A New Scramble for/in Africa: 
the struggle on the continent to set the terms of global health

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Abstract

At population levels, health outcomes are determined more by social conditions than by either biology or technological interventions. Entrenched and increasing inequalities associated with global transformations in political economy are the most significant causal factors for so-called ‘global health’ problems that disproportionately afflict Sub-Saharan Africans. Growing attention is being paid to the social causes of ill health, as evidenced in the WHO’s recently introduced Commission on the Social Determinants of Health. However, as this paper argues, the predominate paradigm continues to view individual diseases as separate biological events amenable to pharmaceutical treatment. At the heart of the debate on social determinants versus bio-medical models is a competition to frame the nature and scope of global health (who defines the term and for what purpose?). This question matters as the majority of current strategies to confront Africa’s health problems follow the dominant biomedical paradigm, leaving issues of underlying social causes and inequalities largely unaddressed by both researchers and policymakers. This paper examines the struggle to define and control global health in the context of African health outcomes. It seeks to identify who is winning and who is losing in the struggles to dominate the research and governance of global health as it affects Africa.

Introduction

According to many observers,¹ a ‘new scramble for Africa’ is underway. The original ‘Scramble for Africa’ occurred during the period of ‘high’ imperialism in Africa in the late 19th and early 20th centuries,² when Africa’s geographical space was divided up among dominant European colonial powers for the efficient and relatively peaceful (that is, in inter-state, western terms)³ exploitation of Africa’s rich and abundant store of natural resources. Those who believe that we are witnessing a ‘new’ scramble see it in the current quest for natural resources, which mirrors the exploitative energy of the earlier period.⁴ It is similar also because of the vigorous competition among the various players⁵, as well as the political and social implications and costs

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³ This period was anything but peaceful for Africans, many of whom were killed, harassed and exploited during the period.
that many countries bear as a result of the exploitation.\textsuperscript{6} This time around, however, there are some differences. First, the ‘new’ scramble focuses mainly, albeit not exclusively, on energy sources.\textsuperscript{7} Also, a different and expanded group of players is involved; the dominant Western power in this current scramble is the US, while several non-Western nations — some African,\textsuperscript{8} but especially China\textsuperscript{9}, and to a lesser extent India\textsuperscript{10} — are now featured in the exploitative nexus. A third difference with the current scramble is with the nature and extent of the humanitarian activities that are occurring in juxtaposition with the economic exploitation. Whereas the first scramble brought a variety of religious groups to administer to Africans, the present one is playing out alongside numerous interventions by a much wider range of actors: faith-based organizations now interact with a variety of international governmental organizations (IGOs), non-governmental organizations (NGOs), philanthropic organizations and individuals, and businesses, which are operating individually, cooperatively or competitively to solve the humanitarian/development problems on the continent.

The relationship between economic exploitation and humanitarianism in present-day Africa is an underlying theme of this paper. Focusing on the recent explosion of interest in African health (usually now discussed under the heading of ‘global health’), we argue, as the title suggests, that the various activities by a host of actors are related, albeit tangentially, to the ‘new scramble for Africa’ that is referred to above. While the activities around health (and/or health and development) are not directly linked to resource extraction, we believe that it is a mistake to underestimate the connections between economic competition and current health practices and policies on the continent. Indeed, we argue that economic interests are driving an almost singular emphasis on infectious disease and simultaneous neglect of the growing burden of chronic disease on the sub-Saharan sub-continent. As well, despite compelling evidence that health at population levels is determined as much or more by social environment and relations than by genetic predisposition or technical interventions, the major focus continues to be on biomedical solutions for a variety of infectious diseases that disproportionately burden Africa. We argue that the lack of attention to the social determinants of disease is due, in part, to

inadequate infrastructures for health, and governance incapacities, but it is due also to the continuing dominance of a biomedical paradigm in health that is supported by prevailing economic interests.

To a large extent, the biomedical paradigm is taken for granted both by scholars in the health/public health field as well as newly engaged scholars from international relations and international political economy, resulting in an unquestioning TINA (‘there is no alternative’) approach to health in sub-Saharan Africa. Yet, the paradigm is not producing significant improvements in health, at least not at the level that would be possible with more appropriate and effective intervention in the social conditions that influence health (CSDH, 2008). Moreover, the engagement in Africa of so many uncoordinated, often competitive, players appears to be undermining many of the efforts that are being made. As a recent article in The Economist with the play-on-words title, ‘A Scramble in Africa’, 11 explains, the sky-rocketing numbers of benefactors (in aid overall, not only the health area) has created a crisis of coordination and management. Indeed, according to the anonymous author of the article, ‘[t]he development aid business is in shambles’.

In the paper, we explore outside actors’ scramble for/in Africa to control the global health agenda on the continent. The paper begins with a discussion of the social determinants of health, providing a brief history of the extant research on the topic, followed by a review of information and insights from the recent report from the World Health Organization’s Commission on the Social Determinants of Health,12 which addresses the need for greater attention to social conditions. We then proceed to an overview of some the current developments in global health research and in new governance arrangements (such as public-private partnerships and the Millennium Development Goals) as they affect African health. Finally, we propose changes that would support a social determinants model of health.

A ‘Social Determinants of Health’ Approach for Improving Health in Africa

In 1980, the Department of Health and Social Services of the United Kingdom published a report (Black Report), which maintained that health, at least at a population level, was determined largely by social status and environment.13 The seminal study upon which the report was based generated considerable interest, and extensive research over the next two decades supported the initial findings.14

Policy applications based upon these insights have been minimal, however, and globally, pharmaceutical and technical intervention, after disease has occurred, continues to dominate in dealing with health issues. This is not to deny some gradual progress in moving away from the exclusivity of the biomedical model; indeed, there has been some rethinking and action, especially in the North, towards accepting that certain diseases are acquired or exacerbated through social behavior as well as by genetic susceptibility. For instance, while cardiovascular diseases (CVDs), once acquired, are still treated with pharmaceuticals and surgery, there is now widespread awareness that preventative measures involving both individual behavior and policy directions can effectively reduce the onset of CVDs and the death rates due to these diseases. In essence, a new normative framework is emerging with regards to health in the North that shifts the emphasis from biotechnical intervention after disease develops to prevention of disease through social behavior (often supported by public policy (as, for instance, with policy on tobacco sales) and even business response (as with the development of low-fat and high-fiber dietary products, etc).

In developing countries, while there are efforts underway to promote a similar normative shift, the evidence suggests that it advancing slowly, if at all, in practical terms. This is interesting given that one of the first examples of attempting to apply a social determinants approach was directed mainly at Southern health. This was the Alma Ata Declaration, released by the World Health Organization (WHO) two years before the Black Report was published. The report recommended that more attention be focussed on primary health care, especially in poor countries that had inadequate resources to develop efficient tertiary care models. Moreover, the report acknowledged, tertiary health care systems did not address the underlying causes of poor population health, which are found in the social environment. As the Report concluded, ‘health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector’. Despite widespread discussion of the primary care model as well as the compelling supportive data from research on the social determinants of health, Alma Ata’s optimistic goal of ‘Health for All by 2000’ fell hopelessly short of aspirations. Acknowledging the failure of Alma Ata, the World Health Assembly adopted a new WHO Declaration in 1998 entitled ‘Health for All in the 21st Century’. In this Declaration, although primary health care was not emphasised, social determinants were not completely ignored; for instance, in highlighting the need to address chronic disease as well as infectious diseases, the Declaration situated them within the social contexts of ‘unhealthy lifestyles and polluted environments’. Shortly following the Declaration, the launch of the United Nations Millennium Development Goals (MDGs) in 2000 gave another boost to re-imaging health in terms of social determinants. In addition to goals directed specifically at

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16 The Declaration is available at http://www.who.int/hpr/archive/docs/almaata.html.
17 Ibid.
health—that is, those to improve maternal and child health and one to eradicate HIV/AIDS—the first three goals—to end poverty and hunger; provide universal education, and achieve gender equality—emphasis critical areas of social determinacy of health. Finally, the most recent international initiative to emphasise the imperative of addressing social conditions to improve health is the WHO Commission on the Social Determinants of Health (CSDH) which was launched in 2000. The final report of Commission published this year asserts that the reduction of social inequities is key to improving global health outcomes, and to reduce social inequities requires a ‘new global agenda for action’ that includes improved governance and power realignments in the global political economy.

Skeptics argue that the CSDH’s recommendations are idealistic and impractical. As argued in a critical review of the report in a recent Economist article, ‘…railing against the distribution of power and money may not be much help to anyone who faces practical decisions about how to allocate scarce medical resources’. Indeed, operationalising a social determinants of health approach is no doubt more complex than functioning under the current system based mainly upon tertiary care and biotechnological solution. The complexity involved in a shift towards a social determinant approach is evident in the CSDH’s ‘overarching recommendations’ to ‘improve daily living conditions; tackle the unequal distribution of money, power and resources, and measure and understand the problem and access the impact of action.’ Not only are these objectives multi-dimensional, they require, as the Commission acknowledges, novel approaches to governance involving ‘civil society, governments and global institutions’ (p.2). Nevertheless, as difficult as these requirements may be, if scarce resources are to be used most effectively and efficiently, the underlying social structures that negatively impact health must be addressed. Otherwise, health outcomes are unlikely to improve significantly and certainly not in line with optimistic projections by WHO and the UN for health in the 21st century. Moreover, despite reservations, such as those expressed in The Economist article about the possibilities of revising governance to deal with these issues, the CSDH’s recommendations are quite consistent with much of the recent literature on global governance: that is, governance of issues (such as health) that have moved beyond the capacity of individual states to address adequately. The emerging architecture of global governance has been described as multiple spheres of authority operating within a network arrangement that involves state and non-state actors inter-connected in novel ways from the local through the national, international and global. In the field of health governance, the CSDH’s most significant contribution is in recognizing such networks as fundamental to improvements in health and proclaiming the need to focus the networks’ attention on social factors and environments that impact upon health. A second valuable contribution is in clearly identifying the key areas that must be targeted, that is, effective surveillance and evaluation of health needs and policy impacts, functioning health systems and underlying political economy.

However, whether these ideas will eventually take hold in the international policy community (including the non-state participants) that directs much of Africa’s health agenda remains to be seen. The possibility of the normative shift in the global health agenda is impeded as we argue

22The CSDH website is at http://www.who.int/social_determinants/about/en/
below by the economic interests of major players currently setting the terms of operation (and thinking).

**Progress and Bottlenecks in African Health Governance**

The 2005 interim report on the Millennium Development Goals\(^\text{25}\) had the following to say about the situation in Africa:

Many countries are on track to achieve at least some of the Goals by the appointed year, 2015. Yet, broad regions are far off track … . Sub-Saharan Africa, most dramatically, has been in a downward spiral of AIDS, resurgent malaria, falling food output per person, deteriorating shelter conditions, and environmental degradation, so that most countries in Africa are far off track to achieve most or all of the Goals. Climate change could worsen the situation by increasing, spreading vector-borne diseases, and increasing the likelihood of natural disasters, while a prolonged decline in rainfall in parts of Africa has already wreaked havoc.

Since the publication of this report, the health of Africans and the social environments that contribute to poor health appears not to have improved significantly, although there have been some positive developments. According to the WHO’s *World Statistics Report 2008*, ‘current data indicate that HIV prevalence reached a peak of nearly 6% around 2000 and fell to about 5% in 2007’.\(^\text{26}\) The Report also indicates that there is progress being made in the fight against malaria in Africa apparently due to the increased use of insecticide-treated bednets\(^\text{27}\) as well as antimalarial combined therapy. It is noted, however, that progress varies among countries, and in some, it appears that it is ‘children living in the wealthiest households [who] are better protected by bednets’.\(^\text{28}\) Meanwhile, a looming global food crisis is affecting Africans disproportionately and threatens to undermine gains in food security made over the past few years in some countries. In countries in conflict such as Cote d’Ivoire or with governance crises such as Zimbabwe, food security and health conditions have deteriorated relentlessly. At present, a major cholera outbreak in Zimbabwe not only adds to the ordeals of an already suffering population, but there is a risk of the disease spreading to other countries in the region. And, as if the lingering traditional health problems were not enough, Africa must now contend with a new problem, the so-called double health burden where continuing high rates of infectious diseases


\(^{26}\) WHO (2008) ‘HIV/AIDS Estimates are Revised Downwards’ *World Health Statistics 2008* (Geneva: WHO), p. 14. According to the article, ‘This reflects significant changes in high-risk forms of behavior in a number of countries but is also a result of the maturity of the pandemic’ (ibid., emphasis added). The article also noted that ‘estimates [of the number of people living with the disease had been] revised downwards’ because of improvements in estimation methodology (ibid., p. 13). This explanation was not usually provided in media reports of dramatic reductions in HIV/AIDS prevalence.

\(^{27}\) Incidentally, bednets are a relatively simple and inexpensive preventative measure, and perhaps an important indication of some shift from the predominance of pharmaceutical solutions.

are combined with growing rates of chronic disease including CVDs, diabetes, cancer, chronic respiratory disease and mental illness.29

To assess what is happening in response to this considerable health burden in Sub-Saharan Africa, we explore below the areas identified by the CSDH as critical to improving health outcomes. In the next three sub-sections, we address, in turn: i) issues involving monitoring and surveillance; ii) promoting effective health systems; and iii) bringing together civil society, governmental and global actors in new governance arrangements. In the final section of the paper we explore the possibilities of meeting CSDH’s recommendation that inequalities in power and resources be reduced.

**Surveillance and Monitoring**

The CSDH notes that better surveillance and monitoring of current health situations is key to deciding on appropriate actions to improve health. It is impossible to address health issues effectively if the actual state of health in counties is not known. Several international organizations have begun to address this issue30 (OECD, Paris Declaration; UNICEF), although much of the intervention on health in sub-Saharan Africa is based upon incomplete, even incorrect data. As the WHO points out, worldwide, ‘there were 78 countries without useable death registration data’. Also, because of improved methods of interpreting mortality data in Africa ‘the GBD [global burden of disease] estimates for 2004 are not directly comparable with the previous estimates for 2002’.31 Best estimates of health conditions are improving, according to recent WHO reports, but also, ‘…there remain substantial data gaps and deficiencies … [and hence] ‘uncertainty of estimates and projections.’ In some regions, ‘… no usable data source was found, and for others the latest data were decades old. Typical uncertainty for regional prevalence estimates ranged from ±10% to ±90%, with a median value of ±41%, among a subset of diseases for which uncertainty analysis was carried out’.32

Moreover, surveillance and monitoring involves more than counting the number of people succumbing to particular diseases. Rather, it also involves the amount and types of research being conducted on the factors that determine or affect health outcomes. A recent call to action from a Global Ministerial Forum on Research for Health34 notes this point in arguing for

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33 Ibid., p. 118.
research on African health that addresses issues of development and equity in relation to health. Surveying the research being conducted on African health suggests that the situation is still far-removed from achieving the objectives of the Ministerial Forum. For instance, the North-South ‘10-90 research gap’, in which 90% of the world’s diseases capture 10% of research attention, has not been significantly diminished since it was identified a decade ago.\(^{35}\) Furthermore, the emphasis in the current research is decidedly in favor of biotechnology when compared with social determinants. We have written elsewhere\(^{36}\) that despite considerable interest in and rhetoric surrounding ‘global health’, funders of health research—national funding agencies, the pharmaceutical industry and philanthropic organisations—tend to devote only a small proportion of resources to global health; they do not clearly define what they mean by ‘global health’; and a major proportion of what is designated as ‘global health’ research is focused on the biotechnical treatments of certain infectious diseases. A large proportion of health research in general is now devoted to biogenetics, which is supposed to have lucrative possibilities. With respect to ‘global health’, specifically, the continuing emphasis on technical solution appears also to be based largely on economic interests. For example, a 2006 UK government report on health research indicated that government actors were well aware of pressures to provide more resources for research on ‘the socio-economic burden of disease’, but opted instead to support translational research to investigate how to improve mechanisms for taking up technological innovation. This thinking had implications for the South; suggesting enthusiasm for engaging in the scramble for research in developing regions, the author of the report noted that ‘…emerging economies also provide new markets and opportunities which the UK is well placed to exploit …’\(^{37}\).

**Promoting Effective Health Systems**

Efforts are ongoing in many countries in the region to provide integrated health services that are accessible, affordable, of good quality; generate the necessary human and physical resources to make that possible; raise and pool the revenues used to purchase services; enhance managerial effectiveness and efficiency and community actions for health, and govern, steer and regulate the health sector through defining the vision and direction of health policy.

Despite these efforts, health systems development has been hampered by poverty; political instability; poor economic performance; heavy disease burden; lack of qualified and experienced health workers; poor health infrastructure; low access to and quality of essential health

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technologies; and weak stewardship. This has slowed down progress in attaining MDGs and other national, regional and global initiatives.

The above quotation is from material published by the WHO Regional Office for Africa. It demonstrates that, despite considerable effort, issues of underdevelopment impede the promotion of effective health systems in the region.

By specifying ‘integrated health services’ the material is dealing with only part of the overall health system, albeit the component that many people most readily associate with health systems. This is health care services, the organized systems that provide medical care to individuals that is delivered by a variety of health care professionals. These professionals operate in a variety of settings (private or public hospitals and clinics, etc.) in any community and, although they may advocate health improvements in areas outside their direct control such as legislation to reduce deaths from traffic accidents or tobacco reduction measures, their main focus tends to be on individual care of the ill. The other component of health systems which is as, or perhaps more important in promoting health is the public health sector. Public health services are generally focused at the population level and include a wide range services targeted at the whole population. Public health services and activities include surveillance of the health status of the population; communicable disease surveillance; emergency response to disasters or communicable disease outbreaks; ensuring a healthy environment through setting, monitoring and enforcing standards in areas such as air, drinking water and soil; food safety throughout the production and distribution chain; occupational health and workplace safety; injury prevention, including road safety; disease prevention such as vaccination and chronic disease prevention services in primary and secondary care; health promotion and health education; the evaluation of services; and health related research.

Improving health generally is closely tied to the need to improve social conditions with respect to such things as nutrition, housing, education and income. From a health systems perspective, the focus tends to be on health care services, yet given the present African economic realities, health promotion and disease prevention within a primary health care framework are the most likely strategies for the achievement of higher levels of health on the continent. Not only are these necessary for promoting health in any society, but given the present scramble for in Africa, countries need the capacity to coordinate the efforts of the many players involved on the continent. This requires the existence of effective public health infrastructure. Unfortunately, many countries have weak health systems and limited infrastructure resulting in a lack of clear strategies and appropriate approaches to health system development making prevention and control programs difficult to implement and sustain particularly at the primary care level.

Although a logical argument can be made that prevention should be given priority, the provision of health care services remains the central issue. Where to make the investment of scarce

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39 What are public health services? Public Health Services, WHO Regional Office for Europe. [http://www.euro.who.int/publichealth](http://www.euro.who.int/publichealth), Accessed December 10 2008
resources and the balance that is established between treatment services and prevention is a difficult choice for many African leaders which is made more difficult given the emphasis placed on biotechnological and curative single disease approaches by the international donor community. In this context it is important that all involved recognize the limitations of curative services to improvements in overall population health and the significant opportunity costs which apply to other potential areas of social investment. Moreover, given the rapidly development burden of chronic disease in Africa countries need to integrate their infectious-disease programs into general public health systems using integrated primary care models which create the capacity to prevent and treat infectious diseases and at the same time deal with chronic disease such cancer, cardiovascular disease and diabetes. Countries therefore, need to develop broadly based health systems with the capacity to tackle the double burden of infectious and chronic disease within the context of limited resources.

Ultimately, a healthy Africa will result from population based interventions targeted to the determinants of health through multi-sector approaches for the promotion of health and the prevention of disease along with the equitable provision of health care.

Bringing together Civil Society, Governments and Global Institutions

The CSDH argues that effective global governance in health requires that civil society, governments and international/global institutions work in collaboration. One might argue that, in institutional terms, this recommendation has been realised with the recent emergence of public-private partnerships (PPPs) in health governance. However, to date, such partnerships have fallen far short of the CSDH’s objective to change the direction of health governance towards a greater emphasis on social determinants.

The number of PPPs has grown exponentially over the past decade. Most of these have developed to deal with specific infectious diseases. Sania Nishtar40 describes the global situation as of 2004, with respect to ‘large transnational’ PPPs for health:

the database of the Initiative on Public-Private Partnerships for Health of the Global Forum for Health Research lists 91 international partnership arrangements in the health sector, which can qualify to be called public-private partnerships. Of these, 76 are dedicated to infectious disease prevention and control, notably AIDS, tuberculosis and malaria; four focus on reproductive health issues, three on nutritional deficiencies whereas a minority focus on other issues (health policy and research (1), injection and chemical safety (2), digital divide (1), blindness and cataract (4).

Carmen Huckel Schneider41 argues that the PPPs emerged out of a combination of factors that accompanied the rise of global neoliberalism. Given the widening equity gaps associated with


neoliberalism, organizations such as the WHO were faced with growing health problems, especially in developing countries, but with dwindling resources to respond. Alma Ata and the primary health care approach had failed and as ‘business actors became wealthier and more influential [as a result of the neoliberal formula], ... the intergovernmental WHO needed to seek innovative ways to ensure adequate resources.’ Huckel Schneider also cites other authors\textsuperscript{42} who offer an alternative explanation for international organisations’ involvement in PPPs: that the international bureaucracy is too inefficient and cumbersome to deal with the immediacy of several current health issues, so new mechanisms were required to circumvent the old processes. As for business actors in either case, profit opportunities appear to be the main motivation for their involvement in these arrangements.

Michael Moran\textsuperscript{43} notes that although it may have been mainly expediency in a changing global political economy that brought the partners together, some beneficial results have accrued. He refers to scholars who have argued that the benefits include: some increased attention to previously neglected diseases,\textsuperscript{44} new ‘efforts to combat communicable diseases and to stimulate the development of new products,’\textsuperscript{45} and ‘improved access to cost-effective healthcare interventions.’\textsuperscript{46} Some have argued that PPPs have also encouraged, ‘in some cases, an improved policy making environment, facilitated by country-level coordinating mechanisms.’\textsuperscript{47} Others are less sanguine about PPPs as a major form in the new global governance of health framework. Moran suggests that the critics settle into two main camps: the ‘systems critics’, who are concerned that the ‘top-down, vertical’ as well as ‘narrow and technical nature’ of PPPs’ interventions ‘do not adequately tackle problems associated with capacity’,\textsuperscript{48} and the structural (or ideational) critics, who believe that the predominately business-oriented focus of the PPPs is inimical to addressing the inequities that underlie health problems in the South. In Moran’s words,

The primary argument of those in the [latter] critical school is that partnerships are part of a broader hegemonic shift, primarily discursive, which acts as a continuation of the neoliberal dominance of development theory and practice. The depoliticised language evident in much of the policy research and official documentation on partnerships, these critics attest, falsely suggests that power relations within partnerships are equitable and benign – a kind of ‘win-win-win’ scenario in which all agents are party to an absolute gain.\textsuperscript{49}

\begin{itemize}
\item Ibid.
\item Ibid.
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Other scholars take issue with the notion that country coordinating mechanisms (CCMs) contribute to improvements in policy making. For instance, discussing the CCMs associated with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Sonja Bartsch observes that CCMs have received insufficient funding to perform the overseeing role with which they are tasked.\(^{50}\) Moreover, the CCMs, installed by external actors in a top-down process, are further removed from the people they are intended to serve, as civil society actors are not widely included or even consulted. According to Bartsch, ‘many governments in the recipient countries were either not prepared or not willing to work with non-state actors [representing] … people living with the diseases, women’s organizations and rural NGOs’.

Another concern raised with regard to PPPs is the influence that philanthropic/business actors exert on the health agenda. The large amount of capital that is being directed towards health in Africa by such organizations as the Bill and Melinda Gates Foundation has the potential to sway the direction of research and policy in PPPs.\(^{51}\) This is of concern given that the Foundation’s main emphasis to date has been on bio-technical solutions to health and therefore the Foundation’s ability to leverage its funds poses an opportunity cost to any actions directed at social determinants. As David Fidler has commented, ‘… governing Bill Gates may prove as challenging in its own way as governing the United States in terms of global health’.\(^{52}\)

The lack of coordination (ie. the scramble \textit{in Africa}) is yet another concern raised regarding PPPs, although not only PPPs. Especially in the fight against HIV/AIDS, there are now several players involved: PPPs such as the GFATM, multilateral organizations (eg. the World Bank) and countries (eg. the US PEPFAR programme). The increase in funds has been considerable: from approximately US$2.8 billion in 2002 to an estimated US$10 billion by 2007.\(^{53}\) While the increased attention to HIV/AIDS, mainly focused on sub-Saharan Africa, is welcome, the rapid infusion of funds has created problems of coordination among the various donors. Acknowledging an ‘urgent need for greater support and collaboration with heavily-affected countries and to avoid duplication and fragmentation’, key donors agree in 2004 to the ‘Three Ones’ principles that include: i) a single action framework for coordinating efforts; ii) national AIDS Coordinating Authorities (NACs); and iii) country-level monitoring and evaluation systems.\(^{54}\) At a broader (ie beyond HIV/AIDS / health), The Paris Declaration on Aid Effectiveness, endorsed by the OECD in 2005, supports efforts for better coordination among donors and for more effective monitoring of results.\(^{55}\) The objectives are commendable, and more effective coordination may be achieved. However, unless more effort is directed at


\(^{51}\) The influence of the Gates Foundation in global health, already well established, was enhanced significantly in 2006 with the infusion of US$37 billion from financier Warren Buffett. With assets now of approximately US $60 billion, the Foundation’s annual donation of around $3 billion to global health research and aid makes it a major player in global health (Okie, 2006, p. 1084). On the possible negative effects of the Gates Foundation influence, see \textit{The Economist}, (2008).


\(^{54}\) Ibid.

developing effective health care systems that can accommodate the bureaucratic burdens that these major initiatives impose, the enormous amounts of resources being directed at HIV/AIDS are going to be directed as efficiently as they might be to address the disease and they are unlikely to create significant improvements to health overall.

Conclusions: The Way Forward

Currently, in the name (and quite possibly the spirit) of humanitarianism, a complex mix of state, inter-state and non-state actors are administering to the perceived health needs of Africans reminiscent of the way in which religious organizations administered to Africans’ spiritual needs in the colonial scramble for Africa. In both periods, well-meaning intentions did/will not necessarily bring the intended benefits to ordinary people. As sincere as most of the main actors may be in their humanitarian motivations, the current scramble for/in Africa to bring medicine to the unhealthy is unlikely to produce the intended benefits if the social environments and relations that contribute to poor health are not simultaneously addressed.

Traditionally, health has been addressed within a bio-medical paradigm that emphasizes curative care and technological interventions. This paradigm tends to operate within a ‘silos’ mentality, that is, actions are focused on specific diseases, without recognition of connections between diseases or between disease and aspects of peoples’ lives beyond the disease itself. Moreover, within this paradigm, health is defined more in terms of the diseases and conditions that describe its absence than in positive terms depicting a state of well-being. While there has been some progress in the North in addressing health maintenance through behaviors and policies that help to prevent disease, this shift has not been as evident in the South, where the prevailing focus is on treating disease through pharmaceutical intervention. Certainly, there has been no noticeable shift away from the biomedical paradigm despite compelling evidence gathered over the past several decades that social environment and status are major determinants of population health outcomes. Nor have efforts to shift thinking on this been successful to date, despite long-time efforts by organisations such as the WHO, with its earlier promotion of primary care and its current emphasis on social determinants.

In the language of constructivist theorists such as Keck and Sikkinck (1998), we might think of actors such as WHO during the Alma Ata period or the CSDH now as norm entrepreneurs; that is, agents for change in thinking that would redirect policy in a meaningful way. However, in order ultimately to have significant change in the normative framework so as to influence central actors to alter their behavior, there must be norm diffusion and acceptance. In the case of health, while there has been recognition of the idea that policy must change towards a social determinants health approach (i.e. norm diffusion) there has been little discernable change at a practical level. One of the main barriers to acceptance (as would be demonstrated by action) is that, in the present health model health ministries have limited or no influence over policy areas that would support a social determinants of health approach. Yet, there are ‘solid facts’ that show a clear connection between ill health and social gradient, as well as between health and levels of stress, living conditions of early life, social inclusion or exclusion, social support, employment opportunities and conditions.56 Clearly, this is an agenda that requires a ‘whole

government’ approach to policy development. Moreover, it is possible to devise strategies whereby these insights can be applied within the health sector. Indeed, a social determinants approach is entirely consistent with well-founded, basic principles and practices of public health. Yet, public health, in the North as well as the South, has been undermined by the neoliberal mindset that has dominated political economy globally for the past several decades. Ideology has been as, or more, responsible for driving policy in the past few decades than has pragmatism or empirical evidence.

In Africa, the concern to apply pharmaceutical interventions to treat infectious diseases, while certainly appropriate, is inadequate particularly when the infrastructure to secure, deliver and/or produce the pharmaceutical products required is given little attention. Moreover, the attention paid to infectious diseases, while necessary to be sure, will not improve overall population health given the scant effort that is being made to address the growing burden of chronic disease on the subcontinent. Finally, overall, while the biotechnical paradigm has focused needed attention on specific diseases that create a significant burden of health for Africans the business interests that drive this agenda are not adequately addressing the important underlying social issues such as inequality (national, North/South, gender, etc.), poverty, employment, education, access to adequate health care and a healthy environment.

Over the last several decades business actors have become increasingly prominent in setting the global health agenda thus reinforcing the traditional health paradigm to the detriment of a social determinants of health approach. Given the current worldwide financial/economic crisis, the neoliberal agenda under which the current system of health governance emerged has collapsed or is at least under major restructuring. It is too soon to predict what the effects will be on African health. In the long term, a global realignment toward greater government intervention could be beneficial, if it means increased spending on such items as health care, education and infrastructure. However, especially in the short term, the worry is that there will be a reduction in the levels of resources going to African health and development and/or that restructuring will be directed mainly at ‘bail-out’ for financial sectors without simultaneous attention to development and recovery of the social sector. The latter scenario appears to be behind a recent plea by Dr. Margaret Chan57, Director-General of the WHO, to set policies so that the poor will not be neglected during the crisis. She argues that ‘impoverishing health care expenditures – that in “good” times push more than 100 million people annually into poverty – are likely to increase dramatically. … Stronger social safety nets [therefore] are urgently needed to protect the most vulnerable in rich and poor countries’. Dr. Chan goes on to argue that supporting the social sector is not only necessary to protect the most vulnerable, but also generates efficiency and is one of the most cost-effective strategies to stimulate economic recovery. Moreover, she argues, equitable distribution of resources, as through policies designed to achieve health equity, encourage social stability and security. The major players in the current scramble for/in Africa’s health must heed Margaret Chan’s advice, if the anticipated gains in health are ever to be achieved.

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