Democracy, globalization and health: the African dilemma[1]

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Health is a prerequisite for the exercise of freedom, crucial to the development and maintenance of all other human capabilities; health is also a human good with value in itself.[2] It is hardly surprising that health and disease occupy a central place in the imagery of contemporary globalization, and the way people think about distant influence and exchange in the global world of the early 21st century. Inter-connectedness, in economic and technological terms, has also spawned fears of illness and contagion. Such panics have long been a feature of historical periods of globalization - HIV/AIDS now occupies a role in the public imagination similar to the 'plague panics' of the nineteenth century.[3] Sub-Saharan Africa occupies a peculiarly central place in this narrative of globalization and health, because the global health crises of the past decade have overwhelmingly been concentrated in Africa. The predominant images of Africa's current condition, John Sender reminds us, are biological – 'mutilations, plagues, deterioration, starvation and pathological crises are said to be imminent.'[4]

Illness is often a metaphor for political decay, for if globalization has facilitated the spread of disease, it has also reconfigured the global and local political institutions through which disease can be understood and combated. There is, of course, a danger of using the concept of globalization 'so broadly it embraces everything and therefore means nothing.'[5] Here, I take it to mean the intensification in speed and scale of the movement of capital, people, ideas, and diseases across frontiers. Economic globalization - which is the most widely used sense of the term - refers to increasing integration and interdependence of world markets, an expansion of trans-national economic activity, and the increased mobility of factors and information.[6] However, there has been a corresponding decline in the ability, and willingness, of 'leviathan states' to regulate and control capital movements. Economic globalization has not been mirrored in the political

sphere by the strengthening of trans-national institutions of representation and decision-making; there has, rather, been a trend towards 'corporate' or public-private governance.[7]

The twin processes of economic globalization and the privatisation of decision-making have, however, been accompanied by the economic marginalisation and political fragmentation of large parts of Sub-Saharan Africa. Lacking the material and human resources to compete in attracting investment and generating exports, much of Sub-Saharan Africa has fallen into a deep-set economic crisis. Certain African states are locked into specific, destructive patterns within the world economy, taking the form of heavy dependence on external aid in the most impoverished countries, and destructive diamonds-arms nexus and criminal networks in Sierra Leone and Angola. The pattern of decline is by no means monolithic: Uganda, for example, witnessed an average annual growth of GDP per capita of 3.9% between 1990 and 2000.[8] Nevertheless, heavily indebted African governments, lacking revenue and facing massive demographic pressure, have at the same time been put under pressure by the international financial institutions to further cut back on state expenditure and social services. With the notable exceptions of South Africa, Uganda and Nigeria – where political legitimacy has, on balance, been strengthened since the early 1990s - the cumulative result has been to greatly erode political authority on the continent. The dramatic increase in civil strife and destructive political tribalism in central Africa, centred around the war in the Democratic Republic of Congo, is the most conspicuous example.

The links between globalization, fragmentation, and the spread of infectious diseases in Africa – particularly HIV/AIDS – are of crucial importance, and are only just beginning to be explored by academics and policymakers. HIV/AIDS is itself a quintessential disease of globalization, as Lincoln Chen has recently argued.[9] It affects both the developed and developing worlds; it has spread through networks of international migration, exchange and travel. At the same time, globalization and fragmentation have reconfigured the political institutions that have historically been the chief means of combating disease: with the retreat of states and public health services, the responsibility for the provision of health care in Sub-Saharan Africa has fallen

increasingly to the private sector, in the form of NGOs, international foundations and, latterly, corporations.

The aim of this paper is, firstly, to explore the process of globalization in relation to public health in Africa. The decay of public institutions and the privatisation of global health interventions raise two related issues: firstly, the ways in which states, particularly in Africa, are able to represent their citizens in the international arena is fundamentally open to question. And at the same time these imperfectly representative states are being bypassed altogether in decision-making. I hope more broadly to raise critical questions over how the values of democracy and accountability relate to health, in this changed context in which many key assumptions of political theory are being challenged.

States in retreat

David Held has argued that increasingly complex systems of global interdependence render 'the idea of a community which rightly governs itself and determines it own future…deeply problematic.'[10] In the context of many African states, compromised by weak economic bases, artificial frontiers, and a lack of functioning institutions, it becomes even more problematic. One could argue that not only liberal democracy, which has never existed in many African nation-states, but many states themselves have been challenged by increasing global interdependence.[11] The uncertainty of Africa's place in the international order, combined with its declining share of world trade and stagnant manufacturing output, has fatally undermined many states' monopolies of political power.[12]

But African states were not stillborn; nor were they doomed from the start, as the current crises might lead us to believe. The majority of African nations achieved independence at a time when long-term planning and state direction was widely seen as the most promising route to 'modernisation' and 'development'.[13] And the first generation of independent African governments were widely characterised by their commitment to fostering a 'developmental state'.[14] Acknowledging the unequal nature of

Africa's insertion into the world capitalist economy, African "developmental states" sought, broadly speaking, to intervene to accumulate surpluses from the agricultural sector, and use them to fund import-substitution driven industrialisation.[15] The result, as Thandika Mkandawire has argued in a recent article, was not the unmitigated failure that it is commonly seen to be. In the period between 1967 and 1980, no less than ten African countries enjoyed average annual growth rates of more than 6%, with Kenya, for example, outperforming Malaysia and Indonesia.[16]

Most notably for our present discussion, first generation African governments were also characterised by their attempts to negotiate social and political contracts with citizens involving the state provision of social services – often in return for popular acquiescence in one-party political systems. These 'social contracts' were particularly in evidence in states that relied on peasant export production, rather than mineral wealth, for revenue. In many cases, governments provided or subsidised provide public goods, in return for tax payments.[17]

Among the results of these contracts was the uneven, fitful development of national health services which sought to redress the imbalances in the restricted, urban and largely curative health services that were a legacy of colonial rule. The available data for the first decades of independence suggest greater improvements in Africa's health than is often recognised, suggesting that the African 'crisis' in health is of more recent origin. Between 1960 and 1980, most African countries enjoyed substantial advances in extending health care coverage; large-scale campaigns were launched against specific infectious diseases, health facilities were expanded, and there was a significant increase in the number of trained health workers.[18] To cite just one example, in 1960 tropical Africa had one qualified doctor for every 50,000 people; by 1980, this had become one for every 20,000. The most significant impact of these advances was 'on endemic childhood complaints'.[19] These successes were followed, after 1980, by a major slowdown in the decline of mortality rates. The past 20 years have been characterised by the emergence of new infectious diseases – most devastatingly AIDS – and the resurgence of older scourges (like TB and malaria).[20] These developments have been fed

by, and have in turn worsened, economic stagnation; a dramatic decline in state capacity, and the erosion of public health services across Africa.

The trends outlined above are well illustrated by the example of Kenya, which can count for many. Kenya's first decade of independence saw rapid economic growth, averaging just below 6% a year – and most of the African population, except the very poorest, benefited. The Kenya African National Union (KANU) made free basic medical services one of the platforms of their campaign in the 1963 election, and proceeded to introduce free outpatient treatment in 1965.[21] The *harambee* self-help movement, encouraged by President Kenyatta, spearheaded an ambitious programme of construction for rural health centres, while the establishment of Nairobi's Kenyatta National Hospital as a teaching hospital led to a large increase in the number of Kenyan doctors. The early successes of Kenya's public health services were undermined, from the 1970s, by a lack of resources and the unsustainable demand for medical care generated by the highest rate of population growth known to history. A recent study has shown that by the late 1970s, Kenyatta National Hospital had no ambulances, and minimal access to running water; in 1980, the operating theatre closed for a week because of a complete lack of supplies.[22] The impact of this deterioration can be seen in the slowdown in the decline of under-five mortality after 1980. The situation was exacerbated in the 1980s by economic stagnation, cuts in public spending and state authoritarianism under Daniel arap Moi.

In terms of the equitable distribution of public health services, the early experience of Mozambique is even more striking.[23] But here too, by the 1980s, economic crisis and state contraction undermined the autonomy of state-directed health policy. Health was an early priority of the independent Mozambique government, with an emphasis on preventive community health services which pre-dated the WHO's announcement of the Primary Health Care (PHC) strategy. State planning was seen as the way to make best use of scarce medical and human resources. Mozambique's innovative drug policy, in particular, was 'an undoubted success'. From 1977 the formation of MEDIMOC, a state company for the import and export of medicines, helped the Mozambique government seek the most competitively priced supplies of the drugs on the

National Formulary, from China, Cuba and Eastern Europe as well as from the major Western pharmaceutical firms.

Yet, as a consequence of the economic crisis that was an unresolved legacy of war, unmitigated by export growth, funds were increasingly limited even for the import of essential drugs. As external aid became an ever more vital part of the health system, the national drug policy was undermined. By 1984 aid received as medicines represented almost 50% of all pharmaceutical supplies, and these medicines were often not those on the Mozambique list of essential drugs. Donated drugs were procured in donor countries, thus shifting the balance of power away from Mozambique's health services and heightening dependence on Western pharmaceutical sources. Concomitant with the donations of pharmaceuticals was pressure from donor organizations – notably USAID – to liberalise the health sector and reduce government involvement.[24]

The state of democracy

The present African 'crisis' set in, to a greater or lesser extent, during the later 1970s – the 'crisis' has been both economic and political, with economic marginalisation and stagnation feeding upon, and in turn exacerbating, political fragmentation and state decline. Economic decline began to show when global terms of trade turned significantly against African primary producers, hard hit by rising oil prices. By the early 1980s the loans that had been freely offered in the heyday of growth and optimism became – with rising interest rates – crippling burdens of debt. As a percentage of GNP, total external debt in Africa rose from 40% in 1980 to 72% in 1998.[25] At the same time, there was a fundamental shift in the basic premises of large donors and the international financial institutions (IFIs), with the ascendancy of 'neo-liberalism'. Policy prescriptions for Africa, once marked by a faith in state intervention in economy and society, were now founded on the withdrawal of the state from the economy and the removal of all barriers to the operation of global market forces.[26] The mechanism through which these intellectual and policy changes transformed African states was a succession of now ubiquitous Structural Adjustment Packages (SAPs). Heavily indebted states across the continent have found

themselves forced to carry out severe cuts in state spending on education, health and other social services. This represented what de Waal calls 'the most important post-independence shift in the moral economy of African government'.[27]

The resultant erosion of the capacity of virtually all African states is well documented, not least because arguments about the state in Africa are so frequently characterised by what is known as 'Afro-pessimism'. In their crudest journalistic form, 'Afro-pessimist' arguments have generated such epithets as 'the coming anarchy', and the 'hopeless continent'. A more credible exponent of such arguments, the influential French political theorist Jean-Francois Bayart, argues that the past two decades have seen the 'radical privatisation of the state, [and] the criminalisation of the behaviour of power-holders' across the continent.'[28] African leaders, in his view, are uninterested in any form of legitimacy and regularly resort to plunder and expropriating resources by any means, including an involvement in the drugs trade. On a related view, Patrick Chabal and Jean-Pascal Daloz argue that states across Africa exhibit 'a general disregard for the rules of formal political and economic sectors, and a universal resort to personal(ized) and vertical solutions to societal problems.'[29]

The Ugandan political theorist Mahmood Mamdani sees the current political crisis as deeply rooted in the colonial inheritance. The crisis of democracy on the continent, he argues, has its genesis in the 'dual' state that was inherited from colonial rule. He argues that the social and political contracts that, as we have seen, many independent African governments tried to establish, were necessarily incomplete and had within them the seeds of authoritarianism. In this analysis, democratisation and accountability in Africa are impeded by the juxtaposition of a notion of civil citizenship in urban areas, with an immutable and un-representative 'ethnic' citizenship, in rural Africa. Mamdani argues that the gap between 'civic' and 'ethnic' citizenship has inhibited the development of a unified political community on the continent.[30]

The task of identifying the origins and the nature of state crisis/failure in Africa is of great significance, because it will, in turn, suggest the potential form and scope of solutions to the erosion of states in the midst of an appalling health crisis. Taking the Afro-pessimist analyses seriously would suggest that there are serious questions to be

raised concerning any sort of state involvement in efforts to ameliorate the health crisis. In the context of states that are invariably failed or 'corrupt', we are faced with concerns about decision-making and accountability, particularly in rural Africa, where health crises are often most acute. In historical perspective, it seems that many current commentators have conceived a conjunctural, albeit severe, crisis as an immutable fact of African politics, but fatalism about the state in Africa has been reinforced by the neo-liberal consensus in economic policy.

Partly because of the influence of 'Afro-pessimism', and partly because of the sheer scale of the health crisis and the failure of public institutions to deal with it, urgent solutions have been sought, solutions to which the concerns of democracy and accountability have been of secondary importance. As we shall see in the following section, the solution currently favoured in policy circles is that of global public-private partnerships (GPPPs). In relating debates on the state in Africa to those on the politics of philanthropy and the GPPPs, we are faced with the interaction of two very different challenges to democratic theory and practice; but in both cases, the fundamental question revolves around what accountability and democracy can mean in the context of institutions that are not elected.

Recent work on GPPPs in health has suggested that the partnerships are governed by their 'corporatist' nature, predicated on the notion of consultation between the various 'stakeholders' in policymaking.[31] They argue that the challenge for research on these developments lies in determining the 'system of rules, norms, processes and institutions through which power and decision-making are exercised'. Accountability, in this context, combines the corporate partners' accountability to shareholders and the international public sector's accountability to member governments, in different ways.[32] We need, however, to reconcile these notions with the very different experiences of accountability and 'governance' that, as we have seen, characterise public institutions in Africa. What are the implications of incorporating an understanding of the African state into our discussions about global democracy and health policy? In reality, this dilemma has often been addressed by bypassing African states altogether. Indeed the very language of 'government' has been replaced, in the discussion of PPPs, by the more amorphous

language of 'governance'. The following section explores some of the implications of this externalization of responsibility for health care in Africa.

The externalization of responsibility

State failure, and new notions of accountability in the disbursement of philanthropic funds have led to the externalization of accountability and political responsibility for social services and welfare across the continent. As we have seen, the impact of African state crises on the health services has been nothing short of disastrous. To give just one illustration of the financial pressure on the health services, government expenditure on health in sub-Saharan Africa declined from an average of 6.2% of GDP in 1972, and 5.3% of GDP in 1982, to just 1.6% in 1995.[33] In a war-torn state like the Democratic Republic of Congo (formerly Zaire) this proportion is a pitiful 0.2% of GDP.[34] Since 1990, this decline in resources has been accentuated by the overall decline in official Development Assistance (ODA) from donor countries as a proportion of their GNP – from 0.33% in 1990, to 0.24% in 1998.[35] Even in the 1980s, formerly bi-lateral aid was increasingly channelled through 'extra-budgetary' contributions to multilateral agencies (earmarked for specific purposes) and through NGOs.

The result, since the late 1970s, has been what Christopher Clapham calls the 'de-stating of external relations with Africa'.[36] Within this overall trend we can discern a 'double privatisation' of sorts. In the first instance, responsibility for health has been assumed by the proliferation of private, not-for-profit organizations across the continent, in the guise of a variety of international organizations and their local ('Southern') partners, grouped together as 'NGOs'. Driven by a growing disillusionment with the UN system, and ideological suspicion of state intervention, donor aid has increasingly been channelled through NGOs, identified in policy discourse as being 'the uncorrupt, the uncynical or the unbureaucratic', and representing the 'civil society strategy'.[37] More recently we have been witnessing a 'second' privatisation of external relations with Africa, with the increasing involvement of the for-profit corporate sector in the wave of GPPPs that are starting to dominate world health policy and research – both through the

profit-derived donations of large philanthropic foundations, and the involvement of pharmaceutical companies in the partnerships. This "new philanthropy" stems from the massive accumulation of wealth in the high technology information and communications sectors in the 1980s and 1990s.

The partnerships have been stimulated by global failures in the development of medicines and vaccines for the major killer diseases in the developing world, and in the delivery of existing drugs to the poorest communities. The issue of vaccines is illustrative: the decline in immunisation rates in the 1990s reversed a decade-long trend of improvement. At the 1990 World Summit for Children, UNICEF announced that the Universal Childhood Immunisation target of 80% had been reached. Yet by 2000 global coverage had dropped to 75%. In 19 countries, mainly in Africa, diptheria, tetanus and polio coverage has fallen below 50%.[38] As a response to this worrying trend, a multi-million dollar Global Fund for Children's Vaccines was established by the Global Alliance for Vaccines and Immunisations (GAVI), a PPP initiated in January 2000. Partners include the Bill and Melinda Gates Foundation, WHO, UNICEF, the World Bank and the International Federation of Pharmaceutical Manufacturers' Associations. The Gates Foundation made a founding grant of US$ 750 million, with the objective of fulfilling 'the right of every child to be protected against vaccine-preventable diseases of public health concern.'[39] The challenge posed by emerging and re-emerging diseases has also contributed to the establishment of PPPs. The urgent need for high technology vaccines and treatments against Multi-drug resistant TB and Malaria, and anti-retroviral treatments against HIV/AIDS have disposed the multilateral agencies towards working with the research-based Northern pharmaceutical industry. This has been manifested in the formation of partnerships like the International AIDS Vaccine Initiative (IAVI).

Thus, the 'new philanthropy' of the Gates and other foundations has provided large sums for the research and development of global public goods – new vaccines and treatments – previously neglected by official development assistance, and national governments. Individual foundations and the partnerships they fund have resources far greater than most African governments. The Global Health budget for the Bill & Melinda Gates Foundation in 2000 was US$ 554.5 million – including vaccines, reproductive and

child health, and 'conditions associated with poverty'. In comparison the national health budget of Nigeria, the most populous African nation, was just US$76 million in 1999. The Gates foundation alone spent more than half as much, in 1999-2000, as the World Health Organization, whose global budget in the same year was less than US$1 billion.[40] Changing markets and new developments in biotechnology have made drug and vaccine development more expensive, and the GPPPs are currently experimenting with a range of institutional arrangements to induce the private sector to invest in the diseases of poverty. Examples include the idea of tiered pricing, championed by the Children's Vaccine Initiative; guaranteed markets, as in the International AIDS Vaccine Initiative's proposed International Purchase Fund; and the public sector assumption of the risks and costs of vaccine development in exchange for a stake in intellectual property rights, as in the Medicines for Malaria Venture.[41]

The argument for democracy

By what standards are we to assess these developments in global health? Why – if at all – should the externalization of responsibility be problematic? At the most fundamental level, this 'privatisation' of global health policy and assistance means that the health needs of several million Africans are now identified and provided for by global consortiums of public and private sector agents, rather than by local governments. A minimal criterion for judging external interventions can be found in John Rawls's 'law of peoples'. He argues that the 'basis of the duty of assistance is not a liberal principle of distributive justice' but in the axiom that each society with 'non-ideal' conditions 'be raised to, and assisted towards, conditions that make a well-ordered society'.[42] For the current health partnerships to be consistent with the law of peoples, interventions must foster local capacity so that progress is sustainable over the long-term.

There is a strong case, however, for going further than Rawls and specifically including democracy and equity as ends which policy-makers, governments and the United Nations agencies should seek to promote when evaluating, and regulating, health interventions. The importance of democracy, accountability and local participation in

health policy has long been recognised. When the German pathologist and politician, Rudolf Virchow, was sent to investigate an outbreak of typhus in the deprived region of Upper Silesia in 1847 – an area with a disenfranchised Polish minority – he concluded that the solution lay in 'political medicine': education, freedom and prosperity. Virchow argued that only democracy and reduced social inequality could prevent future epidemics. He wrote that 'improvement of medicine would eventually prolong human life, but improvement of social conditions could now achieve this result more rapidly and more successfully'.[43] In this era, even where public health measures were coercive in nature – for example, the 1864 Contagious Diseases Act in Britain, which allowed for the compulsory inspection of women suspected of carrying venereal disease – they were implemented by a legitimate agency vested with the authority to act.[44]

In the current context of the HIV/AIDS crisis in Africa, the need for accountable public institutions and democratic participation is stronger than ever. The demographer John Caldwell has recently argued that 'one of the most bizarre aspects' of the African AIDS crisis 'is the reliance placed on NGOs' who are not vested with any legislative or coercive powers. Democracy, manifested in free public discussion and the ability for citizens to influence policy, is crucial. In the absence of an effective vaccine, let alone an accessible one, social and behavioural change –Virchow's 'improvement of social conditions' - is the only way of stemming the AIDS epidemic, and anti-AIDS policies will only be effective if they recognise 'social and sexual reality'.[45]

It is important to ask, therefore, whether the changes in the global health architecture are fostering sustainability, equity and democracy. The concerns that have been raised in these respects relate both to the externalization of responsibility in itself, and – more specifically – to corporate involvement in the process. In the first instance it may be argued that in contrast to local political contracts for the provision of health services that often marked the first decades of African independence, the internationalisation of responsibility for public health amounts to a 'vague and easily evaded moral responsibility – nothing more than an aspiration – rather than a practical obligation for which the 'responsible' institution can be called to account.'[46] When NGOs take on sole responsibility for the provision of essential services, the relationship between

the ‘donors’ and ‘recipients’ of assistance becomes one of ‘goodwill’ rather than ‘contract’. Individuals become ‘passive recipients’ of charity, thus increasing their insecurity.[47]

Along similar lines, the representatives of African states at a 1995 OAU summit cautioned that 'we are witnessing an increasingly marked trend of rivalry between African governments and NGOs. Sometimes the governments were even robbed of their responsibilities. The NGOs should play a supportive role by complementing government efforts but, given their fragility and lack of requisite resources [political, rather than material], these organizations cannot assume the responsibility for the development of the continent.'[48] Furthermore, it is not clear that NGOs necessarily pursue a more democratic or socially responsible agenda than public institutions. Caldwell argues that where African politicians have been complicit in the overwhelming silence on the question of AIDS, in the NGO sector, too, ‘opposition to condom use, and misinformation campaigns are common’.’[49]

The faith in NGOs as a viable, or indeed preferred, alternative to states has had a self-perpetuating effect, as one recent study of Kenya has found. The overwhelming preference of donors for working through NGOs is revealed by the fact that, in 1994, 95% of USAID’s funds in Kenya were channelled through NGOs and private firms. But, as Julie Hearn has argued, the purported comparative advantage of mission, as opposed to state, hospitals in Kenya is politically constructed.[50] The NGO advantage, in fact, lies entirely in access to funds and expertise from external donors whose own preference is to circumvent the state. With mission hospitals dependent on USAID and international Christian organizations for over 90% of their funding, there is no reason to think this is any more sustainable than state health care, given that it was an overwhelming lack of resources, more than anything else, that underlies the crisis in Kenyatta National Hospital.

The problems associated with the privatisation of health care provision in Sub-Saharan Africa need to be differentiated from the issue of philanthropic funding for research into AIDS, malaria and tuberculosis. The large sums spent by the ‘new philanthropy’ on health research have filled a significant gap in global public health,

rather than supplanting state health services. Nevertheless, given the inequality that inevitably exists in global knowledge production, and the profound asymmetry in the relationship between the producers and intended beneficiaries of this research, attention must be paid to the various institutional mechanisms which are currently being employed by GPPPs; as well as the democracy of their means and ends. The partnerships are currently at an experimental stage, using different organizational and institutional mechanisms, but the nature of the partnerships and the balance of power within them, have a significant bearing on whether they are able to produce equitable results. Above all, the development of new drugs needs to be complemented with effective strategies for delivering the drugs to the poorest people, and strengthening local health infrastructures.

Of particular concern to some is the role played by the pharmaceutical industry in initiatives like GAVI. In the words of Carol Bellamy, UNICEF's Executive Director – 'it is dangerous to assume that the goals of the private sector are somehow synonymous with those of the United Nations, because they most emphatically are not'.[51] Participation in philanthropic initiatives might serve to legitimise the pharmaceutical firms' defence of heavily restrictive patent laws, making it difficult for African countries to take advantage of cheap imports of generic drugs from India or Brazil. It would be unrealistic to dissociate corporate involvement in 'partnerships' from their strategies to influence patent and anti-trust regulations. With heavy corporate involvement in public health initiatives, there is justified concern that the economic 'rules of the game' will continue to bring highly unequal benefits for Africa. Whereas in the early 1990s UNICEF's Vaccine Independence Initiative encouraged developing countries to become more independent in procuring vaccines, GAVI works exclusively through its partners in the Western pharmaceutical industry. The dependency this creates has parallels with the experience of Mozambique in the early 1980s, as we have seen.

It has recently been suggested that GAVI places too much emphasis on high tech vaccines to the detriment of basic health services, and that spending so heavily on new vaccines 'runs the risk of compounding health inequalities in the poorest countries'. New vaccines are being sent to countries that already have a degree of immunisation coverage, whereas the poorest countries are not receiving even the most basic immunisations, such

as those against diptheria, tetanus and polio.[52] At a more fundamental level, the trend towards private solutions challenges the once accepted understanding of development as societal transformation.[53] More or less arbitrarily selected local communities are now the focus for immunisation and treatment campaigns, and whilst favoured communities gain from the injection of resources and facilities, other regions remain deprived of benefits. The involvement of private, especially corporate, interests in decision-making signals a shift away from the idea of universal services and equity, and towards fragmentation.

Finally, we need to ask whether the research and development of new vaccines and treatments are fostering local capacity in African ministries of health, research institutes, and universities. A comprehensive 1999 survey by the Wellcome Trust, under the auspices of the Multilateral Initiative on Malaria, concluded that African malaria research institutes were heavily dependent on external funding – 88% of malaria research grants between 1995 and 1997 came from outside Africa - and that there were 'few linkages across Africa'. The 192 postdoctoral scientists identified in malaria research laboratories were spread across 22 countries, leaving relatively few trained researchers in each country. The report concluded that 'the success of any capacity-building initiative is ultimately dependent on local commitment to scientific research. Funding organizations internationally and governments of developing countries must, therefore, work together to build sustainable research expertise to address clearly identified national health priorities.'[54] The majority of funding for AIDS research, too, is external and channelled through NGOs. In this context, a leading medical historian of Africa has written that the lessons of the successful Smallpox eradication, and failed Malaria eradication, campaigns suggest that 'local health infrastructures need to be included, supported and reinforced, not duplicated by single-disease strategy programmes…committing to a search for a vaccine, rather than building up the health care infrastructure is a mistake that has already been made'.[55]

Ultimately, as the responsibility for political decision-making in health is extended far beyond the local political community, the principle of consent, central to democratic theory as we know it, becomes problematic. This is particularly true as the increasingly complex nature of biomedical crises, and solutions, have led to a de-

politicisation of health policy. The result has been the rise of a ‘technocratic discourse’, sealing off the field of health in a ‘citadel of expertise’.[56] What mechanisms are there for the African recipients of decisions – often decisions with life and death consequences – to signal their agreement? This is, surely, one of the critical questions that the debate on the impact of globalization on public health must address. And in doing so, the nature of democracy and citizenship in Africa, the decay of political institutions, and the possibility of their re-imagination must be taken into account.

From pessimism to partnership?

If the argument for the importance of democracy to health is convincing, we are still left with the dilemma – observed at the outset – that democracy is non-existent or, at best, fragile in Sub-Saharan Africa. Is there a way to integrate concerns about the accountability of external interventions in Africa with a realistic assessment of political possibilities? The first point to make is that, since the early 1990s, donors have attempted to impose democracy and 'good governance' as a narrow set of conditions to be fulfilled – legalising opposition parties, holding elections - at the same time as external, disease-specific programmes have assumed many of the functions of public services.[57] In a telling comment on the ‘conditionalities’ attached to external assistance in Africa, Mozambique’s former president, Chissano, lamented that:

> The U.S. said "open yourself to…the World Bank, and IMF.' What happened?… We are told "No Marxism! You are devils. Change this policy." OK. Marxism is gone. 'Open market economy!" OK. Frelimo is trying to create capitalism…now they say, "if you don't do multiparty system, don't expect help from us'[68]

The political history of Africa in the era of 'conditionality' suggests that formal democracy has not led to a deepening of democratic practices on the continent, because ‘compelling as many of the critiques of government corruption, clientalism, and incompetence are, it is not clear that imposed austerity helps to build political capacity’.[59] Support for the reconstruction of African public institutions, from the health services to

the bureaucracies, might prove a more constructive approach than the establishment of alternative, private structures.

Even more important, given the temptation to bypass democratic institutions in 'vertical' health initiatives in Africa, is the recognition that local level democratic institutions can flourish in unpropitious circumstances. Amartya Sen points out that 'the activism of opposition parties is important in non-democratic societies as well as democratic ones'.[60] The weakness of democracy in some spheres – the absence of open political competition, for example – can be at least partly mitigated by other sorts of democracy, perhaps in the form of political participation at a local level. Furthermore, political participation in health initiatives might be fostered through Africa's regional networks of cosmopolitan ethnicity. It is John Lonsdale's compelling argument that 'as among the nations of Europe, so too among Africa's minorities, one can find passionate protagonists for a larger citizenship that could both attract, and discipline, the cross-border interconnectedness promised by postcolonial globalism.'[61]

The survey that follows – cursory and preliminary in nature - is an attempt to capture some of the diverse ways in which 'actually existing' democratic processes in Africa have addressed the AIDS crisis, and helped to render the vital injection of external resources and expertise more accountable.

a) Senegal

The practice of democracy in Senegal has contributed in no small part to its enviable position as the African country with the lowest prevalence of HIV/AIDS. Drawing an unusual degree of unity from Islam and the Wolof language and culture, Senegal – after a period of restricted democracy – restored relatively open political competition in the early 1980s.[62] Historical and cultural factors undoubtedly provided a favourable backdrop to the government's AIDS prevention efforts – a relative lack of sexual promiscuity; late marriage, and low alcohol consumption were all factors inhibiting the spread of HIV when it first appeared in Senegal in the mid 1980s. Furthermore, commercial sex has long

been well-regulated in Senegal (initially in order to cater to the needs of the French military.) Prostitution was legalised in 1969, and commercial sex workers undergo regular health checks, and receive treatment for sexually-transmitted diseases.

The response of the Senegal government to the appearance of AIDS was swift and dynamic. Not only did the government quickly abolish the excise tax on contraceptives and embark on a public education programme, it supported the work of Senegalese researchers who made vital research contributions in studying the epidemiology of the disease – often in collaboration with external researchers.[63] Crucially, the government acted early to engage the religious leadership on the issue of AIDS. This succeeded in garnering the support of the hugely influential religious leadership for promoting, rather than obstructing, AIDS prevention efforts. These efforts were supplemented on a community level by the organization of hundreds of women's groups, and other networks of activists. The licensing of private radio broadcasts in the early 1990s injected more vigour into political debate, and played a role in the first ever opposition victory – in the 2000 elections.[64] The value of democracy in Senegal has been decisive: with a low prevalence of HIV/AIDS, Senegal is not in great need of expensive external intervention and programmes. Furthermore, the success of public discussion in the response to AIDS, and the presence of democratic debate, suggests that there will continue to be local ownership of and engagement with global expertise and resources in the field of vaccines, for example, where Senegal undoubtedly needs external assistance.

b) Botswana

Botswana, on the other hand, has the highest prevalence of HIV/AIDS in the world, with fully one-third of the population thought to carry the virus. Yet it is also – like Senegal - one of few substantively democratic states in sub-Saharan Africa. The state in Botswana is well institutionalised, characterised by open political competition and a dominant-party system. The Botswana state has a history of successful social intervention, including its much-lauded successes in famine prevention since independence.[65]

Democracy in Botswana has allowed for informed public discussion on the accessibility of anti-retroviral treatment for AIDS patients – a critical issue in a society and economy devastated by the epidemic. Discussion addressed the difficult question of whether or not the government should be made responsible for the provision of treatment.[66] Democratic pressure obliged the Ministry of Health to investigate the financing options for such a commitment, including negotiations with GPPPs and donors. As a result, the Botswana government has been the first in sub-Saharan Africa to commit itself to providing HIV/AIDS treatment for all citizens. President Festus Mogae recently devoted a large portion of his national address to the fight against HIV/AIDS.

The government has taken advantage of rapidly falling anti-retroviral prices, discounted by pharmaceutical companies in the light of events in South Africa, to offer triple-therapy treatment in public hospitals in Gabarone and Francistown.[67] What is striking, for the purposes of the present paper, is that this is a properly political legislative contract for health provision. The government's political commitment to fighting AIDS has allowed it to play a participatory role in the GPPP involving the Gates Foundation and the pharmaceutical company Merck. The Botswana Comprehensive HIV/AIDS partnership has pledged US$50 million over five years to help Botswana strengthen its primary health care system.[68] The initiative will be overseen by 'a panel of key stakeholders and global experts', but the accountability of these groups to shareholders or donor institutions will be matched, at a local level, by the Botswana government's accountability to its citizens. The imbalance in the respective parties' command over resources – this single partnership has a value of almost 50% of Botswana's regular annual health budget – makes it clear just how vital this injection of external resources is for Botswana. But it also raises questions about the balance of power within such a partnership.[69] Will Botswana be increasingly dependent on the uncertain price discounts of the large pharmaceutical firms? And, furthermore, with its small population of 1.5 million and plentiful diamond wealth, Botswana is not a model the rest of Africa could easily emulate.

c) *Uganda*

The experience of Uganda offers a more ambiguous example of the role of local political contracts in global PPPs, but one that combines, in complex ways, local democracy; military authoritarianism; strong political leadership, and state weakness. Uganda is considered by many to be the model case of reconstituted authority on the continent. From a point of complete state collapse in the 1970s and 1980s, Uganda has been a widely cited African example of peace and stability in the 1990s, and one of the most enthusiastic embracers of structural reform. State authority has been restored under the leadership of Yoweri Museveni, although not on the Northern periphery. Uganda has also been the first African country to reverse the spread of the HIV/AIDS epidemic: 14% of the population was infected in 1993, and the figure is now under 10%.[70] As a result, Uganda - along with Senegal, Thailand and Brazil - has been held up as a 'success story' in preventive HIV/AIDS policy.

But the 'success story' is not a simple one. Uganda's qualified political success in health illuminates the complex relationship between political commitment, democracy, and international partnership. Under Museveni a 'dual' state has emerged in Uganda, wherein local authorities are relatively open to popular participation, without a corresponding liberalisation of the central state, which remains autocratic and relies on the military to maintain authority. Leadership on the question of HIV/AIDS came from Museveni at an early stage. He was the first African head of state to discuss the problem openly, and encouraged his ministers to mention it at every possible opportunity. This stance came not from popular pressure or participation in decision-making, but through the immense threat posed by HIV/AIDS to the Ugandan army, which was rife with infection. The scale of the problem became evident when Cuban authorities insisted on testing Ugandan soldiers before accepting them for training in the 1980s. Fortunately, this commitment was translated into the relatively open and participatory local government, encouraging debate on the issue and resulting in a successful programme of public education that is very much in evidence in both urban and rural Uganda today. Museveni's government was also amongst the first in Africa to invite Western researchers to study the spread of the epidemic in the country.

Notably, the relative openness on the subject at a high political level, combined with the existence of local political forums for debate on the issue, has meant that the dominance of international organizations in the actual provision of preventive and curative health services has not removed HIV/AIDS from the political agenda. The result of this has been that political leaders and local government have provided a forum for leadership and debate on HIV/AIDS while NGOs – and increasingly, global philanthropic initiatives – have provided resources which the state lacks. Uganda was amongst the first recipients of the discounted anti-AIDS drug, AZT by Glaxo Wellcome, under the UNAIDS Bridging the Gap initiative in 1997; it also received some of the first donations of the potent new anti-malarial Malarone, also by Glaxo Wellcome, in 1996.

It is not clear how sustainable this combination of local political commitment, and international resources and co-ordination will prove in the long run. In many ways, the nature of Uganda's political success on HIV/AIDS contains threats to its own sustainability. Neither the leadership's commitment to open debate and political participation, nor the influx of external resources, is in any way guaranteed. The authoritarianism of Museveni's government seems to be on the increase in the light of the 2001 elections, and is a potential constraint on the continued democratisation of local authority.[71] The election was marked by the widespread intimidation of opposition supporters, and the campaign revealed the President's own tendency to stigmatise people living with AIDS. Many observers went as far as raising the spectre of renewed civil war, averted only because the opposition did not vigorously challenge the election result.[72] Equally, the much-needed 'philanthropic' resources that have come Uganda's way are not backed by a binding commitment. The flow of resources to Uganda was initiated by the perception that Uganda was characterised by reform and stability – both of which are, paradoxically, the partial result of an authoritarian central government dependent on military force.

The threat of militarism

The Ugandan experience brings us to one final point about African states in the context of global health: the role of militarism. Continental war – centred on the quagmire in the Democratic Republic of Congo – is fuelling the spread of disease in Central Africa. No less than 6 national armies, along with myriad rebel movements, are involved in the conflict. The difficulty of any sort of health intervention – philanthropic or otherwise – in the context of war is made tragically clear by the Congolese experience. A recent report estimates that 2.5 million people in Eastern DRC have died since the outbreak of war in August 1998; of these, 2,150,000 are thought to have died as a result of malnutrition and disease.[73] The devastation of health infrastructure, and the displacement of over 2 million people, has led to reports of the re-emergence of bubonic plague and whooping cough, and epidemics of measles and cholera. At least 37% of the population – approximately 18.5 million people – have no access to any kind of formal health care. Given this collapse of an already strained health system, the proportion of the population benefiting from full vaccination has fallen to 29%. While reliable statistics are wholly lacking, the possibility of a massive increase in HIV transmission is a very real one, given the scale of military movements in the DRC. Rape is all too often used as a 'weapon of war', and estimated rates of HIV infection rates within foreign military forces range from 50% of Angolan soldiers, to 80% of Zimbabwean soldiers.[74]

The rise in the incidence of armed conflict in the Great Lakes region is inextricably linked with the process of state erosion, discussed earlier. The present conflict in Central Africa illustrates the spiral of suffering that the interaction of globalization, militarism and public health has produced. The war-generated health crisis is, undoubtedly, a result of long-standing political tensions in the Great Lakes region, many of them dating back to the colonial era (the 'original' wave of globalization in Sub-Saharan Africa). The conflict has its origins in complex debates over citizenship rights and settlement, particularly of the Tutsi diaspora; the access to land of displaced populations; narrowly defined political identities; destabilisation in the aftermath of the Rwandan genocide, and a struggle for resources in a region mired in poverty. Even in the

absence of armed conflict, current African health crises are deeply rooted in political problems: problems of institutions and values, and of inequalities in power. To abstract health concerns from their political context and stress 'vertical', externally devised solutions, is to risk replicating colonial attitudes towards health in Africa which – as the historian Randall Packard has argued - were narrowly technical in their outlook, ignoring the underlying causes of ill-health, and creating a dependency on advanced technology.[75]

Yet, if the processes of globalization have largely resulted in fragmentation and institutional erosion in Sub-Saharan Africa, they have the potential to generate a mutually reinforcing cycle of democracy and health. The greatest benefit of the new global philanthropy lies in its scope for producing innovative solutions, and making information and bio- technologies available to the poor. The flexibility of philanthropic funds allows for riskier social investments than might otherwise be possible using public resources alone. It is because technology has the equal potential to empower and destabilize that it is so important to evaluate the impact of external interventions on local institutions, and on the practice of local democracy – if interventions strengthen rather than undermine local institutions, the possibility for genuine partnership is stronger. African responses to the health crises need to be explored by researchers, and taken into account by policy-makers. Even in the midst of debilitating conflict, African doctors, nurses, and community health workers provide health care, and have clear ideas as to what their local needs and priorities are.[76] And even the African 'success stories' of today – most notably Uganda – were widely characterised as hopeless a decade ago.

In capturing the interconnectedness of social, economic, political and medical problems, the now influential concept of 'human security' is a particularly meaningful one. Global philanthropy has the potential to reduce the insecurity that stems from unequal access to the benefits of science and technology, but this is only one part of an inter-related array of sources of insecurity. As Emma Rothschild has argued, ensuring security must ultimately be the responsibility of local political institutions, empowered by local social and political contracts, for 'the essential characteristic of security is as a political relation.'[77] It is with the question of institutions, local and international, that I shall conclude.

Conclusion

I have suggested here that discussions of 'democracy and good governance' in Africa need to take account of two, almost contradictory, points. The first is that widespread state crisis in Africa makes it necessary to qualify notions of accountability and partnership in the way they are used in much of the literature on new developments in global health. And secondly, that the prevalent pessimism about the potential of the state in Africa is challenged by some very real cases of successful partnership between African public institutions, and global resources and expertise. The practice of democracy at the state and local levels, however, urgently requires the reconstruction of the global framework in which they operate. A prerequisite for the more equitable distribution of the costs and benefits of globalization, is the re-imagination international political institutions capable of regulating, co-ordinating and disciplining economic globalization, and the globalization of infectious diseases.

Within Sub-Saharan Africa itself, we might think through the possibility of a revitalisation of Africa's regional representative institutions. Such organizations certainly exist – at last count, there were over 200 regional, largely inter-governmental, initiatives across the continent, but their potential has remained unfulfilled, and their structures have languished.[78] Yet, Africa's health crises are ideally suited to regional-scale initiatives. The frequent movement of people (and infectious diseases) across flexible frontiers, existing regional economic and cultural coherence, and the potential for 'economies of scale' suggest that the Southern African Development Community, or the newly revived East African Community, for example, could play a far greater role than they do at present. This would be a complement, rather than a challenge, to the reconstruction of public institutions at the state/national level.

It is crucial, above all, that the large sums of money going into the development of new vaccines and drugs are complemented with funds towards (re-)building local health infrastructures, and local capacities. As Paul Farmer writes in a moving account of his experiences treating AIDS and tuberculosis patients in Haiti, what is needed is 'a full range of high-tech *and* low-tech solutions. Why, I wondered anxiously, was it so manifestly impolitic…to press for the former as well as the latter?' The Haitian poor,

when asked what they most wanted, were unequivocal: ‘Not a clinic, a health post or a dispensary. Not vaccines or prenatal care. They wanted a hospital.’[79] Africans need hospitals too, and this need is particularly urgent at a time when individual African states are in retreat and their chief functions are being privatised, whilst millions of their citizens die of curable diseases.

Notes and References

[1] An earlier version of this paper was discussed at the Common Security Forum conference, at the Centre for History and Economics, on 'The new philanthropy and international institutions: the case of global health', on 5-6 July, 2001. I am grateful to all of the participants for their comments, which have been vital to this revision. I am particularly grateful to Emma Rothschild, John Lonsdale, Jean Dreze and an anonymous referee for comments and criticisms. Any mistakes are mine alone.

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[16] Mkandawire, 'Developmental States', *op. cit.*: 303-4. The ten countries were: Botswana, Gabon, Lesotho, Kenya, Cote d'Ívoire, Seychelles, Swaziland, Congo, Rwanda and Nigeria.

[17] An observation I owe to Thandika Mkandawire.

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[19] Iliffe, *Africans, op.cit.*: 244

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