Transforming global health through equity-driven funding

Black people living in Africa must be involved in setting the priorities for global health research, policies and programs that affect their daily lives, in order to move away from a funding culture that fosters colonialism, racism and white supremacy.

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The killing of George Floyd in the United States in 2020 bolstered the Black Lives Matter movement that began in 2013 and sparked unprecedented denunciations of racism by leading health institutions, professional bodies and academic journals across the world, with pledges for remedial actions[1,2]. The planned reforms include a more transparent commitment to equity, equality, diversity and inclusion (EEDI) in the composition of their senior staff, provision of health services, membership of editorial and/or advisory boards and authorship of publications. The global health community of donor organizations, global health institutions, non-state actors and donor recipients has also been confronted with its colonial heritage of racism. Several proposals for translating EEDI pledges into actionable steps have been reported, largely from academics based in the Global North[1–3]. However, the manifestations and impact of systemic racism in global health are more pronounced in the Global South, particularly in sub-Saharan Africa because of its status as the least developed region in the world by almost all population health metrics. The Black people in sub-Saharan Africa are also the most racially disadvantaged and disenfranchised population. In this article, we share some perspectives on racism as Black Africans resident in Africa who are all engaged in global health.

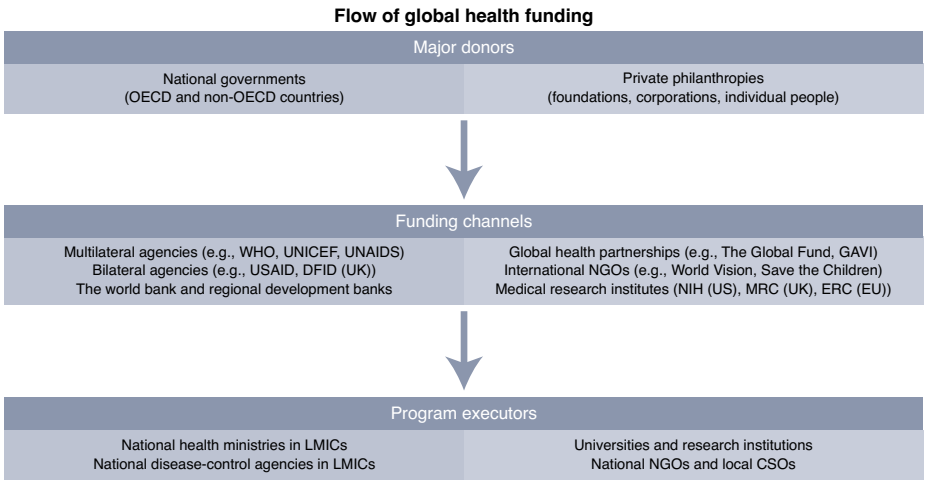

Fig. 1 | An overview of the funding flow for global health policies and programs. The Organization for Economic Co-operation and Development (OECD) comprises 37 member nations, including the United States, UK, Canada, Germany, France, Sweden, Norway, Australia and Japan, whereas countries not in this organization (non-OECD) include China, Saudi Arabia, Kuwait, the United Arab Emirates, Israel, Russia and Turkey. Private philanthropies include the Bill & Melinda Gates Foundation, the Wellcome Trust (UK), The Rockefeller Foundation, the Ford Foundation, the Conrad N. Hilton Foundation, Citibank and Mastercard. Regional development banks include the African Development Bank, Asian Development Bank, Inter-American Development Bank and Development Bank of Latin America. WHO, World Health Organization; UNICEF, United Nations Children's Fund; UNAIDS, The Joint United Nations Program on HIV/AIDs; USAID, United States Agency for International Development; DFID, Department for International Development; The Global Fund, The Global Fund to Fight AIDS, Tuberculosis and Malaria; GAVI, Gavi, the Vaccine Alliance (formerly Global Alliance for Vaccines and Immunization); NGOs, non-governmental organizations; NIH, National Institutes of Health; MRC, Medical Research Council; ERC: European Research Council; EU, European Union; LMICs, low- and middle-income countries; CSOs, civil-society organizations.

A complex landscape

The predominant concept of global health evolved as a humanitarian rescue mission to the Global South by philanthropists, charitable organizations and public-health experts from the Global North[4,5]. The paternalistic origin of global health has fostered a power structure and culture of supremacy that considers prior consultation with the beneficiaries unnecessary before decisions are made on the health interventions to offer. Such lack of consultation with beneficiaries has now become the norm in global health and is true for the public-health efforts to address potentially fatal communicable diseases such as malaria, tuberculosis and AIDS. Although interventions initiated by the Global North to prevent deaths, including the response to pandemics, can be justified as humanitarian emergencies, it is disrespectful and unethical to design and promote health programs purportedly to improve the quality of life of Black people without meaningful engagement with this community.

Unfortunately, the global health system is an unstructured, complex and pluralistic landscape of state and non-state actors with vested interests and lacks effective coordination and governance[6]. With such a diverse array of actors, it is power and influence that dictate which health issues will receive attention. The framework of power and politics for the global health agenda described by Shiffman and Smith[7] shows how, for example, the Global North has prioritized maternal, newborn and child survival to secure massive donor

investment since 1987[8]. This power-politics framework consists of complex dynamics and interactions among four factors: the power of actors connected with a specific health issue; the power of the ideas used to define and describe the issue; the power of some characteristics of the issue, such as the number of deaths caused by a particular disease; and the power of political contexts to inhibit or enhance political support for the issue[7,8]. It is, therefore, not surprising that most global health initiatives reflect the priorities of influential policymakers and funders in North America and Europe rather than the pressing needs and demands of the people in the Global South.

One consequence of the Black Lives Matter campaign has been the momentum and drive for a paradigm shift toward EEDI in the setting of global health agendas for the Global South. A shift toward EEDI would require that those most affected by research projects, policies and programs have substantive involvement in and joint leadership of these initiatives from conception to implementation. This would be a positive change from the status quo, in which programs are solely driven by the vested interests of well-connected and visible academics at prominent global health institutions in the Global North.

The funding flow

Global health policies, programs and institutions thrive on funding received principally from three main sources: national governments in high-income countries, including members of the Organization for Economic Co-operation and Development; business and corporate entities; and private foundations and individual people (Fig. 1). Funding is typically channeled to donor recipients in the Global South through global health institutions, including multilateral organizations within the United Nations (UN) network; bilateral organizations such as the United States Agency for International Development, the UK Department for International Development, and Grand Challenges Canada; global health partnerships such as The Global Fund to Fight AIDS, Tuberculosis and Malaria, and Gavi, the Vaccine Alliance; and international non-governmental organizations such as Save the Children, World Vision and PATH.

In 2018, total development assistance for health reached US$38.9 billion[9]. The United States was the largest single contributor, with US$13.2 billion (33.9% of total development assistance for health), followed by the UK, with US$3.3 billion (8.5%), and the Bill & Melinda Gates Foundation, with US$3.2 billion (8.2%). Global spending on development assistance for health is projected to reach US$45 billion by 2050, after the exclusion of COVID-19-related spending, with the United States as the largest contributor[10]. US global health funding traditionally covers both diseases (e.g., AIDS, tuberculosis and malaria) and population-specific activities (e.g., maternal and child health, nutrition, and reproductive health). The US budget for maternal and child health alone in 2020 was $1.23 billion. The bulk of this ($865 million, or 70%) was to be channeled through the United States Agency for International Development for 25 countries, 17 of which are in sub-Saharan Africa[10]. Funding for global health policies and programs often has unintended detrimental effects on the capacity of the already beleaguered health systems in LMICs to accommodate essential local initiatives. Hence, the Paris Declaration on Aid Effectiveness and the Dakar Agenda for Action call for donors to align their support with recipient-country government priorities to foster ownership[11], but this recommendation is rarely implemented.

Lack of diversity

There are numerous examples of global funding practices in Africa that do not reflect EEDI principles. Recently, a group of global health practitioners from Africa drew attention to a substantial grant awarded to a prominent international non-governmental organization by the US government to support malaria-control projects in African countries—without involving local institutions in those countries but instead being channeled exclusively through seven institutions in the United States, the UK and Australia[12]. Such grants exemplify the practice of relegating indigenous African experts and their institutions as mere donor recipients and laboratories for experimenting with ideas and initiatives conceptualized in the Global North. When decisions about African lives are taken solely in the Global North, this conveys and fosters white supremacy. It is ironic that the non-governmental organization that received this funding displays a diversified leadership on its website (https://www.path.org/leadership/).

A targeted reduction in the mortality of children under 5 years of age ('under-5 mortality') is one of the most strongly and universally supported development goals in global health because it reflects the availability of maternal and child health services, income and food availability in the family, and the health status of the most vulnerable members of society[13]. However, the quality of life of the beneficiaries does not seem to be considered a moral imperative. Massive investment reduced the mortality of children under 5 years of age in sub-Saharan Africa by 61% between 1990 and 2019, but this seems to have inadvertently left the continent with a large population of children who would have otherwise died but are now at risk of sub-optimal development due to lifelong disabilities[14–16]. The likelihood that a child will become disabled before their fifth birthday in sub-Saharan Africa is almost fivefold that of their dying (337 versus 75 per 1,000 live births)[15]. Meanwhile, funding for disabilities decreased by 11% from 2007 to 2016, and it is barely 2% of the total development assistance of US$79 billion disbursed for early childhood development (ECD)-related programs during this period[17].

An equity-driven global health agenda

To address these and similar concerns, we offer some suggestions to complement those of our colleagues based in the Global North[3], and other initiatives proposed for academic journals in global health[18]. First, donors can become effective catalysts and enablers for decolonizing global health by instituting EEDI-compliant governance structures and mechanisms for their funding activities. EEDI must be made to happen and must be seen to be happening, and funders have a rare ability to enforce such policies. For example, the governance structure of some donor organizations such as the US National Institutes for Health, the world's largest funder of global health research through the Fogarty International Center, is committed to EEDI principles and has an independent Office of Equity, Diversity and Inclusion that drives EEDI practices throughout the organization.

Second, diversity is not simply about skin color but is about equality of ideas and intellect. Appointing Black people without extensive lived experience in Africa, the requisite expertise in global health or a publicly verifiable track record in decision-making panels is an attempt to portray legitimacy that is not equitable. Similarly, diversity based solely on geographical location, which has been used to choose white Africans over their indigenous Black counterparts, is not equitable. A selection process for experts based on EEDI principles must be transparent and objective to ensure that the most talented people on the relevant topic are selected into the decision-making panel. Institutional mechanisms should be implemented to identify superficial representation by fund seekers and program managers in the Global North, especially those that exploit vulnerabilities of Black academics through financial incentives. The principle of diversity must also embrace

gender balance, disability inclusion and under-served socio-economic groups[19].

Third, researchers and relevant stakeholders, including civil-society organizations in the Global South, should routinely identify existing global health priorities that violate EEDI principles and are incongruent with the spirit and letter of resolutions and commitments by governments[11,20]. Since 2002, a special UN resolution for the first time called for the development and implementation of national ECD policies, as well as targets for reducing disparities between children with disabilities and special needs and those without[20]. However, current global ECD initiatives by the World Health Organization and the United Nations Children's Fund do not reflect these commitments[21]. But these institutions and their external collaborators continue to mobilize substantial funding from donors to implement ECD programs that are likely to exacerbate health inequalities. The target beneficiaries and their local representatives should be empowered to freely draw the attention of funders to funding programs that do not comply with EEDI principles or with existing global pledges.

Fourth, experts from the Global South should be given a platform to recommend to funding agencies proven interventions that have the potential to address specific health inequalities. As it stands, not everything that counts can be counted. Screening of newborns for conditions such as hearing loss and birth defects is routinely mandated in the Global North but is rare in the Global South, especially sub-Saharan Africa. Such programs should be prioritized for donor support to offer equal opportunity for newborns in the Global South on the basis of social equity and necessity.

Finally, accountability mechanisms are needed to expose facilitators of racism and health inequalities[22]. Social media can be a powerful tool for exposing racism, although it is not without its drawbacks. Accountability mechanisms could include formal complaints to funding agencies directly or through open correspondence to academic journals, if a pattern of discrimination is discernable[12,18]. Sunlight is the best disinfectant, and so exposure may serve as a deterrent to fund seekers and others who may otherwise foster white supremacy, racism and other abuses of power because there are no foreseeable adverse consequences. Moreover, racism is already recognized as a human-rights violation and a crime against humanity[23,24]. An independent EEDI ombudsman should therefore be established at a designated UN agency such as the UN Human Rights Council to receive public complaints that can then be acted upon and periodically published.

Call to action

There are at present no accountability mechanisms for ensuring that global health priorities and funding are equity driven and are from the perspectives of the donor recipients. Investment in global health that lacks ownership among the target beneficiaries will not succeed in advancing the interests of the recipients or achieving the projected outcomes. EEDI is not just a moral imperative—it facilitates the acceptability and effectiveness of global health programs. We recognize donors' prerogatives in choosing what to fund and which global health institutions to support on the basis of prescribed criteria. However, the failure to incorporate EEDI into the donors' eligibility criteria for funding may be construed as tacit support for the status quo and an open incentive to perpetuate colonialist attitudes and white supremacy. The power politics that foster injustices and health inequalities must be overhauled. Like the editors of academic journals[18], donors and funders must leverage their unique influence and capacity to provide moral leadership to decolonize global health for the public good. ❐

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Competing interests

The authors declare no competing interests.