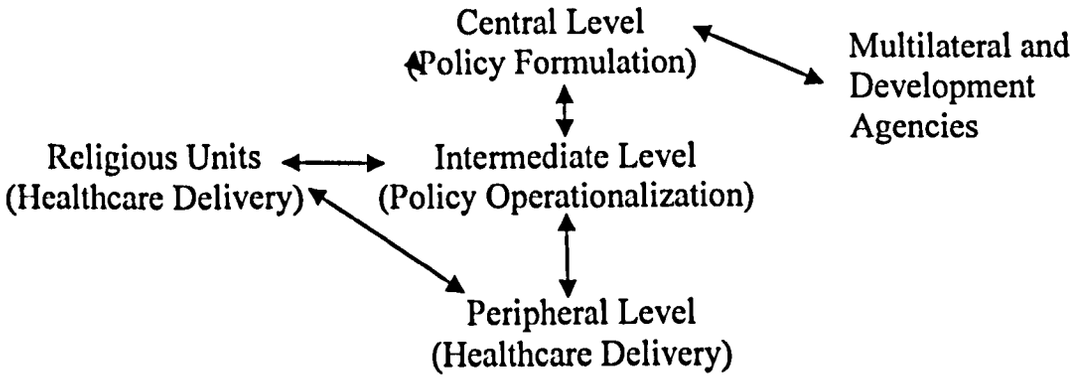
Under the planned liberalism model in the 1960s and early 70s the government nationalised health services and promoted a slogan of free healthcare for all. Health policy formulation was highly centralised under the Ministry of Public Health. However, policy implementation (health care delivery) took the form of partnerships between the state and Christian missions, the former focusing in large urban centres and the latter penetrating into rural areas. The creation of the WHO and later UNICEF added an international dimension to health policy in Cameroon, as these agencies began to respond to disease outbreaks by providing emergency technical assistance. Since the late 1970s, the measures taken to achieve health policy goals always involve the adoption of international (WHO and UNICEF) and global (GHP) models through international health charters, directives and conventions.

5.4.3 The Primary Health Care Model in Cameroon

The most significant international health model adopted by Cameroon following independence is Primary Health Care (PHC), the outcome of the WHO/UNICEF-sponsored Alma-Ata Conference. Since being effectively implemented from 1982, it has undergone numerous transformations (see Ghogomu et al., 2000; Essomba et al., 2003; Ofeh and Njong, 2006). As

illustrated in Figure 4 below, the PHC was *vertical and centralized* around three levels: central (the Ministry of Health and its different departments formulate policies), intermediate (provincial delegations, hospitals and paramedical training structures operational policies), and peripheral (health districts/areas and pharmacies implement policies) levels.

Figure 3 The structural features of the Primary Health Care (PHC) system



Source: Author's processing of technical reports/published documents

Within the framework of the PHC model, communities were mobilised on a low-pay or voluntary basis to construct, donate or rent property to be used as a health post. Each district formed a health committee headed by a person born in that specific district. The intermediate level trained the committees, provided them with drugs and equipments with which to deliver services to their community. Religious missions continued to complement the system as usual. The PHC model operated in parallel with confectioners and traditional healers, enabling the government to deliver its promise of free healthcare until 1990. High economic growth rates in the 1970s and early 1908s supported a rapid expansion of the network of health structures enabled the state to sustain a

strengthened PHC system (Ako et al., 2006), until the economic crisis in the late 1980s began to expose its structural weaknesses.

Instead of dealing with the many determinants of health (as defined at Alma Ata), the PHC consisted of an assortment of vertical programmes (a combination of parallel medical centres supported by missionaries and former colonial masters). The overlapping nature of treatment programmes, the crisis-ridden infrastructural capacity and poverty-ridden communities meant that the overall system could not be sustained. Community health activities were completely halted in 30% of 1913 villages surveyed between 1982 and 1988 (Essomba et al., 2003). Other constraints included the lack of in-service training for over 50% of community health workers by mid-1980s; one district supervisor per ten health villages; one community health worker per 1323 people; rising population growth, increased disease burden and falling government spending on health (Ofeh and Njong, 2006).

The evidence above serve to demonstrate ultimately, that resource constraints were a critical factor that led to the severe drug shortages and closures of pharmacies in the late 1980s and 1990s. Resource constraints also exposed the poor governance mechanism in place for dealing with the effects of the financial crisis in the health sector. These constraints meant that, instead of addressing these country-specific challenges the government turned once again to the WHO/UNICEF for a revised PHC model. The processes involved in adopting and implementing variants of the PHC in shaping policy practices in Cameroon are discussed below.

5.4.4 The Reorientation of Primary Healthcare

At a WHO/UNICEF-led conference on the progress of the PHC in Africa (1985 Lusaka Conference), it was concluded that drug financing and the rising pandemic of certain diseases' (TB, Malaria, Cholera and Meningitis) caused the PHC to fail. An economistic narrative, specifically, the economic crisis and structural inefficiencies was identified as the prime cause of the PHC being overwhelmed (Ntangsi, 1998; Essomba et al., 1993). Drug financing and the rising pandemic of certain diseases such as TB, Malaria, Cholera and Meningitis), it was argued, was making it difficult for the PHC to function effectively. This broad economistic narrative is consistent with that put forward by both the government of Cameroon and the World Bank (Ntangsi, 1998; Essomba et al., 1993; World Bank, 1989).

At a follow up WHO/UNICEF-led conference (the 1987 Bamako Initiative) the PHC was revised into the Reorientation of primary health care (PHC-RO) with an emphasis on partnerships between the state and the community to *co-finance* and *co-manage* healthcare delivery. It was effectively implemented in Cameroon from 1990 (Table 7 and Figure 4 below). Dialogue structures within the different administrative and operational structures were created in Cameroon to encourage participation of both the State and the community (Ngufor, 1999). The PHC-RO model was therefore aimed at eroding the excessive centrality of policy making within the structures of the Ministry of Public Health to encouraging public and private partnerships with local communities and private sectors.

Table 7. The structure of the National Public Health System in Cameroon

Level	Administrative Structures	Role	Operational Structures	Level
Central	Minister's Cabinet, Secretariat & Directorates	Conceptualise and develop policies and strategies	Reference and General hospitals	1st
			Central and University hospitals	2nd
Inter – mediate	Provincial Delegations for Public Health	Technical support to programmes	Provincial hospitals	3rd
Peripheral	Health Districts & Health Areas	Operationalise and implement primary health care	District hospitals	4th
			Sub-divisional hospitals	5th
			Integrated health centres	6th

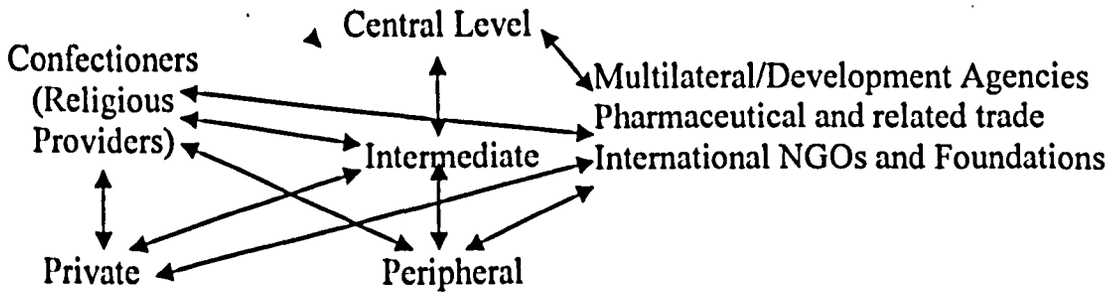
Source: Ngufor (1999) ; Essomba et al (2003)

The delivery of pharmaceutical products followed a similar vertical and decentralized hierarchy. The importation and distribution of drugs by the state monopoly (the National Pharmaceutical Corporation) in the 1970s and 1980s became subject to competition. Each of the levels described above has a pharmacy section that followed the same vertical administrative and operational hierarchy.

The structural pattern of the PHC-RO (Figure 4) was meant to ensure that cost-effectiveness and equity are given crucial importance in the delivery of healthcare and pharmaceuticals. By exposing the national health system to civil society and private sector participation the PHC-RO model eroded the

excessive centrality of policy making within the structures of the Ministry of Public Health to encouraging public and private partnerships at local levels.

Figure 4. The vertical and pluralistic Primary Healthcare System



Source: Author's construction based on published documents

The fact that the implementation of the PHC-RO paralleled the implementation of the SAPs was very significant in attempting to achieve the objectives of PHC-RO. The PHC-RO required the state and the community to work in partnership to *co-finance* and *co-manage* pharmaceutical and healthcare delivery while the World Bank introduced a 'cost recovery' free market system that promoted fee-for-service practices in both public and private sectors (Litvack and Bodart, 1993). The government passed a decree in 1990 authorizing the sale of medicines and the management of drug supply at the peripheral level between local public hospitals and pharmacies and local communities (Essomba et al., 2003).

The centrality of decision making on health care delivery around the Ministry of Health began to weaken as the national health system became *vertical and decentralised,* with multiple sources of public, private and religious healthcare and funding providers (Figure 4 above). The importation and distribution of

drugs that was a state monopoly became subject to competition, as foreign pharmaceutical companies could now benefit from the market mechanism created by the SAPs to supply drugs through private channels. Cameroon is often cited as a success story of the introduction of user fees in the health sector in Sub-Saharan Africa. An article published in the Bulletin of the WHO (Ridde, 2003:533) stated as follows:

> 'To date, there have been only two reports that introduction of fees-for-services had a positive impact on service utilization. The first, in Cameroon, showed that with an improvement in the quality of care, introduction of such fees went hand-in-hand with an increase in service utilization, with the increase being proportionally larger for the poor rather than the rich.

The market-oriented healthcare system allowed individuals to choose the level within the national health system to consult when they are sick (wealthy patients could afford to travel longer distances to seek higher quality treatment at the provincial and central hospitals). Defending this approach, the WHO (2002) argued that, compared with public health services, private units are a valuable resource, located close to, and often trusted by the community despite the huge financial burden and prescription mismatch that is often a characteristic of their activities. By 1996 there were about 200 completely private, 179 Catholic, 122 Protestant healthcare providers, competing with thousands of traditional healers in Cameroon (Ntangsi, 1998).

By the mid-1990s, 2% of healthcare providers were private-for-profit, while 38% were non-profit (confectioner, NGOs and traditional rulers) with the public sector accounting for the rest (Ngufor, 1999). In 1996 there were about 200 completely private, 179 Catholic, 122 Protestant healthcare providers, and

thousands of traditional healers in Cameroon (Ntangsi, 1998). Ngufor (1999) describes this system as evidence of public-private cooperation. First, private non-profit health facilities such as NGOs are increasingly being given responsibility to ensure health coverage for the population in their constituent health districts in contractual arrangements with the government. Second, personnel of both public and private sectors work together in district health teams to ensure supervision of the health centre and other services and to train and retrain the local staff within the principle of continuing professional training.

5.4.5 The Reproductive Health System – PHC-R

In 1995, the PHC-RO was revised by the WHO/UNICEF to *Reproductive Health Care System* (PHC-R) in order to better incorporate the cost-recovery programme introduced by the IMF/World Bank to address the effects of the failed SAPs. The vertical and decentralized structure of the PHC-RO is retained, the only difference being that, PHC-R is the current health system of Cameroon. It further stresses the need for partnerships between the public, private and civil society sectors in ways that give priority over policy implementation to civil society groups (Ghogomu, et al 2000). The main objective of PHC-R was to better respond to more specific public health challenges such as infant maternal mortality, birth control, teenage pregnancy, family planning and human resources (Ako et al., 2006). Unsurprisingly, it paralleled the publication of the World Bank's (1996) 'Participation Sourcebook' in which the local community is at the forefront of policy implementation. This led to the creation of more specific departments within the Ministry of Health (e.g. Directorate of Community Medicine and Division

of Mother and Mental Health) as well as specific programmes and activities (e.g. Medico-Social Centres for Prevention/Treatment of STDs; Mother and Child Care Centres; High Risk Clinics for Pregnant Women) in different regions of the country.

Nevertheless, privatisation and liberalization policies that resulted from the neo-liberal market model meant that these new programmes paralleled rather than complimented the diverse private health units that were already emerging in the country. Thus the interaction among parallel models (variants of WHO/UNICEF-led PHC and IMF/World Bank-led market models) meant that from the 1990s, the national health system of Cameroon became fragmented with public, private and religious health units and pharmacies competing with each other.

Particularly significant from the mid-1990s is the emergence of local community groups (NGOs) as key partners in health development. Local groups are capable of ensuring health coverage for the population in rural districts in contractual arrangements with the government. Personnel of both public and private sectors work together in district health teams to ensure supervision of the health centre and other services in the area and to train and retrain the local staff within the principle of continuing professional training. These processes are animated by the interaction of elements of the public health and economic development models discussed earlier. These interactions, which too place among international, national and local partners, provided the platform in which GHP programmes emerged in Cameroon.

5.5 The Emergence of GHPs in Cameroon

The discussions above suggest that by the time GHPs began to emerge at a global level Cameroon was suffering from many structural and policy problems, the consequences of which include unequal and insufficient access to medication in the face of rising incidence and burden of diseases such as HIV/AIDS, malaria and TB. The effectiveness of a GHP in Cameroon would therefore depend on the extent to which these key issues are embodied in the strategic functions of GHPs – financing, advocacy, R&D and technical assistance in meeting global and national health targets (Caines et al., 2004). This section summarises the barriers to access to medication that ultimately led Cameroon to endorse GHPs.

5.5.1 Barriers to Access to Medication

The institutional structures of variants of the PHC model in Cameroon appear rigorous and complete. However, apart from the fundamental question of lack of funding, several problems persistently hindered sustainable and effective functioning. There were frequent shortages of health professionals and medical supplies. An oversupply of qualified staff had to work with an undersupply of infrastructure, equipment and drugs, or the other way round. A very low doctor-patient ratio of 1:400 was made worse by a large rural-urban differential, limited training and low pay for qualified health workers (WHO, 2002:4). Low salaries and allowances for an overstretched health personnel increased absent rates and severely hindered commitment at work in hospitals

and pharmacies (Ngufor, 1999). These are major barriers to both potential and actual access to medication.

Potential access to medication was also hindered by regulatory and implementation problems. Public health authorities persistently failed to implement key regulations and laws meant to strengthen the health system and promote healthcare delivery (Ako et al., 2006). Poor regulation in turn allowed public health workers to resort to unfair practices (offering under-the-counter consultations, prescriptions and sales of medicines) which in turn increased the demand for private health units and traditional medicine. Ntangsi (1998) illustrates how 14.8% of patients consulted traditional healers while within modern health units; public hospital consulted 43.8% as against 56.2% in private units (despite the latter charging 50% higher than the former). These problems are related to the outcome of the SAPs described earlier.

In many ways the liberal and then neo-liberal models of development had a negative effect on access to medication due to the economic crisis. The cost of drug procurement and local distribution increased persistently, limiting actual access to medication (JSI, 1991). Neo-liberal market models that were meant to deal with the crisis exacerbated the problem, by exposing the PHC model to a mixed competition, one that proved difficult for authorities to regulate. A German-Cameroon programme created to import and distributes medicines at cost-recovery rate with funding from the German Development Agency (Ngufor, 1999) was competing with the formerly monopoly drug system in the MoH, while several private firms also began to operate pharmacies. The

ineffectiveness of public health services and high prices for pharmaceutical and healthcare delivery following the crisis and increased the popularity of traditional medicine despite the fact that incorporating traditional practices into public health policy has never been seriously considered by Cameroonian authorities (MoH, 2002).

As discussed earlier, neo-liberal market models (SAPs) either created new governance gaps in Cameroon or worsened existing ones. Privatization and liberalization opened pharmaceutical and healthcare delivery to competition thereby eroding the centralised drug procurement system under the MoH instead of correcting its weaknesses. Ntangsi (1998) relates the high cost of drugs in Cameroon in the 1990s to major inefficiencies in the drug procurement system caused by complicated administrative procedures and a lack of transparency. Basco (2004) reports large scale diffusion and sales of antimalaria medicines through private formal and informal sectors that did not comply with quality requirements, but which were in high demand due to heavy disease burden. These problems are similar to those in other sectors of the economy mentioned earlier in this chapter. They represent the outcome of *rent-seeking behaviour* (corruption, inequality, black markets, drug trafficking and under-the-counter prescriptions) that resulted from implementing the neo-liberal free market reforms created but unregulated by the IMF and the World Bank under the SAPs (Baye, 2003; Mbaku, 2004).

As already mentioned, multilateral and development agencies attributed Cameroon's problems (such as those in the health sector described above) to

government failures and began to bypass the government and work with NGOs and community organizations as a means of filling the above governance gaps. Such a defensive tactic is generally described as foreign policy diplomacy as both development agencies and national government remain on the defensive when it comes to responsibility for international policy failures (Muraskin, 1998). In this case, for GHPs to claim success in achieving potential access to medication, the GHP model must also be able to achieve both the objective of correcting governance gaps by reconciling the in-fighting among global, national and local actors in global health.

5.5.2 GHP as Facilitators of Access to Medication in Cameroon

The discussions so far suggest that the role of international organizations in facilitating access to medication in Cameroon is not new, with some form of intervention being commonplace since independence. However, unlike the technical assistance and specific policy interventions emphasised by the economic and public health development models up to the early 1990s, such organisations no longer intervene unilaterally. They now intervene through the agency of GHPs. The emergence of GHPs in Cameroon can be attributed to the unintended negative consequences (or failures) of traditional development models in creating a national health system capable of providing access to medication on a sustainable basis. The strategic objectives of GHPs, namely, financing, advocacy, R&D for drug development, healthcare delivery and technical assistance (Caines et al., 2004) suggest that such a country-specific system is needed.

Nevertheless, multilateral and bilateral agencies have always been on the defensive when it comes to the failure of policy measures resulting from the development models they deployed in Africa. The WHO (2002:4) points to human resources and infrastructural problems rather than the rubostness of versions of the PHC model. Similarly, the failure of the SAPs in creating an effective healthcare market is seen by the IMF and World Bank as government failures, pointing to regulatory and governance constraints (World Bank, 2000). Instead of correcting these weaknesses, these agencies began to undermine the structures of the Ministry of Health by aloting more power to local CSOs.

The creation of GHP programmes from the later 1990s was meant partly to resolve the type of blame game and overlapping interventions noted above by ensuring the participation of global, national and local stakeholders in shaping health policy practices (Ngoasong, 2009). It meant that multilateral and bilateral agencies as well as their associated private and international civil society partners would now intervene through the agency of GHPs. This rowing back of direct action allowed the government of Cameroon to resume its role as a major actor without the type of absolute power it had before the 1990s. This change in the government's position was precipitated by the major event of debt relief (HIPIC), while the contiguous development of GHPs created a window of opportunity for an alternative form of engagement and intervention for all stakeholders at global, national and local levels.

The Debt Relief Program in Cameroon came into place in mid-2000, making available $86 million per year of new government expenditure until 2015 for poverty alleviation. $32 million were to be allocated to the health sector in the first three years (MoH, 2000). These funds were for HIV/AIDS, malaria, immunization, TB, essentials drugs, health staff, and health sector strengthening. Prior to the debt relief, Cameroon was one of the most highly indebted and corrupt countries in the world. In a multi-country study assessing the design and application of the medium-term expenditure framework as a tool for poverty reduction, Carlier and Jennes (2003:5) describe the extent of corruption in Cameroon as follows: 'First, first, seventh, fifth: these are the positions Cameroon has occupied between 1998-2001 on the list of Corruption Perception Indices published by Transparency International.'

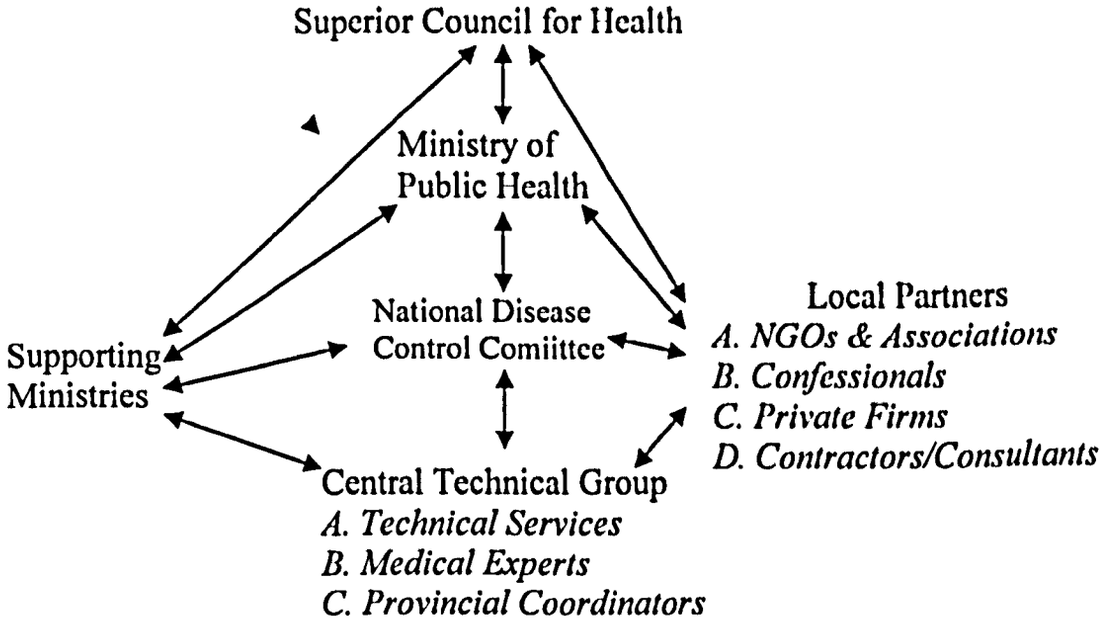
Unsurprisingly, therefore, the World Bank and the IMF made debt relief programme conditional on anti-corruption efforts and other good governance initiatives. As described in (Kabemba, 2003), the government pledged to strengthen budgetary execution and service delivery through anticorruption measures. These measures were to be implemented by special anti-corruption units that that had already been established in ten government ministries. The government also pledged to increase the number of police and customs officers to combat import-export malpractices. The community participation model was also important in the debt relief agreement in the sense that local CSOs were appointed to provide monitoring reports to the government of Cameroon, as well as to the EU, World Bank, and other international donor agencies. The HIPIC programme therefore created a window of opportunity to stimulate

political commitment in the fight against the rising disease pandemics such as malaria, HIV/AIDS and tuberculosis.

The debt relief programme in Cameroon came at a time when numerous GHPs were being signed to facilitate access to medication in developing countries, especially those in Africa. The GHP model is therefore meant to promote a new kind of PPP in Cameroon to replace previously failed individual/community models emphasised by bilateral (e.g. France and Germany) and multilateral (UN-based agencies) initiatives. Crucially, they are supposed to be led by the Ministry of Health, not external actors. They are meant to develop comprehensive healthcare programmes to facilitate access to medication and strengthen the national health system (WHO, 2005a; UNAIDS/WHO, 2002).

GHPs have transformed the vertical and pluralistic PHC system into a *hybrid network* that is no longer directly controlled by the Ministry of Health. Each programme is under the control of a National Disease Control Committee structured as in figure 5. Being partners to many GHPs, development agencies (such Germany, France, USA, Britain and the EU) immediately realigned their bilateral relations with Cameroon in terms of both the Debt Relief programme and the strategic orientation of specific GHPs.

Figure 5. Structure of National GHP Programmes



Source: Constructed based on NSPA (2000a)[54]

The national structure in figure 5 was created for HIV/AIDS, malaria and tuberculosis, being priority diseases in terms of burden, impact and challenges for treatment and controlling at global, national and local levels. Each programme is based on guidelines provided by specific GHP models (Table 8) and exists in parallel with each other as well as with the PHC-R described above. Each programme has a National Disease Control Committee comprising representatives from public, private and civil sectors at global, national and local levels. Thus, any constraints within the PHC-R model would have limited impact on the effectiveness of national GHP programmes. This also facilitates the identification of policy constraints for each of HIV/AIDS, malaria and TB independently of PHC-R, thereby making it easier to address them. In this context, and in relation to the framework developed in chapter two, policy

[54] NSPA (2000a) Plan Stratégique de Lutte contre le SIDA au Cameroun 2000-2005: Rapport du Groupe Technique Central du Programme National de Lutte contre le SIDA au Cameroun Résumé disponible, MoH. (National Strategic Plan for the fight against HIV/AIDS in Cameroon 2000-2005).

constraints includes the extent to which GHP models relate to country-specific contexts (global-national context), while implementation constraints deal with barriers to access to medication at community and household levels (global-national-local contexts).

Table 8. Key GHP Programmes in Cameroon

Global Health Partnership	Strategic Objective	National Programme
Accelerating Access Initiative (2000) & Equitable Access Initiative (2001)	To make HIV/AIDS drugs more affordable and accessible and to improve technical collaboration in the development of national programme capacity to deliver care, treatment and support[55]	National HIV/AIDS Programme
Roll Back Malaria (1998)	Reduce malaria mortality by 60% through health system strengthening and strategic malaria treatment and control tools[56]	National Malaria Programme
Stop TB Partnership (2000)	To diagnose 70% of all people with infectious TB and to cure 85% of those diagnosed[57].	National TB Programme

Source: Own analysis of policy documents and technical reports.

The national committee is in charge of policy making. Political leadership is provided through a Superior Council for Health headed by the Prime Minister. The former colonial masters (such as France and Germany) have realigned their development projects in Cameroon as global partners to GHP programmes. Other global partners such as the WHO, UNICEF, UNDP provide technical assistance to the committee to help define strategic objectives of treatment and control programmes. Funding is provided by the World Bank,

[55] UNAIDS/WHO (2002a:4).
[56] Roll Back Malaria Partnership <http//www.rollbackmalaria.org> (Accessed: 02/02/09).
[57] The Stop TB Partnership <http://www.stoptb.org/stop_tb_initiative> (Accessed: 02/02/09)

Global Fund and bilateral development agencies. These global partners then link the national programme to pharmaceutical companies to negotiate drug prices and supply arrangements. International CSOs (e.g. Medecin Sans Frontiers, Care International, Plan International, etc) participate in the area of advocacy for continued funding, political commitment and local service delivery.

The agency in charge of drug procurement and local distribution is the National Drug Procurement Centre, an autonomous institution within the Ministry of Health. Supporting ministries also play an active role in specific areas. For example the Ministry of Finance releases funds for the purchase of drugs and to finance programmes and activities. The Ministry of Social Affairs is active in advocacy and community mobilization. The Central Technical Group provides the interface between policy making and policy implementation. Consisting of technical and medical experts as well as provincial coordinators, it ensures that plans agreed by the national committee are implemented by the local partners. The local partners consist of specialised treatment centres in urban and rural areas, in line with the pluralistic pharmaceutical and healthcare delivery system in the country.

The National HIV/AIDS Programme and the National Malaria Programme have been selected as empirical case studies for this research. Global policies are transferred through 'policy loops' (Walt et al., 2004) involving transcalar networks of local, national and international partners who support medical intervention in addition to their own strategic objectives. Medicines for

HIV/AIDS are now free of charge and the average Cameroonian is aware of the existence, impact and burden of HIV/AIDS as well as the availability of treatment. As early as 2002, Cameroon was being credited for having achieved both 'Accelerating Access' (UNAIDS/WHO, 2002) and 'Equitable Access' (MSF, 2002). On the other hand, the RBM has significantly increased the use of malaria medicines (ACTs and ITNs) in Cameroon through what the initiators of the programmes term 'health system strengthening', even though all of the ambitious policy goals have yet to be achieved.[58] These outcomes represent evidence that treatment programmes get to 'hard-to-reach' communities.

Nevertheless, the incentive to govern in favour of public interest by using transcalar networks in which community organizations play an active role in implementation (bypassing the state) appears to manifest as corruption in Cameroon. Senior government authorities are being linked to apparent mismanagement of funds allocated to the malaria and HIV/AIDS programmes (Bidjocka, 2008). Corruption also hinders the successful distribution of ACTs and ITNs through pilferage and black marketing by clinical doctors and pharmacies.[59] The huge flow of donor funding in the presence of high levels of corruption obviously increases the possibility for local policy resistance which in turn hinders policy implementation.

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[58] Successive editions of technical reports of the national HIV/AIDS and malaria programmes respectively report how pre-stated targets are far from being achieved. e.g. NACC (2008) *Cameroon: Mise en Oeuvre de la Declaration D'engagement sur le VIH/SID, Rapport De Progress No. 3.* (National AIDS Control Committee), Cameroon; NMCP (2008) *National Multisectoral Programme for the Fight Against Malaria*, Cameroon.

[59] Nsom, K. (2008) 'Cameroon: Corruption Hinders Distribution of Subsidized Malaria Drugs' *The Post Online*, 22/02/08 <http://allafrica.com/stories/200802221214.html> (Accessed: 28/05/08); Lipset, S.M. (2000) 'Corruption, Culture, and Markets,' Culture Matters: 113-124.

Clearly, not all the evidence points to the success of these GHPs. Since the launching of GHPs for HIV/AIDS and malaria at the global level, and the creation of corresponding national programmes and activities at national and local levels, the incidence and burden of both diseases has continuously increased in Cameroon. This has been associated to a combination factors – unemployment, denial, stigma, poverty, high transmission among youth and lack of sex education and polygamy[60]. The approach of the national HIV/AIDS programme has been criticised for doing little to emphasise behavioural changes a vital public health element in the fight against diseases[61]. There are reports of frequent shortage of subsidised ITNs and ACTs in public and private health units, huge price differentials for coartem (costing ten times as much in private pharmacies), failure of people to seek treatment when attacked by malaria and the evidence that many rural communities still consume chloroquine, long declared ineffective and inappropriate by the WHO in the mid 1990s[62]. These evidence points to the need for empirical studies to better understand the role of GHPs on access to medication in Cameroon.

5.6 Discussions and Conclusions

This chapter has explored the national perspective on the emergence of GHPs in Cameroon. It highlights two key issues that make the study of GHPs as

[60] Mosoko, J.J. and Affana G.A.N (2004) 'PRÉVALENCE DU VIH ET FACTEURS ASSOCIÉS (Prevalence of HIV/AIDS and Associated Factors)' In *DHS Final Reports: Cameroon,* Demographic and Health Survey, USAID, Chapter 16: 293-314 <http://www.measuredhs.com/pubs/pdf/FR163/16chapitre16.pdf> (Accessed: 25/05/08)

[61] Njechu, C.J. (2008) 'Scientists Condemn NACC Communication Strategy' *The Post Online,* 17/01/2008 <http://www.postnewsline.com/2008/01/scientists-cond.html> (Accessed: 25/05/08).

[62] Tchenga, M.K. (2008) 'Queen Mosquito: Strides have been made in the fight against the eradication of malaria but the disease's victor, the female Anopheles mosquito, still rules parts of the world' The Post Online: <http://www.postnewsmagazine.com/pages/health06.html> (Accessed: 15/6/08).

models that shape national and local policies all the more interesting. First it reveals that the role of GHPs in influencing national health policies and local delivery practices is a complex one, mainly due to the multiple global, national and local partners involved and the interwoven nature of the links among them. Secondly, it suggests that even if GHPs may be succeeding in shaping national policies to reflect the global activism on universal access to medication discussed in chapter four, the impact on access to medication (as expected by various GHPs) is far from being realised. Apart from these two key issues, this chapter also reveals specific insights on some of the issues that need to be considered when studying the role of GHPs in shaping access to medication in a country such as Cameroon.

The first specific insight raised by the analysis in this chapter is that the concept of multi-stakeholder partnership embodied in GHP models is not new to Cameroon. What seems to have changed over history is the nature of stakeholder participation. In the colonial era, apart from the political arena where the Germans (and later the French) preferred absolute control over political matters, there was substantial evidence of partnerships. Even when the Germans served as colonial master, their medical team collaborated with those of France under Eugene Jamot to eradicate sleeping sickness. In the interwar years, both the British and the French gave the Germans greater autonomy (despite losing the war) over the development of an expanding agricultural economy and its associated railway infrastructure. Similar partnerships were forged with Christian missionaries to better serve rural communities, especially in healthcare delivery and the transformation of traditional values into

acceptance of western ways. These strategic forms of participation have been an inherent part of historical developments in Cameroon.

However, the nature of foreign participation became indirect after independence. With apparent state autonomy, former colonial masters and Christian missions began to operate in partnership with the state and through their influence in international organizations. The international dimension placed enormous pressure on the state, prevented it from acting autonomously and created governance gaps in the system, now labelled in development studies literature as government (rather than interventionary) failures. An interesting feature is the emergence of civil society participation in the 1990s as an important part of the solution to addressing governance challenges. This leads to what is novel about GHP models. For the first time, all these actors, with competing economistic, public health and human rights narratives sit around the same table to formulate and implement policy. This new kind of participation gives absolute political control to no single stakeholder, not even the state. It obviously blurs the North-South divide due to its complex nature. It would be interesting to study specific GHP programmes in Cameroon to uncover the nature of this kind of hybrid network, the type of knowledge that each stakeholder brings and how the combination of these help shape difference aspects of policy and local practices.

The second specific insight from this chapter concerns national health system functioning. The modern functions of the national health system in Cameroon are rooted in the WHO/UNICEF-led PHC model that emphasised a

combination of behavioural and change models at the individual, interpersonal and community levels. Developments in the PHC model paralleled, rather than complemented developments in IMF/World Bank-led neo-liberal free market models. Unsurprisingly, therefore, neo-liberal market models transformed the PHC model from a state-centred vertical and centralised system (1980-1990) to a fragmented vertical and decentralised system with public and private providers (since 1990). The nature of a national GHP programme is assumed in terms of specific disease areas rather than its effects on such a fragmented system. Since the mid-1990s 'decentralization', 'deconcentration', 'devolution', 'privatization', 'contracting out', 'public-private partnership' are used interchangeably to describe both the national health system (PHC model) and GHP programmes. The role of each GHP model needs to be studied in terms of how they shape national policy and local practices both for their targeted disease area and the wider PHC system as a whole. The National RBM Programme fits this context. The RBM explicitly focuses on improving malaria outcomes through health system strengthening. Empirical evidence is needed on the extent to which this can be achieved.

The third issue arising from the discussions in this chapter relates to the embodiment of development models (as narrative strategies) within GHPs. It is particularly interesting to note that most policy documents (even those published by the WHO) are dominated by the economistic narrative (which drugs are most suitable, prices and supply arrangements and systems issues) with very specific and explicit mention of the relevance of medical interventions. Implicitly, the emphasis has shifted from selective identification

and treatment/prevention of diseases (the colonial era and independent era) to a broad and comprehensive PHC approach that emphasises both preventive and curative measures (1978 to mid-1990s). More recently (the GHP era), there has been an increasing emphasis on the medical model (access to medicines) as against non-medical interventions (prevention strategies).

Thus, the role of each GHP in shaping this narrative at the national level needs to be studied empirically to uncover the practical steps used to determine drug prices and supply arrangements. The extent to which GHP programmes and activities target barriers to access to medication also needs to be examined. A comparative study of the national malaria and HIV/AIDS programmes respectively would be interesting from this perspective. Both programmes are similar in terms of types of stakeholders, institutional affiliations and governance arrangements. However, they differ from each other in terms of disease area and strategic orientations, differences that provide for a nuanced analysis on the country-specific impact of GHP models on access to medication. The GHP models used to create the programmes explicitly aim to achieve 'universal access' (UNAIDS-led Accelerating Access Initiative) and 'equitable access' (MSF-led Equitable Access Initiative) to medication through health systems strengthening (WHO/UNICEF-led Roll Back Malaria).

Finally, the choice of Cameroon as country case study is also very instructive. Its history is dominated by the influence of the major western countries and international organizations that initiated the creation of GHPs (Cameroon is always one of the first countries to endorse them). Cameroon is also among the

African countries that has been deeply politicised at international and global levels using contrasting and contradictory narratives. Examples of such narratives discussed in this chapter include 'a model of political stability in the developing world', 'self sufficient in food production', 'a failed state', 'among the twenty safest in the world for foreign investments', 'a global success story in the fight against HIV/AIDS', 'one of the poorest country in the world', 'most corrupt country in the world'. These qualitative classifications and qualifications illustrate the importance Cameroonian authorities attach to international/global networks and the politicisation of Cameroon at a global level. A study of the nature of the networks created by GHPs in Cameroon would therefore contribute to our understanding of the country-specific impact of GHP models on access to medication in Africa countries.

CHAPTER 6: GHPs AND ACCESS TO MEDICATION FOR MALARIA TREATMENT AND CONTROL

6.1 Introduction

The objective of this chapter is to describe the structure and operations of the National Malaria Programme in Cameroon as an example of how GHP models shape national policy and local practices. It argues that it is the ways in which development models embodied within RBM partnership are expressed in Cameroon through the different programmes and activities that determine how national malaria policies are formulated and implemented. The National RBM Programme of Cameroon was launched in July 2002, about two years after the Cameroon government endorsed the global RBM. The fundamental goal of the RBM is to strengthen the national health system's capacity to deliver improved malaria treatment and control through PPPs at global, regional and national levels. Global partners affiliated with the partnership are members of Cameroon's national programme. Apart from technical reports and policy documents, there are to date no empirical studies on the role of the RBM in determining national policy and local practices on access to medication in Cameroon. Thus in addition to being the first in-depth case study on the role of the RBM, this chapter also discusses the relevance of the conceptual framework developed in chapter two in explaining this role through an empirically grounded analysis.

GHPs such as RBM are hybrid networks in which elements of public health, economistic and human rights models are negotiated to produce a GHP model on access to medication for malaria treatment and control. Such negotiations represent expressions of forms of knowledge. At the global level, the narrative strategies of certain GHP partners are influenced by the narratives (forms of knowledge) of other partners and they are connected to organizational actors who initiated the narratives. At the national and local levels, the narratives tend to be dominated by particular transcalar networks of public, private and civil society actors. This chapter explores the practical issues about what this means in terms of malaria treatment and control in Cameroon through the RBM. It highlights instances where the economistic, public health and human rights elements of the RBM model are at their strongest and the contexts in which they are less relevant. It then relates this to global-local linkages in terms of what the RBM claims to do and what it actually does; and what is needed for the National Malaria Programme in Cameroon to achieve its objectives on a sustainable basis.

The empirical analysis is informed by data from policy documents and technical reports complemented by qualitative interviews with representatives from global, national and local levels directly or indirectly involved in the national RBM of Cameroon. A social constructivist approach, namely, NPA has been used to analyse the interviews. All the interviewees recognised that the daunting task of RBM is to set up a coordinated initiative that reaches out to all the different stakeholders at the country level, taking into account differing partners' strategic interests and challenges relating to coordination

mechanisms, monitoring and evaluation. After presenting the historical and political context of the fight against malaria in Cameroon this chapter describes the strategic objectives, structure and operational orientation of the programme. It then explores how different elements of the global RBM model shape policy and local practices in Cameroon, using specific programmes and activities at national and local levels. The challenges facing the RBM in combating malaria in countries like Cameroon are then explored. The conclusion discusses the implications of the findings for the prospects of the RBM model in Cameroon.

6.2 Historicity and Political Context of RBM in Cameroon

Malaria has been a major societal problem in Cameroon's history and is currently endemic in most parts of Cameroonian society. Historically, malaria is the leading cause of mortality in the country particularly targeting pregnant women and children less than five years of age (WHO, 2004b).[63] However, this does not undermine continued political commitment, as the government has always set a national malaria strategy to be an active player in the global fight against malaria. The strategy of the government has been the adoption of international development models and advocating health policy reforms that requires the mobilization of support from a wide range of international and national partners to deal with the country-specific challenges associated with malaria treatment and control.

[63] For the full history of events leading to the creation of the national programme see the website of the national malaria programme: <http://www.pnlpcameroon.org/> (Accessed: 23/06/08)

As Sub-Saharan Africa was excluded from the first ever WHO-led Malaria Eradication Program (MEP) in the late 1950s, having been declared *'not ready'* by international decision makers, the fight against the disease in Cameroon was conducted unilaterally by the government as a part of the national health system (Greenwood and Mutabingwa, 2002; RBM, 2002). In the late 1960s and 1970s the WHO sponsored bilateral vector control projects in Cameroon, but these were largely ineffective at country levels (WHO, 1988). During the resurgence of the malaria epidemic in the late 1970s and early 1980s malaria programs were incorporated as an inherent part of the national health system based on the PHC model. The behavioural element embodied within the model meant that the curriculum of educational establishments included hygiene and sanitation (that every pupil was expected to study) – techniques of malaria prevention, avoiding mosquito bites, responding to symptoms relating to malaria in seeking treatment (WHO, 1988).

Despite the above efforts, the incidence and burden of the disease continued to increase in the 1980s. The causes include a combination of issues such as the effectiveness of behavioural models (socioeconomic determinants of health along with broad-based improvements in medical care), the apparent failure of the medical model (insecticide resistance of mosquitoes and resistance to drugs by the parasites) and systems issues (administrative challenges in consolidating case-finding programs and generally weak health services) (WHO, 1988; MoH, 2002). In relation to the consequences of the 1987 economic crisis discussed in Chapter Five, the WHO/UNICEF-led public health model (PHC-RO) and the

IMF/World Bank-led economistic model (e.g SAPs) were meant to solve these types of challenges.

The PHC-RO model had already begun to shift the emphasis on the broad PHC to a narrow focus on the medical model. For example, in the early 1990s when the WHO began to promote the use of anti-malarial drugs that were believed internationally to be more effective than previous one (WHO, 1994; 1996; 2003a), Cameroon was one of the first developing countries to adopt them. Similarly to the WHO's narrative, the government identified drug resistance and the severe health and socio-economic consequences of malaria as the major policy challenges (WHO, 2004b; NMCP, 2002[64]). The introduction of user fees within the national health system as part of SAPs meant that malaria treatment was now opened to competition from private and religious healthcare and pharmacy providers.

In 1992 the government endorsed the WHO-led Global Malaria Control Strategy (GMCS) (WHO, 1993). This requires the PHC-RO system to give priority to case management of malaria through early detection and prompt treatment. In July 1995, when the PHC-RO was transformed to the reproductive healthcare system (PHC-R) a National Policy Declaration for Malaria was adopted in the place of existing malaria programmes. The declaration aligned Cameroon's malaria strategy to both the WHO-led GMCS of 1992 (described in chapter four) and the IMF/World Bank cost recovery programme (described in chapter five). It was elaborated in 1997 as the

[64] NMCP (2002) Reduire le Fardeau du Paludisme <http://www.pnlpcameroon.org/info.htm> (Accessed: 23/06/08)

National Strategic Plan for the Fight against Malaria (PNLP), emphasising 'treatment of cases and vector control in all public and private health facilities, supported by training, operations research, and epidemiological surveillance'[65]. By bundling the public health and economistic models, the emphasis on malaria treatment was being shifted from a comprehensive PHC model to a narrow focus on the medical model.

The launching of the global RBM, created a window of opportunity that intensified Cameroon's political commitment in the fight against malaria. In December 1998, a Working Group for Malaria Control was created consisting of a National Coordinator for Malaria (within the Ministry of Health) and representatives from the WHO, UNICEF, research institutes and hospitals in the country. The group revised the 1997 PNLP into a more robust National Malaria Control Programme. Citing the plan the President endorsed the global RBM in an official letter to the WHO's Director General on 28th April 1999. He also ratified the Abuja Declaration of April 2000 (RBM in Africa) and set up a strong follow-up process. On 25th July 2002 the National Malaria Programme was launched in a national conference attended by representatives from government ministries, global RBM partners, and local private and CSOs. In January 2001, import taxes on malaria medication (medicines, ITNs and other insecticides) were exonerated. In August 2001 a Situation Analysis laid the basis for the National RBM Strategic Plan for Malaria published by Presidential Decree N° 0334/MSP/CAB of 29 July 2002. The plan is effectively, the National RBM Programme of Cameroon. It is through this

[65] Reduire le Fardeau du Paludisme <http://www.pnlpcameroon.org/info.htm> (Accessed: 23/06/08)

process that the global RBM model eventually shaped Cameroon's malaria policy (Table 9 below).

The historical events above reveal the changing nature of global and national linkages. There has been a shift from public and private partnerships in which WHO/UNICEF-led public health models were implemented in parallel to IMF/World Bank-led economic development models to a PPP approach in which global, national and civil society partners associated with both public health and economic development models sit around the same table to formulate policy.

Table 9. Objectives of RBM at global, regional and local levels

March 1998: The RBM is launched by WHO, UNICEF and affiliated partners

Goal: 50% reduction in global malaria deaths by 2010 through a PPP approach

April 2000: RBM is endorsed by African leaders: Abuja Declaration (WHO, 2000a)

29 July 2002: National Malaria Programme is launched in Cameroon (NMCP, 2002)

Global RBM Policy Strategies

- Early diagnosis and prompt treatment
- ITNs and vector control
- Malaria treatment for pregnant women
- Prevention and response to epidemic

Cameroon's RBM Malaria Policy Strategies

- 60% access to ITNs by pregnant women & children;
- Increased intermittent preventive treatment
- Improved general treatment of malaria

Africa's RBM Policy Strategies (The Abuja Declaration)

- 60% access to treatment within 24 hours of symptoms;
- 60% access to ITNs or preventive measures to children under 5
- 60% access to antimalaria treatment and IPTs to pregnant woman at risk

In addition to the changes in the national health system discussed in Chapter Five, the RBM model shaped policy practices in Cameroon in three fundamental ways. Firstly, the PPP element committed the state to RBM's strategic objectives in the spirit of good governance and the fight against corruption. Secondly, national malaria policy became dominated by the

economistic element of the model (modern and cost effective policy strategies). Thirdly, the nature of the malaria problem was finally shifted from public health programmes which failed in the 1970s and 80s to medical intervention programmes defined in terms of access to ITNs and anti-malarials.

Cameroon has since become an important partner to the RBM at all levels. The Ministry of Health is the representative of the Central African Region in the Global RBM Board since 2005. In addition, the first ever Global Strategic Plan (2005-2015) since the launching of the RBM in 1998 was signed in Yaoundé, the capital of Cameroon. The remainder of this chapter describes the operations of transcalar networks of PPPs involving global, national and local partners created as a result of the endorsement of RBM. The analysis focuses on the ways in which economistic, public health and human rights narratives shaped the structure and operations of the national malaria programme and the associated implementation challenges.

6.3 Structure and Objectives of the National RBM Programme

The National Malaria Programme defines the plan of action for the fight against malaria. The strategic objective is the scaling up of malaria treatment and control through tax reduction and waivers of import duties for ITNs, materials and antimalarial drugs; the distribution and use of ACTs and other antimalria medicines; house screening and the dissemination of information,

education and communication (IEC) through PPPs at national and local levels. The goal is to achieve the following ambitious targets by 2010:

- 75% access to medication for malaria treatment
- 50% of the population have been provided with appropriate treatment
- 70% pregnant mothers have appropriate diagnosis and antimalerial medicines;
- 60% health services are covered by the programme;
- 30% of families are sensitised (awareness campaigns) on the use of ITNs and anti-malarials
- 50% of vulnerable population are sleeping under ITNs in rural communities.

The programme aims to create a shared national vision and a nation-wide network infrastructure for the effective implementation of malaria treatment and control programmes and activities, as well as to empower and connect government agencies with the private and civil society sectors. This vision, it is believed, would create a strengthened national health system needed to achieve the targets above. The strategic plan for 2000-2005 laid the basis for introducing reforms in the following areas: the creation of national, provincial and district malaria centres; decentralization of implementation to rural communities and the promotion of PPPs at national and local levels. Table 10 below presents the key partners, objectives and local interfaces of the national programme as they relate to the five fundamental objectives embodied in GHP models such as RBM: technical assistance, funding, advocacy, drug procurement and supply arrangements, and the provision of healthcare.

Table 10. Global RBM promoters, objectives and status in Cameroon

Global RBM Tasks	Key Global Partners	Objectives	Responsible National and Local Partner
Technical Assistance	WHO, UNDP UNICEF, Development Agency	Advice and guide national strategic plan to reflect both RBM guidelines and local context and for preparing quality grant proposals for funding	The National RBM Committee (NMCC)
Funding	World Bank, Global Fund	Provide funding for RBM programmes based on quality proposals, good governance and the fight against corruption	The Central Technical Group (CTG)
Advocacy	European Union, INGOs	Monitor, supervise and ensure continuous political will and actions at country level including the participation of local CSOs	Cameroon Coalition Against Malaria and other local NGOs
Drug Procurement	Norvatis, GlaxoSmithe	Negotiates quantity, quality, prices & supply of ACTs/ ITNs, other anti-malaria drugs and equipments	National Drug Procurement Centre
Coordination, Monitoring and Evaluation	Development Agencies, Private industry, INGOs/CSOs	Donate ITNs and ACTs to the national programme, operate parallel initiatives with local civil society organizations in line with RBM strategic orientations	Provincial and district units; local initiatives supported by global partners

Source: Author's processing of policy documents and technical reports of RBM

Article 4 of Presidential Decision N° 0334/MSP/CAB of 29 July 2002 creating the National RBM designates the National RBM Committee as the focal point to validate policies and grant proposals and for coordinating implementation. The Committee is supposed to meet twice a year to evaluate progress and agree

on future courses of actions. The nature of the committee was described by a senior member of the national secretariat as follows:

> The National RBM Committee is an innovation by the government in 2002. You have the civil society with NGOs and community associations; the international partners and then you have different ministries involved in the fight against malaria. The advantage is that it is this committee that validates the execution of the orientations of the year. In that way, the international, the public and private partners logically meet in the committee. All the partners give priority to the technical rather than the political and the ensuing plan of action is usually a consensual one.[66]

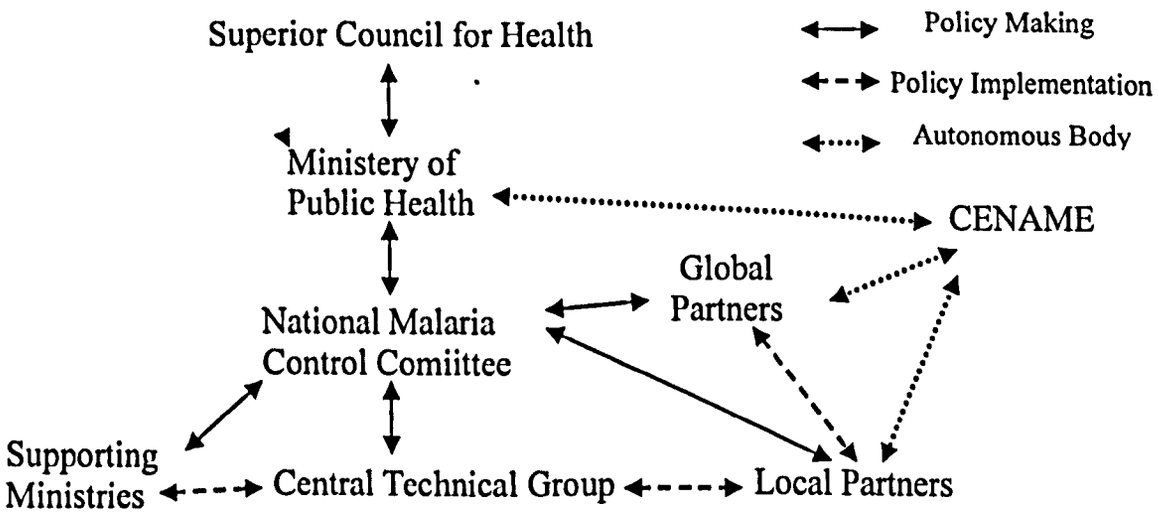
It is the type of PPP approach described by the above quotation that makes the GHP models an institutional innovation; it is different from previous models because it reflects the integration of elements of public health and economic development models mentioned earlier into a single global model (defined by the global RBM). It also has characteristics of transcalar networks as global, national and local partners meet there. Most of the participants interviewed applaud the functional structure of the committee: 'like in all other malaria-endemic RBM countries, the National Committee is decently organised in terms of who is responsible for what and what kinds of requirements, rules and regulations are in place'.[67]

As can be observed from Figure 6 below, the committee consists of a policy community (full lines) and a policy implementation community (dashed lines). The former consists of representatives from the Global RBM (multilateral organizations and development agencies), Ministry of Health and other supporting ministries, a Central Technical Group and elected representatives from local public, private and CSOs in the country. The latter is represented by

[66] Interview: National RBM Secretariat
[67] Interview International Development Representative, Global RBM Board

local partnerships among provincial and district malaria control units with public, private, religious and civil society health and pharmacy units and parallel initiatives with individual global RBM partners (development agencies, private industry, INGOs and foundations). Drug procurement and supply arrangements are the responsibility of the National Drug Procurement Centre (CENAME) (dotted lines).

Figure 6. The structure of the National RBM Programme



Source: Created based on official texts and interviews

From the official text creating the committee, the Minister of Health is the chairperson of the committee. The minister is therefore expected to lead and to some extent control the activities of all other partners as it did in the creation phase of the programme, thus bringing about desired outcomes. In practice, however, the national committee, not the Ministry of Health is the most central actor. This stems from the fact that global, national and local partners are represented in policy making. It suggests that the national RBM programme is particularly vulnerable to any attempt to bypass the committee.

Another role of the committee is to ensure that 'those partners who would normally go on their own because of a lack of confidence in the State can gain legitimacy to do so by virtue of them being represented in the national committee'.[68] This role of the committee is related to the neo-liberal models of community participation that aims to correct government failure (weak states and corruption) by limiting the amount of control exerted by the state over national policy and local practices. This obviously poses a dualism. Firstly, the national committee is expected to supervise the direct involvement of global RBM partners in policy implementation. Secondly, in the event that the state's political interest attempts to override the national committee, measures are needed to ensure that the committee does not over depend on the leadership of the state (through the Ministry of Health).

The Central Technical Group is headed by the Permanent Secretary of the national programme appointed from within the Ministry of Health. As the group is the executing agency of the National Committee, the secretary coordinates the preparation of strategic planning data, collection and processing of the data on basic monitoring of performance including impact indicators for the various programmes and activities executed at provincial and district levels. In effect, therefore, the central technical group connects the policy making community to the policy implementation community in the following ways:

> The national committee gives us political orientations which we use to prepare a grant proposal for the activities in the fight against Malaria, and

[68] Interview: National RBM Secretariat

to transform technical activities into operational resources. On the other hand we maintain a local and international partnership to promote all these actions at provincial and district levels.[69]

Supporting ministries participate in relevant areas of the programme and are therefore represented in the national committee. They also provide technical advice and support services to the Central Technical Group. For example, the Ministry of Finance releases the funds to pay for subsidised medicines (and other expenses associated with the national programme) and determines the extent of import tax exemption for ITNs and ACTs entering the country. The Ministry of Social Affairs is active in sensitisation programmes for the fight against malaria.

The local partners represent the core of the policy implementation community. There are ten provincial malaria control units and hundreds of district centres, local community organizations (NGOs/Associations, confessionals, diverse civil society associations, youth groups) and the private sector all of which coordinate the implementation of activities in various localities in the country. These activities are either initiated by the national programme or by individual global RBM partners. Through this PPP approach, the programme is constantly being strengthened.

It is interesting to note that although the national committee is the focal point for policy making, yet has limited control over drug procurement and supply arrangements that form a core function of national malaria programme. This is devoted to CENAME, an autonomous body within the Ministry of Health in

[69] Interview: Central Technical Group

charge of global procurement and local distribution of drugs in the country. As discussed later, this is due to the dominance of the economistic narrative on access to medication at the global level. The next section explores the interaction between the RBM models and policy practices as a way of showing how the embodiment of forms of knowledge within global models plays out at country level.

6.4 The Role of the RBM Model in Shaping Policy Practices on Malaria Treatment and Control

The country offices of the WHO, UNICEF and the UNDP provide technical assistance to conduct country-specific needs assessments leading to a proposal for action. They then link the national programme to donor organizations (such as World Bank and Global Fund[70]) to finance programmes and activities. They also help to link the national programme with pharmaceutical companies to facilitate bilateral negotiations on drug procurement and supply arrangements. All these global partners then link the national programme with their affiliated private industry and civil society partners to provide additional funding, advocacy support and direct service delivery through parallel programmes and activities in various regions of the country. In this way, the RBM model is able to shape the national programme in line with the objectives presented earlier on Table 10.

[70] Global Fund approve funding only if national grant proposals are '*based on modern and cost effective methods of malaria control designed by the Roll Back Malaria initiative*' : <http://www.theglobalfund.org/programs/grant/?compid=610&grantid=286&lang=EN&CountryId=CMR> Accessed: 20/05/08)

6.4.1 The policy framework for malaria treatment and control

The main objective of the RBM as explicitly stated on its website is 'to provide a coordinated global approach to fighting malaria' and 'the scaling up of interventions at country level to ensure wide spread coverage, particularly to population groups most vulnerable'[71]. Cameroon epitomises the conditions that led to the founding of RBM (a resurgence of the disease after failed efforts at eradication, declining efficacy of drugs and pesticides, program policy and management failures, collapsing health systems, and the global debt burden, making it logical for its endorsement of the partnership). However, there were no specific reforms required from disease-endemic countries in exchange for joining the RBM other than officially endorsing the partnership. This meant that implementation would largely depend on how endemic countries interpret the provisions of the RBM which in turn depends on the narrative strategies of global partners that are embodied within the RBM model.

From the interview data there is some confusion over what the strategic objectives of the RBM are in the case of Cameroon. This was observed in the question of how the RBM fits into the broader national health policy of Cameroon. All the interviews spoke along the lines of the neo-liberal market model and its emphasis on the economistic narrative on access to medication. From a global perspective, the main role of the RBM is 'supplying strategic advice to countries, trickling of money and medicines through the national health system and making sure that access is really there for the poor.'[72] The

[71] See RBM Website: 'Malaria Country Facts'
<http://www.rollbackmalaria.org/countryaction/index.html> (Accessed: 13/06/09).
[72] Interview: International Development Representative, Global RBM Board

most important role of the RBM that was shared by the majority of the national and local partners is 'to improve access to medicines ... to help with health technologies and resources ... to help us to get access to markets at negotiated prices, at prices that are affordable.[73] This quotation suggests that although Cameroon endorsed the RBM, it does not see any need for direct involvement of global partners at local levels.

The general framework set by GHPs such as the RBM for governing relations across and between partners is based on voluntary agreements (Dodgson et al., 2002). This obviously allows the strategic interests of global partners embodied within different elements of the RBM model to shape the nature of participation in the national health system. In an attempt to achieve the objective of correcting government failures and fight corruption, the Global Fund and the World Bank, instead of trusting the State authorities put strict conditions on funding:

> 'There are problems with funds from the Global Fund and the World Bank. They are put in clearly defined categories as additional resources. They do not permit you to function normally if the State does not contribute its proportion. The funding is entitled to pay for mosquito nets, drugs, and other 'big things'. Now in transport, payment of human resources, the State must pay. And when the state does not pay funding is blocked.'[74]

The above claim is not new. As early as 2003 huge amounts of funding for the malaria programme remained blocked within the Cameroonian system since the government had not fulfilled the World Bank's conditions for disbursement (RBM, 2002). This obviously represents new types of governance gaps in the

[73] Interview: Division of Healthcare Organization and Health Technology, Ministry of Public Health
[74] Interview: Central Technical Group

system, one that undermines the effectiveness of the RBM and these are not being debated during policy meetings.

Another policy issue relates to the costs of treatment and healthcare delivery arrangements. The general consensus among the interviewees was that it was important to prevent a recurrence of the situation in the late 1980s when the economic crisis caused the national health system for drug supply to be overwhelmed, forcing the government to abandon its free healthcare policy: 'the government could no longer pay for drugs and there was no alternative source of payment. It is the position of the Ministry of Health that we reduce prices significantly without reaching zero to maintain the habit of having people pay something.[75] This view is shared at the global RBM, especially the pharmaceutical industry partners, which favour 'maximum subsidisation with no minimum equilibrium'[76]. The mechanism in place to achieve this considers 'the willingness to pay and the high cost of the actual drugs; the costs to the system of provided discounted drugs; the transport costs incurred by patient to go get the medicine, which make it difficult to provide the drugs for free. [77]

The above platform is then used by multilateral (WHO, UNICEF) and bilateral (such as the French Cooperation, GTZ, DFID and USAID) agencies to help the Central Technical Group to develop quality proposals for funding to be able to put in place mechanisms for heavy subsidisation. Here again, the economistic narratives, not the public health narratives, play more significant roles in defining policy on malaria treatment and control.

[75] Interview Central Technical Group
[76] Interview: Private Industry Representative of Global RBM Board.
[77] Interview: International Development Representative Global RBM Board

Depending on the quality of grant proposals taking the above economistic issues into consideration (as well as the public health and human rights considerations), funding is provided by the Global Fund under various rounds of grant application[78] and the World Bank through the HIPC agreement (debt cancelation initiative) agreed in 2000 (MoH, 2000) and the Booster Program for Malaria in Africa established in 2005 (World Bank, 2007). For example the Global Fund makes it explicit that national grant proposals must be 'based on modern and cost effective methods of malaria control designed by the Roll Back Malaria initiative'.[79] The impact of donor funding was discussed by the interviewees along the lines of the following quotation:

> 'With donor funding we are heading towards free access to ACTs and ITNs in Cameroon. It will become necessary for two reasons. The first is that the poor can afford and access the drugs. Secondly, since subsidised drugs have a commercial value; economic trafficking has been going on. If today, subsidisation renders drugs free of charge, the product will lose its commercial value and trafficking will fall. That makes me think more and more in our negotiations with the global partners that the prices of ACTs be cancelled even if for just a while because this will spare us contra-banding and counterfeiting. It's a purely technical reason.'[80]

The above quotation relates to the problem of corruption in the drug procurement and supply chain and the black markets for malaria medicines that has been a major feature of the Cameroonian health system since the 1980s (see Baye, 2003; Ngufor, 1999; Basco, 2004). However, the global partners do not advocate providing free healthcare in Cameroon. Most of them oppose

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[78] For details of Global Funding for malaria treatment in Cameroon, see *'Cameroon and the Global Fund'* <http://www.theglobalfund.org/programs/grant/?compid=610&grantid=286&lang=EN&CountryId=CMR> Accessed: 20/05/08)

[79] See 'Cameroon and the Global Fund' (Note 78)

[80] Interview: National RBM Programme Secretariat

giving medicines for free, citing 'the sustainability of R&D for drug development and the fact that donors may not continue to subsidize for ever'[81].

As mentioned above drug procurement and supply arrangements, while an essential policy issue, is the work of CENAME. Negotiations are held on a bilateral basis between malaria-endemic countries and pharmaceutical companies independently of National RBM Programmes. They are highly sensitive and are kept secret; no interviewee was interested to talk about it. This approach is favoured mostly by pharmaceutical companies:

> 'We prefer direct negotiations with endemic countries. The country is responsible for the malaria control programme and can really explain to us what the volumes are likely to be in the next year so we have a better understanding of their requirements. Through a direct contact we can better understand their phasing of the different supplies throughout a given year in terms of how big a given supply delivery should be. This direct contact cannot be replaced by the RBM.'[82]

The quotation above also illustrates the strong influence of the economistic model in shaping the operational orientation of the national RBM. In addition to the CENAME, bilateral development agencies (such as the US, France and the UK) use their affiliated INGOs and foundations to import and distribute drugs at local levels claiming to complement the national programme. These organizations run projects in partnership with local community groups approved by the national malaria committee. As discussed later different global partners take advantage of different elements within the RBM model to achieve their own strategic interests, and at the same time, promote the work of the national programme.

[81] Interview: Bill and Melinda Gates Foundation
[82] Interview: Novartis

Another policy area shaped by the RBM model is advocacy for 'continuous political and civil society commitment, adequate supervision and follow up at national and local levels to ensure that there is consensus between policy making and policy implementation'[83]. The European Union[84] is very active in monitoring and supervising the performance of the national programme. In 2007 a delegation from the European Parliamentary Forum made a 'Malaria Study Tour' to Cameroon to evaluate the realities of malaria in the country and discussed with officials the prevailing challenges as well as propose better organization by the government in terms of tax reductions on the importation of ACTs and ITNs. They also appointed the Cameroon Coalition Against Malaria (CCAM) to act as a civil society intermediary between the European Union and the government of Cameroon to ensure that there is sufficient cooperation with all stakeholders involved in the national malaria programme.

6.4.2 The policy implementation framework for malaria treatment and control

As already mention above, the policy implementation community is coordinated by the Central Technical Group and consists of local public (provincial and district RBM units) and private RBM partners (public, private, religious, civil society healthcare and pharmacies). The former operate under the vertical structures of the Ministry of Health while the latter are mostly supported by parallel initiatives designed and implemented by various global RBM partners in line with RBM's strategic objectives.

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[83] Interview: International Development Representative, Global RBM Board
[84] Cameroon Tribune (06/09/07) <http://allafrica.com/stories/200709060910.html> (Accessed: 13/05/08)

A provincial malaria treatment and control office has been established in each of the ten provincial capitals in the country to supervise and coordinate the subsidization of costs of treatment in all public and private hospitals and pharmacies. Provincial centres also provide malaria related information to urban and rural areas through district and community health facilities to enable them to deal with malaria cases in rural villages. They also have teams of health experts from public hospitals and pharmacies to deal with epidemiological, diagnostic and drug prescription issues. All these activities receive wide coverage by the national radio and TV media channels. Locally trained NGOs and Associations are also active in community mobilization, sensitization and distributing of medicines and materials. *Africa Malaria Days*[85] provide an important medium for dissemination of information on prevention, diagnosis and treatment of malaria throughout the country.

The national malaria programme's activities are also paralleled by a variety of cross-partner initiatives under the guidance of various international agencies that use RBM's strategic orientations. Specifically, the goal is to support the national programme in meeting malaria targets, to increase the capacity to sustain ITN and ACT programming, thereby sustaining the PPP approach. Yet these parallel initiatives are not directly answerable to the national RBM committee; they only share a common RBM objective and participate in national committee meetings.

[85] An example of the Africa Malaria Day advocacy can be found at: "Malaria: The ACT Alternative", *The Post* Online: http://www.postnewsline.com/2008/04/malaria-the-act.html (Accessed: 31/05/08)

The RBM claims to provide a unique approach in that its 'strength lies in its ability to form effective partnerships both globally and nationally.'[86] At the local levels the programmes within the Ministry of Health use the structures created under the PHC model and operate in parallel to specialised initiatives set up by global partners. Such initiatives are described by their promoters as being partners to the national programme. They also compete with non-public health units that are not part of the national programme. One interviewee described the current situation as follows:

> 'It is difficult to have an overall blueprint in terms of organizational set up and this makes it difficult for the RBM to answer the very country-specific needs related to epidemiology, organizational and institutional differences in term of malaria control. We don't know exactly how morbidity is, how morbidity patterns are because various international players bring that into picture only for the regions they are involved in. How do you then give an impression on how effective the different programmes are in terms of malaria treatment and control?'[87]

The general consensus among the global partners was that it is the responsibility of the national government to address overlapping initiatives. Before exploring the challenges involved in this, the next section discusses key parallel initiatives, the type of narratives that inform them, the type of global partners to which they are affiliated and the implications for national policy and local practices relating to malaria treatment and control in Cameroon.

6.4.3 Parallel global malaria programmes and activities

Global RBM programmes basically aim to ensure that CSOs play leading roles in programme design and implementation in various regions of the country. Such processes are however, non-linear and it is also likely that a number of

[86] Interview: Bill and Melinda Gates Foundation
[87] Interview: International Development Representative, global RBM Board.

unexpected events can bring to a halt implementation. The cases examined here are not exclusive; they only serve to highlight the ways in which different elements of the RBM model shape national and local practices.

Integrated Management of Childhood Illness (PCIME) Programme[88]

PCIME illustrates how the economistic element of the RBM model contributed in reframing the malaria problem in Cameroon from public health to fast track medical measures.[89] It was first launched by the WHO and UNICEF in partnership with the Pan-American Health Association in 1990 to reduce infant mortality in developing countries through the PHC model – behavioural (factors that expose children to sanitary risks related to malaria), clinical (capability of public health personnel), institutional (healthcare infrastructure) and capacity building (empower the civil society to play active role in healthcare).

Following a successful feasibility study, PCIME was authorized in Cameroon in 2002 by the Ministry of Health as a partner to the national malaria programme. Funding was providing by USAid and involved Plan International (France), the Helen Keller International (USA), the Cameroon National Social Marketing Association (local implementing NGO) and provincial and district malaria units (technical assistance). It created Women Associations and Children Forums to implement malaria control activities in three provinces. The office of Plan International in Cameroon coordinates monitors and

[88] A more elaborate description of the programme is available on the WHO website: 'Integrated management of childhood illnesses', < http://www.who.int/countries/eth/areas/childhood/en/index.html> (05/09/08)
[89] For more on PCIME Cameroon see http://paludisme.planfrance.org/m/doc/projet_cameroun.pdf (02/07/08)

evaluates the project. Two local NGOs, namely, EMICAM and SAIMED are in charge of creating and supervising these forums. These NGOs and associations are approved by provincial and district RBM units. Public health personnel at provincial malaria units are often invited to provide training and health advice to the forum members.

The Women Associations work as volunteers carrying out community mobilization and sensitization campaigns, distribute ITNs within their constituencies and provide feedbacks to the country office of Plan International in Cameroon. They also perform family visits to encourage residents to use ITNs and to join fellow women groups in their localities. The clinical and institutional aspects of PCIME are ignored as the programme does not even use public health structures. Similarly, capacity building that is meant to link the civil society with the public health system instead bypasses the public hospitals and pharmacies exclusively. The only engagement with the national system is the technical advice they receive through provincial malaria units.

The National Social Marketing Programme

This initiative illustrates how competing interests within the RBM model shape national and local practices in ways that undermine the capacity of transcalar networks to correct governance gaps in Cameroon. It is a partnership between USAID and Population Service International (PSI) and the national RBM in Cameroon. The goal is to compliment the national programme by increasing the capacity of provincial and district malaria centres to sustain ITN programming (USAID objective) and to achieve health impacts through

maternal and child healthcare (PSI objective) in vulnerable segments of the population (Handyside et al., 2004). The global partners sponsored the creation of the National Social Marketing Association (NSMA) to serve as local implementing NGO. The NSMA sells Super Moustiquaire (a bundled ITN and BLOC treatment kit) through private commercial and NGO networks at cost recovery prices in the East, Centre and South provinces. It also runs sensitization campaigns with households on malaria transmission and prevention through the use of ITNs.

The programme emphasises the economistic narrative embodied in the RBM model, by focusing on the procurement (international level) and sales (local distribution) of ITNs and providing staff training (for successful cost-recovery sales). The exoneration of excise duties on ITNs gives USAid the opportunity to provide maximum discounts and enables the NSMA to provide affordable medicines. This contributes by increasing the uptake of ITNs nationally and locally and gives credit to the NSMA as a major local RBM partner. However, there are serious conflict of interest between global partners and national policy makers (PSI, 2004: 7):

> '... announcements are sometimes made by the Minister of Health which can create changes to agreed policy ... The Minister decreed that no health centre ... would receive any free nets if they were found to be selling nets. ACMS was instructed not to sell nets to health centres. This has substantially affected the NSMA program design from that agreed with USAid, in that the roll-out of subsidized nets to clinics has been blocked'

In addition to the above challenge, the exemption of imported nets does not cover certain netting material procured by USAid as part of the programme. Furthermore 'the spectre of leakage of these free nets into the commercial trade

...may affect NSMA's sales (PSI, 2004: 9). From such challenges we see how the economistic element of the RBM model (promoted in this case by global partners such as USAID) is resisted at the national (ministerial decisions) and local (leakage of free ITNs) levels thereby creating new types of governance challenges that further hampers policy effectiveness.

Bolster Program for Malaria

Private multinational corporations are also global partners of RBM. They provide direct local support as well as funding for R&D for malaria vaccines and medicine[90]. Oil giant ExxonMobil joined the RBM in 2001 by launching a Bolster Programme for Malaria, a PPP between ExxonMobil (private donor) and three RBM partners, namely the National RBM of Cameroon (to strengthen on-the-malaria programmes), Harvard Malaria Initiative and Medicines for Malaria Venture (development of new anti-malarial drugs and malarial vaccines). The CEO of ExxonMobile explains the involvement of private industry as follows:

> 'Public health is a cornerstone of opportunity and achievement. Partnerships can result in improved health programs and sustained results for local populations, and we believe that our malaria initiative will demonstrate that corporate investment can make a difference in achieving important public health goals'[91]

As a potential for improved malaria outcomes, the initiative aims to eliminate new malaria cases for its expatriate workers, minimise malaria cases for national project workers (and potentially their families) thereby reducing

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[90] Interview Bill and Melinda Gates Foundation

[91] For more on the bolster programme, see World Bank (2007:16-17) and ESSO (2004) on the Chad-Cameroon pipeline project <http://www.esso.com/ChadEnglish/PA/Newsroom/TD_NewsRelease_170401.asp> (Accessed: 05/06/08)

malaria mortality within the target communities in line with RBM's guidelines. However, rather than channel funding through the national malaria programme, much of ExxonMobil's support is provided directly to local healthcare providers (mostly NGOs) in areas where its pipeline project workers live and work. As an opportunity for achievement, the initiative aims to ensure the successful completion of the Chad-Cameroon Pipeline Project. In this case funding was exclusively meant to prevent the loss of an additional 4.3 project days and US$4 million in expected incremental labour expenses for completing the project[92]. Surprisingly, this region is not among those highly susceptible to malaria mosquitoes in Cameroon (Tchenga, 2008). This undermines the public health element of the RBM model as the economistic interests of global partners override the need to target programmes to the poorest and most vulnerable parts of the country.

Mobilising for Malaria Programme – Empowering local CSOs

This advocacy programme illustrates how the RBM model is being used to empower CSOs to play leading roles in policy implementation. It was launched in 2005 as a partnership between two UK-based global RBM partners, namely Malaria Consortium (civil society partner) and GlaxoSmithKline (pharmaceutical industry partner)[93]. In 2006 funding from the programme was used to create the Cameroon Coalition against Malaria (CCAM) that is currently the most important civil society partner in the National Malaria Committee. It serves as an intermediary (reports directly to the EU) between

[92] ESSO (2002): see note 91
[93] See www.gsk.com/malaria (Accessed: 11/6/2008)

the European Union and the National Malaria Programme. Apart from this, the CCAM performs the following role:

> 'Essentially we offer advocacy services to the RBM especially the regional and national network. We prepare comprehensive documents to serve as information sources for both medical and non-medical persons on malaria. We have monthly programmes with public and private journalists and press including questions and answers sessions. These discussions are broadcasted over their media at different periods as a way to disseminate information on malaria.'[94]

The CCAM sponsors national malaria ambassadors through which pledges are made relating to the fight against malaria. It is also responsible for training local committees in the littoral province on home-based management of malaria with funding from the Global Fund. Here again, the conditions on funding set by the Global Fund, not that set by the national programme committee decides on the allocation of funding to the CCAM.

Brief summary of other parallel global programmes and activities

There are many other examples of parallel initiatives scattered all over the country supported by various global RBM partners. For example, the French Development Cooperation in partnership with Care International (global civil society), Sonafis-Aventis (a private French company) and Provincial Delegations of the national malaria programme implement an *Impact Malaria Program*[95] on access and capacity building, new medicine development and cost recovery sales of ITN and ACTs in the Centre and Northern Provinces (French-speaking regions of Cameroon). Although the programme is based on public health structures (in partnership with private and local partners), the agency responsible for coordinating the programme, instead of being the

[94] Interview: Cameroon Coalition Against Malaria (Local civil society partner)
[95] See more on Sonafis-Aventis program at www.impact-malaria.com (Accessed: 11/06/08)

national RBM programme, is designated to the Cameroon office of Care International. Most RBM-informed programmes are barely presented in technical reports and in most cases on internet sites that are hardly updated. This makes it virtually impossible to compile a comprehensive list of all the initiatives being implemented in Cameroon as a result of the RBM.

From the above context, instead of promoting a country-led coordinated programme, the deployment of the RBM model has led to certain global partners emphasising their own strategic directives. The outcome includes a fragmented transcalar structure in which partners only participate in areas of the country where they have their own strategic interests. This implies an absence of projects in provinces and districts that are not covered by partners. The national partners who hold the key to success and sustainability do not have full autonomy over the national RBM programme. The state no longer plays the central role allotted to it by the traditional liberal models following independence. This role has been eroded by the dominance of the economistic (neo-liberal market models) embodied in the RBM. The state has been entangled within the transcalar networks created by the RBM. This calls into question the significance of the RBM's objective as a global model for health system strengthening. All the persons interviewed agree that more impact could be achieved if partners' interests and overlapping initiatives are linked more consistently to each other. The challenges in achieving this are explored below.

6.5 Challenges facing the National RBM Programme in Cameroon

The normative framework of a GHP model requires two broad conditions to be satisfied in the case of the RBM in Cameroon: absorption of resources to meet Cameroon's specific malaria treatment and control targets and integration of overlapping programmes to achieve health system strengthening. This involves 'localizing' the RBM model. The interplay of competing and conflicting narratives of global partners implies that the extent to which this is achieved depends on the nature of stakeholder participation and the nature of global-national-local linkages. These issues are explored in the following sections.

6.5.1 Participation in the National Malaria Committee

The transcalar character of the PPPs that make up the national malaria programme reveals a clear discrepancy between who *should* decide on policy and who *actually* decides. The role of the National Committee within such a PPP is to ensure that 'the government is able to exert strong regulatory control over all partners and programmes.'[96] Thus, the national committee is defined as the state, what is termed by development studies literature as a transition from government to governance (Dodgson et al, 2002). To facilitate this transition, the community model embodied in the RBM has made it possible to have equal representation of global, national and local partners. The bureaucratic structures of the state have been eroded with previously marginalised groups (the local CSOs) playing a more active role. The state now plays more of a ceremonial role. Representation in the committee gives global partners the

[96] Interview: Provincial Malaria Control Unit, North West Province

legitimacy to participate in areas of state and market failures, bypassing the state.

What became apparent during the fieldwork was the multiple and overlapping roles of the national committee members. Representation in the committee differs from actual participation in the national programme. The Permanent Secretary of the committee is also the Chairman of the Central Technical Group and the expert negotiator between the national and global partners. The multiple roles of the CCAM have already been discussed under the *Mobilising for Malaria Programme*. It is possible to make a similar description in numerous areas of the committee. The members are all the same and they change their titles during the interview depending on whether or not they are speaking in their capacity as representatives of the national committee or head of speficic programmes and activities. This makes the structure of the national RBM programme very complex. However, it implies that the overlapping initiatives are to some extent linked to each other. The possibility exists to integrate these initiatives as long as the partners are willing to do so.

The community participation model embodied within the RBM has led to the empowerment of local CSOs, in particular those that serve the interest of women and children most vulnerable to malaria. This is also related to the human rights narrative that calls for policies to reflect the needs of the poor. By involving CSOs, it is expected that they can better voice the problems of the poor as well as participate in formulating and implementing measures to deal with them. However, although civil society now has a strong presence, their

participation is more evident in policy implementation (as discussed in the programmes above). As the quotation below suggests, their role in policy making is limited to sitting around the same table with the other partners:

> 'The mechanism for electing representatives and the manner in which the rules provide for feedback information presents the biggest problem. There are times when some representatives stand for nothing. So even if we have the largest representation to share power in decision-making which means decisions are consensual, a representative of the civil society who does not render accounts to that sector definitely ceases to represent it. It is difficult to ensure that the mechanism of representation, follow up and accounting is properly done in each case.'[97]

Despite the apparent 'sham representation' described above, when talking informally to some of the local NGOs and associations, it was clear that they are aware of the status of RBM's policy and they feel they are part of the process. They were able to confirm key policy details and some were even able to confirm their contribution in policy making at national level either through their representative CSO or through INGOs and development agencies (specific examples are evident in most of the programmes and activities). Thus, any attempt to integrate overlapping initiatives must not undermine this active role of the civil society. Cameroonian elites now emphasise this basic human rights needs of previously marginalised groups and are obliged to be more accountable for their actions when they sit around the same table with the civil society partners.

6.5.2 Global-Local linkages: Is bypassing the state viable?

In previous models (such as the PHC and the SAPs), foreign agencies created networks around the ministerial structures of the government. The RBM model

[97] Interview: National Malaria Committee (Secretariat)

now gives them the legitimacy to bypass these structures. This enables the programme to achieve quick results; however, it affects the feasibility of the RBM achieving its objective of health system strengthening. The global partners do not even seem to see the state as the most central actor:

> 'Health system functioning does not only relate to how governmental services protrude into the community. The lowest echelon at the village and even the family level is part of the health system not only as a customer, client or patient but also as an active participant in collaborating or contributing with prevention or even preventing transmission of malaria. Let us focus heavily on the civil society organizations and see how far we can influence the malaria transmission and treatment process.'[98]

Such a description of the national health system undermines the PHC model and its subsequent reforms configured before the launching of the RBM. When asked why RBM partners bypass the state, the same interviewee above stated that the 'government officials are keen to maintain their status and job which means income before protection against malaria. They have an interest to maintain a power balance from a national perspective which may differ from the needs of society at the local levels'[99]. On their part, the national policy makers confirm the global narrative that bypassing the bureaucratic structures of the state 'speeds an activity ... the problem is that the State (through the ministry of health) is no longer able to keep the much needed leadership role.'[100] This interviewee also noted that the global partners put their economistic interests before health system strengthening:

> 'The global partners are interested in the number of ITNs distributed, the number of people who have taken medication, etc, but in the conceptualisation ... in developing the infrastructure that is necessary for the whole mechanism to succeed donors are not willing to finance it. We use our resources to establish a plan of action that donors are all too happy

[98] Interview: International Development Representative, Global RBM Board
[99] Ibid (note 98)
[100] Interview: Central Technical Group

to finance. When it does not work, we return to the ministerial structures, which have the difficulty of attracting global partners'[101].

Nevertheless, all the interviewees acknowledge the need for a central actor to coordinate parallel and overlapping initiatives. However, as the attribution of causal factors above illustrate, there are serious differences when it comes to whether the structure of the Ministry of Health has the capacity to function as a national health system. This weakness implies that global partners can play the boundary of different elements of the RBM model to implement their own parallel initiatives with local organizations. The consequences include global RBM partners not respecting national policies on malaria (e.g. the case of the national social marketing programme) the establishment of malaria initiatives in areas that are not the most susceptible to malaria mosquitoes (e.g. the case of ExxonMobil's programme). There was a feeling that Cameroon had no choice but to accept the RBM, due to the influence of multilateral and bilateral agencies including their affiliated donor partners.

The embodiment of different narratives within the RBM model global institutions to exert huge influences on national malaria practices by being able to constraint the elitist behaviour of national politicians. In addition, local CSOs in Cameroon is highly mobilised and is able to act as a suitable counter-balance between the state and the global partners. This is the basis on which any attempt to integrate parallel initiatives and strengthen the health system can be discussed. In addition, the infrastructural capacity to achieve national targets is distorted and conflicting narratives of partners seem to suggest that the stand

[101] Ibid (note 100)

point knowledge of local partners is overlooked. The next section examines the implications of these findings for 'localising' the RBM model in Cameroon.

6.5.3 Localising the National Malaria Programme

As already mentioned, despite the efforts of the various global, national and local partners, the national RBM targets are far from being met. Although this is recognised by all the organizations and institutions involved, a comprehensive statistics on the extent to which targets have been met (or can be met in the near future) is hard to extrapolate given that the different RBM partners only record statistics of the specific programmes in regions of the country where they are involved. Surprisingly, the lack of ITNs and ACTs, the core of the definition of access to medication by the RBM, did not feature in any of the interviews as one of the main challenges in the fight against malaria in Cameroon. However, such a medical model represents a 'technical fix': the use of a particular technology (in this case ACTs and ITNs) to solve the malaria problem with an institutional structure that is not capable of tracking its own activities. If access to ITNs and ACTs is not the key challenge, one questions what Cameroon's needs with regards to malaria treatment and control are. A member of the Central Technical Group summarized it in the following quotation:

> 'Funds necessary are still insufficient ... all actions we take are not always followed up. There is usually a big lapse of time between the time projects are initiated and when they are funded. At the societal and cultural level, Cameroonians still attribute the causes of malaria to other things such that the interventions we initiate are not always adopted by the beneficiary. A radical behaviour change is needed in the population for measures to be effective, and there must be a good orientation in the search for treatment for Malaria.'[102]

[102] Interview: Central Technical Group (Technical Services)

Localizing the RBM in the Cameroonian context described by the above quotation requires measures to be taken along the lines of both the public health, economistic and human rights models on the one hand, and institutional models on the other. Amongst the proponents of the RBM, there was a strong emphasis on the 'importance of the malaria problem, the weight of the disease on development, and the socio-cultural organisation of the country'.[103] These are all elements embodied in the comprehensive PHC model that was gradually abandoned with the coming of the neo-liberal market models from the late 1980s. Clearly, the public health narrative has been largely neglected in favour of the economistic narrative.

From an institutional perspective, there is need to address the social issues (infrastructural capacity) to enable the national RBM programme to supervise and coordinate all overlapping activities. The incentive put forward by creators of the RBM model to govern by bypassing the state has not solved the problem of bad governance and defective health system. Both public, private and civil society actors are being linked to apparent mismanagement of funds and illegal distribution of drugs allocated to the national malaria programme (Lipset, 2000; NMCP; 2008): 'sometimes low pay encourage people to find additional income streams, which may come from diverting medicines out of their facility into the informal sector'[104]. Here, the RBM model is a tool to aid development, but also to satisfy the self-interested needs of some elites at the expense of poor Cameroonians.

[103] Interview: Bill and Melinda Gates Foundation
[104] Interview: Cameroon Coalition Against Malaria

Other challenges affecting national programme that emerged during the interviews include insufficient political will to pull the necessary resources to fight against malaria, shortage of adequately trained and motivated health professionals, lack of supervision especially given the enormous workload on staff and the influence of traditional medicine and self-help groups. Most of the public health centres in urban and rural areas that were visited during the fieldwork were ill equipped to adequately deal with malaria:

> 'a real problem is human resources in terms of disposition (availability) and quality. When there is money we need people to implement activities and to put into place all the programmes that are proposed in the peripheries.'[105]

In terms of the most suitable institution to localize the RBM in Cameroon, the main emphasis was on measures to empower the Central Technical Group (CTG) to tracking all RBM programmes and activities in the country. It is the only actor that interacts with the global, national and local partners:

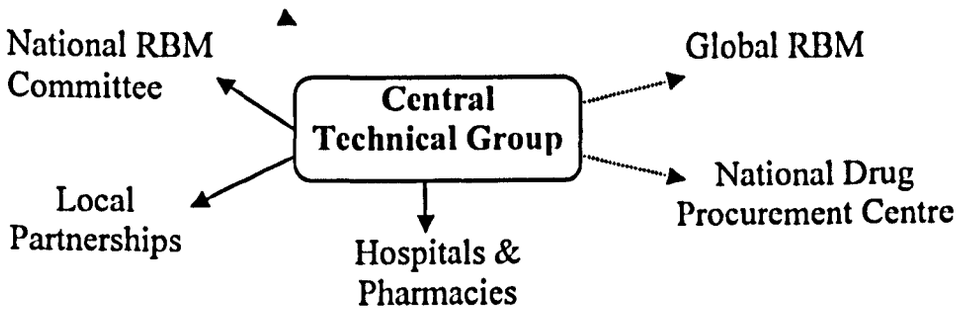
> 'The CTG is an offshoot of the Ministry of Health but in reality we are answerable to the national committee. If you look at the text of the national programme, you have the national committee, the CTG and after that the local partnerships on the one hand and clinical services on the other.'[106]

The centrality of the CTG can be represented as on Figure 7 below. In fact one interviewee even noted that this was the missing link in the fight against Malaria before the launching of the RBM-backed national malaria programme. There was a disconnection between the policies and their operationalisation which hampered action'.[107] The centrality of the CTG suggests that its capacity needs to be strengthened to be able to track the activities initiated by global

[105] Interview: National Malaria Programme Secretariat
[106] Interview: Central Technical Group
[107] Ibid

partners that bypass the national committee in policy implementation. The CTG, by virtue of it being in charge of coordination should also play an active role in decision making on the procurement and supply of ACT and ITNs alongside data collection, monitoring and evaluating of programmes and activities.

Figure 7. The centrality of the Central Technical Group



Source: Author's processing of policy documents and technical reports

The role of the CTG as the most central actor in the national programme was also reflected in the interviews with provincial RBM coordinators who are members of the CTG. Their responses point to the fact that the CTG is in the best position to play this central role since it is more connected with the policy making and policy implementing community. It satisfies the requirements of the global partners in the sense that it is answerable to the national RBM committee (not the Ministry of Health) where global, national and local partners are represented and should therefore be able to provide a more complete picture of what coordination mechanism ought to look like.

6.6 Conclusions

This chapter has explored the role of the RBM model in shaping national health policy and local delivery practices on access to medication for malaria treatment and control in Cameroon. The analysis reveals that the national RBM programme is the embodiment of previously competing and conflicting models of public health, economic development and human rights in relating to malaria treatment and control. This finding enables us to make evaluative statements about the effectiveness of RBM in achieving its country-specific targets in Cameroon (reducing malaria mortality by 60% by 2010 through health system strengthening). The chapter highlights three key areas in which the challenges to achieving this global ambition can be assessed: the nature of stakeholder participation in the national RBM programme, the extent to which the RBM model deals with the barriers to access to medication for malaria treatment and control, and the effectiveness of transcalar networks created as a result of the RBM model in shaping different elements of malaria policy practices.

In terms of stakeholder participation, the human rights narratives tend to dominate the PPP approach adopted by RBM. This is particularly evident in the participation of CSOs (especially local community groups) in policy making and implementation. The involvement of this previously marginalised group has benefited the programme in terms of ensuring that treatment programmes reach the poorest and most vulnerable segments of the population. Community groups have been mobilised, they are represented in national policy meetings, they are involved in sensitization programmes, and they even distribute medicines and ITNs to local households. The concept of human

rights as implicit in the PHC model called for this type of community mobilization and participation. Similarly, development policies of the World Bank had begun to advocate their participation as a way of correcting the governance gap in African countries (under the debt cancellation programme). The integration of these models is reflected in the PPP approach in which global, national and civil society partners associated with both models sit around the same table to formulate and implement malaria policy. The PPP element has also committed the state to RBM's strategic objectives; however, the goal of the neo-liberal model to promote good governance and to fight corruption produces new governance challenges that undermine the effectiveness of the programme.

In terms of the relationship between GHPs and access to medication, the economistic narrative embodied in the RBM model dominates policy and local practices in Cameroon. National malaria policy is now dominated by issues around the modern and cost effective policy strategies, with limited emphasis on preventive measures that formed important elements of the PHC model. From the analysis in this chapter, access to medication is defined in terms of the availability and affordability of ITNs and anti-malarials (such as ACTs). From this perspective, RBM has so far been very effective. The evidence show how, through the technical assistance of WHO and UNICEF Cameroon is able to prepare robust grant proposal which has so far been very successful in attracting grants from the Global Fund and other donors.

Throughout the case study, it was clear that availability and affordability of malaria medicines in no longer a major barrier to access to medication in Cameroon. This also gives credit to negotiations between the National Drug Procurement Centre and individual pharmaceutical companies that participate in the RBM. Nevertheless, the incidence and burden of malaria has continued to rise and the RBM is far from meeting its country-specific targets. This is because, the elements from the public health model that emphasise behavioural and socio-economic determinants of access to medication (potential access to medication), has so far been neglected. Resource constraints (both financial and human resources) has been a major barrier to potential access to medication for several decades, yet the huge amount of funding that has been mobilized by the RBM is substantially devoted to medicines and ITNs (rather than for example strengthening human resources capacity of the national health system as a whole and promoting preventive measures that worked in previous malaria eradication campaigns in the western world discussed in Chapter Four).

The RBM is also failing in the area of its core strategic orientation, namely, health system strengthening. At the national level, the RBM claims to provide a country-specific coordinated PPP. This is true in the case of the national RBM committee which is decently organized. The structure appears to be complete with specific roles allocated to specific partners and with global, national and local partners fully represented. However, at the local level, the outcome of the RBM model has been the creation of transcalar networks involving overlapping malaria programmes and activities favoured by individual global partners.

While the initiators of these parallel initiatives are members of the national malaria committee (where they gain legitimacy), these programmes are neither accountable to the committee nor to the MoH. Thus, instead of 'health system strengthening' the RBM has further fragment the national health system introducing new coordination challenges; making it difficult to track trickling down of funding and equipment to overlapping initiatives.

Since the RBM explicitly targets health system strengthening, the extent to which the structure of the national programme contributes to achieving this goal was explored further in the chapter. The analysis suggests that the Central Technical Group within the national programme is the most central actor capable of ensuring coordination. It provides the interface between the policy making community (the national RBM committee) and the policy implementation community (provincial and district RBM units and parallel initiatives implemented by individual global partners). The capacity for learning across the global, national and local levels can be improved if the varieties of different stakeholders allow the central technical group to access their programmes and activities. Cross-scale linkages improve the quality of the governance process as it allows the national RBM programme to organize itself to increase its capacity for learning from the success and failure stories from overlapping programmes and activities.

However, the extent to which the global partners are willing to render their parallel initiatives accountable to the Central Technical Group (and consequently the national malaria programme) seems less likely due to issues

around foreign policy diplomacy and the North-South divide. Thus, one could adequately gauge the feasibility of integration improving the effectiveness of the RBM. It will facilitate monitoring and evaluation and trickling down of money. However, integration goes somewhat against the neo-liberal market model, as this approach is preferred by multilateral and bilateral development agencies. The RBM could offer a 'technical fix' but investment into these programmes would have to be justified on a sustainability analysis. The likelihood of donors investing in programmers and activities that are of little interest to dominant partners (such as human resources), is limited due to historic and present conditions that favour large scale, resource rich partners.

CHAPTER 7: GHPS AND ACCESS TO MEDICATION FOR HIV/AIDS TREATMENT AND CONTROL

7.1 Introduction

This chapter describes the structure and operations of the National HIV/AIDS Programme in Cameroon as another example of how the embodiment of development models in a GHP model shapes national health policy practices. This globally-backed programme was launched after the Cameroon government endorsed two of the global models discussed in Chapter Four – the UNAIDS-led Accelerating Access Initiative (AAI) and MSF-led EAI. Both initiatives share a common objective, that is, to facilitate access to medication for HIV/AIDS treatment and control in developing countries. However, the nature of the public health, economistic and human rights narratives embodied within each suggest that they have different global strategies. While AAI emphasises discounted patent-protected drugs (emphasis on the economistic narrative), EAI emphasises the ability to pay irrespective of whether drugs are patent-protected or not (emphasis on the human rights narrative). In practice, however, proponents of both models claim that the models, apart from facilitating access to HIV/AIDS medicines and also contribute to health system strengthening.

By bundling both AAI and EAI, Cameroon was able to position its national HIV/AIDS programme so that it found favour with pharmaceutical companies

producing patent-protected medicines as well as those producing generic medicines. Global partners affiliated with both models are members of Cameroon's national programme. From July 2002 Cameroon was being hailed by the main programme initiators as a success story in the global fight against HIV/AIDS in the developing world (UNAIDS/WHO 2002; MSF, 2002a). However, no empirical study has ever been conducted to test and assess these claims. Another objective of this chapter is therefore to present a detailed empirical case study to test and assess the role of the national programme in achieving country-specific HIV/AIDS treatment and control targets.

The AAI and the EAI are examples of GHP models. They are hybrid networks in which different forms of knowledge come into play to shape the structure and operations of the National HIV/AIDS Programme. The economistic, public health and human rights narratives embodied within the two GHPs shape different aspects of policy making and implementation. This chapter highlights instances where each of the two global models are at their strongest and the context in which they are less relevant. Just as the case of the malaria programme described in chapter six, it then relates this to the global level in terms of what the GHPs claims to do and what they actually do; and what is needed for the national programme to achieve its objectives of serving the poorest people in the country on a sustainable basis.

The empirical research is based on documentary analysis and analysis of qualitative interviews conducted with a wide range of partners involved in the national programme. The interviewees noted the daunting task to set up a

coordinated programme that takes both partners' strategic interests and country-specific needs relating to HIV/AIDS. This case study attempts to unpack the network of global, national and local partners by exploring the ways in which the knowledge (or narrative strategies) brought in by each partner contributes to policy making and implementation. The historical context of the fight against HIV/AIDS in Cameroon is presented followed by a description of the strategic objectives of the National HIV/AIDS Programme. The governance mechanisms (including a description of specific programmes and activities) are then discussed, including the normative and operational challenges facing the programme are then explored. Finally, conclusions are presented.

7.2 The Historical and Political Contexts of AAI and EAI in Cameroon

This section describes the historical and political context in which GHPs became involved in the fight against HIV/AIDS in Cameroon. The first AIDS case in Cameroon was diagnosed in 1985 (WHO, 2005a). Since that time hundred of thousands of cases have been reported (NACP, 2001) and HIV/AIDS is today considered to be a 'generalized epidemic' (WHO, 2005a:1) with adult prevalence rates in the range of 4.8-9.8% (NACP, 2008:2). The political commitment of the Cameroon government in the fight against HIV/AIDS had international dimensions from the start (see Eboko, 2001). It involved the transfer of international health polices by the WHO and UNICEF (late 1980s and early 1990s) and the translation of global health policies (the

emergence of GHPs in the later 1990s) to reflect country-specificities. The first National Programme for the Fight Against HIV/AIDS (PNLS) of 1987 reflected guidelines of the WHO's Global Programme on Aids (GPA). In 1996 when UNAIDS replaced the GPA, Cameroon quickly revised the PNLS into the National AIDS Control Programme in 1998 to reflect UNAIDS guidelines.

In December 1999, UNAIDS Country Office was created in Cameroon headed by Dr Emmanuel Gnaoré, a former Director of the National HIV/AIDS Programme in Ivory Coast and formerly UNAIDS Director for Madagascar. His role reflects the international dimension of policy transfer (discussed in Chapter Four) in which 'lessons learned' (from Ivory Coast and Madagascar) are shared with Cameroonian authorities to inform national HIV/AIDS policy practices. In June 2000, Dr. Gnaoré in consultation with the Ministry of Health outlined the following key challenge in the fight against HIV/AIDS in Cameroon (translated from French):

> 'This country has human resources and enormous competencies but it is very difficult for Cameroonians to work collectively ... It is unbelievable to realise that we are trying to put together competent Cameroonians in the domain of HIV/AIDS ... and that it is Cameroonians who have demanded that UNAIDS should be responsible for the fight against HIV/AIDS in Cameroon ... Everything happens as if each and everyone need a foreign partner to avoid doing it alone.'[108]

In this context, UNAIDS proposed a massive social mobilisation effort and became actively involved in negotiating HIV/AIDS policies with Cameroonian authorities. UNAIDS argued that its role was important to ensure that the existing instability and corrupt practices that existed in previous programmes

[108] Eboko, F. (2001) 'L'organisation de la lutte contre le sida au Cameroun : de la verticalité a la dispersion' In: *Un système de santé en mutation : le cas du Cameroun* (Changing a Health System: the case of Cameroon), Bulletin De L'APAD, No. 21, <http://apad.revues.org/document184.html#ftn6#ftn6> (Accessed: 30/03/08)

on HIV/AIDS would not give a negative political publicity to any future HIV/AIDS treatment and control activities. Using this argument, all projects related to HIV/AIDS carried the signature (or symbol) of UNAIDS-CNLS (i.e. both UNAIDS and a newly formed National HIV/AIDS Committee) as well as mentioning the active role of specific UN agencies (UNESCO, UNICEF, UNDP, WHO and the World Bank) who created the AAI. With the technical support from all these partners, Cameroon was able to define its long-term HIV/AIDS policy. The involvement of the most senior government officials in the politics of access to medication for HIV/AIDS in Cameroon is further evidence of strong political commitment. The Superior Council for Health decreed by the President in 1999 and headed by the Prime Minister defined the modalities for creating the national programme.

Cameroon officially joined the AAI in March 2001 after signing an accord with the five original participating pharmaceutical companies. While the details of the accord was kept secret, a ministerial order announced in all national media declaring 76% reduction in the prices of ART to $1000/annum/person (NACP, 2001). Joining the AAI was a very simple task as Cameroon simply had to present its revised national HIV/AIDS programme, which was already backed by UNAIDS, WHO and the World Bank as consistent with the key eligibility criteria: a 'high HIV/AIDS burden' (WHO, 2005a: 1), one of the 'hardest hit regions of the world,' a relevant health infrastructure and 'adequate' health system 'to handle the complicated HIV/AIDS medicines (UNAIDS/WHO, 2002: Annex 1:29).

The endorsement of the MSF-led Equitable Access Initiative (EAI) in April 2001 is the third strand of the evidence of political commitment. In April 2001, MSF organized a conference in Yaoundé, the capital of Cameroon and sensitised the Ministers of Health and Commerce of the OAPI[109] countries on the question of patents and access to treatment within the framework of the Bangui Accords (MSF, 2002b). Challenging the economistic arguments of the AAI, MSF claimed that the alternative it offers, the EAI, ensures that even the poorest individuals could afford ARTs. The government of Cameroon (having previously signed the TRIPS Agreement), ratified the revised Bangui Accord that allowed least developed countries to import generic drugs (despite this being in defiance of the TRIPS Agreement). INGOs such as MSF had already pushed for this argument in WTO during the Doha Round of trade talks discussed in chapter four of this thesis. This position could not also be ignored by the WTO, as the World Bank's Debt Relief Program had classified Cameroon among the poorest countries in the world. In July 2001, under the EAI model, the government signed a deal with generic manufacturer Cipla for the acquisition of 15000 treatments at a price of $350/person/year.[110]

The above political commitment highlights the importance Cameroonian actors give to connections with global networks in the fight against HIV/AIDS. Here we see how drug pricing (economistic narrative) tends to be at the core of negotiations initiated by both global AAI and EAI partners. Within five months the price of ART reduced from $1000/annum/person (adoption of the AAI

[109] OAPI is the African Intellectual Property Organisation for French-speaking Africa (http://www.hahn.co.za/patent-services-oapi.htm) (Accessed: 23/12/2009)
[110] See Pharma-Policy (2001) 'Cipla To Provide AIDS Drug To Cameroon' <http://lists.essential.org/pipermail/pharm-policy/2001-July/001333.html> (Accessed: 27/03/07)

model) to $300/annum/person (adoption of the EAI model). It is therefore unsurprising that by July 2002 Cameroon was already a global success story in the fight against HIV/AIDS credited in terms of such reductions in the costs of treatment. Global partners of AAI and EAI (and their narrative strategies) are members of the National HIV/AIDS Programme alongside national and local partners. A representative of Bristol-Myers Squibb (an AAI partner) justified a GHP approach as follows:

> 'HIV/AIDS effects have hit hardest in countries that cannot tackle it on their own. It is not just about prices, infrastructure and whether medical professionals and nurses are paid the right salaries to administer the medicines. It is a combination of all these factors, which no one group - be it the pharmaceutical companies, UN, national governments - can address. That is why the fight requires commitment from all these groups in a public-private partnership.'[111]

The national HIV/AIDS programme was officially launched in August 2001 with a budget of $189 million over five years (NACP, 2001). This chapter unpacks the transcalar networks of global-national-local linkages through which the national programme attempts to achieve its objectives.

7.3 Objectives and Structure of the National HIV/AIDS Programme

The main objectives of the national programme are defined in the National Strategic Plan for HIV/AIDS for 2000-2005 (Table 11). The plan laid the basis for introducing reforms in the following areas: creation of a national HIV/AIDS committee (the policy making community), specialised treatment centres for scaling up access to ARTs; programmes to strengthen the human

[111] Interview: Bristol-Myers Squibb, AAI pharmaceutical industry partner.

resource capacity; decentralization of implementation to rural communities and promotion of PPPs at all levels.

Table 11. The National Strategic Plan for HIV/AIDS for 2000-2005

HIV/AIDS Policy Challenges	*HIV/AIDS Policy*
• Lack of general mobilization	• Prevention using education & information
• Insufficient program coordination	• Medical and psycho-social support
• Insufficient inter-sectoral implications	• Safety of blood transfusion
• Scarcity of resources.	• Epidemiological surveillance

Political Commitment

- HIV/AIDS is the priority number one of the national health development plan
- Reorganization of national HIV/AIDS program through a national committee
- Increased budget allocation for the fight against HIV/AIDS
- Multi-sectoral and decentralized approach
- Development of a national strategic plan.

Source: NACP (2001); WHO (2005a)

As presented in Table 12 below, the partners, objectives and local interfaces of the national HIV/AIDS relates to five fundamental agendas: technical assistance, funding, advocacy, drug procurement and supply arrangements, and the provision of healthcare.

The structure of the programme and the nature of multi-stakeholder participation is the same as that of the malaria programme described in Chapter 6, that is, a policy making community, policy implementation community and the autonomous centre for drug procurement and distribution. The only difference is that not all the partners are the same. The next section explores the role of the different actors and the forms of knowledge that they bring into the national programme in shaping national policy and local practices on HIV/AIDS treatment and control

Table 12. The National HIV/AIDS Programme: promoters and objectives

Global RBM Tasks	Key Global Partners	Objectives	National/Local Partners
Technical Assistance	WHO, UNICEF, UNAIDS, Germany, France, MSF	Defines national strategic plans; validates grant proposals for submission to donors	National HIV/AIDS Committee
Resource Mobilization	World Bank, Global Fund, Germany, France	Mobilise funding and human resources at global, national and local levels	Central Technical Group
Community Mobilization	European Union, INGOs & Private Foundations	Monitor and supervise programmes; increase civil society participation and awareness campaigns	Treatment centres, local NGOs & Associations
Drug Procurement	Pharmaceutical Companies	Procures drugs and distribute to treatment centres through provincial supply centres	National Essential Drug Procurement Centre
Service Delivery	Development Agencies; INGOs & Foundations	Diagnosis and treatment, care and support for people living with HIV/AIDS	Provincial/district units and parallel global initiatives

Source: Author's analysis of policy documents and technical reports

7.4 How GHP Models Shape HIV/AIDS Policy Practices

The AAI and the EAI model have both played important roles in shaping national policy practices on access to medication for HIV/AIDS in Cameroon. The policy framework for HIV/AIDS in Cameroon is shaped by a combination of public health, human rights and economistic narratives embodied within AAI and EAI. This takes place during periodic meetings between global, national and local partners within the national committee.

7.4.1 Technical assistance

Technical assistance involves the transfer of normative guidelines from the global to the national context through the national committee. During committee meetings issues such as the findings from situation analysis at local levels and lessons learnt from other countries are discussed in the context of GHP guidelines. Under the leadership of UN partners to the AAI (WHO, UNAIDS, UNPF, UNDP, FAO and UNICEF) technical assistance is complemented by two main bilateral donors (France and Germany), small scale support from others western government (e.g. Belgium and Canada) and INGOs (the most dominant of which is MSF).

The policy making community is dominated by global partners of the AAI. The focus areas of policy include developing (or revising) HIV/AIDS health plan within the AAI and EAI frameworks; elaborating policy and strategy documents and guidelines for treatment and control of HIV/AIDS and other sexually transmitted diseases; technical support and catalytic funds to create and equip specialised treatment centres within WHO's guidelines; strengthening human resource capacity; guidelines to undertake situation analysis for procuring and distributing ARTs and implementing recommendations; developing and implementing the Global Fund proposals (WHO, 2005a).

The EAI partners use their human rights narrative to ensure that global normative guidelines reflect human rights principles (by reflecting actual field

conditions or country-specific contexts). In this context MSF is the most important global civil society partner of the National HIV/AIDS Committee.

> 'We share experience on practical inputs on field conditions. Sometimes authorities have different agendas. Their concern may not be that they want things to work well but that they want results to present to donors and have more money. MSF helps authorities to take decisions that are based on actual field cases.'[112]

7.4.2 Resource mobilization and funding

Once the national frameworks have been agreed on the basis of the technical directives and advice above, resources are then mobilised for execution. Resource mobilization occurs at the global, national and local levels. At the global level, the Global Fund and the World Bank are the most important donors. The Global Fund provides funding based on the presentation of a robust grant proposal that is expected to be consistent with the National Strategic Plan Against AIDS. Since the grant proposal is validated by the national committee it is assumed to have the backing of all global, national and local partners of the national programme. The Global Fund also requires grant proposals to demonstrate a high level political commitment (evidenced by both Cameroon's President and its Minister of Health getting involved in mobilisation and making their national contribution to the fund). The Global Fund also emphasises that grant proposal should demonstrate evidence that HIV/AIDS campaigns target the most vulnerable parts of the country.

[112] Interview with MSF

Since the Global Fund provides funding based on the presentation of a robust grant proposal, not all the amount requested is approved.[113] For example according to WHO (2005a), Global Fund Round 3 approved US$ 14.4 millions (out of US$ 55.7 million requested) for scaling up treatment and care for people living with HIV/AIDS and support for orphans and vulnerable children while Round 4 approved US$ 6.3 million (out of US$ 16.3 million requested) to strengthen the participation of CSOs in the fight against AIDS in Cameroon.

As already mentioned, Cameroon benefited from the World Bank's Debt cancellation initiative. The funds released represent the largest proportion of funding mobilised at the national level to support prevention and case management activities. The Government has consistently increased funding for HIV since 1995 and as part of the National Multisectoral Strategic Plan for HIV/AIDS through various government ministries for HIV/AIDS interventions. For example, the government has committed to provide US$ 1.0 million each year to support scaling up antiretroviral therapy during 2000-2004 and US$ 16.6 million for 2004-2005 (WHO, 2005a). In addition, the World Bank Multi-Country AIDS Program (MAP) for Africa launched in 2005 also provide additional financial support of US$ 50 million to Cameroon for public, private and community-level planning of HIV/AIDS activities, training of medical personnel and communication activities related to behaviour change (WHO, 2005a).

[113] See for example see funding decision and distribution of funds on Global Fund website: <http://www.theglobalfund.org/programs/grant/?compid=609&grantid=285&lang=EN&CountryId=CMR> (Accessed: 30/03/07)

A substantial part of World Bank's funding is expected to be contributed by the Cameroon itself under the World Bank's debt relief programme. This involves converting part of its debt relief proceeds into a fund for the national programme. This means that, in terms of funding for HIV/AIDS, 'Cameroon has on its own budget only 5% dependent on external support'[114]. A proportion of the HIPIC fund is thus allocated to the national HIV/AIDS programme. This amount is mobilised at the national and local level through 22 supporting government ministries and other public structures. Funding is also provided by bilateral and multilateral partners such as GTZ, French Corporations, MSF and international foundations directly through the national programme or indirectly through their own initiatives with local partners in various regions of the country. Resources mobilization takes into account the financial costs of treatment (before HIV/AIDS became free of charge) and non-financial contributions such as volunteer activities (through NGOs and community associations) at national and local levels.

7.4.3 Drug procurement and supply arrangements

One of the key global challenges in the fight against HIV/AIDS is the high costs of medicines and care facilities. Most of the funding for the national programme is devoted to payment for subsidised drugs. The CENAME, the focal point for the entry of HIV/AIDS medication into Cameroon was created in 1997 with funding from the European Union (through the GTZ and the French Cooperation). The conditions for this funding required the government to create specialised Provincial Pharmaceutical Supply Centres (PPSC) and to ensure that drug distribution reflected the pluralistic nature of Cameroon's

[114] Interview: German Development Cooperation (GTZ)

health system. Following the launching of the national strategic plan for HIV/AIDS in 2000, the Minister passed a convention aligning drug prices (specialties and generics) in PPSCs to those of CENAME, as recommended by the WHO. The WHO (2005a) explains that this re-centralization brought about substantial fall in prices within the PPSCs. With the monopoly of the CENAME guaranteed, it became easier for the question of HIV/AIDS medication to be put on the national policy agenda by the UN-led AAI.

The GHP approach to the fight against HIV/AIDS in Cameroon was dominated by the economistic model from the start. The shared view among the global partners interviewed is that 'the original argument was that the primary barrier to medication was affordability and a lot was needed to make medicines more affordable to countries that are hardest hit by HIV/AIDS'[115]. This view is similar to those of national and local partners. It therefore suggests that the global economistic narrative was fully embraced in Cameroon. Local partners (in this case the medical practitioners who already had encounters with suppliers of HIV/AIDS medicines before the launching of AAI and EAI) were invited to contribute to policy formulation.

> 'After consulting the Minister of Health, he (Permanent Secretary of the National HIV/AIDS Committee) called a meeting in October 2000 with all the prescribers working in the country and asked them to formulate their needs for ARTs in order to establish a protocol of payment. He did not even know the addresses of suppliers. After establishing the protocol, CENAME wrote to the different pharmaceutical companies (in the AAI) that were manufacturing ARTs.'[116]

The global framework established by the AAI model is that negotiations on drug procurement and supply arrangements must only take place through

[115] Interview: Bristol-Myers Squibb
[116] Interview: National Drug Procurement Centre (CENAME)

bilateral negotiations between pharmaceutical companies and national governments. As mentioned in chapter four, critics of the AAI claim that bilateral negotiations open disease-endemic countries to expensive patent-protected drugs from monopoly pharmaceutical company partners. In the case of Cameroon, the human rights narrative embodied within the EAI model serve to gloss these dominant arguments. As already mentioned, using the MSF-led EAI model, Cameroon was able to procure from generic manufacturers (such as Cipla) at cheaper prices (compared to AAI companies) thereby increasing its choices of pharmaceutical companies. Both generic competition (the EAI model) and discounted drug pricing (AAI model) enabled Cameroon to overcome drug prices as a major barrier to actual access to medication: 'the cost of ART and immunotherapy that was 700.000 FRS, dropped to 200.000 FRS then to 78.000 FRS, 24.000 FRS, 15.000 FRS; 3.000 FRS then to 700 FRS and now it is free of charge.[117]

It is interesting to note that the decision to procure from generic manufactures was not forced on to Cameroon by proponents of the EAI model. It simply served as a window of opportunity in the face of structural problems with drug procurement and supply arrangements with AAI pharmaceutical companies.

> 'The five (AAI partner) companies that agreed to significant reduction in prices could not fully meet the high demand. Several months' deadlines for supply were announced creating a risk of interruption in general supplies a few months after the announcement of price reductions. It was then that the idea of approaching firms making generics in Asia was envisaged. This immediate emergency solution, applied in disregard of the accords on intellectual property (TRIPS) and of those made with firms within the framework of the AAI became an additional response.'[118]

[117] Interview: Provincial HIV/AIDS Unit, North West Province
[118] Interview: CENAME

The above quotation contributes to explaining the dominance of the economistic narrative in the practical steps of formulating HIV/AIDS policy. Even the procedure of the EAI model (that claims to promote human rights) uses economistic language (generic competition) to achieve its goal. Having agreed on drug procurement and supply arrangements, the next challenge for the national programme is to ensure successful implementation. This is coordinated at three levels, namely central, provincial and district levels respectively.

Just as the National Malaria Programme (chapter six) the Central Technical Group is responsible for coordinating policy implementation in the national HIV/AIDS programme. It coordinates and supports specialised treatment centres, districts health centres and clinics that provide HIV/AIDS treatment, support and counselling. Many other international private and civil society (international NGOs and Foundations, research and academic institutions, private firms) are involved at various levels of the national programme through parallel initiatives at local levels. The next section describes some of these programmes and activities.

7.5 National HIV/AIDS Programmes and Activities

The AAI and the EAI models did not only shape policy practices in the area of developing national strategic plans for HIV/AIDS and drug procurement and supply arrangements as discussed above. They also shaped policy implementation at national and local levels. In order to illustrate this, the following section describes the ongoing fight against HIV/AIDS in Cameroon

focuses on how the treatment and control efforts are shaped through the creation of transcalar networks with global-national-local linkages (the interplay of actors and their narrative strategies in relating to access to medication) within the national programme. Two provinces, namely, the Centre Province (with capital Yaoundé) and the North West Province (with capital Bamenda) were the focus of investigation. The former is the capital of Cameroon with the most advanced and well developed hospitals and pharmacies in the country, and also home to pioneer projects on HIV/AIDS created before the deployment of GHP programmes. More than 40 per cent of treatment centres created by the end of 2001 were based in this province (Eboko, 2001). On the other hand, the North West province is one of the poorest regions in Cameroon and got its first treatment centre at the end of 2001 (after the creation of the national programme). Thus the North West Province illustrates the decentralization of programmes to the poorest and most vulnerable parts of the country.

7.5.1 Specialised treatment centres: the Day Hospital of the Yaoundé Central Hospital

The Day Hospital was opened in 1998 with funding assistance from the French Cooperation, in view of France's colonial interest in Cameroon. It is the pioneer project for the introduction of HIV/AIDS medicines such as ARTs in Cameroon through privately negotiated prices with pharmaceutical companies. The major barrier to access to medication at that time according to a senior pharmacist at the centre was the exorbitant prices of drugs:

> 'Because the prices ranged between 400.000 and 500.000FCFA, the question of high costs of ARTs was quickly put on the table with the doctors of the Day Hospital and those of the PTME Programme of the

> Centre Pasteur in order to undertake a joint negotiations with pharmaceutical companies to obtain specialties directly from them. In April 2000 the efforts led to six therapeutic protocols costing 235-300 thousand FCFA a month. Very quickly, increasing numbers of 'rich' patients from many provinces of the country including some from neighbouring countries were coming here for treatment.'[119]

The above quotation is consistent with the AAI argument that drug prices were the major barrier to access to medication. In March 2001, the National HIV/AIDS Programme accredited the Day Hospital (alongside 16 others in the country) as the first specialized treatment centres. In addition, the hospital's pharmacy became the national distribution site for ARTs. Specialized personnel were appointed in CENAME to handle drug procurement issues with the Central Hospital Pharmacy. A Therapeutic Committee, seconded by an Ethical Committee, was quickly put in place to establish and implement the best ART protocol for each patient.

In December 2001, CENAME replaced the Day Hospital and all treatment centres in the country now had to procure drugs through CENAME. This is one area where the global partners were quite successful in shaping local practices. As mentioned earlier, agreement had already be reached with AAI (March 2001) and EAI (July 2001) pharmaceutical companies for the supply of patent-protected and generic medicines respectively. Thus by the time the CENAME gain its monopoly status in the country it was already ready to handle drug procurement and local distribution by virtue of it being created by the upgrade of a private drug procurement centres. The rate of price falls that followed illustrates how the human right narrative (generic competition) forced

[119] Interview: Yaoundé Central Hospital, Centre Province

proponents of the economistic narrative (discounted drug pricing) to resort to drug donation programmes (with funding from World Bank and Global Fund). Increasingly, high drug prices (affordability) quickly became irrelevant as a major barrier to access to medication in Cameroon. An employee at the Yaoundé Central Hospital noted that the GHPs are late movers in the case of the fight against HIV/AIDS in Cameroon:

> 'While they were wondering over there (GHP at global level) whether or not ARTs are feasible in countries like Cameroon, for us in the field, that question was irrelevant since we saw that there were already people on ARTs here and that people could do things by themselves in this country. It was necessary for us to quickly put in place structures to minimize the threat of HIV/AIDS... I believe we were pioneers.[120]

The above example illustrates the importance of involving local actors in policy formulation and implementation. In this case, the local medical practitioners played a crucial role both in setting the stage for the deployment of GHP programmes and in supporting the national and global agenda. However, a major requirement of both AAI and 'Equitable Access' partners is the involvement of the civil society (especially the HIV/AIDS patients) to participate in policy formulation and play leading roles in implementation. However, unlike the medical practitioners, the next sub-section illustrates that the civil society was barely consulted in the events leading to the launching of the national HIV/AIDS programme.

7.5.2 Decentralization to the poorest and most vulnerable regions: the case of North West Province

A 1996 study indicates that it was a pregnant woman who first contracted the HIV/AIDS in the North West Province (Eboko, 2001). Current estimates reveal that the province has the highest infection rate in the country of 8-10% (NACP,

[120] Ibid

2008). The first efforts to combat HIV/AIDS were the creation of an NGO called Fight Against Aids and Sexually Transmitted Diseases (FAAS)[121] in the late 1990s by the Provincial Delegates for Public Health and National Education respectively, with technical assistance from the WHO and UNICEF country offices. As one would expect, given the WHO/UNICEF involvement, the public health model was deployed focusing on sexual behavioural changes (HIV/AIDS prevention). By 2000, FAAS had created and coordinated 58 'Health Clubs' in schools and local communities. A secondary/high school biology teacher was appointed as the head of each club. The programme involved on and off campus sensitisation campaigns, distribution of condoms and counselling, seminars to develop educational programmes on good sexual behaviour. Similar types of health clubs were created throughout the country but taken more seriously in the poorer provinces such as the North West Province.

In 2000, FAAS launched a 'Vaccine Project' for HIV/AIDS polythérapies sponsored by Missouri State University (from USA) and authorised by the Ministry of Public Health[122]. A local epidemiologist was assigned to prescribe treatment using 'clinical guidelines' from Missouri State University, while a medical doctor from the national Teaching Hospital in Yaoundé visited once a month for consultation. The role of the local civil society was now restricted to compliance (local epidemiologist complies with international organizations while local citizens comply with epidemiologists instructions). The emphasis on access to medication swiftly shifted from preventive strategies in the

[121] For more on the FAAS project see Eboko (2001)
[122] For details on the transformation from FAAS to specialised HIV/AIDS projects see Eboko (2001).

'Health Clubs' to a technical fix (identifying and treating cases) within a FAAS centre. During the fieldwork for this research, not a single functioning health club could be located in schools and the community. In addition, the project was not implemented using the structures of the national health system (provincial and district hospitals and pharmacies). It was implemented in a specialised centre created with funding and guidelines from the global partners mentioned above. When asked why global partners should bypass the provincial delegation for public health, a senior member in the delegation explained as follows:

> 'They (international organizations) work with the government and the Ministry of Health. What we are doing is to ensure that the prices and the treatment costs which are the key to facilitative access to medication, are effectively respected and at the levels and different sectors of the province as well as the essential drug list of the WHO.'[123]

This above quotation suggests that the provincial delegate for public health who is responsible for translating national policies into operational strategies within the province has no direct influence on the national HIV/AIDS programme. Talking to members within the delegation and reading through policy documents and technical reports in the secretariat, it was clear that the delegation strictly operates within the guidelines of the national health system (defined on the WHO/UNICEF-led PHC model). As was discussed in Chapter Five, this seems obvious. The deployment of GHP programmes led to the creation of parallel systems (for HIV/AIDS, malaria and TB). This means that the provincial coordinators of GHP programmes in each of these disease areas effectively represent Provincial Delegates for HIV/AIDS, Malaria and TB respectively. This distinction, as well as HIV/AIDS treatment and control

[123] Interview: Provincial Delegation for Public Health, North West Province.

through the national HIV/AIDS programme are substantiated in the next section.

7.5.3 Specialised treatment centres in the North West Province

Following the launching of the national HIV/AIDS programme in November 2001, the FAAS (and the Health Clubs) were replaced by accredited treatment centres under Provincial HIV/AIDS Control Units. These centres report to the Provincial HIV/AIDS Co-ordinators (who are also representated in the Central Technical Group) and therefore not answerable to the Provincial Delegate for Public Health. The role of the provincial units can be described as follows:

> 'We build the capacity of different HIV/AIDS treatment centres, health units and other sectors that provide access and treatment for HIV/AIDS. Treatment centres provide pre-therapeutic wakeup test and other services to patience and the National HIV/AIDS Programme through our office reimburses their expenses. We recruit, train and pay community agents at different levels who provide home-based care. All our treatment centres do not only offer HIV/AIDS testing and treatment they also offer support programmes and activities, for example to prevent mother-to-child transmission.'[124]

During the process of interviewing the above respondent it became clear that at the provincial level the nature of the PPP approach is dominated by the economistic model. PPPs promoted by GHPs are meant to be mechanisms for public-private cooperation where public, private and civil society partners share the responsibility for financing and delivering a particular public service (Buse and Walt, 2000a, 2000b; Buse and Harmer, 2007). This works in the case of the national committees. The participation of HIV/AIDS patients and other civil society partners is meant to ensure that the human rights narratives

[124] Interview: Provincial HIV/AIDS Control Unit, North West Province

are also taken into account. In the case of the provincial HIV/AIDS programme, what we see is a classic PPP mechanism, known as 'contracting out', where the government defines a particular public service in a contract and pay a private (or NGO) partner that is selected in open competition to deliver the service.

This distinction is clearly evident in the distribution of treatment centres to satisfy the multiple and pluralistic nature of Cameroon's national health system (consisting of public, private, religious and community/NGO health centres and pharmacies). To be eligible as an accredited treatment centre, public hospitals are fully financed by the National HIV/AIDS Programme. However, private, religious and civil society sectors must create a fully equipped site before getting approval to operate as an HIV/AIDS treatment centre. The following owner of a private HIV/AIDS treatment centre explained this process as follows:

> 'We equip our laboratory, train our staff and then invite the national committee to come and inspect. If they are satisfied, you are approved as an HIV/AIDS treatment centre. For public centres, government decides that they want a particular site to be a centre and then provide equipment and staffing. So you can say that we the private hospitals are doing more of a philanthropic activity.'[125]

The above quotation reveal why certain profit-making and civil society health units look to global private and INGO partners associated with the AAI and the EAI for funding support as well as direct support with treatment and care for HIV/AIDS patients and HIV positive persons. Firstly, the high costs of creating and equipping a treatment centre for HIV/AIDS is well beyond the financial

[125] Interview: Bamenda Polytechnic and State Hospitals

limit of most private hospitals, let alone local NGOs, in Cameroon. Most of the non-public health units visited talked about various international organisations from whom they get their funding through grants and proposals.

A variety of cross-partner initiatives under the guidance of various international agencies that use either the 'Accelerating Access' or 'Equitable Access' approaches have been established with non-public hospitals. Their participation is often cited by the national programme as additional support in meeting HIV/AIDS targets; increase the capacity to sustain ART and testing programmes, and promoting the PPP approach. Some of these global partners operate their own parallel treatment centres independently of the national programme committee. They gain their legitimacy as members of the national programme because they participate in meetings organised by the national committee. Some of these initiatives are discussed below.

7.5.4 Parallel HIV/AIDS programmes and activities

As mentioned above, many global partners, in addition to their role as members of the National AIDS Control Committee, implement their own programmes at provincial and district levels. The cases examined here are in no way exclusive, they only serve to highlight the contribution of these parallel initiatives and to highlight the perceived governance challenges.

The role of international CSOs: the case of Medecin Sans Frontiere

As discussed earlier, MSF is one of the most important in international **civil society** partners to the National HIV/AIDS Programme in Cameroon. Its role is not only limited to helping the national programme to procure cheap generic

drugs under the EAI and sharing field experiences with the national committee. MSF also uses its human rights narrative as a justification for operating its own HIV/AIDS treatment and care centres in various parts of the country. According to MSF, the key is to scale up access to medication for the poorest people, rather than spend too much time negotiating partners' interests.

> 'For HIV/AIDS many studies confirm the difference in outcome for people who should pay to enable cost recovery and ensure sustainability. If we focus on this debate no one will be treated. Multi-partner interventions for HIV/AIDS are a much larger scale and very complicated. Each partner has its own agenda, political and operational. These different strategic interests and constraints sometimes weaken coordination mechanisms.'[126]

The above quotation is very interesting. One would expect, from the GHP approach (supported by MSF) that the field experiences of MSF would be of benefit to the national programme in terms of aligning programme objectives and partners' interests. Surprisingly, MSF also bypasses the national programme to work directly with local organisations. Between 2000 and 2002, it initiated projects in selected treatment centres with local community groups in selected regions of the country (MSF, 2002b): 'The doctors of MSF in the field were seeing many patients dying of AIDS. It was the main cause of mortality in some countries. You can do a lot of prevention and support but at the end of the day you see people dying. This is what pushed MSF to get directly involved.'[127]

Clearly, **CSOs** such as MSF also pursue a narrow medical intervention strategy. Talking to employees at the MSF country office in Yaoundé, they noted that the role of MSF is very different in different settings depending on what other partners are doing. However, being a medical organization, the

[126] Ibid
[127] Ibid.

main focus is diagnosis, treatment, follow up and to a limited extent 'preventive and support activity for which we prefer to work in partnerships' (Ibid). On the country-specific relevance of the national HIV/AIDS programme, the position of MSF is that the approach adopted by GHPs was not adapted enough to the field conditions in Cameroon: 'A local response, if done correctly, not like the World Bank put it in place, can create a health system that responds to the needs of those who use it.' [128]

MSF is a strong critic of GHPs such as the AAI; however, its strategic interventions are consistent with the global agenda promoted by GHPs especially in terms of an assumed leadership role for programme implementation to local CSOs which bypasses the bureaucratic structures of the state. In practice, then, their criticisms of governance through a centralised network are not entirely consistent with their actions at the local level.

A complex global-local linkage: the National Social Marketing Programme

This programme was set up in 1989 by a US-based INGO, Population Services International (PSI) with initial funding from USAID. A local NGO, the National Social Marketing Association (NSMA), was created to implement the project. The programme set out a public health approach to fight HIV/AIDS. In practice, however, its initial strategy based on HIV/AIDS prevention increasingly became dominated by the econoministic emphasis on 'marketing strategies to promote cost-recovery sales of condoms rather than the public health issues' (GTZ 2004:3).

[128] Ibid.

The changing nature of the NSMP (Table 13) reveals the complex nature of stakeholder participation in the sense that the local partner (NSMA has to deal with multiple objectives and directives from different western donor agencies simultaneously. There are multiple objectives attached to specific funding sources (e.g. USAID, GTZ and Gates Foundation).

Table 13. Time line of the National Social Marketing Programme

Time	*Local Partner*	*Strategic Objective*	*Funding Agency*
1989 to 1995	PSI & NSMP	Reduce transmission and unwanted pregnancy though cost-recovery sales of condoms and counselling services	USAID
1992	PSI & NSMP	Formal recognition by Ministry of Health as partner to the then national programme in charge of condom distribution	USAIDS
1996 to 2003	NSMP	HIV/AIDS prevention through family planning, community mobilization and social marketing	USAIDS
Since 2001	NSMP	Research and address misconception about condom use to specific target groups with skilfully targeted messages.	Gates Foundation
Since 2001	NSMP	Promote social change and mobilization of vulnerable groups to achieve integrated HIV/AIDS control	GTZ

Source: Based on PSI (2004), GTZ (2004), Handyside et al., (2004)

The programme is cited in all policy documents as a major civil society contributor to the national fight against HIV/AIDS. The use of local NGOs to sell and distribute condoms is consistent with the global human rights agenda for civil society participation. Its support for teenage mothers appears on the spectrum of preventive measures while access to donor funding, mobilization

of households to buy and use condoms, and sensitization programmes with local communities are behavioural measures that serve to overcome taboos and stigmatization, making condom use more sustainable. These are important public health measures that implicitly take human rights principles into account. The influence of the economistic models (the neo-liberal market model advocating bypassing the state) has been described by GTZ (2004:3) as follows:

> 'The understanding that ministries or the public sector should finance and deliver all services is disappearing in favour of a more pluralistic, multi-stakeholder approach. There is now increasing support for ... the family planning franchising model of NSMP. Along the same line (there is) a co-operative health insurance scheme (that) is drawing on the experience of PMSC for its marketing'

More crucially, the nature of funding (bilateral development agencies that are global GHP partners provide funding) is what defines the strategic objectives of the programme rather than the local implementing organizations deciding on the basis of local conditions. Apart from this indirect involvement (providing funding and directives) these programmes overlap with those created by the national programme and also bypass the ministerial structures of the state.

The role of bilateral development agencies: German Development Cooperation

As the official first colonial master of Cameroon, Germany has a long standing bilateral cooperation with Cameroon including health policy (and recently HIV/AIDS[129]). As Germany's official implementing body, the German Development Cooperation (GTZ) has been operating in Cameroon for over 30

[129] For a brief description of GTZ's HIV/AIDS programme in Cameroon see the project website: <http://www.gtz.de/en/weltweit/afrika/kamerun/16978.htm> (Accessed: 15/02/09)

years. It continually aligns Germany's long standing technical cooperation with the mutually agreed priorities of both governments. In the case access to medication, GTZ stresses the need to adopt measures aimed at addressing the very high doctor-to-patient ratio and bottlenecks in the supply of drugs and medical equipment in state-run clinics (GTZ, 2008)[130]. In relation to the fight against HIV/AIDS, 'if the Cameroon government asks the German government for assistance and we think we are able to do so then GTZ is the implementing agency ... GTZ is not a donor.'[131] Thus, although GTZ is a global partner to the national programme (by virtue of being represented in the national committee and attending meetings), it implements its own HIV/AIDS related programmes with community organizations in four provinces (Littoral, South West, North West and Centre provinces) independently of specialised centres created by the national programme:

> 'GTZ executes activities that have been negotiated between the two governments. We collaborate with many referral, faith-based hospitals, self-help groups with HIV/AIDS patients, groups with young mothers to prevent mother to child transmission at the local level. The question as to why we are focused on those sub-sectors is historical but also due to the access situation. ... You have a problem with HIV/AIDS, access to health insurance, drug supply and so on.[132]

The historical motive mentioned in the above quotation relates to the fact that GTZ had already begun implementing its activities before the launching of the globally-backed national HIV/AIDS programme. Instead of promoting a *decentralised coordination* agreed by the national HIV/AIDS committee (of which GTZ is a member), the GTZ favours it own strategic directives.

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[130] GTZ (2008) 'Priority Areas for Cameroon' <http://www.gtz.de/en/weltweit/afrika/kamerun/1311.htm> (22/11/08)
[131] Interview: GTZ
[132] Ibid

> 'One of the most important ideas is that ownership (of HIV/AIDS treatment and control) should belong to the Ministry of Health. Ownership also means dealing, piloting and orienting. The Ministry of Health is not playing this role. I will not say this disrupts the donor treatment but there is still some work to do for the Ministry to really claim influence in global alliances.'[133]

Germany is a major supporter of the community model promoted by the World Bank to correct government and market failures by given more power to the private sector and CSOs. From this perspective, it was observed during the fieldwork that the pharmaceutical supply centre in the North West Province (North West Special Fund for Health) was created with direct technical and financial support from GTZ (a German-Cameroon Project). It is an autonomous parastatal structure operating under the Ministry of Health but whose budgetary allocations are determined by funding from the GTZ and mark-up profits from sales of drugs to provincial and district public and private hospitals. This project reveals key areas in which country-specific challenges were ignored during the creation of the national programme:

> 'Attention was not given to the drug procurement chain (when the national programme was created) because the private structures were set up even before the government set up its own structures (i.e. the CENAME). And when government set up its own structures it failed to give a look at the private structures'[134]

The above quotation illustrates how the GTZ, which claims to offer technical advice to the national HIV/AIDS committee, ignores the need to integrate overlapping programmes. In terms of who is responsible for integration, the position of GTZ is that 'it is the government that is responsible for the national health system, not the partners'[135]. Yet, the national committee is unable to

[133] Interview: GTZ
[134] Interview: North West Special Fund for Health (German-Cameroon Project)
[135] Interview: GTZ

decide let alone supervise the activities of global partners such as GTZ. This criticism is meant to highlight the often overlooked challenges caused by a failure to create a centrally connected national programme promised by GHPs; it does not undermine the enormous contribution of the GTZ in the fight against HIV/AIDS and other diseases in Cameroon.

The same type of discussion can also be made for the French Cooperation, again due to France's position as a former colonial master. Similarly, there are many other overlapping programmes and activities on HIV/AIDS treatment by various bilateral agencies and private foundations that bypass the national programme. By operating in parallel to the existing primary healthcare system, one would expect to see that the institutional instability and corrupt practices would be avoided in the national programme. In addition, the involvement of bilateral agencies and INGOs that were already present in the country in the creation of the national programme ought to imply an integration of their existing programmes and activities to promoting a *decentralised coordination,* defined in the national strategic plan. However, as discussed above, policy implementation focuses on verticalising strategic directives of international organizations, concentration of bilateral development agencies in areas where they have their own strategic interests and the absence of projects in provinces that are not covered by partners.

7.6 Challenges facing the National HIV/AIDS Programme

The analysis from the preceding sections suggests that many of the institutional and healthcare problems in the national health system of Cameroon were

largely ignored in setting up the National HIV/AIDS Programme. The impact of GHPs on access to medication for HIV/AIDS is scattered in technical reports or internet sites of parallel initiatives that are hardly updated. This makes it virtually impossible to compile a comprehensive statistical overview of the burden and prevalence of HIV/AIDS, the number of programmes and activities, the extent and sources of funding and a measurable impact of the programme on HIV/AIDS treatment and control.

However, the few projects described above do illustrate that there is a considerable overlap in the development of the infrastructure necessary for the national HIV/AIDS programme. All the interviewees were aware of the fact that greater impact could have been achieved if programmes and activities were linked more consistently to each other, for instance, within the framework of the national programme. The national normative framework of the national programme as highlighted by the interviewees requires two broad conditions to be satisfied: 1) absorption of resources to meet HIV/AIDS treatment and control targets in relation to the nature of the HIV/AIDS problem and 2) integration of overlapping initiatives into a coherent national HIV/AIDS programme and subsequent integration into a strengthened national health system. This is crucial for 'localizing' the national HIV/AIDS programme.

7.6.1 Participation in the National HIV/AIDS Committee

From policy documents and technical reports, it is evident that there is a fair distribution of power amongst the different partners in the national programme. This is seen in the way global, national and local partners are spread across the programme with no single, dominant player. In addition, the fact that the

national committee is defined as the state is related to the liberal argument about the need for government to be replaced by governance. It reveals that the bureaucratic structures of the state have been eroded with more decision power residing with the committee (policy making) and global promoters of parallel initiatives (policy implementation). While these same observations were made in the national malaria programme (presented in Chapter Six), this case study on the national HIV/AIDS programme reveals how the human right principles of community participation embodied in GHP models are ignored as civil society plays more of a compliance role.

In the area of drug distribution, treatment and diagnosis, the civil society plays a compliance role: 'It has to be CENAME, supported by the state as the main actor; these two will never be outclassed by civil society'[136]. In addition, the role of the CSOs in other areas of policy making is more normative than practical:

> 'Each treatment centre has an ethics committee that includes religious persons, traditional leaders, justice department, etc to propose points for eventual legislation. But sitting fees, transport allowances, etc for the committee to meet are not in place. So this part of the structure of the national HIV/AIDS programme does not function.[137]

Global partners of both the AAI and the EAI models frequently stress that HIV/AIDS patients (including HIV positive persons) should be represented at all levels of policy formulation and implementation. The importance of their participation was acknowledged by all the interviewees; however, the extent of their participation was questioned.

[136] Interview: CENAME
[137] Interview: Bamenda Polytechnic Clinic

> 'People with HIV/AIDS are involved in the central, technical and provincial committees. Firstly, their salaries depend on the committee concerned. None of them could really say publicly that things are not working. Secondly they were relegated to minor roles like distributing posters. So their opinion and contribution was not so much looked into. Those few who tried to speak too much are isolated not only by the government but also sometimes by the local groups.[138]

Clearly, the notion of community participation that has long been promoted as part of the PHC model (WHO and UNICEF), a requirement in the HIPIC Initiative (IMF and World Bank) and the 'Equitable Access' model (MFS) is far from being realised in Cameroon. Civil society groups are not given sufficient opportunity, resources, skills and competence to participate. Most of the interviewees argued that it is the responsibility of the state to ensure that their participation is realised. Yet, the global partners also bypass the state. The influence of multilateral and bilateral institutions seems to override those of the state. This calls into question the broader debate around global-national-local linkages as explored below.

7.6.2 Global-national-local linkages: Is bypassing the state a viable option?

All the participants interviewed in this study share the view that at the global level 'every partner has a clearly defined role so you don't really need a formal governance structure'[139]. The globally-backed scenario is completely different when one shifts the attention from the global to the national (global-national linkage). Pharmaceutical companies within the AAI no longer see drug prices as a major barrier to access to medication at the global level. Their views on the question of access relates to structural problems between the global and the

[138] Interview MSF
[139] Interview: Hoffmann-La Roche

national, in particular, 'the complexity of the whole registration process for medications, taxes, quality controls, supply chain and black markets'.[140] The global-national linkage is supposed to be effective if concentrated between the GHP (both AAI and EAI) and the National HIV/AIDS Programme (the national committee).

Nevertheless, the relationship is made complex by the fact that drug procurement and supply arrangements are based on bilateral negotiations between participating pharmaceutical companies and the CENAME independently of the national committee. Thus, although a formal governance mechanism may seem irrelevant at the global level (as the former quotation above suggests), such a mechanism may actually address structural problems at global levels which have implications at the national level (as the latter quote suggests). The implications for the national programme can be described as follows:

> 'As we try to register some medicines, it is not uncommon for it to take two or more years even after receiving approval from a stringent health authority. Some of our medicines in French-speaking African countries get to the local level but are referred back to be approved in France even though they had already been qualified by the WHO. This adds to the time line which again denies access to medicines at the patient level.'[141]

The issues discussed above are also related to the liberal argument that global programmes are often associated with foreign policy and diplomacy at one level, but also aim to deeply transform the current way of working of the bureaucratic structures and the procedures of the government at the local levels. The global partners share the view that 'the decisions that are more

[140] Interview Bristol-Myers Squibb
[141] Ibid

political, strategic and global are the role of the government in partnership with the global partners.[142] Yet their actions seem to suggest that the opportunities for this to be realised do not exist in the current set up of GHPs at global and national level. The strategy of global partners to create their own transcalar networks that constrain the effectiveness of the national HIV/AIDS programme relates to the fact that the participation of global partners at the national level is voluntary (Dodgson et al., 2002; Slaughter 2004). If this be the case, it is not surprising that the GTZ, a major global partner, is not fully aware of the contributions of the AAI to the national programme in Cameroon: 'I only head about this global health initiative (the AAI) a few months ago. At the level of Cameroon I have not seen much from this initiative. In the near future we hope to get some more information about what the Ministry is considering to do in this context'[143]

The discussion above suggests that the strategic interests of partners, not the shared goal on facilitating access to medication (through drug procurement and supply and developing a health system to deliver programmes) tend to dominate GHP processes. Thus, there is constant attribution and 'blame game' when it comes to responsibility for failures. However, this does not undermine the role of both the AAI and EAI model in facilitating access to medication in Cameroon. The human rights model (EAI) pursued by MSF successfully pushed the UN-proposed economistic model (AAI) to reduce prices of drugs as well as agencies such as WTO to allow the importation of generic drugs that are patent protected. The global legacy of the GHP model is therefore that,

[142] Interview: MSF
[143] Interview: GTZ

affordability is no longer a barrier to access to medication for HIV/AIDS treatment and control in Cameroon. However, accessibility, acceptability and quality of care remain major barriers as well as structural problems with policy making and implementation.

> 'The time has passed to ask this kind of question (drug prices) in the case of Cameroon. The national system with all its strengths and weakness relatively ensures availability of drugs all over the country. The question is how to reinforce the capacity of the system to an extent that it is able to buy its own drugs without subventions coming from donors. In future these costs should be covered by government's own budget.' [144]

The above quotation leads to the question of what is needed to localise GHPs in Cameroon. As explored in the next section, the main barriers to the fight against HIV/AIDS in Cameroon through GHPs are more than the interviewee above (and other systems and participation challenges in the preceding sub-sections) seem to suggest.

7.6.3 Localising the National HIV/AIDS Programme

Despite HIV/AIDS medicines being offered free of charge in Cameroon, the impact and burden of the disease has persistently been on the rise. The main reasons for this relates to the fact that both the AAI and the EAI over emphasise the very narrow public health objective of medical intervention (through specialised treatment and care centres). Behavioural changes related to HIV/AIDS prevention are largely neglected. A combination of unemployment, denial, stigma, poverty, lack of sex education and polygamous marriage practices were cited in chapter five as major causes of the high incidence and burden of HIV/AIDS in Cameroon. All the interviewees studied

[144] Interview GTZ

in this research acknowledge this challenge. A MSF medical doctor explains as follows:

> 'The most recent survey shows that 96% of Cameroonians know about HIV/AIDS and how to prevent it. But from a practical point of view can a married woman ask her husband to use condoms even if she knows that he has a woman outside? There are economic and social issues related to prevention that has not been tackled. Sometimes to change behaviour you need to change the underlying cause of this behaviour.'[145]

From the above quotation, it appears that the current set up of the national programme offers a 'technical fix' based on medical intervention to secure quick results to show to global partners and get more support. Talking about an alternative to this technical solution, sensitization programmes meant to create awareness on preventive measures seem to have had limited impact as well (as the above quotation suggests). The lack of funding is not also a major barrier to HIV/AIDS treatment and control, as it is to absorb the huge amount of funding already available to the national programme. Most of the interviewees pointed to the fact that a major challenge facing the fight against HIV/AIDS through the national programme is the sustainability of funding for the future: 'Even the former Minister of Public Health complained about the capacity to absorb this money. It is up to the country itself to create the conditions for adapting its programmes ... if (the country's) proposal is technically sound then it is accepted (by global partners).[146]

Apart from addressing the behavioural changes and sustainability of funding, localising the national HIV/AIDS programme also requires measures to address institutional challenges (Table 14): 'The first problem is the

[145] Interview MSF
[146] Interview with MSF

availability of actual figures about the HIV/AIDS epidemic';[147] 'decisions should be decentralised'[148]; 'there is no sanction and there are people and programmes in places they should not be'[149] Obviously, there is a role for all actors in resolving these challenges with the national government ensuring effective coordination in partnership with the global and local partners. Ultimately, all the partners must be willing to participate in these efforts in the same way as they freely acknowledge the need to resolve these challenges.

Table 14 Institutional challenges facing the HIV/AIDS programme

Objectives	Major barriers	Recommendation
Delivery of service	Insufficient equipment in decentralised structure	Improvements in staff training and equipping treatment centres
Resistance to treatment	The time a patient has to wait before receiving treatment, care and support services	Improve attitude of health staff to combat illicit payments for preferential treatment and to better combat stigma and forgetfulness
Monitoring & Evaluation	Distorted data on incidence, impact, and requirements	Improve transport, documentation and information systems
Timing of services	Delays in the reimbursement of treatment centres	Improve predictability that funding/drugs will be available on time

Source: Author's processing of interview materials

The consequences of the above challenges as well as the structural weaknesses associated with overlapping initiatives seriously distort implementation efforts. All the initiators of overlapping initiatives claim to have created treatment programmes that involve dialogue processes that satisfy the human rights and public health elements of community participation. However, the provinces

[147] Interview GTZ
[148] Expressed: North West Provincial HIV/AIDS Unit
[149] Interview: CENAME

and the districts still have the centralized administrative structures of the ministry of public health. This implies that ministerial decisions (such as recruitment of health personal) often lead to short-term relocation of staff as well as competition for skilled staff between the programmes.

Another structural issue is related to corruption, bad leadership and defective institutions, tactics used by global partners to push forward community participation as a key element within the GHP model. While the general consensus was that corrupt practices is a matter of state officials, several studies on Cameroon had already demonstrated that CSOs also practice rent-seeking behaviour by acting as brokers and confiscating the value-added to development projects (Baye, 1998; Tafa and Asondo, 2000). The evidence from this case study reveals that corruption is a serious societal problem in Cameroon.

> 'The huge amount of money around HIV/AIDS did not help. Many local people who worked in the HIV/AIDS programme came out just for the money while those who were more credible and working initially (before the funding came) were never financed. But there are other grassroots initiatives that worked very well and I believe in them.'[150]

As mentioned in chapter five, senior government authorities are also being linked to mismanagement of funds allocated to the national HIV/AIDS programme. One interviewee noted that the 'global partners are disappointed because of embezzlement by government officials. Some of them have been arrested and locked up by the government; some have been forced to leave the country, and so on. They also wanted some authorities within the programme

[150] Interview with MSF

to be replaced and things like that.' [151] Global partners who bypass the state are faced with corruption at local levels, yet community organizations look up to global partners to put pressure on the government to solve the problem of corruption. It also emphasizes the need for programme integration to facilitate trickling down of money and at the same time identifying specific areas where corruption is rampant. It was observed that the relation between the state and the civil society is quite problematic due to unequal power relations and the poverty situation.

> 'This is the vicious cycle when you talk about community-based organizations, organizations for people with HIV/AIDS and so on. They are too dependent on the government to get money and so most of the time their mouths are shut. Global partners and donors should be much more rigorous in asking for results. They should be much more in the field and understand what is going on.'[152]

The above view was shared by all the interviewees at the local levels. However, it is the view of global institutions that global partners should not, and do not intervene in the domestic affairs of a country. In practice, however, in the case of Cameroon, this is not the case. There are enormous global interventions in ways that create more governance challenges than it solve.

7.7 Conclusion

This chapter has explored the role of the AAI and the EAI, both examples of GHP models, in shaping HIV/AIDS policy practices in Cameroon. At the global level each GHP exists in parallel to each other. At the national level the initiators of both initiatives are global partners of the National HIV/AIDS Programme and it is this involvement that enables them to emphasise their own

[151] Interview North West Provincial HIV/AIDS Unit
[152] Interview MSF

narrative strategies on access to medication in influencing national HIV/AIDS policy formulation and implementation. Just as the malaria case study presented in chapter six, the analysis in this chapter reveals how public health, economistic and human rights ideas embodied within the AAI and the EAI shape different elements of the national HIV/AIDS programme. The chapter therefore provides another case study from which to understand the nature of GHP models both in terms of stakeholder participation, the extent to which the models deal with the barriers to access to medication for HIV/AIDS and the effectiveness of transcalar networks created as a result of deploying the model to shape HIV/AIDS policy practices in Cameroon.

The evidence from this chapter is consistent with the global activism, which favours the view that the key factor determining the nature of GHPs in the case of HIV/AIDS is the human rights needs of the poor. This is reflected in several areas of national policy formulation and local implementation processes in Cameroon. As discussed in chapter four, both AAI and EAI state explicitly the human rights need of the poor in terms of ensuring that the poorest and most vulnerable persons can access treatment irrespective of ability to pay. On the basis of this global activism, negotiations take place between global, national and local partners through a process dominated by the economistic narrative (drug prices and supply arrangements). This initial agreement sets up follow-up processes leading to the creation of the National HIV/AIDS Programme. At this stage we continue to see the dominance of the economistic narrative in the practical steps involved in formulating and implementing policies.

To join both AAI and EAI, Cameroon simply had to sign two separate accords with the global initiators before going on to create implementation systems at the national and local levels. The economistic narrative is the key factor determining the practical nature of national GHP programmes. There is an overemphasis on the prices and costs of treatment. Scaling up access to HIV/AIDS medication (framed in terms of access to ARTs, diagnostic equipments and care facilities) appears to overshadow the requirements to strengthen the national health system. We have seen how specialised centres have been created through the national HIV/AIDS programme to operate independently of the existing public health system as both are now being treated as competing priorities. It was even suggested by some interviewees that the nature of the dialogue processes within the AAI are reflective of specific agreements rather than PPPs since the discussions is dominated by drug procurement and local distribution rather than a comprehensive public health package. In addition, the largest share of funding provided by the World Bank and Global Fund are tied to drug procurement and reimbursement of treatment costs incurred by specialised treatment centres.

There is evidence of some interactive policy transfer within the national HIV/AIDS committee. Apart from UN agencies, global partners such as bilateral development agencies and international NGOs (e.g. MSF) exchange ideas with national and local partners on 'best practices', 'field experiences' to help inform situational analysis, prepare grant proposals and create treatment centres. A key element of the human rights narrative is also taken very seriously, namely, the notion of community participation. Representatives of

local public, private and community groups participate in the dialogue process. This is what gives such a GHP approach the transcalar network character, with the national committee consisting of global, national and local partners with an interest in the fight against HIV/AIDS in Cameroon. In fact, it is a requirement for HIV/AIDS positive persons and AIDS patients to belong to committees at national and local levels. In this way, the GHP model attempts to align the public health (WHO and UNICEF), economistic (World Bank, bilateral development Agencies and private partners) and human rights (CSOs) narratives into Cameroon's national HIV/AIDS programme in which non-state actors are increasingly playing key roles in the policy processes.

The outcome of policy discussions within the national HIV/AIDS committee suggests that the notion of participation is more of a formality than of any major contribution to the policy process. As the discussions on the barriers to access to medication suggests, one would expect that the dominance of the economistic narrative on access to medication (the drugs, the prices and the costs of treatment) would be balanced by the need to address behavioural change (issues related to HIV/AIDS prevention). Despite the emphasis on robust grant proposal that take economistic, public health and human rights needs into account, this does not translate into effective policy implementation. All the participants interviewed even acknowledged that drug prices and cost of treatment is no longer a major barrier to access to medication as treatment is now free of charge throughout the country.

Yet, in the case of AAI the focus is to secure funding to procure patent-protected drugs from designated pharmaceutical companies. Similarly, in the case of EAI, the human rights rhetoric (the need for equitable access to medication) is used to cover up an economistic emphasis on generic competition to secure drugs from preferred generic manufactures in order to pursue their medical intervention strategy at local levels. All the participants interviewed for this study acknowledged the fact that more could have been achieved if the focus was placed on HIV/AIDS prevention. However, while the national and local partners blame the global partners for this policy mismatch, the global partners argue that it is the responsibility of the state to address such issues.

At the local level, the shift from a public health emphasis to the narrow focus on a global medical strategy is therefore more evident. In this context the GHP model in the case of HIV/AIDS appears to be succeeding. Actual access to medication for the poor has been made possible as diagnosis and treatment are now offered free of charge in Cameroon. This is seen from the fact that ARTs are now offered at no cost to patients while an increased number of specialised treatment centres have been created throughout the country including some rural villages. In addition, there is also strong evidence of the high level awareness of the causes and effects of the HIV/AIDS resulting from the mass campaigns and sensitisation programmes. However, the GHP approach appears to be failing to address potential access to medication. The incidence and burden of HIV/AIDS has continued to rise. The number of people dying of the disease is increasing, the rate of HIV/AIDS is also on the rise with a

consequent burden (e.g. shortage of staff and equipment to cope with high numbers of consultations) on specialise treatment centres.

The complex nature of the transcalar network created as a result of the endorsement of both AAI and EAI also becomes evident at the local level. Specialised treatments centres operating within the country are supposed to be answerable to the Central Technical Group. In reality however, several parallel centres have been created with funding from specific global partners and are therefore answerable to such donor organizations (rather than the Central Technical Group). In this context the strategic interests of the different partners tend to overshadow the reality of treatment and care programmes being undertaken. For example, all the partners favour a national programme that reaches out to all the different stakeholders at the local level including coordination mechanisms, involvement of the local community (especially HIV/AIDS patients and HIV/AIDS positive persons). The structure of the national programme is suited to achieve this, with the national committee formulating policies and the central technical group implementing them. However, with global partners running their own HIV/AIDS programmes through their affiliated NGOs and private foundations in areas of the country where they have their own strategic interests, the Central Technical Group is unable to perform the role of coordinator at local levels. These parallel initiatives bypass the structures of the national programme (despite being members of the national committee) and the actors involved are so interwoven that it is difficult to clearly describe the global-national-local linkages involved in shaping national policy practices at local levels.

The evidence in this chapter also reveals crucial similarities to the national malaria programme presented in Chapter Six. A comparison of the two case studies further reveals the role of GHPs on access to medication in Cameroon. Through GHPs, global health policies for malaria and HIV/AIDS respectively, are transferred to Cameroon through a consensual dialogue process involving global, national and local partners. The dialogue takes place within the National Programme Committees for each of these disease areas. Within this network, global health policies are negotiated on the basis of the strategic orientation of specific GHPs. Global and regional targets are set and then dialogue processes are set up within the national committee to develop the national systems for implementation.

The problem of overlapping initiatives is common in both programmes. What is common among overlapping initiatives is that they represent pre-existing projects that have been re-aligned to reflect the narrow objectives of GHPs. Parallel and overlapping initiatives such as this help upgrade equipment; improve education campaigns and family-planning programmes, including supply of drugs and medical equipment. However, international partners use the agency of GHPs to bypass the state (both the structures of the ministry of health and the national committees). In fact, old (the PHC system) and new (national GHP programmes) institutions and programmes operate parallel to each other, achieving actual access but failing to address potential access to medication (as one would expect from a comprehensive public health package that emphasises a strengthened national health system). There is a complex array of local partner who have to deal with multiple economistic (e.g. funding)

objectives and technical directives from different international agencies rather than the consensual policy framework agreed by the national committee. This was seen by some interviewees as a major cause of corruption and mismanagement, persistent structural problems within Cameroon that the GHP model is failing to address. The importance of the GHP framework is seen from the fact that it reinvigorated political commitment in the fight against malaria and HIV/AIDS by providing several opportunities for continued dialogue to coordinate the efforts of public, private and civil society sectors (especially empowering the civil society and involving supporting government ministries). The policy implications of the above issues are explored further in the conclusion.

CHAPTER 8: CONCLUSIONS

8.1 Introduction

This thesis argues that to better understand the role of GHPs as facilitators of access to medication in developing countries, they should be conceptualised as 'models' that occupy the intermediate position between theory and policy practices. GHPs have emerged as a way of dealing with both the presenting problem of access to medication, and organisational and multi-stakeholder challenges to develop and implement such a practice. As such they offer a new and interesting model of mixed-stakeholder interventions. Such interventions take place in hybrid networks animated by global-national-local linkages, what can be termed transcalar networks. The key understanding that emerges from this thesis is that it is the interplay of development models embodied within the GHP model and the strategic interests of their global promoters that ultimately determine the construction of access to medication by specific GHPs and the nature of transcalar networks created to achieve it.

The empirical evidence from this thesis supports a critical evaluation. GHPs emphasise specific medical intervention programmes, and are more effective in this narrow technical sense. Even though their efforts have not reduced the incidence and burden of malaria and HIV/AIDS, they have legitimised the direct intervention of international development agencies, private corporations and CSOs at the local level. The GHPs' pursuit of 'quick results' has fragmented the national health system and undermined the capacity of the state. This thesis proposes that the key to reducing disease burden and improving

public health is a strengthened national health system, one that the GHP model does not currently offer. Developed to address the supposed failure of African states to ensure access to medication, GHPs have further marginalised the role of the Cameroon state, so reducing its capacity to protect and advance the health of its citizens.

To substantiate the above findings, this thesis investigated 1) the global and national (country-specific) perspectives on the emergence of GHPs as facilitators of access to medication, 2) the role of the GHP model in determining national policy and local practices aimed at facilitating access to medication for the poor and most vulnerable population and 3) the conceptualization of the theoretical and empirical challenges associated with such a hybrid network. These are presented in the case of GHPs created to combat malaria and HIV/AIDS (the global perspective) and Cameroon's attempt to deploy the GHP model to develop the institutional capacity necessary to become successful in the fight against these diseases (the national and local perspectives). The next section of this chapter presents a synopsis of the key findings of this thesis and the evidence presented in support of each. This is followed by a discussion of the policy implications of the GHP model for the future fight against disease pandemics in developing countries such as Cameroon. Finally, the contribution of this thesis to the theory and research on global institutions are summarised with suggestions for further studies.

8.2 Synopsis

The first specific research question explored in this thesis relates to the best approach to conceptualise and study the role of GHPs on access to medication.

Existing research on global institutions such as GHPs has not fully explored how the dynamics of the deployment of GHP programmes in developing countries embody issues that go well beyond facilitating access to medical technology. More critically, this thesis stresses the need to unpack the relationship between GHPs and access to medication, not only in terms of their respective meanings and conceptualisations, but also the context in which GHPs emerged as facilitators of access to medication at global and country levels. While many existing contributions in the field of development, international relations and policy studies are relevant to the issues of interests in this research, it is argued that the characteristics of the present study are suggestive of the emergence of a new form of intertwining of medical technology, global institutions and their networks, national policy practices and the public health needs of the poorest people in society for which an interdisciplinary and theoretically distinctive approach is needed.

Chapter Two presents such an interdisciplinary theoretical framework building on the need to consider as equally important, both potential (the presence of an enabling healthcare environment) and actual (the use of pharmaceutical and healthcare delivery services) access to medication (Ngoasong, 2009) when understanding the role of GHPs. The theoretical framework draws on the literature on models and the notion of embodied knowledge found in STS and social constructionist International Relations. This interdisciplinary approach enables us to unpack the systematic forms of knowledge (MacKenzie, 2006) deployed in health technology and with their social infrastructure (Kallon,

1991), issues that remain normative in most previous studies on GHPs highlighted in chapter one.

In terms of models (Cartwright, 1983; Morrison and Morgan, 1999), the theoretical framework used in this research argues that the GHP model is based on integrating different theoretical models from public health, economics and human rights to produce a global 'activism' or collective story on access to medication, including opportunities to introduce new elements to better reflect practice settings. Analytically, the social constructivist approach (Boas and McNeil, 2004), a version of social science for analysing global institutions is adopted. On the basis of this approach, the notion of transcalar networks is introduced to describe the 'social spaces' through which global-national-local interactions take place in a GHP context while narrative policy analysis (NPA) (Ngoasong, 2009) provides a useful tool. Thus, we side-step into different disciplines to provide an interdisciplinary framework for analysing the ways in which public health, economistic and human rights narratives narratives (forms of knowledge) put forward by GHPs partners are embodied within a GHP model and how the narratives shape national policies and local practices on access to medication.

In the late 1990s advocates of 'global health' had already began to suggest that globalization is increasingly causing 'altruism' and enlightened self-interest to converge (Yach and Bettcher, 1998). The 'knowledge (or narrative) approach' developed in chapter two enables us to explore the extent and nature of this convergence within the rhetoric of GHPs and access to medication. We have

been able to substantiate claims that GHPs can only be seen as successful if their proposed policies are consistent with country-specific contexts (Buse and Walt, 2000b; Buse, 2004; Caines et al., 2004). We also realise that although GHPs are of a practical nature, they are implicitly theory-informed and this provides the basis on which they can be studied as the embodiment of development models. Accordingly, the thesis demonstrates three further benefits for adopting a knowledge approach. First, it enables us to present a distinctive conceptualisation of what the GHP model embodies as a global actor within the realm of government in an African country. Second, how the GHP model is implicated in the shifting of the boundaries of the state, its networking with civil society and the changing nature of North-South relationships (described by the characteristics of transcalar networks). Finally, the potential for modalities of achieving sustainable access to medication through a GHP approach are critically examined.

The third chapter highlighted the need to use the social constructivist approach to build on the interpretive case study methodology informed by NPA (Kaplan 1986, Krieger 1986, Roe 1989, Feldman et al., 2004) when researching GHPs (e.g. Ngoasong, 2009). The qualitative case study methodology was adopted. The social spaces in which GHP programmes are enacted was extrapolated by combining the analytical and theoretical tools, targeted qualitative interviews and analysis of policy documents and technical reports to understand the phenomenon under investigation. This has been illustrated in two case studies on the role of GHP models in shaping the health sector reforms and local pharmaceutical and healthcare delivery practices in Cameroon. The case

studies reveal how the GHP model was used to create two National GHP Programmes (for HIV/AIDS and malaria respectively) and how the programmes attempted to achieve *'universal access'* to medication by shaping national and local policy practices for their target diseases.

As presented in Chapter two, the emergence of GHPs can be linked to access to medication. GHPs aim to 'foster collaboration with the private industry' and harness 'the resources to address global health issues and the challenges posed by globalization' (Ngoasong, 2009:952). This is the major global challenge to achieving access to medication in developing countries[153]. Chapter four presents the global perspective on how GHPs are modelled to achieve this goal. It argues that it is the corporatist way in which development models are negotiated through the work of UN agencies and other international private and CSOs that determine the nature of GHPs at the global level.

Different forms of knowledge located within public health, economistic and human rights models of health development are expressed as narratives (such as plots and colourful language) in GHP settings. They are either 'evidence-based' (were 'best practices' and 'lessons learned' are taken from other settings), promises of funding or civil society activism. The chapter link the three narratives to specific global actors to better understand how the creation of a hybrid narrative is essential to hold together new hybrid structures within the GHP network. The economistic narrative is very explicitly expressed (in

[153] Chataway and Smith (2006) have investigated these issues in the case of the International AIDS Vaccine Initiative (IAVI), a Product Development Partnership that also has characteristics of GHPs (Buse and Harmer, 2007). However, while they focus on product development, the case studies in this thesis focus on the development and implementation of national programmes through a GHP approach.

terms of drug prices, supply arrangements, patent-protection, generic competition), the human rights narrative is captured in the very nature of the global activism (that every human being should have access to treatment irrespective of ability to pay) while the public health narrative appears to be withering as the medical model overrides preventive measures. The three narratives are the key factors determining the nature of the GHP model and the involvement of various stakeholders at the global level.

As promoters of the Primary Health Care (PHC) model, the WHO and UNICEF are associated with a public health narrative emphasising a strengthened national health system; the WTO is associated with the TRIPS model (patent-protected medicines) and the IMF/World Bank with neo-liberal market models (privatisation and liberalization) both of which are economistic; the human rights narratives are rooted on the Universal Declaration of Human Rights (UNDHR), later taken up by international CSOs. These global institutions then mobilise their affiliated public, private and CSO partners to support the GHP effort at different levels of action. This is what gives the GHP model the type of global public-private partnership (GPPP) characteristic described in Buse and Walt (2000a). In terms of the theoretical framework developed in chapter two, this also explains the role of theory in the development of the GHP model at global level.

Thus, at the global level, we see the integration of distinctive and complex narratives each of which plays a role in formulating GHPs. From this context, the GHP model is an 'instrument' (Morgan and Morrison, 1992) whose

representative nature provides the tools with which the relationship between public health, economic and human rights theoretical models of health development can be better understood in the context of globalization. Evidence of the influence of the narratives derived from of these three models can be observed in the way that developmental twists and turns in the core narratives are paralleled and reflected in their application in the GHP settings. There is a strong rhetorical emphasis on human rights, defined implicitly in terms of resource constraints – the relationship between poverty and access to medication. This is expressed through statements such as the following by a senior director of GlaxoSmithKline:

> 'There are no easy solutions to the challenge of providing access to sustainable healthcare in developing countries ... lack of resources can be no excuse for lack of action. An effective global response is needed, and needed now'.[154]

Accordingly, the GHP model is innovative. It is not an 'answer machine' for global policy makers as scientific and management literature would suggest. It is a model that is different from previous approaches because it reflects the integration of elements of previous public health, economistic and human rights models (expressed as narratives) into a single global model and a single global strategy to facilitate access to medication for specific disease areas. The GHP model can be seen as a hybrid network of social institutions or what Chataway et al., (2007) call social technologies. It is on this basis that the GHP model is studied in this thesis as 'an engine of enquiry' (MacKenzie, 2006) in order to understand the links among the different actors and their narrative strategies in shaping policy practices on access to medication.

[154] GSK (2005) Statement by Peter Bains, Senior Vice President, International Commercial Development GlaxoSmithKline to the European Parliament's Committee on International Trade Hearing on TRIPS and Access to Medicines, Brussels, 18 January 2005

From a practical (or interactive) point of view, at the global level, the GHP model is a 'political weapon' (King and Kraemer, 1992) used by actors to reconcile their conflicting interests and to establish a common ground on which variables are included or excluded from policies to achieve access to medication. The economistic models tends to dominate, as manifested by the strong interests of the pharmaceutical industry (who seek to protect their market position and secure profitability by patent protection and R&D for drug development) and the need to mobilize funding (through global institutions such as the Global Fund) to achieve affordability and accessibility of medicines.

The case of the three GHPs described in Chapter four supports the argument above. The RBM like the WHO and UNICEF is meant to be a technical partnership that advices government on best public health practices; however, powerful pharmaceutical companies such as Norvatis with an interest in discounted drug pricing makes the RBM too medically focused. The strong influence of western pharmaceutical companies and UNAIDS implies that the AAI appears to be a corporatist movement to supply discounted ARVs and related medicines. Although CSOs such as MSF use human rights arguments to challenge the economistic model of discounted pricing, they seek to promote generic competition which ultimately represents another kind of economistic model (achieving price reductions by procuring from generic manufacturers). Accordingly, the role of the previously popular PHC model has been reduced

to specific medical interventions rather than good public health and health promotion.

The second research question focuses on how the global perspective on the emergence of GHPs relates to the history of the political economy of health development in Cameroon. As detailed in Chapter five Cameroon's efforts to deploy GHP programmes is a combination of three factors: a response to the failures of public health and economic development models mentioned above, international pressure for reforms (such as securing donor support and getting its mounting external debts cancelled by the IMF and World Bank) and more critically, a strategy of the survival of the state. The international dimension of policy placed enormous pressure on the state, prevented it from acting autonomously and ultimately created governance gaps in the system, now labelled in development studies literature as government (rather than interventionary) failures. From this context, the GHP model can be seen as an 'alternative', one that is attractive because of the 'profecies' (Danzig, 1979:6) that it can successfully respond to 'government and market failures to provide public goods to the poorest and most vulnerable people' (Ngoasong, 2009:952). To achieve this, the functions of the state through the bureaucratic structures of the Ministry of Public Health have been replaced by parallel and overlapping National GHP Programmes for malaria, HIV/AIDS and TB respectively. Each programme is not directly answerable to the state (through the Minister of Public Health); each is answerable to a National Disease Committee consisting of global, national and local partners for that specific disease. As a result of this, a sovereign state that seeks to improve the health of

its citizens no longer has the autonomy to regulate pharmaceutical and healthcare delivery, as well as steer and coordinate the network of actors in global health due to the complex characteristic of North-South relationships in GHP programmes.

The discussion in Chapter five reveals that National Disease Committees appear to blur the North-South divide. In particular, the notion of PPPs embodied in the GHPs model redefines the role of the state from one based on 'state-centric bureaucracy' to one that can be termed a 'hybridization of governance' (Dodgson et al., 2002). For the first time, global, national and local public, private and civil society partners with often competing public health, economistic and human rights interests sit around the same table (in the National GHP Committees) to formulate and implement policy. Most notably, a powerful role has been allocated to international and local CSOs as a means of addressing governance challenges caused by state failures. This new kind of participation is different from transnational networks that were characterised by state-centric donor-recipient commitments built around government ministries. The current GHP network is what is described in this thesis as a transcalar network, in the sense that it cuts across the global-national-local boundaries. It can be seen as some sort of multi-actor governance (Utting and Zammit, 2006) to address the democratic deficits in 'weak states' (Dodgson, et al., 2002). As demonstrated in chapter five, Cameroon is an example of a weak state (as evident in the widespread corruption and government failures), one that necessitates the intervention of GHPs to bypass areas of government failures to better serve the poor. This suggests that national GHP programme

partners need to be fully accountable to the national disease committees, thereby correcting existing governance challenges and achieving access to medication. There are many transcalar networks as there are national GHPs programmes. The nature and effectiveness of these networks is the basis of the empirical case studies in this thesis.

GHPs are transcalar networks consisting of the types of global actors mentioned earlier and representatives of state and non-state actors in Cameroon. Each national GHP programme has similar types of networks although and each focuses on a specific disease area (such as HIV/AIDS, malaria and TB). National GHP programmes are meant to introduce new policies, new delivery systems and products, and bring in a new ranges of partners into policy practices in poor countries. Bringing in a new range of actors to either replace or compliment the state's public health services in policy implementation is a different model from the former state-dominated one (although the non-state sector – purely private, religious missions, and civil society hospitals and pharmacies – were already operating parallel services before the creation of national GHP programmes).

Thus, at the country level, transcalar networks enable us to discuss the relationship between the GHP model and policy practices. It reveals the social spaces through which global-national-local linkages are formed and interactions take place. It therefore enables us to analyse the mechanisms through which policy making and implementation takes place (how models shape policy practices). Chapters Six and Seven present two empirical case

studies on national GHP programmes for malaria and HIV/AIDS in Cameroon respectively. In particular, the chapters examine the practical steps used by GHPs to achieve their country-specific global targets focusing on the role of the embodiment of elements of development models in GHPs and the effectiveness of transcalar networks created to formulate and implement policies.

Chapter Six presents the first case study on the National Malaria Programme created after the Cameroon government endorsed the Roll Back Malaria Partnership. As a GHP, the RBM claims to offer a global public health response to previously failed attempts at malaria eradication. RBM explicitly attempts to 'strengthen national health systems to deliver improved malaria treatment and control outcomes' (WHO, 2000a). Interwoven within the analysis of the RBM model, however, is an examination of the conflict between three ideal narrative strategies (economistic, public health and human rights), for understanding the role of GHPs on access to medication.

The distinctive claim of the RBM is that malaria mortality can be reduced by 60% in African countries such as Cameroon by 2010 (and again by 2015) through a global response (WHO, 2000a). To achieve this objective, it sets out to address the complexity of the root causes of malaria transmission through early detection and response; improved and prompt access to effective anti-malaria medication and other locally appropriate means of vector control focusing on pregnant women and children (WHO/UNICEF 2005a:Xi).

However, the case study reveals that the RBM is far from achieving its objectives.

The over-riding influence of the economistic narrative leads to an emphasis on access to medicines (in terms of affordability and availability of ITNs and ACTs). Although ITNs is presented as a medical model, it serves as a preventive measure in line with the RBM's objective of creating a mosquito-free zone in Africa (UN, 2000a). However, the case study suggests that there is limited attention given to a public health package that would strengthen the national health system as a whole to address accessibility, quality of care and preventive measures. This is evident in the fact that the incidence and burden of malaria continues to rise and the disease was still considered by all the participants interviewed in this thesis as the number one cause of death (in comparison with disease such as HIV/AIDS) in Cameroon.

The second case study presented in Chapter Seven examines the National HIV/AIDS Programme created after the Cameroon government endorsed two GHPs – the industry-led AAI and the CSO-led EAI. Initiated by five UN agencies and seven western pharmaceutical companies (under the leadership of UNAIDS), the AAI distinctively claims that the solution to the HIV/AIDS pandemic in developing countries lies in making discounted patent-protected drugs more affordable and accessible, and in developing a proper health system to deliver treatment. However, this narrative stand was firmly challenged by the human rights orientation of the EAI model which favours the use of generic competition to better serve the needs of the poor. By bundling both models,

Cameroon's national programme currently offers treatment for HIV/AIDS free of charge throughout the country and Cameroon was already being hailed by the initiators of the two GHPs as a global success story in the fight against HIV/AIDS (UNAIDS/WHO, 2002; MSF 2002). While these GHPs claim such credits, the incidence and burden of the disease has not declined. In practice, both global models tend to focus too much on medical intervention with less attention being paid to public health measures such as behaviour changes related to HIV/AIDS prevention through healthy lifestyles as well as structural issues related to health system strengthening.

8.3 Comparative Analysis of the Malaria and HIV/AIDS Programmes

This section presents a comparative analysis of the two case studies presented in chapters six and seven on malaria and HIV/AIDS respectively. The emphasis is placed on the key factors determining the nature of the GHP model, the associated transcalar networks linking global, national and local partners and the effects on malaria and HIV/AIDSs policy making and implementation.

A major role of GHPs is to help formulate and implement national health policies. In both the malaria and HIV/AIDS programmes, the global activism described in chapter four is used to convince national and local partners that a focus on specific medical intervention programmes is the key to achieving access to medication for malaria and HIV/AIDS. The RBM sets a global and

regional (Abuja Declaration) targets (e.g. 60% reduction in malaria deaths) thereby initiating dialogue processes with national governments and local groups within the national malaria committee to develop the systems for implementation. Similarly, the government signed an accord with pharmaceutical companies (endorsing the AAI) and endorse the EAI in a MSF-led international conference before finalising launching of the national HIV/AIDS programme to reflect the guidelines of both. From the above contexts, the GHP model is a 'political weapon' used to identify positive (and discard negative) aspects of policies and to make decisions likely to achieve sensible (or acceptable) outcomes.

At the country level the dialogue processes in which policies are negotiated, adopted and/or adapted are evident in the two case studies. Each programme has a separate national committee and each shows characteristics of transcalar networks. Global, national and local actors are not only represented in the committee, but have a chance to present their own narratives on where the emphasis should be placed on measures to achieve access to medication. The competing and conflicting nature of public health, economistic and human rights requirements suggests that policy issues are negotiated based on big stories, promises and colourful language rather than rational planning.

For example, malaria and HIV/AIDS policies no longer reflect the 'evidence-based' or 'lessons learned' perspectives promoted by the WHO and UNICEF in the 1980s and 90s. Successful policy transfer is now defined in terms of the rapid and continuous decline in the prices of medicines and related products at

global and local levels, the increasing number of treatment centres and points of access (especially in rural areas), the high success rate of Cameroon's grant proposals (such as those to the Global Fund), the mobilization of funding by supporting ministries in line with the World Bank's Debt Initiative, the direct involvement of multiple international and local CSOs in policy making and service delivery. The evidence from the malaria and HIV/AIDS programmes reveal that GHPs have been quite successful in achieving these objectives. Clearly, sensible or acceptable outcomes are therefore the key in dermining policy transfer in a GHP context. Such achievements are evidence of the 'important frameworks ... and opportunities for continued dialogue to coordinate the efforts of public, private and civil society sectors' (Ngoasong, 2009:955) offered by the GHP model.

However, the case studies further demonstrate that the GHP model as it is currently being implemented may not strengthen the national health system in Cameroon, supporting instead the conclusion that the economistic interests of global actors override the public health and human rights needs of the poor. Compared to the amount of funding and commitment channelled to specific medical intervention programmes (drug procurement and supply arrangements, construction of treatment sites and points of access, training of local NGOs to sell/distribute mosquito nets and sponsoring policy and evaluation meetings), few incentives have been put in place to address behavioural and structural factors relating to disease prevention (even WHO/UNICEF-initiated hygiene and sanitation programmes that used to exist in almost all primary and secondary schools in the country through health clubs and other programmes

have closed due to a lack of both sponsorship and advocacy). This is an area in which one would expect to see the human rights claims (which is also implicit in the PHC model) coming into play.

In addition, the human rights narrative on community participation is manifested through an overemphasis on elected community members to be represented in national and local committee and/or selling (or distributing) medicines and related products to community members. There is a relatively limited attention to interact with local communities to ensure that communities are primarily responsible towards hygiene and sanitation before medical interventions. Most of the global partners justified this along the lines of the following quotation: 'you can do a lot of preventive activities ... but at the end of the day you see a lot of people dying of HIV/AIDS ... this makes us to focus on the medical side more strongly'.[155] This is an example of the type of 'colourful language' used by global partners to convince the national and local level partners to embrace the medical model. However, this approach questions the extent to which GHP models serve as a partnership between global, national and local partners (as national and local partners seem to be playing more of a compliance role in the 'big' policy decisions).

Furthermore, the national health system has been seriously fragmented by the existence of multiple transcalar networks created as a result of the deployment of GHP programmes. GHP programmes exist in parallel to each other and operate independently of the Ministry of Public Health (whose role as

[155] Interview with MSF

coordinator has been reduced to other 'neglected' diseases). As required by the state-centric PHC model (described in chapter five), healthcare delivery programmes in rural and urban areas are accountable to the Ministry of Public Health through the ten Provincial Delegations in the country. However, the GHP model bypasses this bureaucratic system. In each province, a Provincial Delegate for Public Health (answerable to the Ministry of Health) operates in parallel to Provincial Disease Control Coordinators (for each of the HIV/AIDS and malaria programmes). These two programmes are instead answerable to the National Committees (through Central Technical Group). Similarly, several international agencies work directly with local NGOs to serve hard-to-reach communities, but they overlap with programmes agreed by the national committees. Crucially, such initiatives are still being tied to traditional donor-recipient commitments, instead of trusting them to the various Central Technical Groups (at provincial level) designated by national committees to coordinate activities agreed by national GHP programmes. These are examples of how GHPs bypass the bureaucratic structures of the state in an attempt to achieve 'quick results' on access to medication.

The two case studies also reveal how the complex and interwoven nature of transcalar networks, in the case of national GHP programmes, weaken implementation, promote corruption and distort monitoring and evaluation mechanisms created by the GHP model. By operating in parallel to the existing primary healthcare system, one would expect to see that the institutional instability and corrupt practices of the late 1980s and 1990s would be avoided in the National GHP Programmes. Donor such as the Global Fund and the

World Bank even put good governance and anti-corruption measures as a requirement to the funding they provide to malaria and HIV/AIDS programmes. Crucially, the transcalar structure of the National Committees is suited to achieve good governance, with global, national and local partners represented (and the global partners asking for robust accountability mechanisms when providing funding). Yet, at the level of implementation, specific programmes continue to be determined on the basis of strategic North-South transnational interests. For example, due to their long standing interests as former colonial masters, western development agencies such as the French Cooperation, the German Development Agency (GTZ) continue to run parallel programmes in various urban and rural areas of the country on the basis of their strategic interests instead of direct accountability to the national GHP committees (through the Central Technical Groups). Similarly, other agencies such as USAID and international CSOs such as MSF, who advocate a coordinated GHP approach, run their own treatment programmes and activities with local NGOs in parallel to those operated by the national GHP programmes.

Another similarity between the two case studies is that they show how GHPs have made substantial progress in achieving their intended objectives. Measurable successes in results are presented in terms of increased drugs accessibility and affordability (e.g. HIV/AIDS treatment now free of charge in Cameroon), increase in the number of case of malaria and HIV/AIDS treatment and increase in the number of specialised treatment centres and points of access for drugs. However, new governance and accountability challenges have been

created (as a result of the overlapping nature of programmes and activities described earlier) that tend to undermine these achievements. As a result of this neglect, instead of helping to deal with existing government and market failures, another complex developmentally inhibiting structure of rent-seeking and corruption has been created by GHPs. For example, both national (senior government officials) and local (NGOs and local groups) partners are being accused of misappropriating financial and material (e.g. medicines) resources allocated to the national HIV/AIDS and malaria programmes. In this case, the incentive to govern through transcalar networks that bypass the ministerial structures of the state and gives more autonomy to CSOs also translates as corruption. These findings portray the complexity of global-national-local linkages, which has created a very fragmented national health system and creates new types of dependency on global actors for funding and guidelines as well as new ways through which programmes and activities are captured by non-productive groups.

8.4 Policy Implications

The findings from this thesis lead us to reflect on the unique features of the empirical case studies vis-à-vis existing studies on the impact of GHPs in developing countries. First of all, there is very limited empirical study on the role of GHPs in determining policy practices in African countries. Previous studies have focused on the impact of GHPs in facilitating access to medication by producing measurable accounts reported in policy documents and technical reports by GHPs (such as AAI and RBM annual reports), bilateral developed agencies, national governments and other international actors with an interest in GHPs. These studies evaluate GHPs in terms of the extent to which pre-

stated targets are met (Caines et al, 2004; Sturchio 2004), effective functional or problem-solving strategies, governance arrangements and accountability (Buse, 2004a). Numerous independent studies have produced both normative and measurable claims that GHPs may or may not strengthen national health systems even if they can be credited with scaling up of access to medicines in poor countries. This thesis provides, empirically, more evidence and justification for such claims.

Unlike earlier debates that global institutions (such as GHPs) promote a monolithic 'colonising process or homogenising force against which the local is passive and helpless' (Kickbusch, 1999:451), this thesis finds that GHPs pursue more than the usual model of intervention and impact by opening the possibility that the local and the global can co-produce and co-implement policies even though the global partners largely dominate policy making and implementation. The two case studies explored this co-existence by describing the deployment of GHP programmes, and their application in a local context. The analyses reveal a constant weaving and intertwining of old connections and relationships with new ones through transcalar networks. This is what makes measurable evaluations of GHPs so difficult and renders well established critics of GHPs in development studies more normative than practical. From this perspective, this thesis highlights two areas from which specific policy implications for the future country-specific role of GHPs on access to medication can be understood:

- The adoption of global health policy in a country-specific context

- Reflexivity – GHPs as a new form of North-South governance regime in the context of globalization

8.4.1 The adoption of global health policy in a country-specific context

The first policy conclusion that emerges from this thesis is that there is a need to balance the influence of the economistic narrative on access to medication with the public health and human rights narratives in the policy formulation and implementation domains if the GHP model is to achieve both potential and actual access to medication. The economistic, public health and human rights narratives are equally important for strengthened national health system. However, the two case studies reveal that the influence of public health and human rights are more rhetorical at the level of policy implementation even if they appear to be fully embraced during policy making (and made explicit in policy documents). This finding is substantiated below.

As demonstrated in Chapter Four, 'global health' has effectively replaced 'international health'. Through 'lessons learned', international health policies were transferred and adapted for application in new contexts, based on the experience in often similar local contexts (Walt et al., 1999; Ogden et al., 2003). Chapter Five highlighted this in the case of Cameroon showing how 'lessons learned' during the construction of the Panama Canal was used by the French colonial hygiene team in partnership with a similar German team to eradicate the sleeping sickness in the early 1900s. Similarly, 'lessons leaned' from other developing countries formed the basis for successive reforms of the

WHO/UNICEF-led PHC model adopted and implemented in Cameroon between 1981 and 1998.

From the late 1990s, the GHP model was introduced as a more innovative approach (global health policy) in which country-specific global programmes are designed and implemented to deliver country-specific services. As such, national GHP programmes (such as the malaria and HIV/AIDS programmes) are meant to be dynamic learning programmes in which interactive processes lead to the integration of 'lessons learned' and 'best practices' to deal with country-specific barriers to access to medication. The constitution of membership within the national committee of both the HIV/AIDS and malaria programmes, with global, national and local partners with the right mix of economistic, public health and human rights models appear to be suitable for such dynamism. Most importantly, the human rights concept of 'listening to the poor' is fully embraced through the incorporation of community participation (with efforts made to include a representative of patient groups at all levels). This allows not only the specific health needs of the poor to be sought, but the voice of the poor to be represented in policy making.

The notion of transcalar networks for policy transfer and implementation enables us to understand global-national-local policy transfer process in the case of GHPs, as each national committee demonstrates characteristics of a transcalar network. Within this network, global health policies are negotiated on the basis of the strategic orientation of specific GHPs. This is different from traditional health policy transfers promoted by WHO and UNICEF (e.g. Reich

1995, Walt et al. 2004) in parallel with the development policies of the World Bank (e.g. Baye 2003, Mbaku 2004). Global and regional (Abuja Declaration) RBM targets are set and then dialogue processes are set up with national governments and local groups to develop the national systems for implementation. Similarly, with the AAI, the government simply had to sign an accord with pharmaceutical companies before creating implementation systems.

There is some evidence of interactive policy transfer within the national committees. Apart from UN agencies, global partners such as bilateral development agencies and international NGOs (e.g. MSF) exchange ideas with national and local partners on 'best practices', 'field experiences' to help inform situational analysis, prepare grant proposals and create treatment centres. As emphasised by both the RBM and the AAI, representatives of local community groups participate in the dialogue process. This is what makes the GHP approach a transcalar network, with each committee consisting of specific partners with an interest in specific disease areas (HIV/AIDS and malaria). Unlike the PHC model centralised around the Ministry of Health with limited civil society participation in policy making, GHPs attempt to align health policy (WHO and UNICEF) with development policy (World Bank and Development Agencies) into national disease programmes in which non-state actors are increasingly playing key roles in policy implementation.

However, it is questionable whether these new social, cultural and political contexts are understood and recognised within the GHP policy template. This

thesis confirms claims by Caines et al. (2004), that the GHP approach offers a 'technical fix', based on specific medical interventions to achieve quick results. What is common among overlapping initiatives in the two case studies on malaria and HIV/AIDS in Cameroon is that they represent pre-existing projects that have been re-aligned to reflect the narrow objectives of GHPs. Evidence of the limited attention being paid to the public health, and more importantly the human rights narratives, is the fact that data on the incidence and rate of transmission of HIV/AIDS and malaria are widely debated:

> We don't know exactly how morbidity is, how morbidity patterns are because various international players bring that into picture only for the regions they are involved in. In that case how do you give an impression on how effective the different programmes are in terms of malaria treatment and control?[156]

Even in the case of the HIV/AIDS programme it was clear that 'the first problem (that needs to address) is the lack of availability of actual figures about the HIV/AIDS epidemic.'[157] These quotations point to more questions than answers concerning the role of GHPs in shaping policies: Are the voices of the poor actually present in policy making arenas? Are country-specific GHP policies consistent with field conditions such as actual disease incidences and epidemiological surveillance as national strategic plans and technical reports suggest? Such question reflect the key argument made in this thesis that GHP policies are simply the embodiment of elements from development models that serve the interests of global partners imposed on disease-endemic countries; they involve very limited interactive policy transfer and are not fully adapted to local realities.

[156] Interview Global RBM Board
[157] Interview GTZ

Ironically, at the local level, GHP programmes are animated by specific and overlapping treatment programmes initiated by the very global partners based on the international dimension of policy (through 'lessons learned' from the implementation of health development models in other local settings). For example, Chapter Six explained how the Social Marketing Programme (best practices from USAID's pilot projects) and the *Integrated Management of Childhood Illness* (lessons learnt by WHO, UNICEF and their affiliated development agencies) are being implemented under the national RBM programme. Although these programmes initially emphasised behaviour change element of the PHC model, by joining the national RBM programme, their strategic orientations were redefined limiting their activities to suit the economisitic model such as sales and distribution of ITNs. Similarly, Chapter Seven explained how, despite emphasising a human rights model, the economistic orientation of MSF from its pilot projects (cost-effective HIV/AIDS testing and treatment with generic medicines) as a local partner to the national HIV/AIDS programmes is being recommended for implementation in other countries. These are examples of how the embodiment of different forms of knowledge with the GHP model shapes local practices.

What emerges from the case of Cameroon is that old (previous treatment and care programmes in the pre-GHP era) and new (those created by the national GHP programme) institutions and programmes have become interwoven following the deployment of GHPs, achieving the narrow goal of GHPs (in terms of affordability and accessibility of medicines), but failing to address potential access to medication (as the incidence and burden of malaria and

HIV/AIDS continue to rise year after year). Thus, the case of Cameroon reveals that while scaling-up access to medication might have been successful, more work is needed to understand how the GHP model can be re-designed to be able to address potential access to medication (by not only incorporating the public health and human rights narratives as the core of policy making but translating them into specific programmes and activities).

8.4.2 Reflexivity – the unchanging nature of North-South relationships in the context of globalization

The second policy conclusion from this thesis is that the GHP model has introduced new structural challenges in the national health system without addressing the previous ones. As explained below, the analyses from this thesis provide empirical evidence for this conclusion. The PPP nature of the GHP model, in which the traditional central element of the political economy of health development is no longer the state (having replaced the Ministry of Public Health with National Disease Control Committees) have created transcalar networks whose activities have led to overlapping treatment programmes and activities being scattered all over the country. Traditional transnational networks that were being built around government ministers have been replaced by a mechanism in which the state has become entangled in transcalar networks of PPPs created by GHPs at global and local levels.

Before the official launching of any National GHP Programme, a series of preparatory meetings are held with representatives of UN agencies, the national government and associated global and national partners. The outcome of these meetings ensures that the types of support provided by UN agencies must

reflect the Millennium Development Goals of the UN, the Poverty Reduction Strategy Papers of the World Bank, the Paris Declaration on AIDS Effectiveness and the WHO's Essential Drug List.

The national frameworks developed are meant to ensure that the national programme promotes good governance, eradicate corruption and encourage civil society participation as demanded by the above international conventions and chartters. It also ensures that National Strategic Plans for specific GHP programmes meet the requirements for donor funding (as demanded by the World Bank and Global Fund) while targeting programmes to the needs of the poor (as illustrated in the two case studies on malaria and HIV/AIDS). This is the way in which the collective 'activism' developed by GHPs at the global level converges at the national level. This approach dismantles long established transnational networks (North-South divide) and creates transcalar networks (global-national-local linkages) thereby blurring the North-South divide.

Such reforms, as demonstrated in chapters two and five respectively, are based on the liberal argument that both the government and the market (Mathews, 1987; Dodgson et al., 2002) were failing to deliver. In this case, one would expect that the formulation and implementation of GHP programmes, while aiming to achieve access to medication would address these failures. GHPs have actually included the private and non-state sectors in governance arrangements for more transparent ways of receiving funds. This has also been done as the result of the human rights narrative on the need for civil society participation. For the first time, we are seeing a multi-stakeholder mechanism

in which government is unable to prevent funding and other support reaching the poor; we are also seeing new efforts to improve quality in the private sector, and global partners seeking to fund only proposals that use robust national GHP plans. Clearly, the GHP model presents a new form of hybrid structure, one that plays the boundary between global vs national, public vs private, state vs. non-state, profit vs non-profit thereby bypassing traditional forms of state governance. Nevertheless, the practical lessons from this thesis reveal the unchanging nature of donor-recipient relationships, as state-centric governance structures have not been replace by a fully functioning multi-level governance framework that is capable of governing policy implementation at local levels.

Global models are meant to be flexible and reflexive at global and local levels (e.g. King and Kraemer, 1992). In this sense, national GHP programmes introduced in African countries, such as Cameroon, are supposed to have positive impacts on their targeted populations, but also in the explicit knowledge that they will satisfy the interests of global partners. Over time (as the programme is being implemented) the unexpected and less desired challenges may be overcome through innovative and adaptive country-specific responses in a continuous (reflexive) process. Analysis of the case studies suggests that reflexivity is imposed on the national GHP framework by the global partners, supporting instead the claim that global models are alternative processes (Danzig, 1979) or political weapons (King and Kraemer, 1992) used to convince those actors who would otherwise oppose the strategic objectives of GHPs (e.g. certain CSOs and local groups).

For example, the rhetoric of good governance promoted by global partners tends to override the need for reflexivity, as specific programmes and activities are still being tied to donor-recipient commitments in the pre-GHP eras. If GHPs are meant to promote good governance and fight corruption it is rather surprising that the state, which urgently needs to become more transparent to be able to govern, and working directly with local community organizations is not directly responsible for the implementation of GHP programmes. From the case studies, policies are successfully transferred very willingly, with government participation all the way, but implementation remains poor due to weak governance. Even the national committees that ought to decide how funds should be allocated to different programmes and activities tend to play a more ceremonial role as some global partners prefer to work directly with local CSO in urban and rural areas. This leads us to question the nature of North-South relationships in the context of globalization. Specifically, the issues that policy makers must address can be expressed along the lines of the following quotation:

> 'One has to question the role of these global partnerships. What are their actual functions? Are they there to foster their own aims or are they there to support countries solve their health problems? If you take the example of the French bilateral aids project (part of the World Bank's Debt Initiative), most of the funds have been allocated to the private sector, especially non-profit sectors.'[158]

From the above quotation it can be argued that global policies have simply been adopted because policy makers (the national committee members at global, national and local levels) could see how they could take advantage of

[158] Interview, Division of Healthcare Organization and Health Technology, Ministry of Public Health.

the transcalar networks to which they belong, given the relatively poor governance mechanisms of national GHP programme (as evident in corruption, poor legal frameworks, weak financial assessment, overlapping initiatives). At the local level the community participation model, which tends to dominate the PPP approach of GHPs appears to be a search for legitimisation in the face of a democratic deficit that comes from bypassing the state. As already mentioned, such programmes and activities are so overlapping that it is difficult (as demonstrated in chapter two) to provide any robust description of the specific links among the different stakeholders within the varous transcalar networks.

For example, while specialised treatment centres for HIV/AIDS within the public sector are created (and equipped) by the national programme, those in the private sector are only approved by the national programme after showing evidence that they are fully equipped. In such context, non-public centres turn to international donors for direct funding and equipment support to create HIV/AIDS treatment centres. This has led to the proliferation of HIV/AIDS treatment centres in the country that were not initially created by the national programme (and that are not directly answerable to the national committees). As the two case studies on HIV/AIDS and malaria suggests, these issues are not being dealt with at periodic national committee meetings, they are only being acknowledged. What is more crucial for Cameroon is the fact that the same approach (National GHP Programme approach) is currently being debated by national policy makers for application in other health sectors.

> Most of the (public health) institutions are gone (to GHP programmes such as malaria, HIV/AIDS and TB). A whole set of instruments are being drawn to define the role of the government as a regulator and increasingly, to upgrade or reinstate the non-state sectors to deliver

> health services. So increasingly the regulatory framework is tailored such that NGOs will have a bigger role to play since the government will put stronger emphasis on their contribution. ... (But) so many local community groups operate health structures without the appropriate authorisation simply because they receive donor funding. They do not respect basic principles of health care ... and need to be closed.[159]

The above quotation from a senior director within the Division of Healthcare Organization and Health Technology at the Ministry of Public Health suggests that what the GHP model has achieved at the national institutional level is to create parallel national health systems for specific diseases. It is telling that this division is not a partner to any of the national GHP programmes. The Director is at the same level as the Permanent Secretaries of the National GHP Programmes for HIV/AIDS, malaria and TB respectively. This obviously puts the heads of each of these programmes (including the Minister of Public Health) in a difficult dilemma. They have to ensure that the demands of global partners are met (to continue to receive donor support) and at the same time they are accountable to the regime that appointed them through the executive powers of the President. In addition, they are forced to tolerate unethical practices by local community organizations simply because they want to maintain the survival of regime.

This leads us to question the strategy of the GHP model to favour an approach that bypasses the state. This thesis proposes therefore that the political capacity to achieve potential access to medication does not necessarily lie within the formal GHP processes. It needs to gain the leadership of the state in being able to coordinate overlapping and parallel programmes and activities as well as

[159] Ibid (see note 3)

aligning the national GHP programmes into the national health system. In this context, the case studies presented in this thesis suggests more general findings that go beyond the case of Cameroon:

- Even if transcalar networks of PPPs created by the GHP model can help access to medicine for the poor by involving the civil society in rebuilding the capacity of the government along the lines of better and more co-operative governance structures, this may not be a substitute for effective (strong) state governance if overlapping initiatives are answerable to specific international donor agencies (rather than the state).
- Unless serious steps are taken to reduce the country's dependence on global institutions (especially funding agencies), the processes of transformation pushed by GHPs (such as technical directives on community participation and good governance) might end up by exacerbating the persistent structural constraints in the national health system.
- Developing countries willing to implement GHP programmes following the integration of best practices or lessons learned with country-specific needs in relation to access to medication should have a strong efficient state (and government) *ex ante*, as GHPs may not be conducive to a strengthened state capacity *per se* due to the powerful strategic interests of global partners.

Thus we have seen that the presents of transcalar networks enable international agencies to use local CSOs to bypass (or operate in parallel with) formal state

structures, thereby halting the effective coordination necessary to sustain the realisation of GHPs programmes. There is need for the various national GHP programmes to become really 'locally owned' via empowering the local CSOs not to be barely represented in specific committees and parallel programmes but to be able to interact with the public sector at all levels. Without this the transfer of technology, policies, systems and expertise by GHPs, remain a dubious perpetuation of the status quo.

The case study thus reveals that the elements necessary for GHP programmes to be legitimate in the Cameroonian social and institutional setting need to balance the public health, economistic and human rights needs of national and local partners. It appears, at the moment, that these needs are taken more seriously only at the global levels. In particular it directs the attention of policy makers to the wider political, social and historical context in which diverse institutional systems operate and interact which has become transcalar as against transnational in character. This means that both formal policies that are consensually agreed during national committee meetings and the informal (and sometimes unofficial) activities of those public, private and civil society institutions whose legitimacy stems from being affiliated to key GHP partners need to be documented on the GHP template as a stepping stone to re-designing the GHP model at the national and local levels.

8.5 Envisioning a Re-design of the GHP Model on Access to Medication

This thesis demonstrates that the GHP model is a form of global activism, a global political narrative on how access to medication can be provided to the poor. The evidence presented suggests that the model provides an institutional solution to the problem of access to medication but fails to solve the disease problems. At the national level the power of the state has diminished while the role of government as a service provider is increasingly being transformed by more civil society participation. This draws our attention to the subtle dynamics which link together institutions and organizations across various global health contexts. The various state and non-state actors involved in the realisation of GHP programmes are difficult to coordinate in the current global context as their responsibility is configured within wide (and apparently uncontrollable) transcalar networks of institutional activity.

The 'narrative (or knowledge) approach' used to understand the role of GHPs on access to medication in this thesis focuses on the global activism within GHPs and how this shapes policy practices. It does not address the specific institutional or organizational challenges posed by the GHP model at global, national and local levels. A specific configuration of relationships across the global-national-local linkage that would generate different impacts on access to medication seems impossible to explore within the scope of this thesis. For example, this thesis suggests the need to integrate overlapping programmes and activities into the national health system under the Ministry of Health. In other instances, it is agued that global partners ought to trust the Central Technical

Group designated to coordinate policy implementation instead of implementing programmes at provincial and local levels that are answerable to specific western donor agencies. If these suggestions are to be taken on board, what would be the nature of the national health system? What sorts of institutional and organizational challenges would GHPs face? Taken these questions into consideration, would GHPs succeed to solve the disease problems? These are issues for further research, as the evidence from this thesis does not allow us to answer such questions.

However, the approach used in this thesis brings to the attention of a wider community of researchers studying the relationship between STS, development and globalization, the possibility of a research agenda that can develop new theoretical understandings of the phenomenon of global institutions, programmes and policies. The cases presented highlight interesting issues for theoretical and empirical enquiry. By combining the notion of embodied knowledge in STS and social constructionist IR, we have been able to identify and better understand how certain theories have shaped the narrative strategies in access to medication which are then supposedly 'embodied' in specific 'organizations' that are called GHPs and then transferred to national and local settings for implementation by specific 'organizations' called National GHP Programmes. This is certainly valuable and there are very interesting insights of what we could call a political story of activists involved in a specific struggle to frame specific claims (around access to medication). More research is needed to better understand this political story and how this type of 'hybrid network' gives new insights about how specific claims are likely to be carried

on across frontiers both in other GHP settings and global institutions in general.

In addition, the arguments developed in this thesis focuses on 'pure' health and medicine-related issues, as well as health policy. The knowledge approach enables us to identify the relevant development models and objects of study, the narrative analysis method chosen to address it contributes to our understanding of public health, economics and human rights in the context of global, national and local health interventions. The approach that has been developed (as presented in Chapter Two and applied throughout this thesis) has not allowed us to discuss in greater detail the organizational aspects of GHPs at global and national levels. Specifically, the very idea of hybridization of networks, the reasons why GHPs are actually developing this type of orientation and how this generates different impacts on access to medication needs to be explored further by clearly delimiting the links and specific role of each global, national and local partner. This is another area for further research, for example, by applying variants of social network analysis.

Furthermore, this thesis highlights the institutional and organizations dynamics, whereby different levels of analysis are linked, insights from different perspectives and/or disciplines are synthesized, and complexity (legal, societal, political and economic) is embraced. While the thesis does not really look inside the organizational complexity or the political story of GHPs in greater details per se, it provides a very promising empirical and theoretical track to be pursued around the collective nature of the 'activism' that is described in the

different chapters (in terms of public health, economistic and human rights narratives). Further research is needed which might for instance require that we dig into a sort of Social Movement Theory or Actor-Network Theory to see whether the narratives could be analyzed through a proper 'framing' perspective that follows the actions (not merely reviewing documents and interviewing a selected few as has been the case in this thesis) of specific actors in global health to better understand the linkages that animate transcalar networks in the GHP domain.

Finally, there are certain issues concerning the research methods explained in chapter three that are worthy of mention. First this is a single country study (Cameroon) and the empirical case studies focus on two provinces to reflect socio-economic (rich/poor, urban/rural) cultural-colonial (e.g. English vs French-speaking regions) and health inequalities (e.g. areas with access to high quality hospital as against villages in remote areas). As this is not a representative sample (as elaborated in chapter three), it can be suggested that a comparative (cross-country) study of more than one African country would add more robustness to the arguments presented. In addition, on reflection more local public, private and civil society groups could have been included in this research. Although many of these local partners were contacted (especially representatives from patient groups) they were only interviewed informally. Including more of this group would have given a deeper insight to GHPs from their local perspective and perhaps add new levels of complexity on the role of GHP in Cameroon (e.g. how policy issues agreed at the global and national level are translated into programmes and activities in rurual villages).

Nevertheless key aspects of their role documented in technical reports and programme evaluations by specific GHP-affiliated organizations have been cited were necessary.

8.6 Contributions to the Theoretical Literature

The contribution of this thesis to the study and research on STS is threefold. The first is identified with the object of study itself. GHP programmes offer for analysis a rather different set of issues with respect to the discipline as well as its relationship with globalization and development. As Sheila Jasanoff puts it:

> 'STS already has a long history of engagement with development, as well as numerous achievements to its credit. For example, the "old" discourse of "appropriate technology" implicitly accepted that the development of technological systems in "developing" locations should be attentive to their social and cultural contexts. Similarly, one can see citizen activism and protest ... as challenging the epistemic, teleological, and normative assumptions of development specialists. It is against this backdrop of ongoing critique that we should, in all modesty, consider what STS can offer today.'[160]

This thesis contributes by adding to this ongoing critique a theoretical methodology that combines STS and International Relations (IR), approaches that have been used primarily independent of each other to the study of GHPs. Previous STS-related studies have explored the ways in which development policies promoted by GHPs attempt to address global market failures, institutional and organisational uncertainties in ensuring that pharmaceutical products get to reach the poorest people who need them (e.g. Chataway et al., 2007; Chataway and Smith, 2006). IR-related studies on GHPs are dominated

[160] Sheila Jasanoff gave a Panellists' Introductory Statements to start off a Roundtable: "Development, Globalization, and STS" during the *Joint EASST/4S Conference*, Erasmus University Rotterdam, Netherlands, 20-23 August. For details of the roundtable see http://www.st-and-dev.net/sts/node/18 (Accessed: 14/05/09).

by liberal and neo-liberal interventionist approaches (e.g. Dodgson et al., 2002; Buse 2004a; Abbot, 2007) which have long been considered as being too normative due to their overemphasis on the role of the state or specific international actors (Boas and McNeill, 2004). Both sets of studies point our attention to the network of interactions taking place among global, national and local actors in global health, issues that are explored in this thesis. Thus, the present study differs fundamentally from other studies in objectives, development and results.

The research presented in this thesis therefore adds to existing research an account of what the GHP model embodies as a global actor within an African country and the consequent transformation of the state through its networking with the global and local civil society. It enables us to better understand global-national-local linkages in global health beyond specific project or programme evaluations published as technical reports and policy documents by specific or a combination of GHP partner organizations. Specifically, this thesis unpacks complexity of the hybrid network structures in which global institutions (e.g. GHPs) are modelled to deal with country-specific problems (e.g. barriers to access to medication). In this way we have been able to understand the various state and non-state actors involved at national and local levels, and their responsibility within the wider GHP network.

Previous research has also not studied the effects of the meaning ascribed to 'access to medication' in a process of globalization, mostly taken them as given. This study therefore contributes to move the research frontier of the

discipline to address also how the construction of access to medication by key GHP partners affects the design of policy, organizations and institutions during the process of creating national GHP programmes. These have remained implicit in policy documents and technical reports. By making them explicit, this thesis highlights the powerful role of 'rhetoric', 'promises', 'colourful language', or 'plots' in transforming the traditional conceptualisation measures to achieve access to medication from a strengthened national health system to parallel and overlapping GHP programmes and activities.

The second contribution that this research seeks to make relates to the problems within existing theories in addressing the phenomenon of the role of GHPs on access to medication. As discussed in chapter two, STS and social constructionists IR perspectives in isolation (including their multiple consequences and variants) do not seem to provide an appropriate framework for studying GHPs even if they are widely used to address different expressions of such phenomenon. Each focuses on different though relevant aspects to interpret the functional and operational mechanisms of global institutions such as GHPs and their implications for national policy formulation and implementation. However, each reveal the presence of a diversity of organizational, institutional and policy contexts on a global scale, implying that diversity of the networks (characterised in this thesis as having a transcalar character) on which GHPs programmes are built need to be addressed.

The contribution to theory in this thesis is therefore based on the benefits of taking a 'narrative (or knowledge) approach' to the analysis of GHP, by

looking at the ways in which different models are used to create transcalar networks and how this process shapes policy practices. The framework presented in chapter two contributes along this line in terms of providing interdisciplinary approaches to the study of GHPs as well as offering new insights for answering questions about globalization and development. Further research in this direction would have the ability to answer questions that GHP programme produce in different social settings, where the role attributed to medical technology changes in meaning in the face of different stakeholder ideologies in different contexts. These in turn influence several drivers of policy in relation to the development, transfer and implementation of health policies taken into account the transcalar network characteristics of GHP programmes. This is not (of course) simplistically determined by technical knowledge (public health, economics and human rights) or the socio-political contexts but by a continuous and dynamic process of negotiation between the two, connecting the global, national and local.

Finally, as the promotion of GHP programmes is a recurrent element of political economy (especially health sector) reforms of many developing countries, what GHPs represent in terms of a new form of governance (and the changing North-South relationships) becomes central to understanding the future direction of research in this area. The intrinsic characteristics of global actors and their narratives require, to a certain extent, a unified vision as to the requirements for achieving both potential and actual access to medication. Apart from this, they can be catalysts for discovering the diversity of transcalar networks and the extent to which established relations are (or are not)

perpetuated, consolidated and extended to the complicities of specific diseases. In this case, the framing and analysis of GHP programmes as theoretically linked to global 'models' should be an object of continuing enquiry and one that can provide institutional, organizational and policy network mechanisms facilitating their conceptualisations, analytical frameworks, policy directions and local practices.

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APPENDIX: INTERVIEW SCHEDULE

A. The National Context of Access to Medication

This interview schedule was prepared for those respondents at national, provincial and district levels of the National health System who are not directly responsible for GHP programmes. This includes the Division of Health Technology and Healthcare Organization (Ministry of Health), Provincial and District Delegations for Public Health in the Centre and North West Provinces including a selection of hospitals and pharmacies.

Tell me about Cameroon's national health system. How can you describe the structures in place that hospitals and pharmacies can follow?

There are public, private and NGO sources of financing and health care providers in Cameroon today. In what ways do national health policies relate to the role of health care providers in these different sectors? What are the systems and policies in place to ensure acceptable standards of health care delivery?

How can you assess the structure of the national health system in terms of the need to serve all segments of the population (rural vs. urban, rich vs. poor, public vs. private, profit vs. non-profit)?

My research focuses on malaria and HIV/AIDS. What do you see as the major barriers to access to medication for malaria and HIV/AIDS and what is the role of the government in dealing with those barriers?

As you may know Cameroon has endorsed several GHPs. Why do you think the government decided to join these initiatives (R&D and marketing vs. philanthropy and drug donation programmes)?

How would you classify the national health system within the institutional set up of a GHP? How compatible are national GHP programmes within the national health system in Cameroon?

What types of assistance do you receive from GHPs in designing and implementing health interventions? In what ways does the government allocate such assistance to satisfy the pluralistic health care system?

How would you judge overall country and local level awareness and satisfaction with the role of GHPs in providing, monitoring and evaluating national and local level programmes?

How well do you understand the direction of the Government (at national and local levels) in regards to National GHP Programmes and activities and the benefits that have been realized?

B. GHPs and Access to Medication for Malaria and HIV/AIDS

This interview schedule was prepared for global, national and local GHP partners. The questions were modified depending on which of these levels a respondent is located, the type of GHP (RBM, AAI, EAI) and the disease area (malaria, HIV/AIDS).

What do you see as the main problems that a country like Cameroon is facing in the fight against malaria (or HIV/AIDS)? How is it that everyone has suddenly realised that such problems need to be addressed through GHPs ?

Why did your organization become involved in GHPs? What does your organization benefit out of this? How can you describe your role in GHPs at global, national and local levels?

How does institutional diversity affect the allocation of initiative among partners within GHPs for defining goals and assessing results (governance issues and organizational arrangements in scaling up access to medication)?

Can you tell me how bilateral negotiations take place between pharmaceutical companies and individual developing country governments? What is the role of GHPs in the effectiveness of such negotiations?

What are the conditions that a developing country like Cameroon had to put in place before being accepted to join a GHP?

What steps are being taken within the AAI to ensure compatibility with country context...to ensure that the AAI does not end up as one of those previously failed policies?

What are some of the problems of access to medication in Cameroon that you can attribute to the a) government (national health system) and b) global pharmaceutical and healthcare market?

GHP policies are implemented in Cameroon through National Malaria (or HIV/AIDS) Programmes. In what ways does this take place? What is the role of your organization in the policy making and implementation process?

A fundamental principle of GHPs is civil society participation (especially the representation of patient groups) in designing and implementing programmes and activities. How does this happen in practice? What are the benefits of this approach? Do you know of any associated challenges?

What measures are being taken to ensure that the selection of health units for malaria (or HIV/AIDS) patients satisfies the pluralistic nature of Cameroon's national health system (government, private, religious, NGOs, etc)?

Most people undergoing treatment pay a certain amount of money per year and the government covers the remaining costs (through funding mobilized with the help of GHPs). To what extent is the government able to cover these costs?

To what extent do treatment costs impede effective delivery and utilization of medicines and care facilities?

What (national and global) guidelines do specific GHP partners use in delivering treatment to patients and local levels? How do you perceive the type of activities that you implement in terms of the overall contribution to access to medication (potential vs. actual)?

What do you see as the knowledge, perception and acceptability of treatment offered to patients in Cameroon by your organization as a partner to the National GHP Programmes? To what extent does this determine whether patients will seek treatment through your health centres as against specialised centres designated by national GHP programmes?

What are some of the criticisms that have been directed at GHPs and what prospects do you see for the future?