Transcalar networks for policy transfer and implementation: the case of global health policies for malaria and HIV/AIDS in Cameroon

Michael Zisuh Ngoasong

Institute for Science and Society, University of Nottingham, Law & Social Sciences Building University Park, Nottingham NG7 2RD, UK. Tel. +44 115 846 8142. Fax. +44 115 846 3649. E-mail: lbxmzn@nottingham.ac.uk

Accepted 6 February 2010

This paper explores the nature and type of policy transfer promoted by global health partnerships to facilitate access to medication in Cameroon and the associated implementation challenges. Using concepts from policy transfer, multi-level governance and the politics of scale, the paper conceptualizes the social spaces (global-national-local linkages) through which global health policies are negotiated as transcalar networks. The framework is used to analyse policy documents, technical and media reports and journal articles focusing on two global health partnerships (GHPs)—Roll Back Malaria and the Accelerating Access Initiative—in Cameroon. Both GHPs helped to create the national Malaria and HIV/AIDS programmes in Cameroon, respectively. Global policies are negotiated through dialogue processes involving global, national and local partners who constitute the national HIV/AIDS and malaria committees. Successful policy transfer is evident from the consensual nature of decision-making. Analysis of policy implementation reveals that GHPs offer a ‘technical fix’ based on specific medical intervention programmes with a relatively limited focus on disease prevention. The GHP approach imposes new governance challenges due to policy resistance strategies (strategic interests of international agencies and country-specific challenges). Evidence of this is seen in the existence of several overlapping programmes and initiatives that distort accountability and governance mechanisms defined by the national committees. Finally, the implications of these challenges for achieving access to medication are discussed.

Keywords Global health partnerships, health policy, transcalar networks, malaria, HIV/AIDS, Cameroon

KEY MESSAGES

- Through Roll Back Malaria and the Accelerating Access Initiative, global health policies for malaria and HIV/AIDS are respectively transferred to Cameroon through a consensual dialogue process involving global, national and local partners.

- Unlike the primary health care model, centralized around the Ministry of Health, GHPs attempt to align health policy with development policy to create national disease programmes in which non-state actors have become key players in both policy making and implementation.

- Successful policy transfer is evidence of a consensual decision-making process while the process of implementation reveals serious challenges (relative neglect of preventive measures, overlapping initiatives that distort accountability and transparency mechanisms).
Introduction

In 1986, the Ottawa Charter (WHO 1986) put forward the claim that ‘health promotion can only make sense as a ‘global’ phenomenon—its full value, impact and use cannot be appreciated by applying it within one country or society’. Since then, global health policies have come under increasing scrutiny in relation to their applicability in country-specific contexts. Over the last decade, global health partnerships (GHPs) have been created to formulate global health policies that are supposed to be implemented on a country-led basis. As global public–private partnerships (PPPs) (Buse and Wilt 2000a; Buse and Harmer 2007) involving hybrid networks of global, national and local partners (Dodgson et al. 2002), two questions to be raised about GHPs in relation to access to medication are: (1) How do global policies assist with country-specific barriers to access to medication?; and (2) What are the challenges involved in the process of policy transfer and implementation?

The above questions are especially relevant in the case of malaria and HIV/AIDS in Africa. Despite a long history of campaigns against malaria, Africa still accounts for 80% of 300–500 million cases of malaria detected globally (RBM 2003: 5) and 90% of global malaria deaths in 2004 (WHO 2000; Shetty 2004: 319). The burden of malaria on the continent as a whole is estimated at US$3–12 billion annually (United Nations 2000). Similarly, despite being a more recent pandemic, HIV/AIDS has hit hardest in Africa with up 29.4 million cases by 2002 (UNAIDS/WHO 2002a: 6). From this perspective, Ngoasong (2009) suggests that the role of GHPs must be judged in terms of their potential to help African countries access medicines and health care services (as judged by availability, accessibility, affordability and quality). This article examines policy transfer in the context of how GHPs grapple with the challenges of creating an enabling environment in which this objective can be achieved.

In particular, the article explores the nature and types of policy transfer promoted by GHPs and analyses the implementation challenges in relation to access to medication. Analytically, it builds on the literature on policy transfer (Dolowitz and Marsh 2000; Walt et al. 2004), multi-level governance (Marks 1993; Marsh 1998) and ‘politics of scale’ (Brenner 2001) to conceptualize the policy transfer process as taking place within transcalar networks (global–national–local linkages). The analysis reveals that the country-specific claims on the capacity of GHPs to achieve access to medication can be substantiated. However, the GHP approach imposes new governance challenges that must be resolved if access to medication is to be achieved on a sustainable basis. Such challenges are primarily due to competing interests of international agencies and country-specific challenges, all of which hinder effective policy implementation.

This article looks specifically at the Roll Back Malaria partnership (RBM) and Accelerating Access Initiative (AAI), both of which created windows of opportunities from which Cameroon developed its national malaria and HIV/AIDS programmes, respectively. As one of the first countries to endorse international/global initiatives historically, Cameroon presents a rich context for understanding the role of GHPs in Africa. The remainder of this article is organized as follows: the research approach is presented followed by a brief discussion on the context of global policy transfer in Cameroon. The case studies on malaria and HIV/AIDS are then presented followed by discussion and conclusion.

Research approach

The relationship between GHPs and access to medication

From the conceptualization of ‘global health partnership’ (Buse and Harmer 2007) and ‘access to medication’ (Ngoasong 2009), five other key terms were selected: ‘global’, ‘health’ (problems affecting the poor), ‘access to medicines’, ‘health policy’ (procedures and processes for achieving targets) and PPPs. Using various combinations of these seven terms, an extensive search was conducted to identify the key literature on the role of RBM and AAI in Cameroon. The databases consulted include United Nations (UN) agencies, bilateral development agencies [France Coopération, the UK Department for International Development (DFID), Germany and USAID] and Cameroon government’s sources. The literature included empirical, agenda and evaluation accounts published in peer-reviewed journals, policy documents, technical reports and independent external evaluations. From these sources, links to reports disseminated on the websites of international civil society organizations, media and academic/research institutions associated with GHP-related activities were also studied. The existence of such links justifies the use of sources such as local media to discuss the role of GHPs in access to medication.

GHPs are ‘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 and Harmer 2007: 239). This definition captures the involvement of non-state actors, private industry, multilateral and bilateral agencies, and national governments in formulating and implementing policies. The World Health Organization (WHO) and UNICEF launched RBM in 1998 to reduce global malaria deaths by 50% by providing ‘a coordinated global approach to fighting malaria’ and ‘the scaling up of interventions at country level to ensure wide spread coverage, particularly to population groups most vulnerable’.1 Similarly, under the leadership of UNAIDS, UN agencies and five western pharmaceutical companies launched the AAI in May 2000 ‘to make HIV/AIDS drugs more affordable and accessible in developing countries and to improve technical collaboration in the development of national programme capacities to deliver care, treatment and support’ (UNAIDS/WHO 2002b: 4).

The objectives of both RBM and AAI are relevant for achieving access to medication, defined in terms of potential and actual access to medicines and health care services (Ngoasong 2009: 949). In terms of potential access, both GHPs attempt to empower governments to emphasize health system strengthening through political commitment and capacity development (Caines et al. 2004; Carlson 2004; Buse and Harmer 2007: 261). In terms of actual access, while the AAI promotes drug donation and bulk purchase of discounted medicines for HIV/AIDS treatment (UNAIDS/WHO 2002b; Buse
Transcalar networks as mechanisms for policy transfer and implementation

There is a general concurrence that policy transfer takes place through informal networks of public and private actors who have distinct but interdependent interests, and who are striving to solve similar problems. In this context, policy transfer is ‘the process by which knowledge about policies, administrative arrangements, institutions and ideas in one political system is used in the development of policies, arrangements, institutions and ideas in another political system’ (Dolowitz and Marsh 2000: 5). Multi-level governance, ‘a system of continuous negotiation among nested governments at several territorial tiers’ (Marks 1993: 392), reveals how this transfer process has transformed the role of the state towards new strategies of co-ordination in the face of accountability challenges and the increased participation of non-state actors (Bache and Flinders 2004: 197). In this context, policy networks enable actors to ‘play the boundary’ of national/international, public/private, formal/informal, market/bureaucracy, state/non-state, legal/illegal in shaping policy practices (Stone 2003: 43; Sikkink 2005: 152).

Apart from the above boundary problem, Bache and Taylor (2003: 283) refer to country-specific challenges and partners’ strategic interests as ‘policy resistance strategies’ that may hinder effective transfer and implementation—the same factors described by Ngoasong (2009) as crucial for understanding GHPs in Africa. The notion of ‘the politics of scale’ (Brenner 1999, 2001) then becomes useful to expose areas where policy transfer clashes with policy resistance. Unlike transnational policy networks built around government ministries (Reich 1995; McCormick 2001; Walt et al. 2004), we now have GHP programmes in which the state (through various ministries) no longer has this centralized bureaucratic authority (Dodgson et al. 2002; Abbott 2007). National GHP programmes have been created in which representatives of public health (WHO, UNICEF and ministries of health), donor agencies (Global Fund, World Bank and private foundations) and civil society organizations at global, national and local levels sit around the same table to formulate and implement country-led global health policies.

This article uses the term ‘transcalar network’ to describe this new type of global–national–local linkage. The existence of networks indicates levels of institutionalized authority (McCormick 2001) and their transcalar character reveals the existence of social spaces through which global, national and local actors interact (Scholte 2005). Castells (2000) also demonstrates how globalization has transformed the ‘social space’ found in traditional network studies from a ‘space of spaces’ to a ‘space of flows’. A similar transformation is evident in the GHP context. For example, while GHPs recognize the autonomy of the state, the failures of ‘weak states’ in Africa (Dodgson et al. 2002) suggest that GHPs use civil society organizations and donors to bypass the bureaucratic structures of the state to produce ‘quick results’ (Caines et al. 2004; Buse and Harmer 2007). This transcalar characteristic of contemporary global institutions has been shown, in the case of forest exploitation, to constrain national politicians’ capacity for corrupt practices (Compagnon 2008). The fact that key GHP partners (e.g. the World Bank) put good governance as a major condition for funding, as well as channel funds directly to non-state actors (CREDES 2004; World Bank 2007), suggests that the role of GHPs also needs to be understood in terms of whether they have such underlying objectives. This is crucial because, if local non-state actors are also deeply penetrated by neo-patrimonial tendencies, as suggested in Compagnon (2008), they may become another form of local policy resistance. After discussing the context of global health, the above framework is used to examine transcalar networks in the case of RBM and AAI in Cameroon.

The context of global health policy transfer in Cameroon

Since achieving independence in 1961, the goal of health policy in Cameroon has always been to improve the health of the population by increasing accessibility to high-quality public health services. However, the measures taken to achieve this goal have always involved the adoption of international health policy directives (Table 1). In particular, variants of the WHO/UNICEF-led primary health care (PHC) model were adopted in parallel with the IMF/World Bank-led Structural Adjustment Programmes (SAPs). The GHP approach attempts to integrate the objectives of PHC and SAPs, as well as the strategic interests of global, national and local agencies in global health, into a global PPP approach for facilitating access to medication.

Variants of the PHC model created a national health system that faced serious implementation challenges in the wake of a devastating economic crisis in the mid-1980s and the failure of the SAPs to create a market economy capable of dealing with the crisis (Baye 2003; Mbaku 2004). Actual access to medication was hindered by persistent increases in the cost of drug procurement and local distribution, undersupply of infrastructure (health professionals and medical supplies), large rural–urban differentials (Ngofor 1999; Ghogomu et al. 2000; WHO 2002) and the popularity of traditional medicine (Niangsi 1998).

In 1990 the government introduced user-fees and authorized private provision of health care, justified under the co-finance and co-management recommendation of the WHO/UNICEF-led Bamako Initiative to reorient the PHC and the World Bank’s Cost Recovery Programme (Litvak and Bodart 1993; Ngofor 1999; Ridde 2003: 533). The state-centric health system (a vertical/bureaucratic system under the Ministry of Health) now had to compete with multiple private, religious and community health care providers and funders. New types of regulatory and implementation procedure (potential access to medication) emerged, including complex administrative procedures that authorities struggled to implement. Health workers at all levels...
could freely practise rent-seeking behaviours (under-the-counter consultations, prescriptions and sales of medicines) (Ntangsi 1998; Ako et al. 2006). Such corrupt practices have been described as both government and market failures resulting from international policy interventions (Baye 2003; Mbaku 2004). They therefore represent policy resistance because they constrain the effective implementation of policy reforms.

Cameroon therefore epitomizes the types of government and market failure that necessitate a GHP approach. By the mid-1990s, international agencies had already begun to acknowledge this and stress community participation (Tafah and Asondoh 2000) as well as the need to realign international interventions (e.g. the Paris Declaration on AIDS effectiveness). This rowing back of action gathered momentum with the launching of the World Bank’s Debt Relief Programme in 2000. At the same time, the contiguous development of GHPs created a window of opportunity for an alternative form of engagement and intervention for all stakeholders. The debt initiative in Cameroon provided US$86 million per year of new government expenditure until 2015 for poverty alleviation, with $32 million allocated to the health sector in the first 3 years (Ministry of Health 2000). With the country classified as ‘First, first, seventh, fifth: ...between 1998 and 2001 on the list of Corruption Perception Indices published by Transparency International’ (Carlier and Jennes 2003: 5), it is not surprising that the initiative was conditional on anti-corruption and good governance initiatives (Kabemba 2003).

As GHP partners, western development agencies began to realign their bilateral relations with Cameroon to reflect both the debt programme and the GHP approach. Accordingly, separate national GHP programmes have been created for malaria, HIV/AIDS and TB (seen as priority diseases in terms of incidence, burden and impact) with hybrid structures that are consistent with the notion of transcalar networks described earlier. Crucially, they are PPPs under the control of national committees (Figure 1) instead of the bureaucratic structures of the Ministry of Health (the PHC model).

From the official texts creating the national committees for each disease area, the Minister of Health is the chairman. In practice the national committee, not the Ministry of Health, is the most central actor (Figure 1). This is because global, national and local partners are represented in policy making (full lines in the Figure), implying that decisions are consensual. As discussed in the following case studies on the malaria and HIV/AIDS programmes, the ways in which global health policies are transferred appear to be rigorous and complete. However, implementation challenges (dotted and dashed lines) reveal the complex nature of transcalar networks in the case of GHPs and the associated country-specific governance challenges.

Table 1 The emergence of global health partnership (GHP) programmes in Cameroon

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of policy</td>
<td>Colonial</td>
<td>National and colonial</td>
<td>International</td>
<td>Global</td>
</tr>
<tr>
<td>Health policy development</td>
<td>Colonialism (dictatorship)</td>
<td>Government (state-centric)</td>
<td>Government (privatization &amp; regulation)</td>
<td>Governance (PPP)</td>
</tr>
<tr>
<td>National policy makers</td>
<td>Germany, France, Britain</td>
<td>Ministry of Health</td>
<td>Ministry of Health, UN Agencies</td>
<td>National GHP programmes</td>
</tr>
<tr>
<td>Health policy goal</td>
<td>Curative &amp; preventive</td>
<td>Curative &amp; preventive</td>
<td>Primary health care</td>
<td>Access to medication</td>
</tr>
</tbody>
</table>


Global malaria policy transfer and implementation in Cameroon

Malaria is the leading cause of mortality in Cameroon, particularly affecting pregnant women and children less than 5 years of age. Cameroon is a classic example of failed WHO programmes in the 1960s/1970s (Greenwood and Mutabingwa...
2002) and anti-malarial campaigns in the early 1990s (RBM 2003). Drug resistance, rising incidence of malaria and socio-economic factors have always been the major policy challenges (NMCP 2002; WHO 2004). In December 1998, a Working Group on Malaria (a National Coordinator, WHO and UNICEF, and local organizations) developed a robust National Strategic Plan for Malaria to reflect RBM’s strategic objectives (NMCP 2001). Cameroon also ratified the Abuja Declaration to Roll Back Malaria in Africa, in which more than 50 African leaders pledged to reduce malaria deaths by 60% by 2010 (WHO 2000).

Under the leadership of the WHO and UNICEF, the initiators of RBM convinced African leaders that pharmaceuticals for malaria treatment (e.g. artemisinin-based combination therapies) and insecticide-treated bednets (ITNs) for malaria control would be available; donors pledged to fund the programme. In response, African leaders pledged to develop their national health systems’ capacity to deliver the 60% target at country level. In 2001, Cameroon exonerated import taxes on those products (January) and completed a situation analysis on malaria (August). In July 2002, the National Strategic Plan for Malaria was launched at a national conference (NMCP 2002). In effect, it represents the National RBM Programme. As with the global RBM and the Abuja Declaration, it aims to provide 60% access to malaria medicines and ITNs by 2010, and to increase intermittent preventive and general malaria treatment (especially for pregnant women and children) within the poorest and vulnerable populations.

The National Malaria Committee (structured as in Figure 1) is expected to meet twice a year. Multilateral (WHO, UNICEF) and bilateral (e.g. French Cooperation, GTZ, DFID and USAID) agencies provide technical advice to the national partners (especially the Central Technical Group) to assess progress on malaria treatment and control and to develop grant proposals based on field conditions and donor requirements. Funding is provided primarily by the Global Fund (Rounds of Applications), the World Bank’s debt initiative (Ministry of Health 2000) and the Booster Program (World Bank 2007). Just as the World Bank, the Global Fund prefers grant proposals that are ‘based on modern and cost effective methods of malaria control designed by the Roll Back Malaria initiative’.² With the strategic plan and funding guaranteed, the National Drug Procurement Centre (CENAME) then enters into bilateral negotiations on discounted drug procurement and supply arrangements with pharmaceutical companies (such as Novartis) endorsed by RBM. Local partners (e.g. Cameroon Coalition Against Malaria) intermediate between the global and national (government) partners, thereby representing the voice of the poor in policy making (Tamfu 2007). It is through such a transcalar networking process that policy transfer takes place within the RBM, with participation by all actors involved.

In terms of implementation, the Central Technical Group coordinates the activities of provincial and district malaria units to ensure that malaria policies translate into actual treatment and control activities to serve the poor in urban and rural villages. Public health experts provide epidemiological, diagnostic and drug prescription services while locally trained public, private and NGO health units assist with community mobilization, sensitization and distribution of medicines and ITNs. Africa Malaria Days (e.g. Opio et al. 2008) and other forums provide important opportunities for disseminating information on preventive, diagnostic and treatment services that are available throughout the country.

Several parallel malaria initiatives have also been created by global RBM partners in partnership with local partners (private, religious and NGOs) operating independently of the Central Technical Group. Their creators justify such initiatives in terms of their affiliation with RBM’s strategic orientations. For example, the Integrated Management of Childhood Illness (ICIM)³ is an initiative by USAID (donor), Plan International (with the Ministry of Health, selected local partners and country representatives of other UN agencies (UNESCO, UNICEF, UNDP, WHO and the World Bank) who initiated the AAI, and presented the case for a country-led GHP approach (translated from French): ‘It is unbelievable to realise that we are trying to put together competent Cameroonians in the fight against HIV/AIDS … and that it is Cameroonians who have requested that UNAIDS should be directly involved’ (Eboko 2001).

Global HIV/AIDS policy transfer and implementation in Cameroon

First diagnosed in 1985, HIV/AIDS in Cameroon is currently described as a generalized epidemic (WHO 2005: 1) with prevalence rates of 4.8–9.8% (NACAP 2008: 2). National policy to combat the disease had international dimensions from the start. The first National Strategic Plan on HIV/AIDS, prepared in 1987 using guidelines from the WHO’s Global Programme on AIDS (GPA), incorporated HIV/AIDS policies within the national health system (Eboko 2001). When UNAIDS replaced the GPA in 1996, the plan was revised as the National AIDS Control Programme in 1998. UNAIDS established a country office in December 1999. In June 2000, a month after the launch of the AAI, UNAIDS Country Director (Dr Emmanuel Gnaore) met with the Ministry of Health, selected local partners and country representatives of other UN agencies (UNESCO, UNICEF, UNDP, WHO and the World Bank) who initiated the AAI, and presented the case for a country-led GHP approach (translated from French): ‘It is unbelievable to realise that we are trying to put together competent Cameroonians in the fight against HIV/AIDS … and that it is Cameroonians who have requested that UNAIDS should be directly involved’ (Eboko 2001).
Cameroon officially joined the AAI in March 2001 after signing an accord with the participating pharmaceutical companies. This was followed by a ministerial order announced in the national media declaring a 76% reduction in the price of ART to $1000/annum/person (NACP 2001). Joining the AAI was an easy task as Cameroon’s revised National HIV/AIDS Programme already had the backing of UN agencies. In July 2001, through the Equitable Access Initiative (EAI), promoted by Médecins Sans Frontières (MSF 2002), an international civil society partner, Cameroon also signed a deal with Cipla for the acquisition of 15 000 generic treatments at US$350/person/year (Pharma-Policy 2001). These international agencies now represent global partners in the National HIV/AIDS Committee alongside national and local partners (Figure 1).

The National HIV/AIDS Programme, defined in the National Strategic Plan for HIV/AIDS for 2000–2005, was officially launched in August 2001 (NACP 2001). The plan laid the basis for introducing reforms in the following areas: creation of a national HIV/AIDS committee (the policy-making community), specialized treatment centres for scaling up access to antiretroviral therapy; programmes to strengthen the human resource capacity; decentralization of implementation to rural communities; and promotion of PPPs at national and local levels. The National HIV/AIDS Committee operates in the same way as the malaria committee described earlier. It reviews and updates the national plan within the framework initiated by the AAI. The WHO, UNICEF, UNDP and MSF share field experiences with national partners (Central Technical Group) and provide technical assistance to improve programme performance. They also help the national committee to mobilize funding (from the World Bank, Global Fund and private donors). Similarly, CENAME negotiates drug procurement and supply arrangements with pharmaceutical companies as well as coordinating local distribution. Local partners, including elected HIV/AIDS patients, also attend policy meetings. This ensures that policy incorporates country specificities.

The Central Technical Group coordinates policy implementation at the central, provincial and district levels. Since 2001, over 200 specialized HIV/AIDS treatment centres have been created to provide treatment, control, support and counselling services. These are coordinated by provincial and district HIV/AIDS coordinators. Unlike the malaria case study where treatment programmes are incorporated within public health structures, the HIV/AIDS programme presents a more interesting insight about the nature of transcalar networks. HIV/AIDS treatment and control activities are contracted to selected health units in open competition. To be eligible as an accredited treatment centre, public hospitals are selected and equipped by the National HIV/AIDS Programme. However, non-public (private, religious, NGO) hospitals must be fully equipped before getting approval from the national programme. Once selected, the national programme then provides medicines, reimburses the treatment centres for the number of HIV/AIDS cases dealt with, as well as providing medical and social advice and support.

Unsurprisingly, therefore, non-public centres turn to international donors for direct funding and equipment support to create treatment centres. This has led to the proliferation of treatment centres that were not initially created by the national programme. It is within this context that evidence of programmes that bypass the structures of the Ministry of Health and the National HIV/AIDS Committee can best be understood. For example, apart from facilitating access to generic drugs under the EAI and sharing field experiences with the national committee, MSF has operated several treatment centres with community organizations in Cameroon (MSF 2002). The National Social Marketing Programme (NSMP) receives direct funding support from USAID and the German Development Agency (GTZ) to implement cost-recovery sales of condoms. GTZ also operates a health insurance scheme, and provides financial and logistic support directly to NGOs and community organizations for HIV/AIDS treatment and care (GTZ 2004). Other popular examples include ESTHER (Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau), Chantal Biya Foundation, and HIV/AIDS programmes by French Cooperation. Just as the malaria case study, treatment centres that ought to operate under the direct supervision of the Central Technical Group are instead answerable to specific international agencies.

Discussion

Through RBM and AAI, global health policies for malaria and HIV/AIDS are respectively transferred to Cameroon through a consensual dialogue process involving global, national and local partners. The dialogue takes place within the National Programme Committee for each of these disease areas. Each national committee demonstrates characteristics of a transcalar network (global–national–local linkages). Within each network, global health policies are negotiated on the basis of the strategic orientation of that specific GHP. As discussed below, this is a different approach from traditional health policy transfers promoted by WHO and UNICEF (e.g. Reich 1995; Walt et al. 2004) in parallel with the development policies of the World Bank (e.g. Baye 2003; Mbaku 2004). For example, global and regional (Abuja Declaration) RBM targets are set and then a dialogue process is initiated with national governments and local groups to develop the system for implementation. Similarly, with the AAI, the government signed an accord with pharmaceutical companies on the basis of agreement with UN agencies on creating the right implementation systems.

There is evidence of interactive policy transfer within the national committees. Apart from UN agencies, bilateral development agencies and international NGOs (e.g. MSF) exchange ideas with national and local partners on ‘lessons learnt’, ‘best practices’ and ‘field experiences’ to help inform situational analysis, prepare grant proposals and create treatment centres. Representatives of local community groups participate in the dialogue process. This is what gives the GHP approach its transcalar character, with each committee consisting of global, national and local partners with a genuine interest in facilitating access to medication for the poor. Unlike the PHC model, centralized around the Ministry of Health with limited civil society participation, GHPs attempt to align health policy (WHO and UNICEF) with development policy (World Bank and Development Agencies) to create national disease programmes in which non-state actors have become key players in both policy making and implementation.
The GHP approach seems to be working, as can be seen by the progress made in achieving the objectives defined in the national strategic plans. HIV/AIDS treatment is now free of charge in Cameroon, and as early as July 2002, Cameroon was being credited as a global success story in scaling up access to medicines in the developing world (MSF 2002; UNAIDS/WHO 2002b). The number of treatment access points has increased substantially in both programmes (especially in rural areas) (NACC 2008; NMCP 2008). These are evidence that treatment is getting to ‘hard-to-reach’ communities. The high success rate of Cameroon’s grant proposals (such as those to the Global Fund), the mobilization of other sources of funding and the direct involvement of multiple non-state actors (especially local groups) in policy making and service delivery are evidence of the ‘important frameworks...and opportunities for continued dialogue’ (Ngoasong 2009: 955) offered by the GHP approach.

However, as suggested in Caines et al. (2004), it appears that the GHGs’ pursuit of quick results through specific medical interventions prevents them from dealing with country-specific barriers to potential access to medication. At the national level, the largest share of funding is designated to drug procurement from specific pharmaceutical companies. At the local level, treatment programmes have specific and overlapping initiatives whose links to the national programmes are hard to clearly establish. What is common among these overlapping initiatives is that they represent pre-existing projects that have been re-aligned to reflect the narrow technical objective of GHGs. For example, the Social Marketing Programme now focuses on ‘marketing strategies to promote cost-recovery sales of condoms rather than the public health issues’ (GTZ 2004: 3). Similarly, the Integrated Management of Childhood Illness has changed its strategic orientation (on a comprehensive public health package) to a strong emphasis on sales and distribution of ITNs as a local RBM partner.

Clearly, not all the evidence points to the success of GHGs in Cameroon. The incidence and burden of HIV/AIDS and malaria have persistently increased due to a combination of factors such as unemployment, denial, stigma, poverty, high transmission among youth, lack of sex education and polygamy (Mosoko and Affana 2004). There are reports that the HIV/AIDS programme ignores preventive measures (Njechu 2008). The emphasis on drug prices and local distribution appears to override these important determinants of public health. The frequent shortage of subsidized drugs in rural communities, the failure of people to consult treatment centres for diagnosis and the continuing sales of drugs (e.g. chloroquine) long declared ineffective by the WHO (Njechu 2008) are other examples of country-specific policy resistance that question the potential for GHGs to achieve access to medication.

Another challenge relates to health system strengthening. By operating in parallel with the PHC system (which now concentrates on diseases other than TB, malaria and HIV/ AIDs), one would expect to see that the institutional instability and corrupt practices of the late 1980s and 1990s would be avoided in the national GHP programmes. Donors such as the Global Fund and the World Bank even put good governance and anti-corruption measures as a requirement to the funding they provide to national programmes. Crucially, the transcalar structure of the national committees is suited to achieve good governance. In both programmes, for example, the Central Technical Group is designated to coordinate all programmes and activities at all levels, and prepare grant proposals that are validated by the national committees. However, in practice, many initiatives are still based on the strategic interests of international agencies and therefore operate outside the direct supervision of the Central Technical Group for both programmes.

For example, GTZ (2004: 3) states: ‘The understanding that ministries or the public sector should finance and deliver all services is disappearing in favour of a more pluralistic, multi-stakeholder approach. There is now increasing support for...the family planning franchising model of [Social Marketing]. Along the same line, a co-operative health insurance scheme is drawing on the experience of [Social Marketing Programme] for its marketing’. Parallel and overlapping initiatives such as this help upgrade equipment, provide educational campaigns and family planning, increase the supply of drugs and medical equipment. However, they either impose new governance challenges or exacerbate existing ones. Through the agency of GHGs, old (the PHC system) and new (national GHP programmes) institutions have become interwoven, achieving actual access but failing to address potential access to medication (as one would expect from a comprehensive public health package that emphasizes a strengthened national health system).

There is a complex array of local groups who have to deal with multiple funding objectives and directives from different international agencies rather than the consensual policy framework agreed by the national committee (e.g. the use of local NGOs to sell/distribute condoms and ITNs rather than specialized centres created by the national programmes). This distorts governance and accountability mechanisms within transcalar networks and manifests as corruption. Senior government authorities are being linked to misdemeanours of agencies rather than the consensual policy framework agreed by the national committee (e.g. the use of local NGOs to sell/distribute condoms and ITNs rather than specialized centres created by the national programmes). This distorts governance and accountability mechanisms within transcalar networks and manifests as corruption. Senior government authorities are being linked to mishandling of funds allocated to the malaria and HIV/AIDS programmes (Bidjocka 2008). Other reports point to ‘the spectre of leakage of free nets into the commercial trade’ (Handyside et al. 2004: 7) and pilferage and black marketing of ACTs and ITNs by clinical doctors and pharmacies (Lipset 2000; Nsom 2008).

Such activities reveal that whatever regulatory and accountability systems are defined by national GHP programmes, their implementation is ineffective due to overlapping initiatives. For example, ‘announcements are sometimes made by the Minister of Health which can create changes to agreed policy...The Minister decreed that no health centre would receive free nets (in future) if they were found to be selling nets...This has substantially affected the (social marking) program design from that agreed with USAID, in that the roll-out of subsidized nets to clinics has been blocked’ (Handyside et al. 2004: 7). Similarly, ExxonMobil’s funding exclusively focused on preventing incremental labour costs for completing the Chad–Cameroon pipeline project; this region is not among those highly susceptible to malaria mosquitoes in Cameroon (Tchenga 2008). Thus, while attempts by international agencies to use the agency of GHGs to achieve their strategic objectives can facilitate access to medicines and treatment support, they undermine the need to better serve the poorest and most vulnerable parts of the country.
The HIV/AIDS and malaria programmes also overlap within the national health system. Reading through the technical reports of agencies operating as partners to these programmes, they all point to their contributions to health system strengthening (such as training of health workers and upgrading of infrastructure in deprived communities). However, it is not clear where all these contributions fit within the national health system as a whole. There is a proliferation of NGOs and community groups whose activities ought to be incorporated into public health structures. Local groups have been trained to work as health care workers (some as volunteers) with limited attention given to the possibility of integrating them into the public health service, which is highly understaffed. The case of Cameroon reveals that while scaling up access to medicines might be succeeding, more work is needed to understand how the GHP model can be re-designed to address potential access to medication.

Conclusions

This article has explored the nature and types of global policy transfer and implementation promoted by GHPs to facilitate access to medication in Cameroon. Using the notion of transcalar network, it discusses policy transfer in the case of the national malaria and HIV/AIDS programmes respectively created after the Cameroon government endorsed RBM and AAI. The analyses suggest that policy transfer takes place through dialogue processes within transcalar networks consisting of global, national and local GHP partners (a global–national–local policy space).

Within the national committee of each programme, UN agencies and their affiliated public, private and civil society partners sit around the same table with representatives of government ministries and local organizations (public, private and civil society groups) to formulate country-specific policies. In terms of types of policy, GHPs offer a ‘technical fix’ (affordability and availability of medicines and facilities) with a limited focus on preventive measures. The result is that coordination to better serve the poorest and most vulnerable parts of the country is highly distorted due to policy implementation challenges. Accordingly, despite successful scaling-up of treatment, the incidence and burden of malaria and HIV/AIDS have actually increased.

The process of policy implementation reveals a serious lack of coordination. In each province, a Provincial Delegate for Public Health (answerable to the Ministry of Health) operates in parallel with Provincial Disease Control Coordinators (for HIV/AIDS and malaria) who are answerable to the national GHP committees. Similarly, several international agencies work directly with local organizations to serve hard-to-reach communities but they overlap with programmes agreed by the national committees. Crucially, such initiatives are still being tied to traditional donor–recipient commitments, instead of trusting them to the various Central Technical Groups designated to coordinate activities agreed by national committees. These new forms of policy resistance obviously weaken implementation, promote corruption and distort monitoring and evaluation.

This leads us to question the nature of North–South relationships in the context of GHPs in Cameroon. It appears that global policies have been agreed by certain partners simply because they enable them to achieve their strategic interests (a search for legitimization in the face of a democratic deficit that comes from a ‘weak state’). Accordingly, three policy implications can be drawn from this paper on the effectiveness of a GHP approach at country level. First, both formal policies (agreed by national committees) and overlapping initiatives need to be documented on the national GHP template as a stepping stone to re-designing GHP policies at country level. Secondly, the strategy of GHPs to use civil society organizations to rebuild the state’s capacity (through PPPs) does not guarantee effective (strong) state governance. Finally, measures are needed to reduce Cameroon’s dependence on international funding agencies if the processes of transformation pushed by GHP partners (such as community participation and good governance) are to strengthen the national health system. Empirical studies based on a combination of secondary and primary data are needed to test and assess these claims.

Endnotes

4 Chad–Cameroon Development Project, online at: http://www.esso.com/ Chad-English/PA/Newsroom/TD_NewsRelease_170401.asp.

References


