Global prescriptions and neglect of the 'local': What lessons for global health governance has the Framework Convention on Global Health learnt?

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GLOBAL HEALTH GOVERNANCE IS AN OPEN ACCESS, PEER-REVIEWED, ONLINE JOURNAL THAT PROVIDES A PLATFORM FOR ACADEMICS AND PRACTITIONERS TO EXPLORE GLOBAL HEALTH ISSUES AND THEIR IMPLICATIONS FOR GOVERNANCE AND SECURITY AT NATIONAL AND INTERNATIONAL LEVELS.

THE JOURNAL PROVIDES INTERDISCIPLINARY ANALYSES AND A VIGOROUS EXCHANGE OF PERSPECTIVES THAT ARE ESSENTIAL TO THE UNDERSTANDING OF THE NATURE OF GLOBAL HEALTH CHALLENGES AND THE STRATEGIES AIMED AT THEIR SOLUTION. THE JOURNAL IS PARTICULARLY INTERESTED IN ADDRESSING THE POLITICAL, ECONOMIC, SOCIAL, MILITARY AND STRATEGIC ASPECTS OF GLOBAL HEALTH ISSUES.

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SPECIAL ISSUE ON THE FRAMEWORK CONVENTION ON GLOBAL HEALTH

Global prescriptions and neglect of the "local": What lessons for global health governance has the Framework Convention on Global Health learned?

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The Framework Convention on Global Health comes amid wider recognition of health inequalities and several recent calls for greater democratization of the world order. The framework suggests wider consensus on principles of human rights, equity and justice in addressing global health. In this paper, we draw on our empirical research and wider literature to discuss the lessons learned from the application of global "ideas" and "innovations" and reveal institutional and political processes and structural constraints that affect their implementation. We present our approach on the basis of two key arguments. First, gross inequalities and unequal distributional effects of the current global political and economic environment do not offer a level playing field for nation states to translate principles enshrined in the framework into practice. Second, such a "view from above" undermines processes of empowering communities to create responsive health systems. Through a case vignette of the People's Health Movement, we then discuss substantive ways to facilitate local ideas and action.

INTRODUCTION

Several calls for a global movement and "planetary action" for health equity have been issued in the recent past.[1] These respond to an on-going crisis in global health, which is characterized by growing social and health inequities within and among nations, increasing trans-border threats of disease outbreaks, and dominance of perverse market forces,[2] making public health incidental to trade and economic growth.[3]

Concerned with persistent indefensible differences in life chances of a child born in Sub-Saharan Africa and another in North America, the global health community is drawn into discussions on what might a post-2015 development agenda look like. As debate on the much touted 'Sustainable Development Goals' gathers heat, global health actors are unified in their desire to explore solutions to contemporary challenges in global health. One such proposal, the Framework Convention for Global Health, would create a global health treaty advanced by a coalition of academics and civil society members, namely the Joint Action and Learning Initiative. The framework responds to concerns about fragmentation of the global health system and the weakening of the World Health Organization and other institutions charged with global governance.[4] Endorsed by the UN Secretary-General, the framework purports to "reimagine global governance for health" as structured around human rights, equity and justice, and legally bind governments to standards that catalyze accountability and guarantee inclusive participation. It establishes clear goals in response to seven "grand challenges in global health" identified as struggling leadership, inadequate and volatile funding, poor coordination, neglected priorities, reduced accountability, and insufficient intersectoral influence[5]. These goals include increasing government health spending for domestic and external needs, re-setting global governance arrangements for

health through incremental protocol negotiations, and realizing the human right to health by clarifying the necessity of universal health coverage. The proposal has garnered wider support on national and global responsibilities for health, due to its transformative intent in reforming global health governance. The framework is not without its critics. Several concerns have been articulated, not least about the 'unintended' consequences likely to result from its implementation. Critics draw attention to direct and opportunity costs of such international law, mainly reducing possibilities of political dialogue, imposing foreign values and externally defined goals on less powerful nations, prioritizing individual rights over issues that merit population-wide responses, and offering sub-optimal solutions for challenges to global health.[6] In addition, these scholars argue that framework proposals, through development of new protocols, structures and obligations, duplicate efforts and undermine existing human rights treaties. Of significance are conflicting mandates of the regime likely to implement the framework and the functions and mandate of the World Health Assemblies. Such tension is likely to contribute to weakening the WHO although the proposal recognizes its centrality to the Framework's governance architecture.

The unparalleled interest received by this proposal brings to the forefront historic debates on universalist vs relativist paradigms for development. There are important questions to be asked about how such rights-based frameworks in global health can be operationalized given the conceptual ambiguity around what constitutes 'global health'[7] and its varied use, both descriptive and prescriptive.[8] Also, what are the limits in its application in a non level-playing field marked by significant geo-political, economic and historical differences? Lastly, these debates must facilitate critical reflections on why historic milestones in global health such as the promises of Alma Ata and other conventions /declarations did not bear fruit. In this paper, we ask some of these fundamental questions by drawing on our empirical research on international health systems and policy to reflect on what we stand to gain and lose from applying universal prescriptions to improve 'global health'. We first present a brief account of the global health governance landscape, and the scholarship defining it, in order to illustrate the unprecedented growth in the quest for normative frameworks for good governance. Through two case vignettes we then explicate the contestations and implications of applying ideas without critical reflection on their normative underpinnings, the processes through which institutional arrangements are mediated, and their underlying structural and contextual determinants. These, we argue, are important lessons to be learned from history with implications for the application of the Framework Convention on Global Health.

GLOBAL HEALTH GOVERNANCE AND ITS QUEST FOR NORMS, IDEAS AND VALUES

Global Health Governance is a rapidly expanding field of scholarship. The term, coined by Dodgson and colleagues,[9] emerged amid growing recognition of the impact of globalization on health determinants and outcomes and the arguable limits of nation-states in determining matters transcending national frontiers.[10]

For the purpose of this paper, we restrict the study to describing key characteristics of the concept and discussing its normative dimension. We adopt the conception of Global Health Governance as a complex open adaptive system,[11] but also as a "process of contestation"[12] between a variety of different ideas and discourses, each of which takes a particular approach to health and generates certain policy responses. Global health governance can thus be defined in terms of its key

constituents, namely i) architecture and organization (or the lack thereof) with multiple actors, their transient relationships, and complex networks they are embedded in; ii) core functions; and iii) normative ideas and frameworks that create paradigms for investments in health.

Governance 'architecture' is the "overarching system of public and private institutions, principles, norms, regulations, decision making procedures and organizations that are valid or active in a given issue area of world politics".[13] The contemporary governance architecture is characterized by an 'unstructured plurality',[14] whereby new actors emerge/ are created (for example, 120+ global health initiatives that provide a substantial portion of funding and products) while pre-existing actors (e.g. World Bank, private foundations, NGOs) re-define or carve out new roles for themselves in health. This has re-configured the political space for global health; first, the focus of decision-making is shifting as power is getting dispersed from G8 concentration to growing economies and regional powers represented by the G20 (especially emerging economies), and the recently founded G7+1.[15] While this shift challenges the broader political/institutional relationship of power (and strengthens southern nation-states,[16] including those perceived as 'fragile'), in itself it does not trigger equity in health. Rather, as some have argued, health priorities are becoming secondary to finance, trade and security objectives.[17] Second, greater engagement with non-state actors has undermined legitimacy of the state, across several functions of governance including agenda setting, enabling dispersion of power and decision making among multi-lateral institutions. Global health governance literature is deficient in examining state sovereignty and growing legitimacy of non-state actors vis-à-vis the roles and functions of governance. Peter Haas purports that "effective governance rests on the performance of multiple governance functions",[18] formally or indirectly performed. He outlines 12 core functions of governance, from agenda setting and issue linkage to monitoring and capacity building (through technology and skill transfer), and maps these across diverse actors while evaluating their performance. The Framework Convention does not offer insights into how either the international community or nation-states (constituencies cited) will perform these different functions, and how a human rights framing can affect such division of task.

Normative ideas and frameworks towards 'good' governance

Several proposals have been put forward to correct deficiencies inherent in the existing global health governance system and the vagaries of international development assistance in health. Some call for transformative changes to redress the "unconscionable health gap"[19] (e.g., Global Plan for Justice); others propose strengthening of existing institutions, for example, through formation of Committee C of the World Health Assembly[20] or the creation of new entities (e.g., a Global Fund for Health). Proposals seek to either address cross-cutting challenges facing the global health community (e.g., UN Global Health Panel) or target specific policy areas and constituencies to ensure equitable drug development and distribution (e.g., Health Impact Fund for incentivizing pharmaceuticals) and achieve sustainable and ethical economies (UN Global Compact for businesses). Notably, the latter

[1] The G7+ established a new foundation for collaboration between 20 fragile states, donor nations and other global governance structures focused on state building and peacebuilding, based on the principles of the Paris Declaration on Aid Effectiveness.

agreements are premised predominantly on mutual advantage and cooperation strategies.

This persistent quest for innovations in institutional arrangements and approaches to managing the externalities arising from intensive cross-border flows have come to define the global health governance system and produced a *complex mosaic of institutions*,[21] often with overlapping norms and constituencies. These innovations take a variety of forms: i) regulatory "trans-border-agreements" to protect health, for example formal instruments such as the Framework Convention on Tobacco Control (FCTC), International Health Regulations (IHR); ii) technical interventions and technological silver bullet solutions to global health problems[22] that are often determined by institutions (such as the Gates Foundation) largely with representations from HICs; iii) new funding mechanisms and incentives to correct resource scarcities and low prioritization of specific health problems, which have given rise to a number of disease-specific and product development partnerships that are perceived to enhance 'country ownership';[23] and iv) application of unifying international principles for achievement of 'good' global governance. While there is no consensus on conceptions of 'good' governance and therefore principles to attain it, the hegemonic 'problem solving' discourse tends to focus on creating structures to enhance administrative efficiency and management[24] to correct perceived governance failures defined primarily in terms of corruption, transparency and accountability problems in fund utilization and procurement /supply chains as well as those emerging from uncoordinated action.[25] These principles are embraced by mechanisms adopted by complex configurations of state and non-state actors and their assemblages into 'public-private partnerships' to steer achievement of public health goals.

There is a simultaneous resurgence of interest in equity, rights and social justice as the basis for health investments and programming, and more broadly in re-shaping substantive ways in which 'the system beyond governments' be governed.[26] These notions of solidarity and justice are taken up by all, albeit with varying degrees of acceptance and incremental or piecemeal approaches.[27] These developments occurred in the context of wider support by donors and global actors, and in the last decade, to more integrative modalities of aid such as sector wide approaches, poverty reduction strategy papers (PRSP), and direct budgetary support, although these make greater use of economic frameworks in decision-making.[28]

Scholars offer a range of economic and political explanations for the failures of global health governance[29]. However, few address how these factors are maintained and reinforced by existing approaches. Critical scholarship, albeit limited, questions structural inequities, power imbalance and ethical foundations of global health governance calling for transformative shifts[30]. As well as material power, popular policy 'innovations' are shaped by deeply entrenched ideas or *frameworks of thought*,[31] both of which must be examined for a careful assessment of the contemporary field of global health governance.[32] One such hegemonic idea structuring this field is that of *neoliberalism*, which has evolved over a period marked by economic, political and financial crisis and shrinks any alternative policy space and sites of resistance.[33]

Neoliberalism serves as the overarching logic for several contemporary paradigms and framings of the global health and public policy agenda. Rushton and William[34] articulate three ways in which neoliberalism shapes global health policy: first, through the roll back of the state, thus dispersing power across a wider range of both public and private actors, and second by promoting the uptake of a series of policy preferences by powerful actors, notably the international finance institutions

who apply these across countries through a variety of mechanisms. These policy preferences underscore liberalized and privatized health care systems and economies, and explain current policy trends. Neoliberalism shapes global health policy in a third way by colonizing many global health paradigms and concealing the macro-economic, political, and social determinants of health. Initiatives and conventions designed to enable coherence (such as IHP+, Health 8, Paris declaration) have gained traction. However, these remain focused on vertical program delivery in countries, with limited attention paid to upstream drivers of health concerning changes in agriculture, trade, and other policy sectors.

We illustrate these pathways through specific examples of reform attempts within the global health system; through principles of participation and human rights; and the policy approach of health systems strengthening. We present two case vignettes that demonstrate contingencies of practice and the extent to which the hidden transcript of policy innovation and its underpinning principles depart from the public transcript. A third case study then illustrates a case of organic bottom-up reforms that have both normative and substantive impact in health governance.

CASE VIGNETTE: GLOBAL HEALTH INITIATIVES' TRYST WITH RIGHTS AND EQUITY

Global health initiatives (GHIs) have assumed dominance within global health policy networks[35] and are regarded as the backbone of the global response to HIV.[36] In particular, the Global Fund, PEPFAR, and GAVI Alliance, together with new philanthropies, namely the Gates Foundation, are credited for leveraging unprecedented amounts of financial resources for the roll-out of large scale treatment programs, especially ARV and other life-saving therapies, and associated with a significant reduction in rates of new infections and associated mortality.[37] Notwithstanding these gains, GHIs came under severe criticism for their unintended consequences (fragmentation, competition, misalignment with national/ local priorities) implicating already weak health systems.[38] Responding, in part, to these criticisms as well as growing policy consensus on aid effectiveness, a number of more prominent GHIs have embraced the Health Systems Strengthening (HSS) agenda.[39] Such renewed commitment to health systems, and more recently human rights,[40] comes amid international debates on the trade-offs between vertical programs and integrated health care; short-term health goals (and provision of life-saving therapy) and building sustainable health systems. It is reflected in recent strategic frameworks of GHIs such as the Global Fund, GAVI Alliance and in program priorities endorsed by other global health actors. A recent assessment of the Global Fund's Round 8 grants shows that 37% (US$ 362 million) of funding in Round 8 was devoted to health system strengthening.[41]

Viewed as a positive development in the fractured global health system, GHIs embracing "the health system action agenda" (WHO 2006) has been argued to be "putting to rest the longstanding debate of vertical vs horizontal approaches".[42] However, recent evidence reveals significant departure from the rhetoric supportive of holistic health systems. Storeng[43] illustrates how by adopting the above rhetoric, GHIs and the World Bank have captured the global debate about HSS in favor of their specific ethos and single-minded focus on vaccines or specific diseases. Through ethnography of GAVI, Storeng reveals how its support to HSS is partly conditional on a set of targets for immunization/ vaccination coverage. Although the HSS strategy espouses the principles of aid harmonization and country ownership, in practice, any proposals for mitigating negative health system effects arising from their grants (such as reducing reporting burden by adhering to country systems)

were dismissed. In effect, the systems approach was reduced to strengthening the components needed to achieve disease–specific goals; suggesting a significant departure from the comprehensive vision and legacy of the Declaration of Alma Ata. Globally, the power and political expediency enjoyed by global partnerships such as the GAVI Alliance and large philanthropies backing these have led to an "ideological convergence around the so-called 'Gates approach' to global health",[44] whereby, as typical of the techno-managerial paradigm within global health, debates on health systems are re-cast as technical debates about healthcare and product delivery systems. These findings resonate with our country level research on the *governmentality* of the Global Fund and contracting experiences in health systems of fragile states.

A simultaneous resurgence of interest in the principles of *rights and social justice* as the basis for health investments and programming can be seen since 2009. Arising in part from recognition of the failure of neoliberal health reforms adopted in LMICs to reach the most poor and vulnerable,[45] these principles have made their way into public transcripts of several global health institutions. However, where principles of human rights and social justice have been included, they have been molded into existing approaches, as evidenced by the new funding strategy of the Global Fund, which incorporates human rights in a narrative structured around i) more rigorous performance based funding, ii) fiduciary risk management, whereby aid is granted on the basis of recipients' rankings on international benchmarks of good governance; and iii) financial austerity emphasizing value for money.[46] Critical evidence on global health initiatives has emerged globally as well as in countries such as India, South Africa, Zambia, and Peru. This evidence is examined below to highlight how principles of partnership, participation, and human rights are translated at the national level and into local practices, and the extent to which these transform global governance.

The term partnership implies collaborative development and implementation of policy with community involvement, consistent with principles of good governance.[47] However, partnership is being effectively used, at the global level, by powerful commercial interests to gain a seat at the decision-making table, while marginalizing less powerful communities and voices. Global agencies unequivocally seek civil society representation and *participation* as a gateway to enhanced representation, transparency and accountability,[48] the three tenets of reforming and democratizing the global health system. However, decision making in their governing bodies continues to be skewed with the private sector 'over represented' despite their modest contributions, and the WHO and civil society constituency under represented.[49] The Global Fund has been at the forefront of this debate. At the country level, through its structures including country coordinating mechanisms, the Global Fund is credited for fostering country ownership and creating space for participation of sections of communities hitherto marginalized in the political process, such as men who have sex with men in China or people who use drugs.[50] However, detailed analysis and ethnography of the *governmentality* of the Global Fund in India revealed how grant disbursements and management structures steer the direction of program priorities, privilege donors, NGOs and national elite networks over grassroot initiatives in decision making forums,[51] reinforcing the democratic deficit characteristic of the contemporary global health governance landscape.

Evidence from other countries corroborates these findings and suggests that the pursuit of goals of participation and rights by global health actors has been tokenistic. Entry of the Global Fund and the authority of its protocol have

transformed HIV governance in various ways. Studies suggest that annual grant making calls resulted in a proliferation of consortia with sometimes overlapping objectives and activities competing for funding and legitimacy in country level policy and governance. While some local groups received greater visibility and leverage to influence national policies, they were simultaneously exposed to inflexible funding and associated conditionalities. Pressures for scale-up, demonstrating achievement of targets (such as improvements in adherence rates) through computerized information systems resulted in opportunism and manipulation at facility level, loss of social capital, and a shift from more critical and political to technical and managerial discourses.[52]

CASE VIGNETTE: OPERATIONALIZING THE POLICY INNOVATION OF CONTRACTING OUT IN CAMBODIA, A 'FRAGILE' STATE

Greater attention to 'fragile states' began in the late 1990s with a concern that 'good governance' and aid effectiveness agendas had overlooked situations of conflict or weakly governed states.[53] Such states are considered to "lack the *functional authority* to provide basic security within their borders, the *institutional capacity* to provide basic social needs for their populations, and/or the *political legitimacy* to effectively represent their citizens at home or abroad."[54] The fragile state concept, now normalised and applied to many diverse situations, was mainly "intended to guide the interactions and relationships between donor countries and recipient countries facing conflict and poverty".[55] In these situations, the donors are in the driving seat, a predicament acknowledged by Akwetey,[56] who states: "fragility involves a heavy dependence on external assistance in the spheres of political, economic and social governance." The policy of 'contracting out' as a mechanism for the delivery of public health services has been widely applied in fragile states such as Afghanistan, Cambodia, the Democratic Republic of Congo, Rwanda and South Sudan.[57]

In Cambodia, the institutional, technical, and management capacity of the health system, at the end of the war in 1991, had deteriorated significantly, particularly with the dramatic loss of many professionals to the years of genocide and on-going war.[58] From a recent life history study with Cambodian people regarding episodes of illness, deaths and births of participants to the years of genocide and on-going war,[59] it was apparent that many had relied solely on self-medication and indigenous practitioners for much of the period up to 2000.[60] Given these constraints and the urgent need to re-establish a functioning health system, it appeared sensible—to the donors—to introduce ccontracting into the public health system in 'partnership' with the state, particularly where the contractors were well-known international NGOs with established track records in Cambodia and other fragile states.[61] Introduction of contracting in fragile contexts often allows states with limited institutional capacity to deliver health services within a relatively short period of time,[62] addressing health care needs of the local population. The trade-off is that state mechanisms may be bypassed by donors and contracting agencies, anxious to achieve relatively quick returns in terms of health coverage. This potentially undermines the much longer-term process of re-engaging citizens and the government through a 'social contract' with the public.[63]

In fragile states, posing the problem in terms of expanding health coverage alone presents tensions with the wider objectives of state-building and peacebuilding, considered by several[64] as core processes in re-establishing effective services. The tensions arise from different perspectives on what should be prioritised – universal health coverage delivered by non-state actors, or rebuilding the

legitimacy of the state. Fritz and Menochal[65] suggest that the legitimacy aimed for in fragile states is often normative, and does "not derive from its ability to produce outcomes (including economic growth and service delivery), but rather rests on a principled commitment to the democratic process." Kruk et.al[66] suggest a more instrumental legitimacy calling for specific attention to the health system's political, social and capacity-building functions when designing the strategy for its rehabilitation as it "may help national governments and international development partners to harness the potential gains in social cohesion and rebuilding of trust that are critical to state-building.[67] The contracting model, introduced and implemented by external agencies and contractors, however, produces limited accountability to either the state or the population, and facilitates an ongoing "condition of aid dependence"[68] and donor surveillance.

Baird and Hammer [69] have documented how the policy on contracting-out was designed poorly for the circumstances of the remote North-East province of Ratanakiri in Cambodia. Ratanakiri was selected for inclusion in the second stage of contracting-out on the basis of its high levels of poverty and vulnerability. Following the health system strengthening policy introduced in 1996, operational districts were created across Cambodia, covering between 100,000 and 200,000 people; in the weaker operational districts, a policy of contracting-out to international NGOs was implemented to try to achieve wide coverage of the population with a 'Minimum Package of Care'. An innovation in the Cambodian experience was the introduction of the Health Equity Fund (HEF), which aimed not only to offset the charging of user fees on the poor,[70] but to cover transport, food and related costs.[71] In Ratanakiri, the HEF component was under-financed as the contract designers had failed to recognize the higher proportion of the population that would qualify, and had to be suspended.[72] The project design also failed to recognize that the social relations of indigenous groups in Ratanakiri tended not to be mediated through cash transactions leaving user fees an extremely unpopular mechanism for health care funding. Equally excluding were the communication difficulties between Khmer speaking health staff and the population's more prevalent indigenous languages. Narrow measures of program 'success' failed to capture the breadth of health sector activities; for example TB services were not incentivized, and consequently appeared to be neglected. Neither did the contractor fully engage in building the capacity of local state health actors, considered a central component of the stated model; for example, the health budget of the international contractors was not revealed to them, leaving a critical gap. Of particular concern, Baird and Hammer found no evidence of a sophisticated understanding of local realities when establishing the contracting arrangements; they describe lip service to the requirement for participatory planning mechanisms by which implementers might have developed useful learning, and document a lack of effort of the implementing NGO to build capacity in the operational district.

Couched under the systems strengthening agenda, the contracting experience of Cambodia has been widely viewed as successful innovation, premised on analyses of national household surveys, and experience in a few specific sites. On the basis of this evidence, there has been widespread enthusiasm for the rolling out and scaling up of a generic model. However, the evidence cited above suggests, there is insufficient recognition of the specifics of contexts into which global policy models have been rolled out and scaled up which is likely to be detrimental to the populations of regions distinctly different across diverse contexts. It is evident that health system interventions in fragile states often follow similar templates in

situations "qualitatively different from one another, with unique problems that often require novel policy responses."[73]

THE (DIS)CONTENTS OF FCGH AND THE RISK OF SUBVERSION OF THE RIGHT TO HEALTH

The two case vignettes presented above focus on distinct ideas of policy 'innovations' that are couched in progressive conceptions and normative goals of attempted health systems and governance reform in diverse social, economic and political realities. The first draws on emergent scholarship on critical ethnographies of GHIs (including the primary author's research) that examine the contested social processes through which local effects of global policies are produced, and legitimized. This body of literature opposes the dominant view that "local" effects are "unintended consequences" of well-meaning global health actors, and challenges the perceived neutrality and desirability of such initiatives.[74] In the dominant view, any failures arising in countries are credited to inefficiencies in decision making, resulting from weak governance and ill-defined hosting arrangements at country level[75] and to the dynamics of "open source anarchy."[76] Extending this argument, reform in global health governance is likely to be achieved through creation and/or endorsement of policy innovations towards a more centralized, harmonized regime (through aid effectiveness, systems strengthening, and principles of rights and justice), as also suggested by the Framework. Instead, we argue that these failures are inevitable outcomes of structures that are underpinned by the logic of competition and embedded in a neoliberal discourse. For example, studies examining the GHIs in India, Namibia, South Africa and Zambia illustrate how grant disbursement structures, and the push for rapid scale-up and performance- and target-based approaches foster competition. This serves to reproduce power asymmetries and differences between international and local, for-profit and non-profit entities, and affect the most disadvantaged. The latter is evident in the second case vignette, which examines how the wider health systems strengthening debate, and its specific proposal of "contracting out" to extend coverage, plays out in Cambodia, a context reflecting political, institutional and social fragility. In this context, adoption of health equity and participatory proposals within an externally developed and implemented program did little to prevent further weakening of a system hollowed out through decades of colonialism, political conflict, and macro-economic reforms. Nor did the presence of "global" implementers, who were aware of "constraints such as language, culture, poverty and access"[77] routinely faced by the indigenous population, alter their program in ways that would reduce their exclusion from services and guarantee their "right to health." The potential to build capacity and local ownership, to re-engage with the public health system by both health workers and local population, was thus undermined.

Against this backdrop, despite its commitment to proposals with a redistributive intent, the proposed Framework is implicated in some fundamental flaws. We discuss these below.

Rationale

The Framework Convention on Global Health is premised on the success of two binding multilateral treaties: the IHR and the FCTC. These, arguably, demonstrate the "potential of hard law to improve health outcomes," albeit with inconclusive evidence on how policy changes facilitated by the treaties affected health outcomes in

countries, nor the nature of civil society engagement these evoked. The proposal recognizes their singular focus and limitations in addressing key social determinants of health and establishes the insufficiency of 'soft law' (codes and declarations) for ensuring global health justice, making a compelling argument for a broader framework that allows a marriage of the two to achieve this.

While the Framework recognizes key governance challenges (for example, mis-aligned priorities, trade and economic regimes impacting health goals, fund volatility and differential capacities) and their country level effects, the structures and mechanisms producing these are treated as largely unproblematic, and therefore replicative. Global endeavors such as the Global Fund are described as "embodying several key principles of good global governance," and failures attributed to the 'voluntary nature of its funding scheme." As we demonstrate in the cases above, the key governance threat that GHIs such as the Global Fund present is not the depleting funding pledges but the additional burden their funding mechanisms, parallel systems, and conditionality generate. The cases also illustrate the need for re-orienting the debate on obligations in the multi-level global health system to highlight the responsibility of (and to hold to account) transnational elites. Not only do diseases cross borders and issues have a global genesis, global actors (commercial and non-commercial) influence policy response at the national and sub-national level by leveraging resources and mutually co-producing outcomes through 'partnerships' with national elites i.e. wealthy and influential actors who control and/ or benefit from maintenance of power in the global health enterprise.

Gap between analysis and solutions

Recommendations proposed for an effective global health governance architecture fall short of the robust analysis of governance challenges developed in the proposal. Onus is primarily put on nation-states in meeting the human-rights based targets, while the role of the international community is limited primarily to managing fiscal deficits. Furthermore, the Framework lays emphasis on a target/ indicator driven approach, which as country studies demonstrate, fosters competition, opportunism, narrow constructions of health system strengthening, and lack of accountability to local populations. Disproportionate attention is given to alternative financing innovations,[78] and channeling funding through the global fund for health is envisaged as the solution to simplify the complex and politically contested landscape of health actors. While the Framework strongly commits to refining priorities locally through participatory, equitable processes, it is not clear how such bottom-up, inclusive processes would operate; nor how this will be distinct from what earlier and ongoing endeavors, such as PRSP and the SDGs, aimed to achieve.

Why have transformative proposals and promises of Alma Ata not delivered?

In their review of the Primary Health Care (PHC) strategy, De Maeseneer and colleagues[79] examine the factors underpinning the failure of Alma Ata. Some of those failures are attributed to the philosophical conflicts between selective and comprehensive primary health care and the presence of ideology over concrete, adaptable practice recommendations. PHC was perceived by many as not only a roadmap to achieving international health equity, but also an approach encompassing social and political reform.[80] In the period immediately following Alma Ata, the wider macro-economic environment propelled by the oil crisis, global recession, and the introduction by development banks of Structural Adjustment

Programmes, shifted national budgets away from social services, including health.[81] As Abhay Shukla[82] highlights in his powerful critique of the Alma Ata Declaration, "however noble the intentions…, these could not be converted into action if the forces blocking the way to 'Health for all' were not identified and challenged;" Thus for a reimagined global health governance, its structures and institutions must be fundamentally revamped. Binding nation states to human rights is not sufficient, and far from transformative for global health governance. While states continue to be "normatively and empirically the most appealing primary locus for social cooperation in health"[83] solutions to health problems that are rooted in political and commercial interests demand wider mechanisms for ensuring moral responsibility and remediating harm from actions of global actors (that produce conditions that hinder protection and promotion of individual and population health). It is unclear how the Framework proposes to address one of the key challenges for global health today, i.e. ensuring meaningful accountability, in particular holding corporations accountable beyond proposals for enforcing taxation policies. The Framework instead makes a more significant contribution to strengthening accountability of nation states (and systems) to their people. In the vignette below, we describe an alternative approach to attaining a similar objective.

STRENGTHENING HEALTH GOVERNANCE FROM BELOW: THE PEOPLE'S HEALTH MOVEMENT (PHM)

The World Health Conference in Alma Ata (1978) ended with the promise of 'Health for All by 2000'. Despite the failure to achieve HFA, the year 2000 marked an important year for advancing equity and social justice in health. At its onset, civil societies across the world mobilized under the umbrella of the PHM to commemorate the goal of HFA and propose an alternative vision and pathway to realize the right to health, resulting in a people's health assembly (PHA) in Bangladesh in December 2000. As part of this movement, Indian civil society facilitated a country-wide process to examine progress towards HFA in India, which led to the establishment of *Jan Swasthya Abhiyan* (People's Health Campaign). In the years since 2000, the JSA has emerged as a key policy advocate on health.

At the 25th anniversary of 'Health for All' in 2003, JSA launched a nationwide campaign on the 'Right to Health Care'. In collaboration with the National Human Rights Commission (NHRC), JSA held a series of public hearings across India, where violations of health rights (including denial of care, sub-standard care, and failure to address wider determinants such as occupational health hazards) were heard and redressed by a panel. These further informed a national public consultation where over 250 JSA members from 16 states analyzed the content of the Right to Health Care and, jointly with NHRC, developed a campaign strategy to recognize it as a fundamental right, outlining constitutional obligations for the state. Cognizant of the outstanding need to strengthen weak and dysfunctional public health systems in rural India, JSA members became involved in shaping, critiquing, and monitoring the National Rural Health Mission, the country's flagship health program launched in 2005. In particular, through its strong grassroots networks within states, JSA contributed to strengthening public health systems by empowering communities to be involved in the planning and utilization of these systems through a rights-based framework. Members shaped the community based monitoring (CBM) approach, a mechanism implemented within the mission that aims to strengthen the citizen-state relationship and ensure accountability of health systems. Although CBM continues to evolve as a methodology and in terms of coverage, emerging evidence reveals

tangible contributions to the strengthening of health services. Besides improvements in quality of care, recent independent external evaluations[84] emphasize its potential to empower communities to demand services, and to create positive pressure on the system to become more responsive and accountable. The CBM experience in Maharashtra[85] reported an increase of 18 percent (from 48% to 66%) in the community's rating of health services as 'good' and a decline in the percentage of services rated 'bad' (25% to 14%) over three subsequent cycles of monitoring. Improvements were also observed across specific indicators, for example, immunization services, supplementary nutrition, and use of untied funds by 21 (from 69% to 90%), 33 and 31 percentage points respectively; and PHC level services such as 24-hour delivery, in-patient services, laboratory, and ambulance services. More significantly, qualitative changes were reported in availability, attitudes and practices of health workers (elimination of unnecessary prescriptions and user charges for services) as well as health systems provision of safe drinking water and sanitation facilities,[86] indicating appropriate and "effective coverage" aspired to by the Framework. Further, growing acceptance among health officials of the significance of community-led action has transformative potential for health systems strengthening agendas. The CBM approach, though specific to health services, offers a pathway for extending commitments on universal health coverage to a broader set of social services. Concurrently, another mechanism adopted by the JSA involved successfully lobbying national political parties before the general elections to include the right to healthcare in their election manifestos and commit to an increase in health spending. The JSA continues to be one of the leading overseers of health policy implementation and campaigner for strengthened social accountability processes within health systems in India.

DISCUSSION

The above vignette reinforces the notion that States have particular ethical obligations to their citizens, and, more importantly, this model of responsibility allocation and social accountability can be invoked through citizen-led action premised on principles of justice and agency. There is growing traction for normative approaches that incorporate voices from the ground and include concepts such as agency and capabilities central to flourishing human lives. For example, frameworks of shared health governance and provincial globalism[87] recognize the need for a consensus on the morality of health, not a top-down world government with coercive powers to compel compliance.

While our thesis departs from the premise of shared health governance, that all actors will aspire towards global health justice, and that chaos is an unintended consequence of their actions, we concur that creating conditions for global distributive justice (and ensuring functionality and morality of global health) requires a multi-level system of, as Ruger argues, "mutually reinforcing governments (nation states) and governance (both global and domestic) and a strong evaluative structure."[88]

At the country level, citizen-led processes and principles embraced by such normative frameworks such as self- determination and individual and collective agency, hold promise. The Framework recognizes the value of this bottom-up approach but only so far as countering "the opportunist costs of an arduous treaty process", carving a role for civil society in monitoring the compliance of nation-states to the Framework obligations, and in the process enhancing their access to governments and legitimizing their advocacy roles. This does not resonate with the

emancipatory objectives of bottom-up approaches described above. Moreover, at the global level, mere representation in policies and governing bodies of global health institutions, albeit promising, does not necessarily translate to exercising sovereignty and agency given the power and resource asymmetries. Thus, simultaneously realizing the systems of government and governance (at the global and domestic levels) requires different degrees and explicit instruments to establish harm, causality and evaluate public standards of accountability of state and non-state actors at the global and national levels. Notably, what is needed is an assessment of who is responsible, and thus accountable, for undermining health equity. This necessitates the development of mechanisms of effect and instruments established to shape the public norms (of accountability towards who the global health system is purported to serve) necessary for a normative structure of global health rooted in a theory of justice.

CONCLUSION

Recently, the WHO Director General declared the West African Ebola crisis a "public health emergency of international concern" underscoring the urgency of coordinated action and the imperative of strengthening capacities and systems of low income states. Amit Sengupta argues that the analysis of factors responsible for concentration of the epidemic in West Africa must go beyond the focus on pathology of the disease to address "the pathology of our society and the global political and economic architecture."[89] Decades of civil, political and economic unrest (triggered by colonial rule followed by neoliberal economic reforms) have systematically eroded capacities of health systems in low-income countries. Such weakened capacities have created conditions where outbreaks, such as Ebola, fester.

Amid this crisis, the Framework is timely and its call for a new law that binds nation states resonates with anxiety in many areas and constituencies of international relations for governance reform. However, the Framework needs clarity in its purpose. Nation-states are central to any guarantees of human rights to populations, but envisioning the grossest impacts of global capitalism to be solved through technical or legal instruments that hold states to account is misdirected not least because powerful instruments already exist. At the country level, people-led movements have immense potential to realize a rights-based approach to health, build local accountability and democratize power structures, especially decision-making related to how best financial resources be utilized. The task for such a Framework, therefore, must complement these processes by affecting structural and political power mediated by global and transnational elites by holding corporations and global institutions accountable.

The case studies reinforce how global mechanisms adapt poorly to local circumstances, especially in the most poverty stricken parts of the world. There is compelling evidence that global prescriptions of values such as participation, human rights, and accountability have tended to ignore local understandings and ways of 'doing' and served to reinforce power and structural inequities. Neoliberalism has increasingly come to frame such prescriptions in global health and is also deeply embedded in institutional behavior, political processes, and understanding of socio-economic 'realities'. Hence, any alternative conceptions of governance must challenge the values that undermine organic processes of reform, address patterns of power that result from implementing global mechanisms, and contest processes that disadvantage countries and the "global health underclass". A Framework must be cognizant of how structural and material reality is transformed so that application of

human rights principles do not become another tokenistic exercise, or impede the bargaining position of weaker states in the emerging global order. In contrast to the conceived forceful marriage of emancipatory rights and justice principles with global structures and norms, we conclude that guaranteeing health and social entitlements to people can be achieved through strong citizen-led movements.

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