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Discussion paper

HEALTH COOPERATION: ITS RELEVANCE, LEGITIMACY AND EFFECTIVENESS AS A CONTRIBUTION TO ACHIEVING UNIVERSAL ACCESS TO HEALTH



ABOUT THIS PAPER

Medicus Mundi International – Network Health for All (MMI) is a diverse, horizontal network of development NGOs and other organisations. This paper on health cooperation and its relevance, legitimacy and effectiveness was discussed at the MMI workshop “Health cooperation beyond aid” in Berlin, on 29 September 2016, and published afterwards.

The current document is not intended to be a position paper representing a homogeneous view of the Network. It is a discussion paper that feeds a core activity of the MMI Network; to serve as a platform for critical reflection on the role and future direction of development cooperation for health.

We invite the members of the MMI working group on Effective Health Cooperation (MMI EHC) and other Network members and partners to engage in this process.

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CONTENTS

- 1. THE OVERALL POLICY AIM: UNIVERSAL ACCESS TO HEALTH..... 5
 - 1.1. Universal Health Coverage and beyond5
 - 1.2. The socio-economic conditions that shape health outcomes5
 - 1.3. The health sector’s role and contribution5
 - 1.4. Solidarity with whom?6
 - 1.5. The need for a global “social contract” for health.....6
 - Questions for reflection (1) 7

- 2. WHAT’S WRONG WITH DEVELOPMENT COOPERATION? 8
 - 2.1. Legitimacy , values, interests.....8
 - 2.2. Impact and outcomes.....8
 - 2.3. Actors and behaviours.....9
 - 2.4. Methods and practices..... 10
 - Questions for reflection (2) 10

- 3. DEVELOPMENT COOPERATION IN TIMES OF THE SDGs: MOVE IT BEYOND AID!..... 11
 - 3.1. SDGs: Agreement on goals, but how to achieve them? 11
 - 3.2. Move cooperation beyond aid! 11
 - 3.3. From developing systems to redistributing resources 12
 - 3.4. Improve input legitimacy 12
 - Questions for reflection (3) 14

- 4. EFFECTIVE HEALTH COOPERATION..... 14
 - 4.1. Aid effectiveness principles 14
 - 4.2. Aid effectiveness in the health sector 15
 - Questions for reflection (4) 16

- 5. WHAT NEXT?..... 16

INTRODUCTION

“We promote knowledge sharing and mutual learning between actors in international health cooperation” (MMI Network Strategy 2016-20)¹

Traditionally most of the members of the Medicus Mundi International Network (MMI) are rooted in development cooperation for health, a field of activities that has, such as the terms to describe it, considerably developed over time.

We will use the term “health cooperation” in the sense of international or transnational development cooperation for health: organizations which lead health programmes in low- and middle income countries (“developing countries”) or support public or private partner organizations technically and/or financially in order to improve health outcomes and access to health care.

Promoting “effective” health cooperation towards improving health outcomes and strengthening health systems has become an important aim of bilateral and multilateral health policies during the last 50 years and mainly also in the era of the Millennium Development Goals (MDGs). At the same time there has been an increasing critique on the role of development cooperation in general and International NGOs specifically in developing health systems with the aim to achieve Universal Health Coverage.

Contextually a gridlock in global cooperation for health is observed, with traditional aid budgets being reduced and reverted to issues such as mitigating refugee streams, adapting to climate change and the risk of terrorism. Development cooperation for health focuses more and more on in fragile states and on building resilient health systems with the aim to prevent transnational infectious disease outbreaks and social instability. At the same time the Sustainable Development Goals (SDGs) provide an ambitious and universal agenda to ensure healthy lives and well-being for all. The World Health Organization considers Universal Health Coverage the overarching policy framework to reach this goal.

This paper aims at contributing to the debate on ways in which actors in development cooperation such as international NGOs or bilateral agencies could engage in a relevant, legitimate and effective way to achieving universal access to health.

In our understanding, relevant, legitimate and effective health cooperation:

- contributes to achieving universal access to health;
- is fully aware of its structural role, responsibilities and limitations; and
- continuously reflects on how to improve its approaches and practices.

There is still a lack of platforms in which actors in health cooperation can critically reflect their own practices and approaches, share information and experiences, learn from each other and have an opportunity to further develop their institutional and personal skills and practices. As agreed in the MMI Network Strategy 2016-20, this is a major focus of our Network’s current activities.

We invite institutions and professionals engaged in health cooperation to critically position themselves, to refer to the criticism of development cooperation and to participate in an intersectoral dialogue on how to do things better. If we take this seriously, we might need to accept that a paradigm shift is required that breaks with the continuum process of development cooperation for health as it has been conducted during the last 50 years.

Questions for reflection

In each chapter, we enclose a box of critical questions which we recommend that actors in health cooperation should answer to assist in reflecting on their work.

1. THE OVERALL POLICY AIM: UNIVERSAL ACCESS TO HEALTH

What is needed to achieve universal access to health within and beyond the health sector? We invite you to position your organization in the triangle of (a) provision of essential health services, (b) strengthening health systems and institutions, and (c) addressing determinants of health at a national and global level.

1.1. Universal Health Coverage and beyond

“Unless Universal Health Coverage is implemented within a framework of social and economic transformation, it will not transform health as profoundly as hoped.” (MMI²)

Universal Health Coverage (UHC) is generally framed as follows: “All people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.”³ Health financing policies must be aligned with health systems reforms that aim explicitly at improving coverage and the intermediate objectives linked to it, namely, efficiency, equity in health resource distribution and transparency and accountability.⁴

Discussing the health sector’s contribution to the achievement of the UN Sustainable Development Goals (SDGs)⁵, the World Health Organization currently promotes an explicit focus on Universal Health Coverage: “The UHC target is the linchpin of the health-related SDGs; the one target that, if achieved, will help to deliver all the others by providing both population and person-centered high-quality services that are free at the point of delivery and designed to meet the realities of different people’s lives.” (Kieny⁶)

Universal access to health goes beyond the mainstream UHC definition - or requires a fundamentally different definition of UHC⁷: Health is a social, economic and political issue and above all a fundamental human right.⁸ Beyond access to timely, acceptable, and affordable health care of appropriate quality, it includes guaranteeing a standard of living which enables a healthy life. Obviously this cannot be achieved by the health sector and through health sector policies alone.

1.2. The socio-economic conditions that shape health outcomes

“In view of the wealth existing in today’s world, the prospect of Health for All must not be an illusion any longer. The world doesn’t lack the resources for health; it requires a fair use of what is available, in other words: the redistribution of wealth guided by the concept of solidarity. The world is awash in

money. What is missing is the political will of those in power and – to challenge ourselves – the public pressure to make change happen.” (Gebauer⁹)

The social determinants of health are the “conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.”¹⁰ Addressing these societal, political, economic and environmental determinants of health needs an integrated and holistic approach. It is a radical and highly political programme.¹¹

Obviously, to achieve this, business as usual will not be sufficient.¹² It does not mean less than aiming at changing the world from how it is to how we want it to be.¹³ In the words of the People’s Health Charter: “Health for all means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed.”¹⁴

A current holistic vision of the political and societal transformation needed is expressed quite convincingly in the UN 2030 Agenda for Sustainable Development (SDGs)¹⁵ adopted by the UN General Assembly in September 2015. The next years will show if this “indivisible, interlinked and integrated” agenda of change agreed by all countries will be transformed into action.

But we are far from that.¹⁶ As Bill Easterly puts it: “The UN SDGs summit recommends actions that failed to happen after being recommended in many previous UN summits. The SDGs are about as likely to result in progress as beauty pageant contestants’ calls for world peace.”¹⁷ Not much to add to this if we look at mainstream politics at domestic and global levels.

1.3. The health sector’s role and contribution

“Health policies and programmes have the ability to either promote or violate human rights, including the right to health, depending on the way they are designed or implemented. Taking steps to respect and protect human rights upholds the health sector’s responsibility to address everyone’s health.” (WHO fact sheet¹⁸)

“Public systems need to be reclaimed by citizens, reformed in the interest of the people and made accountable. Peoples’ movements and organizations have much to lose from the present drift legitimized by the UHC discourse.”
(Sengupta)¹⁹

Defining the core qualities of a national health system in order to consider it “strong” and fit for the purpose of providing universal health coverage is the issue of both political and technical debate.

“Health systems strengthening” had its ups and downs over the last years. The Ebola epidemic in West Africa brought it back to the core of global attention. Under the Ebola spotlight, the WHO and other international institutions as well as many authors discussed not only the political and economic determinants of the epidemic²⁰, the disastrous track record of development cooperation²¹ and the failure of international institutions and global health governance to properly address a major health crisis, but also the fragility, structural weaknesses and failures of the health systems of the countries concerned and what it would need to overcome these failures and to achieve stronger and “resilient”²² health systems.²³ The latter would not only require strengthening the six building blocks of a health system but would need as well to develop the essential public health functions needed to prevent and prepare for health crises such as large scale epidemics.²⁴

Democratic governance and domestic resource mobilization are key elements in this. Low- and middle income countries can afford to increase their spending on health by making different policy decisions about how they raise and spend public money.²⁵ Decisions about tax and spending are vital and should be in the control of governments, even of the poorest countries. For sure, the national government, albeit not perfect, is in the main responsible for creating the conditions, the policies and system needed for addressing the social and economic needs of the population.

1.4. Solidarity with whom?

There is a fundamental debate if international solidarity should only be with “countries” (in the sense of governments) or also/mainly with “people” and “communities”. According to the analysis of the political system and governance in a particular country, but also according to their own political and structural position, actors in development cooperation and other sectors will answer this question very differently.

However, it becomes increasingly clear that solidarity should also be directed toward people and not only to countries. If this is agreed, this will also reduce the choice of possible approaches for achieving Universal Health Coverage: “UHC has no single road: its paths are multiple, and are context-dependent. The latter does not mean that ‘anything goes’: time has come to realise that the unit of analysis should be a population (not a sub-population benefiting from a particular financing scheme), and that approaches that compromise equity are not desirable.” (GIZ)²⁶

In recent years, income inequality (and very likely also health inequality) measured between people, and hence not between countries, has increased. This also implies that health inequalities have grown in richer countries such as in Europe. UHC, and social protection in a broader sense, is thus a universal agenda, and not only a matter of “developing” countries.²⁷ Secondly, there is a glaring neglect of interests, ideas and institutions that do not conform to national borders. There is a growing disconnect between our political institutions (country governments) and new polities emerging²⁸, such as transnational business associations, international financial institutions, global civil society networks and an international “angry voters” cohort that have one thing in common: “they have been left in the dust by globalization”.²⁹

1.5. The need for a global “social contract” for health

There is a simple fact that many countries and governments just do not have sufficient financial means and policy space to implement the policies needed for achieving universal health coverage. “The debilitating effects of capital flight and tax avoidance on resources available for the widely accepted objective of UHC are normally ignored in discussions of how to improve (global) governance for health”.³⁰

Overcoming this shortfall requires a “social contract” at global level and related mechanisms for support and redistribution, including reforms in the global governance of key areas such as international taxation.³¹ A combination of domestic and international financial mechanisms is required to accomplish the ambitious (health related) sustainable development goals and targets such as Universal Health Coverage.³²

In the MMI discussion paper on Universal Health Coverage (2013), we promoted the consideration of UHC as both a responsibility of every government and as matter of “global domestic health policy”.

UHC should be regarded as an international public good, advancing the universal right to health, as well as a means to mitigate global risks (such as epidemics). There is hence the need to share responsibilities to advance these goals. This will eventually lead to global financial frameworks and governance mechanisms.

To an extent these already exist for health such as the Global Fund and The Global Financing Facility for Maternal and Child Health. However, these are built on “aid” logic, including the donor vs recipient thinking. A global social contract for health would move “beyond” aid and be based on legal agreements, rather than only on political commitments.

Redistribution – regulation – rights: “The overarching principles and recommendations for global governance for health can be summarized in three points (the three R’s): Systemic resource redistribution between countries and within regions and countries to enable poorer countries to meet human needs; effective supranational regulation to ensure that there is a social purpose in the global economy; enforceable social rights that enable citizens and residents to seek legal redress.”³³

Global political economy of UHC: In an input to a consultation recently hosted by IHP+, and referring to the “UHC cube”³⁴ promoted by the WHO, Jesse Bump provides an outline of the political economy of Universal Health Coverage at both domestic and global levels³⁵. He adds to the “domestic political economy” of Universal Health Coverage (fairness of protection and risk, fairness of access to services, fairness of financing) an “international political economy”: At a global level, fairness of protection and risk is expressed as production of global public goods, e.g. environment and natural resources, surveillance, cross border activities; fairness of access requires fair trade regimes, intellectual property, corporate accountability, and fairness of financing requires redistribution by international taxation. The problem is that, while at national level, the state is accountable to its citizens, accountabilities at global level remain unclear, as there is no established global “social contract”.

Questions for reflection (1)

- How/where does your organization define the overall goals (expected outcomes) of your engagement in international health cooperation? Are you happy with this definition?
- Would you agree with an overall health policy aim of “achieving universal access to health” or, in the words of the SDGs, “ensuring healthy lives and promoting well-being for all at all ages”?
- Do you have a “theory of change” which defines how you expect health outcomes to be improved and your organization’s particular role and contribution?
- How do you position your organization in the triangle of (a) provision of essential health services, (b) strengthening health systems and institutions and (c) addressing determinants of health at a national and global level? Why? What are your historical and current references for this approach? Are you still happy with it?
- How are your organization’s or your local partner’s structures and programmes integrated in the national health policies and systems of the countries you collaborate with / work in? Is there an overall policy paper on this integration, or do you handle it in a more strategic or pragmatic way, according to the respective political and structural setting?
- How do you deal with the (potential) conflict of your solidarity with people and communities and your collaboration with government institutions?
- How would you assess the progress of the country in which your organization has its origins towards achieving universal access to health? Are you also working in this country? Why/why not?
- Any question we forgot to ask you?

2. WHAT'S WRONG WITH DEVELOPMENT COOPERATION?

Fierce criticism of development cooperation is not at all new, and it covers the whole field: Its legitimacy, its intrinsic values and interests behind, its outcomes, its methods and practices, its actors and their behaviour. We do not quote the rich literature ³⁶ (you might add further references), but list some main points of analysis and criticism and invite you to consider them honestly.

2.1. Legitimacy³⁷, values, interests

“Gradually, aid has been removed from its previous social context and transformed into a ‘product’ which, just like any other product, does not necessarily correspond to the needs of the recipients any longer.”³⁸

Neo-colonialist, neoliberal, destructive: Throughout recent history, aid and the conditions linked to it has been used to exert control and influence. Mainly the World Bank and the International Monetary Fund (IMF) have been rightly criticised for promoting, through their “structural adjustment” agenda and conditions, a neoliberal agenda. The World Bank and IMF “leveraged debts to impose crushing ‘structural adjustment’ programmes on poor countries, forcing them to privatise public assets, open their markets to Western goods, cut social spending and reduce wages, and give foreign companies access to extra cheap labour and raw materials. Structural adjustment was one of the greatest single causes of poverty in the global South in the late 20th century, and it continues to this day under the guise of ‘austerity’”.³⁹

The dominant influence of these International Financial Institutions overriding United Nations’ (UN) policy objectives has not always been the case. The UN, including its policies on international development cooperation, are grounded in principles of universal rights and an international order aimed at sustaining law, order and peace. This was after 1945, deemed necessary after the destruction of two World Wars and also a means to stabilise post-colonial independent, sovereign, states, with the idea that these states had the right to develop autonomously. It was already foreseen that such a stable world order, based on principles of free trade, economic growth and liberal democracies should include the transfer of resources for social goods (education, health etc.) from developed to developing countries. This was the origin of agreement on the 0.7% Official Development Assistance target to be provided by “developed” countries in the early 1960’s.⁴⁰

However, as part of the *Pax Americana*, and with neoliberal values becoming prominent since the 1970s, aid has become a project of stepping in and filling gaps in the national provision of essential

services created through austerity regimes. Doing this, aid saved lives, but also contributed to the stabilization of a thoroughly unfair and destructive system of trade and development.⁴¹ The transformative potential of development cooperation has never been realised.

Distractive: In this sense, aid is also distracting attention from addressing the “real” causes of inequality and dispossession. “The aid project is failing because it misses the point about poverty. It assumes that poverty is a natural phenomenon, disconnected from the rich world, and that poor people and countries just need a little bit of charity to help them out. People are smarter than that. They know that poverty is a feature of the global economic system that it is very often caused by people, including some of the people who run or profit from the aid agenda. People have become increasingly aware - particularly since the 2008 crash - that poverty is created by rules that rig the economy in the interests of the rich.”⁴²

Donor driven agenda: The policies, priorities and programs of development cooperation provided by Western governments and institutions are rather defined by the donors and development agencies than by the demand expressed by governments, communities and people in “recipient” countries. It is only if/once a topic gains international attention that funds and action can be granted. This is particularly obvious in the health sector where vertical programs and technical “quick fix” ambitions dominate over integrated and systemic approaches. Although emerging economies (such as the BRICS countries) have more influence in the diplomacy and framing of global health issues, this political will still requires to be translated in sustained financial investments in international health programs.⁴³

2.2. Impact and outcomes

Creating additional burdens and distorting national priorities: In countries in which governments struggle with the essentials of establishing a proper and effective administration and planning system to steer and improve social development processes, the myriad of aid agencies with their priorities, programs and reporting requirement create an additional burden and have a great potential to

distort national planning priorities and budgeting processes.

Stabilizing bad governance and perpetuating dependency: In countries with an “extractive” government, international cooperation normally has no means to overcome the “let the west deal with it” attitude of the ruling regime, either if it works with the government – accepting that resources are wasted through corruption and ineffectiveness – or it establishes parallel structures for the provision of basic services such health care, education or infrastructure. Aid is “the perfect means to overcome a lack of political legitimation.”⁴⁴

Distorting domestic economies: In addition to the criticism of the austerity regimes and their consequences for national economies, there are very concrete distortions of economies and markets through development programs and projects themselves. Cheap “aid” goods (from food to insecticide treated bednets) crowding out local production, high salaries in the “aid business” creating incentives to leave the public sector etc. are some examples. The local ownership of health cooperation projects is often limited.

Overall track record: According to many analysts, and despite some achievements, the “aid paradigm” has failed as a whole, including its flagship “Millennium Development Goals”: Globally and in many countries, inequality has grown, and in absolute numbers, there are currently more people living in absolute poverty than 40 years ago⁴⁵, not to mention the urgent demographic (population growth) and ecological (climate change, biodiversity loss) challenges ahead of us.⁴⁶ If there would be progress, it is rather a result of an overall economic development and cannot be attributed to aid.

2.3. Actors and behaviours

“Too small to be agents of economic transformation; too big and bureaucratic to be social movements; banned from politics because of their charitable status and structurally removed from the societies they’re trying to change, Oxfam and the others end up sitting uncomfortably in the middle as the real action takes place around them - doing what they can to save lives, speak out and build on small successes in the process.” (Edwards)

Interventionism: In activist development projects and programs of all kinds and at all levels, the “what to do” (building or supporting a hospital, digging a well, creating 1 Million health workers) is often much more obvious than the “how to do it”, creating problems of ownership and sustainability. And besides, the interventionist attitude of development actors hides the fact that it is better to

Do No Harm in the first place. Inequality and poverty are in many counted historically rooted in injustice and unfair trade relations. Hence first abandon policy measures that demonstrably increase health inequity, such as those limiting the scope for public provision for basic health-related needs, or resulting in their commodification.⁴⁷

“Poverty porn”, paternalism and cynicism: Sometimes there is an incredible difference between how international development organizations talk with their local “partners” and how they “sell” their work to their domestic public and potential donors. In a paternalistic paradigm, agency lies almost exclusively with the powerful givers. Pretending that they can make the difference, development agencies “use the scale of their ambition to attract public support, while actively maintaining blindness to their inability to deliver their stated goals. This tendency is at best misguided and counterproductive, at worst cynical and dishonest.”⁴⁸

Institutional self-interest and insularity: Development cooperation is undertaken by people and institutions with a particular history, institutional setting and focus. But development cooperation cannot work effectively if each partner thinks of itself in isolated terms. Institutional learning and repositioning is not at all self-evident in many organizations.

Aid (and) business: Some aid agencies have themselves become economic giants – you might call them corporations. But also for smaller organizations working “professionally”, with considerable budgets and numbers or employed staff, promoting and sustaining the organization has become an end in itself, limiting their choice of strategies and the freedom to act politically. They need to take money and partnerships where they find it.

The legitimacy of international NGOs and civil society: Civil society has contributed to improving the accountability, transparency and effectiveness of development cooperation actors in health as well as within Global Health Initiatives such as the Global Fund. It is hence also important that they contribute to the development of the new UHC 2030 Alliance. Nevertheless, there are concrete deficits in their functioning.

“CSO interventions in respect of global governance (for health) have in many situations tended to reinforce arbitrary power hierarchies in global politics and to legitimate rather than challenge global governance arrangements that may be significantly flawed.⁴⁹... CSOs from impoverished

countries, underclasses, indigenous peoples and marginalised circles have been largely left out of the exchange. Instead, the field of global governance consultation has generally been disproportionately occupied by CSOs with bases in the global North, metropolitan cities and professional classes".⁵⁰

2.4. Methods and practices

That which has been stated so far is also relevant in relation to concrete methods and practices. Development cooperation programs and projects are often – and often rightly – criticised as follows:

Vertical, not integrated approach: The problem with vertical approaches can be effectively demonstrated in the health sector: One main criticism of the “Millennium Development Goals” was that they promoted vertical, disease focused health interventions – fighting HIV/AIDS, promoting maternal and child health etc. – neglecting that there a functioning health system is needed to make such interventions sustainable. Vertical interventions have the potential to distract from tackling the systemic causes and to further weaken existing health systems.⁵¹

Lack of coordination: Development cooperation causes problems when there is insufficient coordination. We refer to a story from Kenya where 18 different types of water pump had been provided by 18 different donors. Each required a different instruction manual and set of spare parts.⁵²

One-way accountability: Accountability has become a central theme in the dialogue about the framing and implementation of the Sustainable

Development Goals, and rightly so. But in the field of development cooperation, the key issue is who is accountable to whom? Normally development agencies report back to their domestic audience and donors only from whom they expect support, following their reporting requirements. And national governments and local institutions report back to the development agency. Being accountable to the “owner” of development, to the developing country and the “beneficiaries” is much less common.⁵³ Downward accountability is ultimately about defining impact in a way that places the perceptions of people and communities center-stage.⁵⁴ Accountability also requires an agreement about how to measure impact and the tools to implement it.

Evidence base: The call for “evidence based cooperation” has been very prominent over the last years. Also the MMI Network has promoted evidence based health cooperation in its documents and events.⁵⁵ In fact, “understanding and demonstrating the effectiveness of efforts to improve the lives of those living in poverty is an essential part of international development practice. But who decides what counts as good or credible evidence? Can the drive to measure results do justice to and promote transformational change – change that challenges the power relations that produce and reproduce inequality, injustice and the non-fulfilment of human rights?”⁵⁶ Evidence and scientific facts are to an extent socially constructed. The conceptual paradigms of the Sustainable Development Goals and Social Justice might differ hence also the related theories and scientific evidence might be incommensurable.⁵⁷

Questions for reflection (2)

- Who “owns” your institution and its programs in international health cooperation? Who defines your institution’s policies and approaches? To whom is your institution accountable?
- Does your institution report back to the “beneficiaries” of your work and to your partner institutions in developing countries? If yes, do you explain them who you are and what you do in the same way you report to your owners and donors? If not, why? Could you share your domestic fundraising material with the people and institutions you work for without feeling uncomfortable?
- Would you accept the labelling of your institution as “a business”? How do you handle the dilemma between doing “the right things” and your institution’s economic sustainability? Is there a “business” and “marketing” approach in your definition of policies and programs?
- “Your work saves lives, but also contributes to the stabilization of a thoroughly unfair and destructive system of trade and development.” – What is your formal institutional answer to this challenging question? And are you happy with it?
- Has your institution, your overall approach and practices been publicly criticised? How did you react? Are you still happy with this reaction, or would you do it differently? What did you learn out of it? What did you change?
- Would you call yourself a “learning organization”? If yes, what are your instruments and structures, and who is in charge of your institutional learning?
- Would you call your organization’s work “evidence based”? If yes, what evidence do you refer to and why, and how is it generated and continuously reassessed?

3. DEVELOPMENT COOPERATION IN TIMES OF THE SDGs: MOVE IT BEYOND AID!

In a holistic and universal agenda for sustainable development as expressed in the UN “Agenda 2030” (SDGs), there is no obvious space for the distinction of “us” and “them” and no such things as “donors” and “recipients” of aid. In this sense, and taking up the criticism of development cooperation expressed above, we invite you to deal with a challenging question: Is it time to come to an end of development cooperation for health? If not, what is needed to improve its relevance and legitimacy?

3.1. SDGs: Agreement on goals, but how to achieve them?

In the UN Agenda 2030, the achievement of sustainable development is framed as a shared responsibility of all countries (but “respecting each country’s policy space and leadership to establish and implement policies for poverty eradication and sustainable development”⁵⁸). This requires a global and national political movement to promote and achieve it.

Creating a “global partnership for sustainable development” (SDG 17) has become the new lead paradigm.⁵⁹ This is clearly expressed by a CSO participant at a recent consultation on the creation of a “Universal Health Coverage 2030”. He states: “UHC is a totally revolutionary way of thinking about health in developing countries. It is a real move from the MDGs which focused on specific targets and specific help from donors and actually to a world where we talk about the right to health and the responsibility of governments to provide that for their citizens. I’m really hoping that UHC 2030 will bring us all together ...most importantly build a political movement in countries and globally for UHC.”⁶⁰

Not surprisingly, if one again looks at Jesse Bump’s “to-do list” at the level of the global political economy of Universal Health Coverage (above, 1.5), “development cooperation” is not part of it. In the optimistic view of the SDGs, the change required to achieve health for all is the result of a “multisectoral” or “multistakeholder” partnership at national and global levels. In a more critical view, change will happen - or not - as an outcome of transformative societal and political struggle. Nevertheless, the Sustainable Development Goal 17 still refers to “international support to developing countries”, to “fully implementing official development assistance commitments” and to other elements of the classical development aid agenda such as financial support, technology transfer, and capacity building. The SDG paradigm does not provide a clear answer to the questions of how to move “beyond aid as we know it” by critically repositioning development cooperation and promoting greater equity.

3.2. Move cooperation beyond aid!

“There is a little more awareness that the poor are more likely to save themselves than to be saved by middle-aged white male experts.” (Easterly).⁶¹

“Poverty is not a natural condition. It is a state of plunder. It is delusional to believe that charity and aid are meaningful solutions to this kind of problem.” (Hickel)⁶²

*“Even if the Medicus Mundi International Network is rooted in international health cooperation and health aid, we are aware that the solution for the future cannot be charity, but justice.”*⁶³

According to Jason Hickel, the “aid industry” is well aware of the criticism it faces. But instead of changing its approach to development, it just changes its language: “In the end, the existing aid paradigm remains intact, and the real problems remain unaddressed. The strategy goes like this: Talk about the poor as ‘equals’ who share our values; emphasise that development is a ‘partnership’; stop casting rich people and celebrities as saviours of the poor; and above all, play up the idea of ‘self-reliance’ and ‘independence’, with special attention to empowering women and girls. Progressive Westerners love this stuff.”

Hickel’s conclusion is obvious: Stop aid, promote justice, and deal with the real political and social causes of poverty and inequality.

If “aid” cannot be repaired, one might indeed rather let it go as Michael Edwards put it in his recent article *What’s to be done with Oxfam?*: “Just like the United Nations, NGOs have become a comfortable part of the furniture of foreign aid that was first designed in the 1950s, so it’s not surprising that they now look a little dated. But you don’t get rid of that old armchair in the corner of the living room just because the upholstery is frayed around the edges. Eventually, however, you do have to let it go.” (Edwards)⁶⁴

To be clear: We do not promote the cessation of cooperation for health, but to move it beyond charity and aid. The next sections of our paper will

explore how development actors, and in particular NGOs and civil society could contribute to, and must shift to, a new paradigm.

Authors have argued that civil society organizations can become a catalyst for ensuring health in the sustainable development agenda, by fulfilling eight essential global health functions: “These include producing compelling moral arguments for action, building coalitions beyond the health sector, introducing novel policy alternatives, enhancing the legitimacy of global health initiatives and institutions, strengthening systems for health, enhancing accountability systems, mitigating the commercial determinants of health and ensuring rights-based approaches. Given that civil society activism has catalyzed tremendous progress in global health, there is a need to invest in and support it as a global public good to ensure that the 2030 Agenda for Sustainable Development can be realised.”⁶⁵

3.3. From developing systems to redistributing resources

Without going into much detail, there have been many discussions how to move beyond aid.⁶⁶ In this section, we would like to highlight a (recent) proposal that is worth further development and dialogue. It is basically the idea of transforming ODA into *International Finance for Sustainable Human Development and Social Security*.⁶⁷

In a recent paper, the same case was made to transform development cooperation into international cooperation on rights and redistribution. Such a system of international cooperation would be based on three pillars. The first one would consist of a redistributive bilateral mechanism of financial transfers to promote social health policies between richer societies to poorer societies, to start with organising one integrated social security systems in Europe, but likewise at the global level, e.g. via a coordinated United Nations body or other mandated institution. Secondly, to develop a multilateral global fund for health as to cover basic health needs globally, in coherence with other global social protection mechanisms and with the idea that such a fund could partly be funded by an international taxation body, hence not relying on ODA (only) anymore. The third pillar would consist of networking civil society organisations on universal issues like health equity and human rights across high-, middle-, and low-income countries and income groups as to provide pressure and provide solutions to fulfil universal health care.⁶⁸

These civil society and popular movement groups should not only work on social policy implementation and activism, but would also link with those civil society groups that focus on the ‘first do no harm principle’, such as in the field of economic policies (austerity), unjust trade regimes and climate change. It is a networked approach, based on mutual values, respecting pluriformity, and with the belief that health challenges connect societies across countries. It will require international NGOs not only to work in LMICs with legitimate counterparts but also have a deep, sincere, connection with movements for social justice in their own country and region.

3.4. Improve input legitimacy

In an ever-more interdependent world, the need for more collective action has increased drastically. The range of public goods has expanded and now includes sustainable development, growth and health. New forms of cooperation have developed, which include governments, International Organisations, non-governmental organisations (NGOs), the corporate sector, and even (powerful) individuals as actors. Most of these collaborations fall under the generous heading of “transnational governance” or “multistakeholder governance”, a catch-all concept encompassing multiple forms of institutional innovation, and often informal ways to address transborder problems and challenges. Since multistakeholder governance involves more than states and formal treaties, it raises the question of the democratic quality of the procedures of decision-making, and hence the legitimacy of the policy outcomes.

Reacting to the strong criticism, mainly bilateral aid agencies have invested a great deal in developing principles of how to improve development cooperation and its governance. Improvements will be needed at different levels. We propose an overall approach focusing on legitimacy: Democratic legitimacy in international⁶⁹ cooperation, also in the health sector, can be analysed through five prisms:^{70 71}

- (1) Effectiveness
- (2) Accountability
- (3) Transparency
- (4) Deliberation
- (5) Representation

The accountability, transparency and effectiveness prisms are addressed in the next chapter of this paper on effective health cooperation. Dealing with these elements of *output legitimacy* has become, in general, part of the mainstream debate on how to

advance development cooperation in the Sustainable Development Era.

What is relatively neglected in international health cooperation is the part of input legitimacy.

Discussing the two prisms of deliberation and representation and how to improve them is not easy. It requires us to ask almost existential questions; and to be reflective and inward looking about our role as actors in health cooperation, examining our mandate, who do we represent in our work, and the governance of global health bodies. This is a challenging task, but truly needed as international cooperation moves beyond aid and there is much more (public) focus on agency, power, values (belief systems) and interests.

“Deliberation” refers to the platforms, fora and spaces where practices, values, concerns in relation to health development and cooperation are discussed. How can such platforms be organized in an open, transparent way? How to manage diverse positions? What is the internal mechanism for consultation and feedback?

Although a lot of professional meetings, focus group discussions with “target groups” and even frameworks for engagement with non-state actors exist at the global, national, and local level; they are “corrupted” by inherent power imbalances and (financial) dependencies of the agencies involved.⁷²

A truly participatory forum on global health development does not yet exist, despite all the big events on a range of health topics and despite so-called multi-stakeholder forums like the World Health Summit.⁷³ A proposal in 2011 to organise a regular World Health Forum in coherence with the World Health Assembly was not approved by the member states of the WHO. The People’s Health Assembly, organised through the People’s Health Movement, is held approximately every five years, which draws in civil society organizations and networks, social movements, academia and other stakeholders from around the globe.⁷⁴ Despite its great promise, it has lacked structural financial and personal support, as well an involvement of more powerful policymakers and governments active in global health.

There is hence first a need to exert pressure on global health actors to democratize their practices^{75,76} and secondly to initiate democratic and properly regulated fora in global health in order to further structured dialogue on how to advance global health development and cooperation. There are good examples to be built on at national and regional levels such as participatory health fora in El

Salvador, Brazil and Thailand but limited innovation in this regard is seen at the global level.⁷⁷

The UHC 2030 alliance might play a role in this but it should truly move beyond its exclusive ‘club’ meetings as has been the case during the global consultation in Geneva in June 2016. Other global spaces in development cooperation where the governance of health might be discussed include the CSO Partnership for Development Effectiveness⁷⁸ and the Development Cooperation Forum of the United Nations Economic and Social Council.⁷⁹

Strengthening deliberative platforms within health cooperation would be a shift away from interventionism and direct service delivery to broader learning and self-reflective communities - a function that deserves proper attention in a universal Sustainable Development Agenda.

“Representation” refers to mechanisms within an actor itself such as delegation, information sharing, voting, internal accountability participation of citizens, target groups, geographical distribution etc. As Health Poverty Action puts it, there is an issue of internal power that needs to be addressed and often isn’t.⁸⁰

This point is the most contentious, mainly for international NGOs as part of “civil society”: Could NGOs become “‘whitewater rafts’ instead of ‘supertankers,’ working in the spaces between governments, civil societies and markets; bridging across different geographies and constituencies; and focused on embedding values of equality, sustainability and rights into larger systems instead of implementing aid-funded projects”?⁸¹

There is heterogeneous track record here but all in all there are “strong tendencies towards an undemocratic dominance from the Global North and professional elites in the civil society that engages with global initiatives (such as the UHC 2030 alliance) and regulatory agencies.”⁸²

“Civil society engagement has widely manifested and reinforced class hierarchies favouring reformist adjustments in global structures with a hegemonic character rather than a being a transformative, counterhegemonic, force.”⁸³

Questions for reflection (3)

- Could you subscribe to one of the following statements: (a) “We are at the end of aid.” (b) “We need to move beyond aid.”? Please provide your own insights about if/how “aid” or development cooperation needs to change in order to improve its legitimacy.
- Has your organization – related to a critical overall assessment of your role and not because of an economic crisis –, ever considered closing down? If yes, what made you change your mind?
- Do you share the assessment that we lack platforms, fora and spaces where practices, values, concerns, in relation to health development and cooperation can be discussed in an open, transparent way?
- If your organization is involved in thematic, regional or global platforms and fora on health development and cooperation: Are the right people around the table? How can we redefine and improve deliberation?
- How would you assess the “representation” quality of your organization’s mechanisms on information sharing, voting mechanisms, internal accountability, participation of citizens, target groups, geographical distribution etc. ?
- Any question we forgot to ask you?

4. EFFECTIVE HEALTH COOPERATION...

In this section we discuss how international cooperation for health can achieve better *output legitimacy*, in an overall sense of improving its effectiveness. We refer to general aid effectiveness principles and discuss their application in the health cooperation sector. Admitting the limitations of international development cooperation and its great problems with input legitimacy and agency, we assume that “how” matters⁸⁴ and invite you to reflect on how to “do it better”.

4.1. Aid effectiveness principles

“One of the things that I have found most frustrating in my career in development is the way that any discussion must lead immediately to answering the question: What should we do?”
(William Easterly)⁸⁵

“Is working to transform the sector from the inside helpful, or are we legitimising something that fundamentally is part of the problem?”⁸⁶

“Aid effectiveness” principles are defined by the OECD’s Paris Declaration on Aid Effectiveness (2015) and the Accra Agenda for Action (2008)⁸⁷ followed by the Busan Partnership for Effective Development Co-operation (2010)⁸⁸ Endorsed by more than 100 “donor” and “partner” countries in order “to base development efforts on first-hand experience of what works and does not work with aid”, the Paris Declaration is formulated around five central pillars:

- Ownership
- Alignment
- Harmonisation
- Managing for results
- Mutual accountability

The Busan Partnership document specifically highlights a set of common principles for all development actors that are key to making development co-operation effective.

- Ownership of development priorities by developing countries: Countries should define the development model that they want to implement.
- A focus on results: Having a sustainable impact should be the driving force behind investments and efforts in development policy making
- Partnerships for development: Development depends on the participation of all actors, and recognises the diversity and complementarity of their functions.
- Transparency and shared responsibility: Development co-operation must be transparent and accountable to all citizens.

“Doing Development Differently” was the topic of a workshop at the Harvard University in 2014, resulting in the “DDD Manifesto”⁸⁹ which states: “Many development initiatives fail to address complexity, promoting irrelevant interventions that will have little impact. Some development initiatives, however, have real results. Some are driven domestically while others receive external

support. They usually involve many players – governments, civil society, international agencies and the private sector – working together to deliver real progress in complex situations and despite strong resistance. In practice, successful initiatives reflect common principles:

- They focus on solving local problems that are debated, defined and refined by local people in an ongoing process.
- They are legitimised at all levels (political, managerial and social), building ownership and momentum throughout the process to be ‘locally owned’ in reality (not just on paper).
- They work through local conveners who mobilise all those with a stake in progress (in both formal and informal coalitions and teams) to tackle common problems and introduce relevant change.
- They blend design and implementation through rapid cycles of planning, action, reflection and revision (drawing on local knowledge, feedback and energy) to foster learning from both success and failure.
- They manage risks by making ‘small bets’: pursuing activities with promise and dropping others.
- They foster real results – real solutions to real problems that have real impact: they build trust, empower people and promote sustainability.”

A group of “thinkers and doers” have deepened the DDD Manifesto and make a case for “Thinking and Working Politically” (TWP) in development cooperation ⁹⁰. According to the authors the TWP and DDD agendas are driven by three core principles:

- Strong political analysis, insight and understanding;
- Detailed appreciation of, and response to, the local context and
- Flexibility and adaptability in program design and implementation.

“TWP is an approach to improve delivery of any aid program that involves reform and behavioural change - it is as relevant to better delivery of health services or economic policy reform as it is to an anti-corruption initiative. TWP takes the naivety out of institutional relationships by understanding that change happens as a result of decisions that invariably have a political dimension.”⁹¹

4.2. Aid effectiveness in the health sector

*International Health Partnership*⁹², a platform jointly hosted by WHO and World Bank, formerly known as IHP+ and currently transformed into “International Health Partnership for UHC 2030”, was created in 2007 “to accelerate better health results by putting the Paris principles on aid effectiveness in practice in the health sector. This was premised on the assumption that providing aid in an effective way (aligned to country priorities, in a transparent and predictable manner, using country systems and focused on results), will lead to improved health outcomes and improved development.”⁹³ To achieve effective health cooperation IHP+ promotes “seven behaviours”:

1. Agreement on priorities that are reflected in a single national health strategy and underpinning sub-sector strategies, through a process of inclusive development and joint assessment, and a reduction in separate exercises.
2. Resource inputs recorded on budget and in line with national priorities
3. Financial management systems harmonized and aligned; requisite capacity building done or underway, and country systems strengthened and used.
4. Procurement/supply systems harmonized and aligned, parallel systems phased out, country systems strengthened and used with a focus on best value for money. National ownership can include benefiting from global procurement.
5. Joint monitoring of process and results is based on one information and accountability platform including joint annual reviews that define actions that are implemented and reinforce mutual accountability.
6. Opportunities for systematic learning between countries developed and supported by agencies (south-south/triangular cooperation).
7. Provision of strategically planned and well-coordinated technical support

Obviously this is a strongly “inter-national” approach, focusing on well-functioning countries as main actors. In order to promote and assess the implementation of these behaviors, IHP+ uses global performance reports and associated scorecards.

In the NGO field, the “NGO Code of Conduct for health systems strengthening”⁹⁴ frames the task as follows:

- I. NGOs will engage in hiring practices that ensure long-term health system sustainability.
- II. NGOs will enact employee compensation practices that strengthen the public sector.
- III. NGOs pledge to create and maintain human resources training and support systems that are good for the countries where they work.
- IV. NGOs will minimize the NGO management burden for Ministries of Health.
- V. NGOs will support Ministries of Health as they engage with communities.
- VI. NGOs will advocate for policies which promote and support the public sector.

There are more formal and informal “checklists” and references for “good” or “effective” health cooperation, and it might be useful to have a more comprehensive collection as reference for our related work.

Questions for reflection (4)

- (How) Do the five “aid effectiveness” principles – ownership, alignment, harmonisation, managing for results, mutual accountability – resonate in the policy documents and practices of your organization?
- How/where do you define and measure effectiveness of your organization’s work?
- Have you ever taken the “seven behaviours” promoted by IHP and answered them on behalf of your own institution? (Try to do it: Answer every question with a simple “yes”, “no” or “I do not know”. If there are many “no” or “do not know”, ask yourself what might be wrong – and how to change it. Ask other representatives of your institution to do the same. Compare. Start talking. Start acting.)

5. WHAT NEXT?

As initially indicated, our discussion paper intends to be both normative (in the “soft” sense of MMI being a horizontal Network whose members keep their full independence) and inspiring. The Medicus Mundi International Network wants to provide the members of its working group on Effective Health Cooperation (EHC) and other interested MMI members and partners with a reference for their engagement in this field, both at a global level (policies, institutions, governance) and in their concrete health cooperation programmes.

In this sense...

- let us admit the limitations and challenges of health cooperation, but let us not give it up too easily. Health cooperation still has a role to play;
- let us not allow business as usual nor a “strategic marketing” approach for the further development of our own work, strategies and instruments;
- let us invest in shaping and sharpen our analytical instruments, our policies and approaches and our technical skills towards contributing more effectively, sustainably and legitimately to strong, people centred national health policies and systems.

We expect to contribute to a paradigm shift – if not yet done – of health cooperation from interventionism to critical self-reflection, and we mainly hope to contribute to a vivid dialogue among those engaged and interested in health cooperation. Such a dialogue – and creating spaces to lead it in a frank and honest way – are still much needed.

In its Network Strategy 2016-20 the Medicus Mundi International Network states: “In the arena of international health, there are already a great number of thematic communities. However, there is still a lack of platforms where actors in health cooperation can critically reflect their own practices and approaches, share information and experiences, learn from each other and have an opportunity to further develop their institutional and personal skills and practices. This is where the MMI Network will invest into the development of further services. The focus will be on policies and instruments for international health cooperation.”

For the further planning and implementation of concrete activities in this field the MMI Network launched, in May 2016, a working group on effective health cooperation (MMI EHC)⁹⁵. Join us, if you like.

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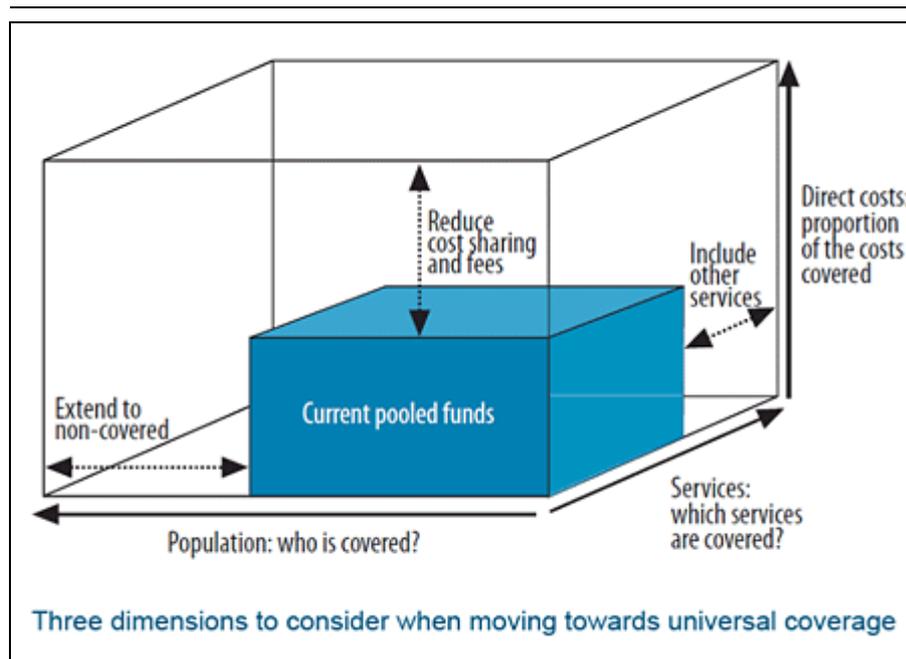
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