



The emergence of global health partnerships as facilitators of access to medication in Africa: A narrative policy analysis

Michael Zisuh Ngoasong*

Institute for Science and Society, University of Nottingham, West Wing, University Park, Nottingham, Nottinghamshire NG7 2RD, United Kingdom

ARTICLE INFO

Article history:

Available online 17 January 2009

Keywords:

Africa
Global health partnership
Health policy
HIV/AIDS
Malaria
Narrative policy analysis
Medication

ABSTRACT

Over the last decade global health partnerships (GHPs) have been formed to provide a better policy response to Africa's health problems. This paper uses narrative policy analysis to explain the historical processes and challenges facing national and global health policy in facilitating access to medication in African countries. An overview of the historical context of events leading to the creation of GHPs is followed by a content and context analysis of two GHPs – Roll Back Malaria partnership and the Accelerating Access Initiative. The historical narratives implicitly reflect the context in which policy decisions are produced and implemented. The deployment of GHPs in Africa reflects a convergence of the competing and conflicting narratives, in relating to strategies previously promoted by various multi-lateral and bilateral development agencies, international civil society organizations, and the private commercial industry to facilitate access to medication.

© 2008 Elsevier Ltd. All rights reserved.

Introduction

The objective of this article is to understand the narrative strategies used to formulate international and global health policies intended to facilitate access to medication in African countries. The article argues that policy makers in Africa, far from being able to respond locally and autonomously, face enormous global pressures in setting and implementing health policy to facilitate access to medication. Access itself is externally defined. The UN highlights four principles for achieving access: availability, accessibility, acceptability and quality (UN, 2000, para. 12), while Andersen (1995) distinguishes potential access (the presence of healthcare) from realized access (the actual use of health services). Potential access is a function of availability and accessibility; for example the rural–urban differential and the time to reach a health facility (Thind & Andersen, 2003). Actual access depends on quality and acceptability in relation to the presence of traditional medicine, self-help treatments, alternative healings and the costs of treatment (Thind & Andersen, 2003; Essomba, Bryant, & Bodart, 1993). Major barriers to access in Africa include rising disease pandemics, the high prices of patent-protected drugs, poverty, infrastructure and political will (Heywood, 2002; Piachaud, 2005; WHO, 2005).

Over the last decade, global health partnerships (GHPs) have been formed to deal with these challenges. GHPs are collaborative relationships among pharmaceutical companies in partnership with UN-based organizations, developing country governments and public and private foundations to ensure efficient product development, healthcare delivery and technical support for the implementation of national disease programs (Buse & Harmer, 2007; Buse & Walt, 2000; UNAIDS/WHO, 2002). These stakeholders have their own narrative strategies about where the emphasis of global health policies should be laid in relation to actual and potential access to medication. The task of GHPs is to reconcile these (sometimes competing and conflicting) strategies into a single global policy, but also to prove that global health targets are met in the context of disease-endemic countries (Buse & Harmer, 2007). This article demonstrates that to better evaluate the impact of GHPs in African countries, it is important to understand the historical context in which different narratives emerge leading to the formulation of global health policies for specific GHPs.

The historical context of events presented in GHP reports, policy documents, articles and newspaper magazines is studied using narrative policy analysis (NPA) (Kaplan, 1986; McBeth, Shanahan, Arnell, & Hathaway, 2007; Rhodes, 2000; Stone, 2002). The justification of NPA as a relevant framework is discussed followed by analysis of the historical context of access to medication leading to the formation of GHPs. Two GHPs, namely Roll Back Malaria partnership (RBM) and the Accelerating Access Initiative (AAI) for HIV/AIDS treatment and care are then analysed in greater details. Finally, conclusions are presented.

* Tel.: +44 115 846 8142; fax: +44 115 846 6349.

E-mail address: lbxmzn@nottingham.ac.uk

Using narrative policy analysis to understand health policy decisions and impacts

Policy makers can approach the difficult task of selecting the best criteria to apply to achieve specified goals in a number of ways. One method is policy analysis, described positively as ‘*the choice of the best policy among a set of alternatives with the aid of reason and evidence*’ (MacRae, 1980: p. 74). However, Quade (1975) had already argued that most immediate social goals are usually the result of opportunities offered by newly discovered or perceived choices rather than a source. This undermines the possibility of such a rational or linear process suggested by MacRae. Narrative analysis, the application of narratives that takes social values and historical contexts into consideration (Kaplan, 1986), has emerged as a way of dealing with these problems. In the presence of policy questions with controversial law-like explanations, narrative policy analysis (NPA) is useful to describe change over time and to uncover the hidden assumptions that are implicit in policy documents (Kaplan, 1986). NPA uses narratives such as characters, contents, plots, colourful language, and metaphors (McBeth et al., 2007) to explain the occurrence of and the linkages between events in an attempt to select and justify desirable courses of action (Zilber, 2007).

It is this capacity to address a range of complex characteristics and distinctive narratives that suggest the NPA can successfully be applied to the issue of access to medication. To describe the historical context of access to medication, a systematic reading of the literature is summarized as content, context and narrative analysis respectively (Zilber, 2007). Generating and categorising analytical, abstract and wider themes, comparisons are made across different conventional timelines in Africa’s history. The conventional timeline of public health (diseases and policy strategies) is linked to development policy (colonial hierarchy, planning and capitalism), often based on western ideologies (Vaughan, 1991). The emergent themes (see Table 1) provide a basis for summarising narrative strategies. The relations among the different themes highlight the barriers to access to medication. The historical pattern leads to two common themes: 1) ‘frustration with state-centric systems and fascination with the power of public–private partnerships’; 2) ‘access to medication goes beyond medical and non-medical interventions strategies’. The historical narratives implicitly reflect the context in which policy decisions are produced and implemented.

From the 1970s national health policy goals in Africa were largely influenced by the WHO and UNICEF, while development policy was largely influenced by the IMF and the World Bank, with development agencies participating in regions where they had their colonial interests. From the late 1990s GHPs emerge to bring all these partners together including, private corporations (e.g. pharmaceutical companies) and civil society organizations (philanthropic donors, foundation and NGOs). A fourth group comprised of patients or potential patients is frequently mentioned, but with little chance to voice their own positions. Analyzing the distribution of stories across these groups consistently reveals that actors deliver different stories within a shared theme. NPA then becomes useful as a way to uncover the attribution of causal relationships between GHP and access to medication and the responsibility of

actors. Actors explicitly provide a shared story on equitable access to medication (every human being should have access to treatment irrespective of ability to pay). However, they present their own counter-narrative (who pays the costs of R&D and access to medication for poor countries). The counter-narratives serve to undermine the shared and explicit narrative and justify the case studies on the AAI and RBM.

The historical context of access to medication

Sachs and Malaney (2002: p. 2) rightly state “*the lessons of history serve us well as we look to the future in our battle against (malaria, tuberculosis and HIV/AIDS).*” Historical paradigms are produced by actors and their roles and by events in society and the economy. Thus, history appears as both an independent force and a process influencing narratives. The historical paradigms in Table 1 are discussed below to identify the main actors and highlight their narrative strategies in relation for access to medication.

Access to medication under colonial rule (19th century to 1950s)

Historical accounts reveal three ideal types of actors: European colonial masters playing the role of the State; religious missionaries complementing the colonial agenda; and traditional healers sticking to various aspects related to the customs and tradition of their society. Each of these actors presented a different narrative strategy to define access to medication.

Most accounts on Africa hold that access to medication reflected the hierarchical nature of Colonial society: ‘*the military campaign was the only model available in the Colonial context*’ (Vaughan, 1991: p. 43). African countries had to ‘*assume whatever jurisdiction may be needed for*’ the effective exercise of a protectorate (Young, 1994, p. 92). In the Ivory Coast, France put in place ‘*the undebatable principle of our authority*’ (Young, 1994: p. 101) and most French medical services were under the armed forces up to around 1965 (Patton, 1996). Similarly, a British Colonial Medical Service, established in 1901, laid down a strict hierarchy (Patton, 1996). Efforts to treat or prevent epidemics among the local population were conducted like military campaigns, and interventions were dictatorial and bureaucratic (Manderson, 1999; Vaughan, 1991): ‘*When it came to practice ... the Medical Officer became indistinguishable from the administrator in the eyes of the African community*’ (Vaughan, 1991: p. 43). In Eastern Nigeria the treatment of yaws involved identification, compulsory stripping and treatment with militaristic precision (Vaughan, 1991: p. 52). In Nyassaland, ‘small pox’ police enforced vaccination campaigns while persons with sleeping sickness received prison-like isolation in the Belgian Congo (Vaughan, 1991: p. 43). Access to medication thus involved selective treatment and prevention of epidemics by military medical officers.

Religious missionaries complemented and facilitated the colonialist agenda from an evangelical perspective: ‘*faith and prayer were sufficient to ensure native health*’ (Good, 1991). Unlike the military campaigns of the colonial administration, missionary services attempted to establish a ‘*connection between body and soul and ... show greater compassion for human suffering*’ (Good, 1991: p. 2). The aim of the military campaigns was to selectively prevent diseases and epidemics in areas where colonialist citizens lived and

Table 1
Historical narratives in relation to access to medication in Africa.

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

to protect the black labour force. The complementarities of missionary services were useful in the sense that they penetrated the rural areas where military campaigns could not reach.

Traditional healing practices that existed before the arrival of both colonial masters and religious missions continued to be popular. Traditional healers attributed sickness to spirits, sorcery or physiological problems and operated fee-for-service (financial or non-financial) mechanisms for divine and lay healing (Feierman, 1985; Illiffe, 1998: p. 11). These covered a wide range of activities including well structured associations, diviners and lay healers.

Therefore, at independence, access to medication was constructed in three conflicting ways: the selective treatment and prevention of diseases under strict hierarchy and bureaucracy by the colonial masters; emphasis on faith and prayer in the case of religious missions; and spiritual healings in the case of traditional medicine. One would expect that after securing independence from former colonial masters, the new African states would attach importance to the need to reconcile these conflicting narratives. As the next section suggests this was not to be the case.

Access to medication in the Neo-colonial or planning era (from the 1950s to the 1970s)

The transition from colonialism to neo-colonialism was defined as a shift from 'colonialism to government', that is, the 'bureaucracies of the commissioners, courts, and bizarre configurations of 'customary law' had been institutionalized' (Barnes, 1999: p. xv). In reality, the 'new states' continued to adapt rather than transform the Colonial state. They became 'successors to the colonial regime, inheriting its structures, its quotidian routines and practices, and its more normative theories of governance' (Young, 1994: pp. 285, 287). Mamdani (1996: p. 288) illustrates how 'development became a top-down agenda enforced on the peasantry' (see specific examples in Copans, 1980). The major changes to the system were that the colonial administration was replaced by sovereign African states.

In relation to the political context above, health policy changes involved indigenising health services without necessarily transforming them. For example the Kenyan Minister of Health stated in 1963 that 'Kenya must copy the British model of medical services and nothing else' (Illiffe, 1998: p. 131). Thus, national governments replaced the colonial administration providing free healthcare especially in urban areas. On their part missionaries adopted a more voluntary and welfare cultural conversion approach by penetrating rural areas to provide free healthcare, while emphasising the connection between spiritual (faith and prayer) and bodily (curative services) issues (Good, 1991; Vaughan, 1991). As noted earlier, traditional medicine continued to play a dominant role in the health sector.

At independence, African governments did not place much emphasis on the need to reconcile the conflicting narratives on access to healthcare. Instead, they focused more on establishing their grip on power while attempting to provide free healthcare to their citizens. An important feature of this period is that the medical profession became an important determinant of health as medical practitioners replaced colonial military officers and began to dominate the hierarchy of healthcare delivery in matters such as deciding on the role of assistant doctors, quality of services and in some case service fees (Good, 1991; Illiffe, 1998). The planning period also coincided with the creation of international organizations such as the WHO, UNICEF and the Breton Woods Institutions, all of which intervened in cases of epidemics by providing drugs, funding or technical assistance based on international (rather than country-specific) contexts. These led to an increase in the number of actors and narrative strategies. While there was a general feeling in the 1970s that free healthcare under State authority could not be

sustained, there was increasing pressure from African states to gain international recognition by endorsing internationally proposed development policies to better facilitate access to medication.

Access to medication: privatisation, liberalization & international involvement (1970–1990s)

This period is characterised by a move from planning towards market reforms (privatisation and economic liberalization) proposed by the World Bank in the face of rising disease pandemics that were accompanied by breakthroughs in pharmaceutical innovations (international trade). The debate on where to put the emphasis on access to medication (access to medicines vs. access to health services) intensified significantly. The general consensus in the international environment was that the planning era was causing both state and market failures in African countries. In relation to access to medication, three emerging narratives were independently put forward to help developing countries such as those in Africa to face the challenges of providing access to medication for the poor: public health (WHO), human rights (UNCHR) and economic (WTO and World Bank) narratives respectively. These narratives took the form of international conferences sponsored by these multilateral organizations in which African governments were invited to participate. During such meetings, success stories and best practices from various parts of the world are highlighted in the form of empirical accounts.

The WHO initially emphasised public health as the main determinants of access to medication. It designed and supervised the implementation of a vertical Primary Health Care (PHC) system in African countries. The first of this was the 1978 *Alma-Ata Declaration* that emphasised treatment and prevention strategies. The system was constantly being revised to the Reorientation of Primary Health Care (PHC-RO) system (*The 1987 Bamako Initiative*) and the Reproductive Healthcare System (1995). These recent reforms call for community participation in managing and funding supplies of healthcare, decentralization of management process to health districts and centres, and integrating all PHC activities. Throughout the 1980s and 1990s access to medication was a responsibility of the State in partnership with the community supported by the WHO and UNICEF (Essomba et al., 1993).

The WHO's (2001) report on *Macroeconomics and Health* and the WTO Agreement on Trade-Related Aspects on Intellectual Property Rights (TRIPS) provided an economic narrative of access to medication. The WHO (2001) defines public health as an instrument of economic development while the TRIPS agreement emphasises access to medicines more than access to health services. The WTO and its affiliated partners argue that patent protection under TRIPS facilitates innovations in R&D and ensures that essential medicines will always be available (Attaran & Gillespie-White, 2001). This narrative is also related to the IMF/World Bank proposals to privatise and liberalise public utilities, including those in the healthcare sector. This market-oriented strategy has an important impact in the sense that, from the 1990s, the vertical primary healthcare system mentioned above was transformed into a vertical and pluralistic system with multiple sources of healthcare providers and financing (public, private-for-profit, religious missions, civil society initiatives).

By contrast, the Universal Declaration of Human Rights (UNDHR) provides a distinctive human rights narrative which situates access to medication in the context of the right of everyone to 'a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services' (UN, 2000: pp. 27–29). The declaration claims that access to medication 'includes the creation of a system of urgent medical care ... the provision of disaster relief and humanitarian assistance (and) the

control of diseases (through) States' individual and joint efforts to, inter alia, make available relevant technologies' (pp. 43–47).

The three narratives above dominated the formulation and implementation of health policy goals in relation access to medication in much of Africa in the 1990s. By the mid-1990s, these international strategies were being challenged by the emergence of international civil society organizations and interest groups. These groups argued that international trade agreements such as TRIPS maximises profits for pharmaceutical companies, discourages research on neglected diseases and increases the prices of essential medicines for the poor (MSF, 2002; Thomas, 2002). Many commentators argue that the three narratives above fail to reconcile private and public interests, or to distinguish between national and international standards of healthcare (Heywood, 2002) in relation to "disadvantaged and marginalized individuals and groups" (UN, 2001b, para. 8 and 15). The formation of GHPs will be seen as an attempt to define access to medication globally, by integrating these narratives and counter-narratives.

Access to medication – the emergence of global health partnerships (Since the late 1990s)

The historical analysis above reveals distinctive disagreement on the meaning and strategic objectives of access to medication. From the late 1990s, numerous studies sponsored by multilateral and bilateral development agencies began to highlight the implications of these disagreements in ways that suggest the need to integrate all three strategies and partner organizations in the following ways:

- Government and market failures to provide public goods to the poorest and most vulnerable people (Buse & Waxman, 2001; Towse & Kettler, 2002).
- To resolve widespread bureaucracy, infighting and inefficiencies among multilateral and bilateral agencies (Börzel & Risse, 2005)
- The need to foster collaboration with the private industry (Richter, 2004a, 2004b) through alternative development solutions for UN-based and international development agencies (DfID, 1997; USAID, 2003; WHO, 1999a; World Bank, 1998).
- The 'unavoidable necessity' of harnessing the resources to address global health issues and the challenges posed by globalization (Buse & Walt, 2000).

The convergence of the three narrative strategies was summed up in a speech by a former WHO Executive Director when she constructed access to medication as 'a moral problem, a political problem and a problem of credibility for the global market system' (Brundtland, 2000: p. 7). The formation of GHPs was a first attempt to define access to medication in Africa in this moral sense, with the ultimate objectives of solving the four challenges above. It is also reflected in most multilateral initiatives that were created from the late 1990s to tackle these four challenges for specific diseases. In the case of nations states such as those in African, Dodgson, Lee, and Drager (2002) illustrate their inability to act unilaterally 'or in cooperation with other states, to deal with global health challenges' (p. 8) and how this led to access to medication becoming a 'global' responsibility. Buse and Harmer (2007) introduced the term global health partnerships (GHPs) to integrate the role of corporate social responsibility of private industries to governmental or inter-governmental organizations. Thus, GHPs are reciprocal collaborations (Dodgson et al., 2002) in which state and non-state actors voluntarily agree to undertake specific functions to improve access to medication at global and national levels.

Global health partnerships as facilitators of access to medication

UN-based agencies and their affiliated partners have sponsored several studies on the impact of GHPs. The general consensus is that GHPs are meant to supply a better policy response to the challenges of access to medication. The strategic objectives include: product discovery and development of new diagnostics, drugs and vaccines; support for improved service access and technical assistance; advocacy for international and/or national response and resource mobilization; and funding for specific disease programs. There are five key terms associated with the literature on GHPs and access to medication: *global* signifies cross-border or worldwide nature of initiatives; *health* signifies that the goal to deal with health problems especially those affecting the poor in developing countries; *national health system* signifies procedures and processes for achieving national health targets; *public-private partnership* signifies a multi-actor or inter-organizational relationships in which 'risks and benefits are shared in pursuit of a shared goal' (Buse & Walt, 2000); GHPs refer to "relatively institutionalised initiatives, established to address global health problems, in which public and for-profit private sector organisations have a voice in collective decision making" (Buse & Harmer, 2007). To better understand the narrative strategies put forward to achieve national targets, the next section looks at two GHPs: the Roll Back Malaria partnership and the Accelerating Access Initiative for HIV/AIDS treatment and control.

GHPs and health system strengthening – the Roll Back Malaria partnership

The historical context of access to medication for malaria

The historical narrative focuses on the extent to which medical intervention (treatment and prevention strategies) was responsible for suppressing short-term malaria cases and achieving long-term control over malaria epidemics. International organizations such as the WHO formulated and implemented prevention and control strategies in the face of rising levels of drug resistance or resurgences of malaria (WHO, 1993, 2003; Gallup and Sachs, 2001). The strategy of the WHO and UNICEF was to use prevention strategies that were successful in some developing countries as 'success stories' (see Mabaso, Sharp, & Lengeler, 2004; Rosenberg, 2004) in making recommendations for the future and in formulating policies for other countries. However, from the early 1990s, empirical evidence began to emerge that the WHO malaria programmes in Africa were largely unsuccessful and left in the hands of the government.

Specifically, the evidence suggested that adherence to treatment and control by households and country/region-specific strategies rather than the use of insecticide and the generosity of donors (De Zulueta, 1994; El Gaddal, 1985; Greenwood & Mutabingwa, 2002) were hardly taken seriously in designing malaria programmes in the 1980s and early 1990s in Africa (Najera, Kouznetsov, & Delacollette, 2004). Much of this literature coincided with the resurgence of malaria and its associated burden on the most vulnerable and poor segment of the population. These issues dominated consultations on strategies to reduce the rising incidence and burden of malaria between 1990 and 2000 spearheaded by several regional and international initiatives – Africa Initiative on Malaria (1997), Multilateral Initiative on Malaria (1997), Medicines for Malaria Venture (1997) and the Harvard Malaria Initiative (1997). The efforts formed the basis for the creation of the Roll Back Malaria (RBM) partnership.

The Roll Back Malaria partnership for malaria treatment and control

The WHO, World Bank, UNICEF and their partner organizations launched the RBM in November 1998 to reduce the amount of

malaria deaths by 50% by 2010 (Nabarro, 1998; WHO/UNICEF, 2005). As a public–private partnership, the RBM combines the expertise of pharmaceutical companies (such as MMV, MIM, and Novartis), the field experience of the public sector (WHO, UNICEF and national governments and civil society organizations) and donor support (such as the World Bank and the Global Fund). The context is a tri-sectoral network (to operate on a global, regional and local level respectively) to address the complexity of the root causes of malaria transmission through four core technical strategies: 1) improved and prompt access to effective treatment; 2) increased use of insecticide-treated nets (ITNs) and other locally appropriate means of vector control; 3) early detection and response; 4) and improved prevention and treatment of malaria in pregnant women (WHO/UNICEF, 2005: p. xi). It also emphasises malaria R&D and evidence-based action and impacts to help African countries to achieve their national malaria targets.

The RBM was launched on the pretext that malaria has become a global public health crisis requiring a public health (not private) intervention. Accordingly, a series of narratives were offered to defend RBM's strategy. The Abuja summit concluded that previous malaria eradication campaigns in Africa were fragmented and uncoordinated. Subsequently, the narratives shifted to the potential effectiveness of medical intervention in malaria treatment and control. For example, a Cochrane review (Lengeler, 2004) shows the potential of ITNs to prevent children from being infected by malaria while the WHO and the UNICEF, backed by the World Bank and advanced countries, demonstrate the feasibility of generating funding to ensure a 30-fold increase in the availability and affordability of drugs between 2000 and 2005 (WHO/UNICEF, 2003). In response to concerns from NGOs and civil society organizations that patents prevent affordability of medicines for poor households, the WHO stated that the pharmaceutical industry was open for negotiated discounted drug prices (Nabarro, 1998).

More than 50 African leaders endorsed RBM under the Abuja Declaration (WHO, 2000) by pledging to halve Africa's malaria deaths by 2010. The Heads of African states were convinced by UN agencies that anti-malarials such as chloroquine can treat malaria, that insecticide-treated bednets (ITNs) for malaria prevention would be available, and that donors would fund the programme. In response, the African leaders undertook a commitment to clarify the strategy to achieve the Abuja targets at country levels. This is the main narrative on which RBM programmes emerged in Africa. However, a counter-narrative emerged a few years later from civil society organizations and research institutes. The WHO was criticised for promoting drugs like chloroquine and sulfadoxine–pyrimethamine, despite knowing for several years that they were ineffective (Attaran et al., 2004). The same article supported ACTs as a more effective alternative. Médecins Sans Frontières had already advocated a change from Chiloquin to ACTs during a malaria epidemic in Ethiopia (MSF, 2004).

The timing of these counter-narratives is very interesting as the WHO and the Global Fund to fight AIDS, tuberculosis and malaria quickly change to ACTs from 2004 (ACTs is today the core of malaria treatment in Africa). While the Lancet Article is often cited in the RBM website, most recent *Africa Malaria Reports* discuss the WHO's reluctance to quickly embrace the ACT in relation to the fact that African countries did not have the health system to deal with the change.

The RBM and the challenge for malaria treatment and control in Africa

The analysis above suggests that the nature and success of any RBM programme at country level do not only depend on the country-specific mobilization and the generosity of donors. It also

depends on the narrative strategies used by RBM partners, and counter-narratives put forward by opponents in relation to previous narrative strategies. In contrast to the public health response promoted by the WHO in the 1970s and 1980s, the RBM has focused on mobilizing donor funding to purchase nets, insecticides, and effective malaria drugs for distribution in resource poor countries. This places greater emphasis on actual access to medication at the expense of potential access to medication. Lessons from earlier malaria eradication campaigns that are identified by RBM as failures suggest that access to medication extends beyond access to ITNs to include the many factors determining the behaviour of households in spraying insecticides or using ITNs. The WHO (2003) identifies (emphasis added) '*dwellings that offer protection against mosquitoes (and) transportation to a health facility capable of treating the disease*'.

The RBM's use of terms and phrases such as 'Africans cannot afford', 'poorest Africans' is reflected in its policy of heavy subsidization of drugs. This implicitly undermines an economic narrative (e.g. the World Bank's cost recovery programme) that would emphasise long-term sustainability in the absence of donor funding (as is increasingly becoming the case). The market for ITNs and ACTs involves negotiations between selected pharmaceutical companies and donors (large foundations, UNICEF and the Global Fund) on the basis of price, thereby contradicting a competitive healthcare market that emphasises quality (WHO, 2005). This undermines the economic suggestion that a developed healthcare market could serve the most vulnerable and poverty-ridden segments of the population. These conflicting narrative strategies have serious implications for access to medication, and are discussed in the concluding section.

GHPs and pharmaceuticals – the Accelerating Access Initiative

The historical context of access of medication for HIV/AIDS

HIV/AIDS took more than fifteen years to become a global health crisis and now requires a global community to face the challenges together. When life-sustaining treatment for HIV/AIDS went into circulation in 1996 at a cost (\$10,000–\$15,000) far greater than the average per capital spending (US\$8) on health for least developed countries, there was a general outcry that these countries could not cope with the rising number of HIV/AIDS cases and resulting consequences (Joseph, 2003). Multilateral organizations, led by UNAIDS (2000: p. 11) described HIV/AIDS as 'only' a health problem and identified inadequate healthcare infrastructure, scepticism within the global health community, and the costs of chronic therapy as major barriers to access (UNAIDS, 2002). However, there was global recognition that '*treatment is technically feasible in every part of the world*' as long as there is political will (WHO, 2002: p. 9) and '*sustainability of drug financing*' (WHO, 2002a: p. 9).

Despite the devastating nature of the disease the story conveyed optimism regarding the future. Advocates expressed admiration for breakthroughs in pharmaceutical innovation and the supporting role of the pharmaceutical industry in public health interventions: the development of drugs that can treat both HIV/AIDS and other opportunistic infections that kill people with HIV/AIDS (Harvard Consensus Group, 2001; WHO, 2002: p. 8). Another shared theme was the difficulty to live up to the rising pandemic of HIV/AIDS and its devastating consequences at all levels (UNAIDS/WHO, 2002). In the Ouagadougou Commitment (May 2000), African leaders declared that while '*health constitutes a right and a foundation for socio-economic development*' the AIDS epidemic is a major '*public health, development and security problem for Africa*.' This implied that '*access to treatments, including antiretroviral, is indispensable ... and must be established on a permanent basis*' (WHO, 2000). At the

same time civil society organizations and activist groups argued that the strategy of pharmaceutical companies and the WTO to charge prices of ARV at levels that are incompatible with the financial capacities of African government is not a long-term solution for nations or for people with HIV/AIDS. In contrast, pharmaceutical companies defended both their pricing policies and the patent system stating that social, political, and infrastructural barriers, not drug prices, impede access (Attaran & Gillespie-White, 2001; Joseph, 2003). These narratives and counter-narratives informed the creation of the Accelerating Access Initiative in May 2000.

The AAI and access to medication for HIV/AIDS

The AAI was formed in May 2000 as a partnership between six UN organizations and five pharmaceutical companies (UNAIDS, 2000) with three objectives for Africa: 1) accelerate sustained access to and increased use of 'appropriate, good quality interventions'; 2) strive to reach significantly greater numbers of people in need through 'new alliances involving committed governments, private industry, the UN system, development assistance agencies, NGOs and people living with HIV/AIDS'; and 3) implementation 'in ways that respond to the specific needs and requests of individual countries, with respect for human rights, equity, transparency and accountability' (UNAIDS/WHO, 2002: p. 4). The AAI proceeded along two intersecting tracks: 1) a national plan developed for each interested country with technical support from the UN system is transmitted by UNAIDS to specific pharmaceutical companies; 2) bilateral negotiations on prices and supply arrangements take place between national governments and individual pharmaceutical companies facilitated by the UN staff in the country support-working group (UNAIDS/WHO, 2002: pp. 5–6).

The AAI Statement of Intent includes '*consideration ... to reducing the prices of medications*' as a strategic response to the HIV/AIDS pandemic and calls for '*an international bid to buy drugs in bulk at the lowest price for all countries in need*'. It assumes that real price reductions allow global and national actors to rapidly develop infrastructure to provide treatment. However, activists such as Drug Action Campaign South Africa and Project Inform joined MSF in demonstrating that the AAI does not provide any long-term solution to the HIV/AIDS problem, citing unfair competition between patent-protected drugs and generics. These opposing narratives are integrated at the World AIDS Conference in Durban in July 2000 and a subsequent UN Declaration of Commitment (UN, 2001a), both of which set out a renewed approach to tackle the disease: '*the complementarities of prevention and treatment and the urgency of addressing the needs of the developing world*'; collaboration between the pharmaceutical industry and the UN organizations; funding from rich countries and the role of African Governments to develop and implement country-wide programs. The Global Fund, the World Bank's Multi-Country HIV/AIDS Program and other donors have made significant progress towards realising the targets of the AAI. Individual pharmaceutical companies also have initiatives operating within a combination of AAI, WHO and UN rules (see Table 2).

The AAI and the challenge for accelerating access to medication for HIV/AIDS

The various bilateral and multilateral public-private partnerships above highlight the fact that a successful medical intervention (access to ART) in poor countries can reinforce non-medical intervention (HIV/AIDS prevention). As highlighted in WHO/UNAIDS/UNICEF (2007) a public health approach also requires addressing longer-term financial sustainability in the event that donor funding

Table 2

HIV/AIDS programmes initiated by AAI pharmaceutical companies.

Pharmaceutical Company	Initiatives	Descriptions
Abbott Laboratories	Abbott Access, Step Forward, Tanzania Care	ARTs at no profit, capacity building, PMTCT
Boehringer-Ingelheim	Drug Donation, Joint Ventures, Licensing	Free Viamune® for PMTCT, licences to generic manufacturers
Bristol-Myers Squibb	Secure the Future	ART for PMTCT, funds for health system strengthening
Gilead Sciences	Gilead Access	ARTs at no profit, clinical trials for prevention of HIV/AIDS
GlaxoSmithKline	Pricing Schemes, Licensing, Positive Action	Preferential price for Global Fund projects, vaccine R&D, community investment, license to generic producers
Merck & Co., Inc	ACHAP programme in Botswana	Cash donations, ART at no costs to government, awareness campaigns
F. Hoffmann-La Roche	No patent for Roche medicines, Joint Venture	Voluntary and compulsory licensing, building local medical infrastructure

Source: author's processing of secondary information from the websites of pharmaceutical companies involved in the AAI.

becomes insufficient. The human rights' focus has mobilised resources that are being used to pay for HIV/AIDS treatment (global access to medication) as well as advocacy for national commitment and transparency in the effective and equitable utilising of donor support. The creation of the Global Fund and World Bank Multi-Program, for example, is important steps to solve the discrepancies between the highest attainable standard of help on the basis of global resources vis-à-vis that attainable on the basis of national resources. In addition, there are national commitments both on the part of industrialised countries to publicly adopt a global plan and the government of African countries to ensure transparency and resolve within their countries. A human rights perspective is important to ensure that while providing the additional funds needed, partners may recognise that '*prevention and care are mutually reinforcing elements of an effective response*' (UN, 2001b: supra para. 17). The civil society organizations have played a key role in placing the issue of access to medicines as a fundamental element even in the WTO agendas and in mobilizing national level support in the realization of the right to health.

The economic perspective has shifted from strategies to penetrate Africa's healthcare markets to philanthropy (drug donation) and discounted pricing. In addition, the provisions of the TRIPS agreement have been increasingly relaxed such that voluntary or compulsory license system now allows many African countries suffering a health crisis to permit generic production or importation. ACT UP Paris has called for '*countries to find their own solutions, by using generic medications produced by national drug companies, by building up regional markets, and by purchasing from suppliers that offer reasonable prices*.' This involves, for example, integrating HIV/AIDS and sexual reproduction health services, finding innovative financing mechanisms and eliminating structural barriers such as foreign debt burdens to help countries scale up responses, and building the required infrastructure to strengthen healthcare system to better deal with HIV/AIDS treatment and control.

Analysis and conclusions

This article argues that good policy analysis sometimes leads to the setting of clear and generally agreed upon criteria existing separately from the problem that needs to be solved (Kaplan, 1986). In RBM, the relative values of malaria control tools are not adequately defined in relation to the country-specific context. In

addition, inter-sectoral and multi-sectoral collaboration highlighted by RBM is hardly implemented. In the AAI, scaling up access to HIV/AIDS medication appears to overshadow the requirements to strengthen the national health systems as both are treated as competing priorities. These challenges are reflected in the narrative of events from different actors at global and national levels. The article suggests that a history of colonial, post colonial, international and global health agenda placed considerable pressure on Africa's health systems and prevented complete restructuring. The poorest and most vulnerable population was hardest hit.

GHPs put forward a moral claim for 'universal access' to medication to protect the interest of the poor. In practice, however, the public health and economic criteria used by proponents of GHPs to make strategic choices are continuously challenged by opponents for being inconsistent with human rights' principles. This questions the rationalist basis for the implementation of GHP programs and highlights their failure to meet target objectives. RBM sets a global target for reducing the malaria burden, yet ignores countries that are not interested irrespective of the incidence and burden of the disease. The debate over the prices of ART for HIV/AIDS treatments, rather than the causes of the disease, dominates the creation and implementation of the AAI. The under-representation of African governments in GHPs (Buse & Harmer, 2007) undermines the need for a focus on macroeconomic reforms (a responsibility of national governments) that are necessary to get the best out of technical and financial supports from GHPs.

The narratives analysed in this article further reveal that there is confusion over the nature of demand and supply sides of access to medication (problem-oriented, patient-oriented, demand-oriented) and their relationships; the necessary levels of commitment expected at community, country and global levels; and the strong position of pharmaceutical companies vis-à-vis civil society activism. In addition, the transition from national to global health governance leads to conflicts of interest among, for example, profit vs. non-profit partners or those who favour patent protection (high drug prices) to those who campaign for cheaper generics. The under-representation of African partners in decision making makes it hard to understand their own narrative strategies through a study of GHP policy documents, and undermines their potential influence on the process. On the other hand, the strong position of pharmaceutical companies, UN organizations and philanthropic organizations enable them to decide, on the basis of their capacity and interest (and not in relation to the needs of African countries), the area in which they will be primarily active.

Nevertheless the narrative strategies of RBM and the AAI provide important lessons for the future fight against disease pandemics in Africa. RBM reinvigorated the global and national effort to control malaria in Africa after a long history of failed eradication campaigns. There are several opportunities for continued dialogue to coordinate the efforts and public, private and civil society sectors (for example, empowering the civil society, involving other ministries and local governments with the aim of making malaria everybody's business). Similarly, the AAI sparked an expansion in HIV/AIDS treatment, care and support in Africa by setting an important framework for dialogue, negotiations and learning among public, private and civil society organizations at all levels. However, there is a need to evaluate the narrative strategies of GHPs in terms of how they are aligned and integrated with those of national governments to better appreciate their potential to promote country-specific access to medication. In this case, it could be interesting to investigate the changing narratives highlighted in this article from a country-specific perspective and how they reflect the operational orientation of specific GHPs in relation to access to medication.

References

- Andersen, R. M. (1995). Revisiting the behavioural model and access to medical care: does it matter? *Journal of Health and Social Behavior*, 36, 1–10.
- Attaran, A., Barnes, K., & Curtis, C. (2004). WHO, the Global Fund, and medical malpractice in malaria treatment. *Lancet*, 363(9404), 237–240.
- Attaran, A., & Gillespie-White, L. (2001). Do patents for antiretroviral drugs constrain access to AIDS treatment in Africa. *Journal of the American Medical Association*, 286, 1886–1892.
- Barnes, T. (1999). *We women work so hard: Gender, urbanization, and social reproduction in colonial Harare, Zimbabwe, 1930–1956*. NJ: Heinemann Press.
- Börzel, T. A., & Risse, T. (2005). 'Public-Private partnerships: effective and legitimate tools of international governance?' in Grande, E. & L.W. Pauly (eds.). *Complex Sovereignty: Reconstituting Political Authority in the 21st Century*. Toronto: University of Toronto Press.
- Brundtland, G. H. (2000). *Towards a strategic agenda for the WHO secretariat*. Statement by the Director General to the Executive Board at its 105th session. EB105/2. WHO.
- Buse, K., & Harmer, A. (2007). Seven habits of highly effective global public-private health partnerships: practice and potential. *Social Science & Medicine* 259–271.
- Buse, K., & Walt, G. (2000). Global public-private partnerships: part I – a new development in health? *Bulletin of the World Health Organization*, 78.
- Buse, K., & Waxman, A. (2001). Public-private health partnerships: a strategy for WHO. *Bulletin of the World Health Organization*, 79(8), 748–754.
- Copans, J. (1980). *Les Marabouts et l'arachide: la Confrérie Mouride et les Paysans au Sénégal*. Paris: Le Sycamore.
- De Zulueta, J. (1994). Malaria and ecosystems: from prehistory to post-eradication. *Parassitologia*, 36, 7–15.
- DfID. (1997). *Eliminating world poverty – A challenge for the 21st century*. White Paper on International Development. London: DfID.
- Dodgson, R., Lee, K., & Drager, N. (2002). *Global health governance: A conceptual review*. Discussion Paper (1). Department of Health and Development, WHO.
- El Gaddal, A. A. (1985). The Blue Nile Health Project: a comprehensive approach to the prevention and control of water-associated diseases in irrigated schemes of the Sudan. *Journal of Tropical Medicine and Hygiene*, 88(2), 47–56.
- Essomba, R. O., Bryant, M., & Bodart, C. (1993). The reorientation of primary health care in Cameroon: rationale, obstacles and constraints. *Health Policy & Planning*, 8(3), 232–239.
- Feierman, S. (1985). Struggles for control: the social roots of health and healing in modern Africa. *African Studies Review*, 28, 73–145.
- Gallup, J., & Sachs, J. (2001). The economic burden of malaria. *American Journal of Medicine and Hygiene*, 64(1–2 Suppl.), 85–96.
- Good, C. (1991). Pioneer medical missions in colonial Africa. *Social Science & Medicine*, 32(1), 1–10.
- Greenwood, B., & Mutabingwa, T. (2002). Malaria in 2002. *Nature*, 415, 670–672.
- Harvard Consensus Group. (2001). Full statement online. <www.hsph.harvard.edu/bioethics/pdf/consensus_aids_therapy.pdf>. Accessed 10.02.07.
- Heywood, M. (2002). Drug access, patents and global health: chaffed and waxed sufficient. *Third World Quarterly*, 23(2), 217–231.
- Illiffe, J. (1998). *East African doctors, a history of the modern profession*. Cambridge: University Press.
- Joseph, S. (2003). Pharmaceutical corporations and access to drugs: the "fourth wave" of corporate human rights security. *Human Rights Quarterly*, 25, 425–452.
- Kaplan, T. J. (1986). The narrative structure of policy analysis. *Journal of Policy Analysis and Management*, 5(4), 761–778.
- Lengeler, C. (2004). Insecticide-treated bed nets and curtains for preventing malaria. *Cochrane Database of Systematic Review*(2), CD000363.
- Mabaso, M. L. H., Sharp, B., & Lengeler, C. (2004). Historical review of malarial control in Southern African with emphasis on the use of indoor residual house-spraying. *Tropical Medicine and International Health*, 9(8), 846–856.
- MacRae, D., Jr. (1980). Concepts and methods of policy analysis. *Policy Studies Annual Review*, 4, 74–80.
- Mamdani, M. (1996). *Citizen and subject: Contemporary Africa and the legacy of late colonialism*. Princeton: James Currey.
- Manderson, L. (1999). Public health then and now. *American Journal of Public Health*, 89(1), 102–107.
- McBeth, M. K., Shanahan, E. A., Arnell, R. J., & Hathaway, P. L. (2007). The intersection of narrative policy analysis and policy change theory. *The Policy Studies Journal*, 35(1), 87–108.
- MSF. (2002). *Untangling the web of price reductions: A pricing guide for the purchase of ARVs for developing countries* (3ed.). Geneva: Médecins sans Frontière.
- MSF. (2004). Ethiopia: advancing treatment for deadly diseases. MSF online 06.12.04. <<http://www.msf.org/msfinternational/>>. Accessed 21.02.07.
- Nabarro, D. (1998). *Roll Back Malaria (RBM): WHO malaria briefing*. UK Department for International Development. <www.malaria.org/ppt/rbm.htm>. Accessed 04.04.07.
- Najera, J. A., Kouznetsov, R. L., & Delacollette, C. (2004). *Malaria epidemics detection and control forecasting and prevention*. (Online). WHO. <www.rbm.who.int/docs/najera_epidemics/naj_toc.htm>. Accessed 19.02.08.
- Patton, A. (1996). *Physicians, colonial racism and Diaspora in West Africa*. Miami: University Press of Florida.
- Piachaud, B. S. (2005). Challenges to improving access to essential drugs: perspectives from across the divide. *International Journal of Technology and Globalisation*, 1(2), 225–238.

- Quade, E. S. (1975). *Analysis for public decisions*. New York: Elsevier.
- Rhodes, R. A. W. (2000). The governance narrative: key findings and lessons from the ESRC's Whitehall Programme. *Public Administration*, 78(2), 345–363.
- Richter, J. (2004a). Public–private partnerships for health: a trend with no alternatives? *Development*, 47, 43–48.
- Richter, J. (2004b). *Public–private partnerships and health for all: How can WHO safeguard public interests?* Helsinki: Ministry of Foreign Affairs of Finland.
- Rosenberg, T. (2004). What the world needs now is DDT. *New York Times*. 2004 April 11.
- Sachs, J., & Malaney, P. (2002). The economic and social burden of malaria. *Nature*, 415(6872), 680–686.
- Stone, D. (2002). *Policy paradox: The art of political decision making*. New York: W.W. Norton.
- Thind, A., & Andersen, R. (2003). Respiratory illness in the Dominican Republic: what are the predictors for health services utilization of young children? *Social Science & Medicine*, 56, 1173–1182.
- Thomas, C. (2002). Trade policy and the politics of access to drugs. *Third World Quarterly*, 23(2), 251–264.
- Towse, A., & Kettler, H. (2002). *Public–private partnerships for research and development: Medicines and vaccines for diseases of poverty*. London: Office of Health Economics.
- UN. (2000). *The right to the highest attainable standard of health*. E/C.12/2000/4.
- UN. (2001a). *Global crisis-global action, UN general assembly, special session on HIV/AIDS*. (26th special session). Resolution A/RES/S-26/2(27/06/2001).
- UN. (2001b). *Substantive issues arising in the implementation of the international covenant on economic, social and cultural rights*. E/C.12/2001/15. Geneva: UN.
- UNAIDS. (2000). *New public/private sector effort initiated to accelerate access to HIV/AIDS care and treatment in developing countries*. Geneva: UNAIDS. 11 May.
- UNAIDS. (2002). *Keeping the promise: Summary of the declaration of commitment on HIV/AIDS*. UNAIDS/02.31E. Geneva.
- UNAIDS/WHO. (2002). *AIDS epidemic update: December 2002*. UNAIDS/02.46E. Geneva.
- USAID. (2003). *Building public private partnerships to address HIV/AIDS*. Washington D.C.: AED/SARA, USAID.
- Vaughan, M. (1991). *Curing their ills: Colonial power and African illness*. California: Stanford University Press.
- WHO. (1993). *Report of a WHO Study Group on the implementation of the global plan of action for malaria control 1993–2000*. WHO technical report series 839.
- WHO. (1999a). *WHO guidelines on collaboration and partnerships with commercial enterprises*. Geneva: World Health Organization.
- WHO. (2000). *The African summit on Roll Back Malaria, Abuja, April 2000*. Geneva: World Health Organization. WHO/CDS/RBM/2000.17.
- WHO. (2001). *Macroeconomics and health: Investing in health for economic development*. Geneva: Commission on Macroeconomics and Health, WHO.
- WHO. (2002). *A commitment to action for expanded access to HIV/AIDS treatment*. International HIV Treatment Access Coalition, WHO.
- WHO. (2002a). *Scaling up Antiretroviral Therapy in Resource-Limited Settings: guidelines for a public health approach*. WHO: NLM classification: QV 268.5.
- WHO. (2003). *Improving affordability and financing of artemisinin-based combination therapies*. WHO/CDS/MAL/2003.1095.
- WHO. (2005). *Price, availability and affordability, an international comparison of chronic disease medicines*. Background report. Geneva: WHO.
- WHO/UNAIDS/UNICEF. (2007). *Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector*. Geneva: WHO/UNAIDS/UNICEF.
- WHO/UNICEF. (2003). *Africa malaria report*. Geneva: WHO.
- WHO/UNICEF. (2005). *World Malaria Report*. WHO/HTM/MAL/2005.1102.
- World Bank. (1998). *Partnership for development: Proposed actions for the World Bank*. Washington, DC: World Bank Group.
- Young, C. (1994). *The African colonial state in comparative perspective*. New Haven: Yale.
- Zilber, B. T. (2007). Stories and the discursive dynamics of institutional entrepreneurship: the case of Israeli high-tech after the bubble. *Organization Studies*, 28(7), 1035–1054.