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The Role of Think Tanks and Academic Institutions in Accelerating the Implementation of the Health-Related SDGs

Special Guest Editors:
The International Development Research Centre and
Global Health Centre, the Graduate Institute, Geneva

Editor's Picks

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GLOBAL HEALTH GOVERNANCE IS AN OPEN ACCESS, PEER-REVIEWED, ONLINE JOURNAL THAT PROVIDES A PLATFORM FOR ACADEMICS AND PRACTITIONERS TO EXPLORE GLOBAL HEALTH ISSUES AND THEIR IMPLICATIONS FOR GOVERNANCE AND SECURITY AT NATIONAL AND INTERNATIONAL LEVELS.

THE JOURNAL PROVIDES INTERDISCIPLINARY ANALYSES AND A VIGOROUS EXCHANGE OF PERSPECTIVES THAT ARE ESSENTIAL TO THE UNDERSTANDING OF THE NATURE OF GLOBAL HEALTH CHALLENGES AND THE STRATEGIES AIMED AT THEIR SOLUTION. THE JOURNAL IS PARTICULARLY INTERESTED IN ADDRESSING THE POLITICAL, ECONOMIC, SOCIAL, MILITARY AND STRATEGIC ASPECTS OF GLOBAL HEALTH ISSUES.

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The Role of Health Policy Think Tanks in Accelerating the Implementation of the SDGs in East and Southern Africa

Francis Omaswa and Patrick Kadama

INTRODUCTION

African countries gained independence from colonial rule with high expectations for their futures. Indeed, the early post-independence years showed much promise in many countries, with a scaling-up of education, healthcare, other social services and infrastructure development. This optimism, however, dissipated from the mid-1970s onwards due to a combination of internal and external shocks; in particular, bad governance and military dictatorships that were partly condoned during the Cold War, and partly as a result of the - sharp fluctuations in commodity prices and skyrocketing interest rates[1, 2]. The International Monetary Fund (IMF) and the World Bank gradually became the chief architects of policies, known as "the Washington Consensus"[3]. Implementation of these policies is documented as being "responsible for the worst inequalities and the explosion of poverty in the world, especially in Africa". Between 1980 and 2000, Sub-Saharan African countries had paid more than $240 billion as debt service, which is, about four times the amount of their debt in 1980. Debt ratios in Africa deteriorated due to inability of countries to service their external debt, African economies collapsed and countries needed urgent help from developed countries and the Bretton Woods institutions to provide basic care to their populations and to get back on the road to recovery. Many countries were classified as Heavily Indebted Poor Countries (HIPCs), being dependent on others for resources, as well as for ideas on national reconstruction.

The legacy of this negative experience left African institutions weak and African professionals demoralized and disempowered. The last two decades, however, have seen an 'Africa rising', with sustained economic growth underpinned by political and social stability, and zero tolerance for military rule by the African Union and the New Partnership for Africa's Development (NEPAD)[4], which promotes an African renaissance and the restoration of African self-pride.[1] This period has also been inspired by a global movement advocating for social justice, human rights, equity and the empowerment of women. Despite this positive trend, many have been left behind evoking a call for universal health coverage.[5]

The Millennium Development Goal (MDG) effort played out during this emergence of a new, more hopeful Africa, and witnessed laudable achievements; for example, one of the most impressive reductions in child mortality – which fell by 54% between 1990 and 2015[6] – and the arrest of HIV-related mortality in some countries, among others[7] This was achieved through the vertical program mobilization of African communities and global partnerships, initiatives and alliances, such as Roll Back Malaria, Gavi, The Global Fund, the Stop TB Partnership and the Global Health Workforce Alliance. These partnerships were guided by compacts such as the Paris Declaration on Aid Effectiveness, and global gatherings at the United Nations (UN) General Assembly, the World Health Organization, and the Beijing and Cairo conferences on women's empowerment. In Africa, several summits were convened with heads of states on malaria, HIV/AIDS, and maternal and child health. These initiatives were further supported by the championing of better governance through the African Peer Review Mechanism, which operates under the aegis of NEPAD.

Moving towards a systems approach to improve equity of health outcomes through strengthening services delivery has however been slower. The effort to address health workforce management through improved information on stocks and flows at country level using the WHO code on international recruitment of health professionals has not been

widely adopted by African countries[8]. Service to address demographic trends need to be scaled up while services for the youth and adolescents which are recommended by WHO and partners, are being contested with resistance to adopt sexual, reproductive health and rights policies in parts of the region[9].

THE TRANSITION FROM MDGS TO SDGS

It is against this background of a more hopeful and resurgent Africa that the Sustainable Development Goals (SDGs) were launched, following an extensive consultative process in which African countries played a significant role, including that of the presidency of the UN General Assembly during the adoption of the SDGs.

The MDGs were completed with a celebration of achievements that include 19,000 fewer children dying every day, a 44% reduction in maternal mortality, an 85% cure rate of tuberculosis cases, and a 60% decline in malaria mortality, particularly in Africa, among others. These achievements show many variations across and within countries leaving Sub-Saharan Africa still having the highest child mortality rates

On 25 September 2015, the UN General Assembly adopted the new development agenda, 'Transforming our world: the 2030 Agenda for Sustainable Development.[10] The agenda comprises 17 goals and 169 targets that integrate all dimensions of sustainable development, namely, economic, social and environmental, as well as five themes: people, planet, prosperity, peace and partnership. The third SDG specifically aims to attain Health and Well Being for all. The SDGs continue to priorities the fight against poverty and hunger, while also focusing on human rights for all, and the empowerment of women and girls to achieve gender equality. The SDGs also tackle other aspects of the unfinished business of the MDG era[11].

The adoption of the SDGs was accompanied by a separate political declaration, which sits alongside the SDG agenda and ensures that the SDGs enjoy buy-in from all UN member states, in a non-patronizing, interconnected and cross-cutting manner. While the declaration is not legally binding, it is politically and morally binding, meaning that member states owe it to themselves and to each other to pursue the SDGs and, through peer pressure, to implement and report on progress. The African Agenda 2013 for development and the Agenda 2030 for SDGs have much convergence especially in adopting a multi-sectoral approach for inclusive growth and sustainable development. The goals and priority areas for the first Ten Years of implementing the African Agenda 2063 provide a strong foundation for countries to domesticate "SDG 3". Universal Health Coverage as a critical transformative policy instrument of moving towards equality in health outcomes can then be placed within the goals for "A High Standard of Living, Quality of Life and Well Being for All Citizens and the goal of "Healthy and well-nourished citizens" for implementation through priority areas of Social security and protection as well as for Basic Quality Services[12]. Work is underway to identify and initiate collaborative work of Health Policy Research Institutions (Think Tanks) within countries and across countries of the east and southern Africa. A few other consultations of Think Tanks in Africa on general aspect of SDGs have also taken place.

THE ENTRY POINTS FOR HEALTH POLICY THINK TANKS (WORKING WITH OTHERS)

SDG3 is devoted specifically to health, and is framed in deliberately broad terms that are relevant to all countries and all populations: "Ensure healthy lives and promote well-being for all at all ages". Although SDG 3 is the only goal dedicated solely to health, it is paramount to note that health is linked to many of the other goals. This highlights the fact that a population's health affects and is effected by economic, social and environmental determinants. More than a dozen targets in other goals can be considered health-related[13]

and should be given special attention in strategies, policies and plans to achieve and monitor the health goal.

The potential contribution of Health Policy Think Tanks (HPTTs) in accelerating the achievement of the SDGs in Africa and globally can, therefore, be discussed in the context of expected actions from and by nation states and non-state actors, including the private sector at the subnational, national and global levels. Member states must undertake specific actions to build upon complementary platforms that exist for implementing the SDGs in their countries, namely:

- to identify a central coordinating point for the SDGs in each country
- to integrate the SDGs into national development plans
- to convene a high-level political forum attended by development ministers in July each year to receive progress reports from member states

It is expected that inputs into this high-level forum will be received during the course of each year.

HPTTs in individual countries or regions can play a key role in working with the SDG central coordinating point in each country to provide information and data on the choices that countries make and on the progress, that is being made, while also advising on course correction as required. HPTTs should be able to cultivate a reputation as the go-to place for information on diverse aspects of health policy and its interconnectedness to the other SDGs. HPTT will be critical in interpreting research data and finding for decision making to diverse stakeholder groups to share and learn for informed lobby and advocacy in support of development policy choices. Furthermore, HPTTs should familiarize themselves with national development plans in the countries or regions in which they are active, and play a leading role in helping to institutionalize the 'Health in All Policies' approach to national policy formulation and in monitoring implementation across all sectors. The annual high-level forum, mentioned above, provides an excellent opportunity for the network of global HPTTs to work together to prepare carefully analyzed background documents and policy briefs for the use of development ministers and other non-state actors who will be attending these meetings. HPTTs can also support their governments to prepare for these meetings and lobby for them to send the most appropriate set of delegates each year, and to provide forums for reporting back to the population following the meetings as well as provide facilitation for policy dialogue platforms.

SUPPORTING CROSS-SECTORAL WORK

A consultation meeting of African regional HPTTs in Kampala, Uganda,[14] identified the need for strengthening multi-disciplinary cross-sectoral work to accelerate the achievement of the SDGs in the African region as the overriding strategic priority. The consultation agreed to conduct further work in each country to map the work and challenges of existing think tank networks. The way forward was, therefore, articulated against this background for action at three levels:

- At national level, cross-sectoral work is the priority for achieving the SDGs. This approach provides health think tanks with many entry points for contributing to the implementation of the SDGs. In each country, health think tanks should consult with their respective governments and assign themselves specific areas of work to take forward in synergy.

- At regional level, health think tanks should continue to work together and bring in others for collaboration through a regional network. This will initiate the establishment of an African regional network of health think tanks, supporting the implementation of the SDGs in the region. This network of African health think

tanks will, therefore, have a common interest in taking health outcomes as a center-stage objective for supporting the implementation of the SDGs.

- At global level, the African region health think tanks and their network will aim to link up with other institutions from around the world engaged in similar streams of work to learn from each other, build capacity through mutual support, and engage in collaboration.

SUPPORTING RESOURCE MOBILIZATION AND MANAGEMENT

Another important entry point for HPTTs is in supporting the mobilization of resources to implement the SDGs. African countries have witnessed strong economic growth over the last decade. Considering this, the new approach to development assistance agreed during the Third International Conference on Financing for Development in Addis Ababa, Ethiopia in 2015[15] is that developing countries will, from now on, move towards depending more on domestic resources to implement national development plans that have SDGs integrated into them and much less on overseas development assistance, as was the case in the past. In order to mobilize domestic resources, it will be critical to provide national policy-makers with evidence that supports the preeminent position of health as a contributor to economic growth, inclusion and poverty reduction. The return on investment in health is now accepted as significant at 10–20% and, according to Baumol,[8] health spending should increase in proportion with GDP growth. However, allocating national budgets to health is a hard sell in most African countries today. For example, while the Abuja Declaration, which was signed by heads of state and government in 2001, allocated 15% of national budgets to health, fewer than five countries in Africa have met this target[16]. That said, the UN secretary-general has appointed a High-Level Commission on Health Employment and Economic Growth,[17] and laid out a five-year action plan to implement its recommendations, as evidence that health is now seen more as a service industry stimulating the creation of jobs, especially for women, and improving the quality of life of populations. Actions to mainstream this message to country level HPTTs will be required to strengthen their role in popularizing this message as one of the approaches for accelerating the achievement of the SDGs.

SUPPORTING UNIVERSAL HEALTH COVERAGE

HPTTs also have a key role to play in achieving universal health coverage (UHC), which is the agreed approach for reaching SDG 3. UHC is narrowly defined as "all individuals and communities receive the health services they need without suffering financial hardship"[18] but is much broader than this including social protection aspects as defined in the earlier WHO Report of 2008 on Renewal of Primary Health Care. The full spectrum of essential, quality health services should be covered, including health promotion, prevention and treatment, rehabilitation and palliative care.[19] Arrangements for social safety nets will be important to include. This people centered effort can also be interpreted as one of 'leaving no one behind', and "reaching the furthest behind first". To provide high-quality and credible health services within the framework of UHC, resources will need to be pooled and managed so that they meet the greatest needs. Countries will need to define for themselves what package of services across the life cycle of their populations would be affordable with the resources available to them, and the quality that would be acceptable to their populations. HPTTs will have a critical role to play in generating the evidence to be used for prioritizing service packages for national UHC, and for monitoring the performance of the national health system. Creating awareness and mobilizing the general population to support and contribute to pooled resources also requires the dissemination of credible

information from credible sources, which is a role that HPTTs can play. At a recent meeting of the Network of African Parliamentary Committees of Health in Kampala, associations of health professionals and academics as well as HPTT were called on to provide the evidence that parliamentarians need to draft the necessary legislation that will support access to affordable health services in African countries.

SUPPORTING NATIONAL, REGIONAL AND GLOBAL PARTNERSHIPS FOR HEALTH

The interconnectedness of the SDGs means that collaboration and partnerships will be critical for their successful implementation. This will be applicable at both the national and global levels. HPTTs can contribute to nurturing and promoting partnerships and collaboration by sharing good practice and joint learning, where richer countries can learn from poorer countries, and vice versa. The opportunities provided by technology are also available to HPTTs to use for brokering and convening to advance collaboration, joint learning and partnerships. A stream of work is required to learn and to define more clearly the partnership principles and practices that work best in different contexts. It is gratifying to note that there are many such partnerships that are active, and that these are expected to grow in both number and scope.

CONCLUSION

The SDGs provide an exceptional opportunity for African and global HPTTs and other institutions to contribute to the renewal of local ownership, accountability and commitment to transformative and sustained institutional capacity building in Africa and other developing countries. Strong institutions will be key to achieving SDG 3 and UHC through the implementation of a well-coordinated cross-sectoral effort. Networks will help support the pooling of the diverse range of skills needed to support implementation of the Agenda 2030 in low resource settings. A compelling case for evidence-informed advocacy and action is needed to create a climate of opinion for policy-makers to prioritize population health and allocate the requisite resources. Similarly, capacity to ensure access by all to the appropriate service packages through continuous quality and performance improvement requires strong African institutions that work closely with their communities and governments. The ideal approach in these relationships with governments is one of “inform and inspire”. However, there are times when dissent is called for and HPTTs should be prepared to manage such stressful interactions with their governments. As responsible members of their societies that are accountable to citizens, African HPTTs have a duty to support the implementation of the SDGs.[20]

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The 2030 Agenda, Sustainable Development Goals and Think Tanks in Latin America

Paulo M. Buss, Luiz Augusto C. Galvão, Sebastian Tobar and Luiz Eduardo Fonseca

The Latin American health sector has had difficulty embracing and integrating global agendas defined at high-level meetings, such as Rio 92, Agenda 21, the Millennium Declaration and the Millennium Development Goals (MDGs). The health sector has preferred to define and follow its own mandates and agendas and, to a certain extent, to ignore the agreements and commitments reached by world leaders and embraced by other sectors, such as the economic, diplomatic and environmental sectors. This attitude towards global calls for action offers the advantage of being able to operate more freely, but at the same time, it can isolate the health sector and prevent it from benefiting from intersectoral coordination and access to valuable and highly needed resources. The THINK_SDGs initiative is a call to change and, at the same time, aims to commit and engage think tanks and academic institutions to promote and actively participate in the strategizing and implementation of the 2030 Agenda and the Sustainable Development Goals (SDGs). This can be a unique opportunity to turn health into one of the top sectors in the global governance process for sustainable development, and to prevent the Latin American health sector from merely reporting the results and assisting the governance process provided by other actors who are not naturally part of the public health community.

INTRODUCTION

In recent history, Latin America and the Caribbean have focused special attention on the development process, creating a regional theoretical framework consolidated by the Economic Commission for Latin America and the Caribbean (ECLAC), which has been acknowledged and adopted by most of the region's schools of economic thought and authorities.[1] It is, therefore, no coincidence that two of the most significant conferences for the establishment and advancement of the sustainable development concept and framework for action were held in Rio de Janeiro, namely the United Nations Conference on Environment and Development (UNCED, or Rio 92) in 1992[2] and the United Nations Conference on Sustainable Development (UNCSD, or Rio+20) in 2012.[3]

The ECLAC school of thought has consistently highlighted the social aspects of development, with public health as a key focus of regional development. Meanwhile, and influenced by ECLAC, the debate on public health in the region has also been based on the relevance of economic and social development for health outcomes, as illustrated in important documents analyzing such trends.[4,5]

During the Rio 92 conference, the Oswaldo Cruz Foundation (FIOCRUZ), a leading regional public health institution, spearheaded and published an intense debate on sustainable development and health.[6] In 2012, in preparation for the Rio+20 conference and as part of an intense regional dialogue on the post-2015 development goals, numerous institutions in the region – the Pan American Health Organization (PAHO),[7] FIOCRUZ,[8] the University of São Paulo, the Union of South American Nations, the Council of Ministers of Health of Central America and the Dominican Republic, Caribbean health authorities, and others – organized meetings, webcasts, and publications to provide input on the 20 years of implementation of Agenda 21, leading up to Rio+20. Prompted by all this activity,

health ministries issued resolutions, which were then approved by PAHO's directing council.[9]

The concept of development and the more recent concept of sustainable development are close to the very essence of public health and social public policies in Latin America and the Caribbean. As such, the 2030 Agenda for Sustainable Development and the Sustainable Development Goals,[10] approved by the UN member states in 2015, represent a major instrument in international relations for dealing with the enormous challenges of global sustainability and equality, including issues of governance that are essential to the necessary coherence of the whole process. As ECLAC Executive Secretary Alicia Bárcena says in the report *Horizons 2030*,[11] "It is about moving from a culture of privilege to a culture of equality."

The ECLAC report addresses the status and future direction of many of the environmental and social determinants of health, such as climate change, the economy, education, equity, employment and governance. While Latin America and the Caribbean have made several important strides in recent decades, they now face stagnation in some key indicators, as life expectancy and mortality rate, and have already suffered setbacks in relation to the huge social progress achieved in the recent past due to the world economic crisis.

The generally adverse environment, the emergence of new public health challenges (such as epidemics) and problems with the financing of health systems all make the issue of intersectoral governance for public policies, along with equity, a paramount theme for the region, and place the 2030 Agenda and the SDGs at the heart of academic and government discussions.

One advantage for Latin America and the Caribbean is the existence of health sector agreements, as the Regional Plan of Action on Health in All Policies and the Sustainable Development and Equity Plan of Action – both from PAHO, that urge governments to focus attention on the implementation of SDG 3 – "Ensure healthy lives and promote well-being for all at all ages" – and all other health-related SDGs.[12,13] These agreements have sparked a dialogue at national and regional level, but – apart from synchronized work by think tanks and academic institutions to provide training and to respond to some key questions through public policy research – this is still at a very initial stage.

THINK TANKS IN THE LATIN AMERICAN REGION

Relatively little is known about Latin American think tanks collectively in terms of their current activities relating to the 2030 Agenda and the SDGs; for example, the scope of their research, human resources training, and assistance in formulating strategies and actions to implement the agenda and achieve the selected SDGs. As a response to this reality and as a follow-up to the global initiative THINK_SDGs,[14,15] the Second Meeting of Global Health Policy Think Tanks and Academic Institutions was held in Rio de Janeiro on 7–8 November 2016. The meeting aimed to address the following central question: The implementation of the health-related SDGs: Are we on the right track? The event was sponsored by FIOCRUZ, through its Global Health Center (CRIS/FIOCRUZ), the Global Health Centre at the Graduate Institute, Geneva, and the Think Tank Initiative of the International Development Research Centre (IDRC), Canada. The meeting was attended by 30 institutions from 29 countries in Latin America and the Caribbean, Africa and other regions.

Participants reached a consensus on the importance of the health sector adopting the 2030 Agenda, and the implementation of the SDGs in Latin America and the Caribbean by governments, parliaments, and civil society, as well as the important role that think tanks could play in supporting this activity in the region. However, the reality is far from ideal. According to an initial survey of public health associations and think tanks,[16,17,18] few events

have focused on these issues, while only a handful of institutions explicitly focus on the 2030 Agenda and the SDGs. These include FIOCRUZ,[19] the Institute for Applied Economic Research (IPEA),[20] the Latin American Alliance for Global Health (ALASAG)[21] and ECLAC.[22]

The think tanks participating in the Rio meeting considered the 2030 Agenda and the SDGs to be not only one of the most important, but the main global public policy for sustainable development, given the fact that the Agenda was developed through an extensive and participatory process, from Rio 92 to Rio+20 and, lastly, Resolution A70/1, which was unanimously adopted by the UN General Assembly in September 2015.

Latin American think tanks, therefore, believe it is important for them to commit to the implementation of the 2030 Agenda and the SDGs at the regional and national levels to focus on research to produce new knowledge and evidence, to develop opportunities for training human resources, and to offer technical cooperation with the region's main stakeholders. To facilitate this action, and as a response to discussions at the 2016 meeting in Rio, the THINK_SDGs initiative plans to establish a regional hub, based at FIOCRUZ, to follow up and facilitate dialogue and collaboration among the existing institutions and networks, including greater access to the available tools and resources relating to the 2030 Agenda and the SDGs.

As well as the specific participation of the region's institutions, there is also interest in including existing networks and associations in this initiative, such as the Union of South American Nations (UNASUR) Network of National Institutes of Health, the UNASUR Network of Public Health Schools, and the UNASUR Network of Technical Health Schools, which are already structured and interested in collaborating to implement the 2030 Agenda. Another network that is being organized in the subregional context in Central America and the Caribbean is expected to join the initiative at a later date.

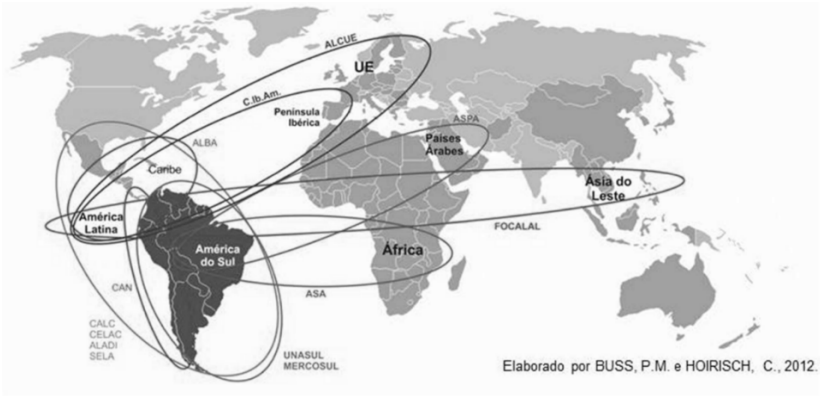
These networks, together with intergovernmental organizations such as PAHO, the WHO Regional Office for the Americas, could facilitate the integration of regional academic research output into political structures and the health divisions of regional and subregional government bodies such as UNASUR,[23] the Southern Common Market (MERCOSUR),[24] the Andean Community,[25] the Central American Integration System,[26] the Caribbean Community (CARICOM),[27] the Bolivarian Alliance for the Americas (ALBA),[28] and the Amazon Cooperation Treaty Organization (OTCA).[29]

The Community of Latin American and Caribbean States (CELAC) is at a more advanced stage of organisation.[30] Contrary to possible expectations – for example, clashes and disputes between various structures – what has been observed is a fair, harmonious and cooperative process of integration,[31] both on matters of more general interest and specifically in health.

A study by the UNASUR Network of National Institutes of Health concluded that the institutes were gradually expanding their role – described as that of "public health laboratories for disease control" throughout most of the 20th century – to currently play an important role in generating evidence and providing necessary arguments on health equity and the social determinants of health which include hexes and benefits originated from any social, political, economic and environmental decision or action (deforestation, unequal trade, lack of citizenship or freedom, illiteracy among others). This represents a fundamental step forward in understanding and acting on the 2030 Agenda and the SDGs.[32]

The International Relations Offices of the Latin American and Caribbean Ministries of Health (ORIS) represent another highly relevant set of resources for contributing to the implementation of the 2030 Agenda and the SDGs in the region. The centers were recently mobilized by PAHO[33] in a process of staff training and policy formulation. They have identified sustainable development and health as a prime possibility for cooperation among the different governance schemes of their respective countries, which has been defined as a priority for the ORIS network.

Figure 1. Health is present in several intraregional and interregional integration processes - ALBA, CAN, CELAC, ALADI, SELA, UNASUR, MERCOSUR, ASPA, ASA and FOCALAL[1]



In addition to these organizations, with their networks of 'official' institutions or operating within the sphere of government, there are many think tanks with the capacity and willingness to join the effort to support the implementation of the 2030 Agenda and the SDGs in the region.

World Health Organization (WHO) collaborating centers are positioned to collaborate in technical cooperation on public health in the region and globally in many different areas aligned with the priorities established by WHO member countries. In the Americas, there are 181 collaborating centers in 16 countries,[34] many of which are connected through specialized networks, such as the Collaborating Centers for Health and Sustainable Development, which includes 40 of the most influential institutions in this area.[35] The centers meet every two years to discuss relevant issues – such as climate change, inequities and health and, more recently, the 2030 Agenda and the SDGs – and to plan collaboration with the WHO Regional Office for the Americas.

This vast array of resources for thinking and action can be channeled towards the implementation of the 2030 Agenda and the SDGs in the region.

NEXT STEPS

Many institutions in the health sector act as think tanks, linking the academic world with policy-making and civil society, whether as independent groups or otherwise, such as Abrasco[36] (Brazilian Association of Collective Health), ALAMES[37] (Latin American Association of Social Medicine) and the NCD Alliance.[38] Even with such relevant work, most domestic health policy and global health policy think tanks, particularly those in Latin America, do not feature in the 2016 edition of the University of Pennsylvania's 'Global go to think tank index report',[39] a comprehensive global assessment of think tanks.

This is a disappointing result, particularly when one considers the efforts that have been made in the region in the area of health, as well as the relevance of public health institutions in defining critical public policies in the region's countries.

[1] ALBA (Bolivarian Alliance for the Americas), CAN (Andean Community of Nations), CELAC (Community of Latin American and Caribbean States), ALADI (The Latin American Integration Association), SELA (Latin American and Caribbean Economic System), UNASUR (Union of South American Nations), MERCOSUR (Southern Common Market), ASPA (Summit South America-Arab Countries), ASA (South American-African Countries), FOCALAL (Latin America-East Asia Cooperation Forum)

Despite the report's many limitations, which have been acknowledged by the author, it is an excellent document that serves as a solid reference on the relevance of think tanks in today's world, while also setting a challenge and an opportunity for public health policy research institutions in Latin America. There is much to be done with this reality, ranging from a better understanding of the basics of think tank operations, to identifying and accessing the share of resources reserved for health.

This all serves to underline the potential of think tanks and their activities in implementing the 2030 Agenda and the SDGs in Latin America.

The THINK_SDGs initiative has been acknowledged as an important global movement to establish a mechanism for facilitating academic collaboration in implementing the 2030 Agenda. In the coming years, it may prove to be an appropriate response in order to better include existing health-related think tanks in the mainstream of global think tank institutions. FIOCRUZ – for many years a nationally important and internationally acknowledged public health think tank – with the support of the Graduate Institute's Global Health Centre, and the IDRC, has agreed to serve as the regional hub for think tanks and academic institutions that are willing to participate in THINK_SDGs.

The hub's first task will be to develop scoping studies[40] to identify what existing efforts are being made by think tanks and academic institutions to support the implementation of the 2030 Agenda, which will also help to identify best practices. A digital platform will serve as a virtual hub for THINK_SDGs in Latin America, where a toolbox containing all the existing methodological and training materials will be available to participating institutions.

This framework paper aims to serve as the starting point for collaboration by including the region's existing institutions. If the necessary coordination and alliances with other relevant public policy think tanks can be established, the results may lead to an exchange of sectoral and intersectoral ideas and solutions, and resources may be mobilised to support the implementation of the 2030 Agenda's health-related SDGs in the region.

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THINK SDGs

The adoption of the Sustainable Development Goals (SDGs) in September 2015 has ushered in an ambitious, inclusive, and transformative agenda for global development. The Global Health Centre at the Graduate Institute of International and Development Studies, in partnership with the International Development Research Centre, has embarked on a project to highlight and explore the role of think tanks and academic institutions in accelerating the achievement of the health-related SDGs.

Under the name THINK (Think Tanks, Health policy Institutions, Networks and Knowledge)_SDGs, the project seeks to build and coordinate a Network of Global Health Policy Think Tanks and Academic Institutions that does not only enhances the role of Southern think tanks, but also enables new partnerships to emerge. This goes hand-in-hand with the aim to strengthen the capacity of research institutions to produce quality research, generate evidence-based policy options, and provide critical analysis to inform public health policy processes. Through collective engagement in timely policy dialogues on the health-related SDGs, think tanks and academic institutions can connect based on their experiences and catalyse innovation in this field.

In order to support think tanks to fulfil their role in accelerating progress towards achieving the SDGs' health targets, the project focuses on the following six areas: better governance for the SDGs; political accountability for SDG implementation; stakeholder engagement; systemic, intersectoral health challenges; knowledge sharing as a global public good; and policy research.

Find out more on the upcoming meeting of Global Health Policy Think Tanks and Academic Institutions on 4-5 December 2017 in Geneva, as well as other project activities and publications at ghptt.graduateinstitute.ch/

The Sustainable Development Goals in the Central America Region: Current Situation, Challenges and Opportunities for Think Tanks

Walter Flores

The Central American region includes 7 countries and 43 million inhabitants. The region is highly unequal both across and between countries. Whereas Costa Rica and Panama present a high human development index, Guatemala, Honduras and Nicaragua have the largest percentage of the population living in poverty, including high maternal and child mortality. The north triangle (Guatemala, El Salvador and Nicaragua) is also affected by endemic violence and crime. The Sustainable Development Goals (SDGs) are both an opportunity to close the gaps that remain from the implementation of the Millennium Development Goals (MDGs) and also to advance towards a comprehensive framework for social and economic development that is both equitable and sustainable. Think tanks can play several roles such as (a) proposing the technical design of policies (b) analyzing data and producing independent evidence related to performance of public services, impact of fiscal policies and accountability (c) facilitating the engagement of all relevant actors at national, regional and local level. However, to complement their specific expertise, promote organizational learning and overcome the challenge of financing activities, think tanks must organize themselves as networks.

INTRODUCTION

The Central America region consists of seven countries: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama. The total population in the region is about 43 million inhabitants. Although these seven countries all coincide in a small geographical area (202,000 square miles) and share a common history, they are heterogeneous when it comes to social, economic and political development. Whereas Costa Rica and Panama present social and economic indicators that are above the Latin American average and are also ranked high within the human development index (HDI), the rest of the countries present the worst indicators within Latin America.[1] Guatemala, Honduras and Nicaragua are the 3 countries with the largest percentage of the population living in poverty (almost 50% of total population). Maternal mortality rate for Guatemala, Honduras and Nicaragua at 75-90 per 100,000 live births is the highest in Latin America. Infant mortality at 23-35 per 1,000 live births in these same countries is among the highest.[2]

Although most countries in Central America are middle-income, they are highly unequal-both within and across countries. Guatemala, Honduras and El Salvador are among the countries in the world with the largest socioeconomic inequalities within their own subpopulation groups.[3] Overall, inequalities are far greater among indigenous and Afro-descendant populations.[4] For instance, in Guatemala, an indigenous household is 2.5 times more likely to be living in poverty than a non-indigenous household.[5]

The northern triangle of Central America (Guatemala, El Salvador and Honduras) was greatly affected by that lasted more than two decades. Although war in these countries ended over 20 years ago, the present realities are very much characterized as post-conflict situations, particularly in terms of relatively weak public institutions, social polarization, violence and crime. Several metropolitan areas in these countries are among the most violent cities in the world. Three cities are in the top ten, including San Pedro Sula in Honduras which ranked as the third most violent city in the world with 112 homicides per 100/inhabitants.[6] This rate is even higher than countries engaged in armed conflict.

The endemic violence and crime in countries of the north triangle has created forced displacement of populations and a significant illegal immigration up north towards Mexico and the USA. Several experts coincide that the displacement and migration has created an unseen humanitarian crisis for territories that are not at war.[7]

It is within the above context that countries implemented the Millennium Development Goals (MDG). Although the region as a whole achieved important advances in health such as decreasing maternal mortality rate by over 33%, it still presents unacceptable indicators for a situation of middle-income countries.[8] All countries have now embraced the Sustainable Development Goals (SDGs), which represent both an opportunity to close the gaps that remain from the MDGs and advance towards a comprehensive framework for social and economic development. The 17 goals are interconnected and emphasize pursuing equity and tackling inequalities. There is even a specific goal aimed to reduce conflict and violence and to strengthen institutions (goal 16). For all the above, the SDGs are highly relevant for Central America. The next sections will address key challenges ahead and how think tanks in the region may support countries for a successful implementation.

Successful social policies of the past two decades and remaining gaps: the case of CCT

Latin America, including the sub-region of Central America, has been at the forefront of public policy innovations. Conditional cash transfers (CCTs), a social policy widely used around the world, was first developed and tested in Mexico. This policy was further developed in Brazil, after which it spread to all countries in the region. Several studies have identified that CCTs were effective in reducing poverty levels in several Latin American countries such as Mexico, Brazil, El Salvador, Ecuador, Colombia and Peru.[9] Across the region, think tanks have been actively collaborating with public authorities to design, implement and evaluate the results of CCT policies.

Although CCT programs have been widely and successfully used across the region, they have yet to reach the most marginalized sections of society due to language barriers and limited access to public services. A recent study within the Central American countries showed that monolingual indigenous communities in rural areas have yet to benefit from CCT policies. In these places, information must be translated into local indigenous languages in order to reach the target population.[10]

Despite successful CCT programs in some country settings, countries will clearly need more than just a single effective policy if they are to make progress in achieving the Sustainable Development Goals (SDGs). By design, CCTs require inter-sectorial action. Due to the interconnectedness of all SDGs, the experience gained through CCT implementation will be important. It is claimed that the first thousand days of implementing the SDGs represent a very important milestone. For Central America, countries should take decisive actions to insert the SDGs within the social and economic matrix that guides public priorities and resource allocation at national level.[11]

CURRENT CHALLENGES AROUND SDGS

One of the major challenges in implementing the SDGs lies in the social and economic contexts of countries in the region. For instance, by being classed as middle-income countries, Central America receives a relatively small amount of international aid. Compared with South America, Central American countries, particularly those of the northern triangle, are small economies with few natural resources, which means they cannot directly benefit from commodity trading. Their fiscal and taxation systems are also poorly designed; inefficient and highly regressive.[12] All these factors represent challenges in efforts to expand the fiscal space, which will be needed to finance the public policies and investments required to advance the SDGs.

Fiscal policy, which includes taxation and transfers to the population in cash or in kind through infrastructure and public services, is the most important policy that countries have to tackle poverty and inequality. In countries where taxation is unfair (regressive) and the transfer of benefits to the population are inequitable or insufficient, there are negative consequences for development-including health.[13] A recent study by the Central American Institute for Fiscal Studies using the Commitment to Equity (CEQ) methodology demonstrated that in countries of the region, fiscal interventions increase poverty. This is due to a heavy reliance on indirect taxes in which poor people pay a higher proportion of their income than the non-poor and the benefits they receive (as cash and in kind transfers) are of lesser value. This study also concluded that a higher public expenditure in health and education has the greatest impact to reduce inequality.[14]

Several United Nations (UN) agencies claim that in order to advance in social and economic development that is required to successfully achieve the SDGs, countries in the region must take decisive steps and involve not only the state, but also the private sector and civil society.[15] The society as a whole should dialogue and agree on common targets and goals which inevitable should include taxation and fiscal reform, improved effectiveness of public expenditure and improved transparency and accountability.[16]

THE ROLE OF THINK TANKS IN ADVANCING THE SDGS IN THE REGION

Since the Central American region includes several post-conflict countries, civic participation and the continued strengthening of democracy and political institutions are very important to transit toward peaceful and equal societies. Within this context, SDGs should not be addressed as yet another public policy but as part of nation-wide efforts to improve equity, rule of law and social inclusion. All relevant actors– including the private sector and civil society – should be part of the implementation and monitoring of the SDGs at national, regional and local level.[17] [18] This represents a major challenge, which think tanks can help to address.

A recent study identified that indicators for indigenous and Afro-descendant populations is highly constrained in the region due to lack of disaggregation and ineffective data collection methods. This same study states that universities and think tanks may have the technical capabilities and skills required to designing and field testing alternative and innovative methods for data collection, analysis and monitoring.[19]

In addition to the work of national and subnational authorities, as well as academic institutions and think tanks, the participation of citizens who rely on public services is crucial for advancing the SDGs and strengthening democratic governance. Citizens have the unique legitimacy – through their ability to vote and elect representatives, among other factors – to create a civic movement that can both monitor the effective implementation of government commitments and mobilize to support progressive authorities that are championing the SDGs cause at the national and subnational levels. Think tank organizations that work in health and civic participation can play an important role in helping to facilitate the conditions for an SDG implementation movement that includes the active participation of citizens in alliance with progressive authorities and policy-makers.

It is also important to note that in order to advance the health-related goals, there need to be serious efforts to implement SDG 16: “Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.” This goal provides the space to include citizens in the monitoring of goals and in demands for the accountability of public institutions. Because of the inter-sectorial and interdisciplinary nature of thinks tanks, they are uniquely and well-positioned to support the collaboration among these different actors.

In general, think tanks have the relevant skills, knowledge and expertise that, in

many cases, focus on political and policy dimensions, and that they also have expertise in the monitoring and evaluation of public policies – all of which constitute important contributions towards achieving the SDGs.[20] Thinks tanks are expert civil society organizations that can play a very important role in mediating and connecting grass-roots social movements with efforts to transform public policies and make them more equitable.[21] In summary, think tanks can play several roles such as (a) proposing the technical design of policies (b) analyzing data and producing independent evidence related to performance of public services, impact of fiscal policies and accountability (c) facilitating the engagement of all relevant actors at national, regional and local level.

A NETWORK OF THINK TANKS SUPPORTING IMPLEMENTATION OF SDGS

There are several think tanks that are active in the region and with specific expertise. For instance, the Central American Institute for Fiscal Studies monitors public budgets and fiscal policies and their impact on social protection and the reduction of inequalities.[22] The Institute for Inclusive Health designed and field-tested a model for culturally appropriate healthcare services that has been up-taken by Ministries of Health in several countries and is now supporting the scaling-up in those countries.[23] The Centre for Equity and Governance in Health Systems works with rural indigenous populations to promote democratic governance, citizen participation and accountability.[24] The Centre conducts applied research and the findings are used to design and implement capacity building processes for indigenous organizations in order to strengthen their engagement with government authorities, demanding accountability and building coalitions with broad-based civil society organisations.[25]

The expertise of each of the think tanks described above are both complimentary and relevant for the inter-sectorial and interdisciplinary knowledge and skills demanded from the SDGs framework. Instead of working as isolated think tanks, the collaboration among them would increase the potential positive impact of their engagement with key actors at national, provincial and local level.

A second major benefit of a think tank network is the possibility of organizational learning. The network could support and help members to engage with each other by sharing experiences and providing mutual support. Through this engagement, think tank organizations can also contribute by producing knowledge as a public good that can benefit practices at regional and global level.

A key challenge for think tanks in the region is obtaining funding to implement their activities. In some cases, funding may come from national public sources, although this may interfere with academic independence. A network of think tanks may help mobilize international resources from cooperation agencies and private foundations to avoid dependence and conflict of interest with national authorities. The network may also achieve economies of scale and improved efficiency, which may be attractive to some donors.

Funding from non-public sources- either national or international- may also expose think tanks to potential conflict of interest. Because of this, the network of think tanks must develop a code of practice with clear procedures to assess and regulate conflict of interests.

The long term sustainability of think tanks remains an open challenge for which there are currently not clear solutions. In the meantime, think tanks are a resource that can effectively contribute to implement the ambitious SDGs agenda.

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The Role of Think Tanks and Academic Institutions in Implementing Health-related SDGs in North America

Yanzhong Huang

North America faces unique challenges in implementing health-related sustainable development goals (SDGs), no less because two high-income countries in the region (United States and Canada) themselves have only partially met the health-related SDG targets. Through research and outreach, think tanks and academic institutions (TTAIs) in the region have played a key role in placing the post-2015 framework in place, but they have paid relatively less attention to implementation issues at home. They can be mobilized to play a greater role in the implementation process, including setting priorities, identifying core obligations, generating action plans, and leveraging the strength of the private sector. More efforts should be made to overcome the funding and capacity constraints faced by TTAIs in the region while facilitating their access to SDG-related decision making.

INTRODUCTION: THE DEVELOPMENT GAP IN NORTH AMERICA[1]

Starting in January 2016, the Sustainable Development Goals (SDGs) replaced the Millennium Development Goals (MDGs) to guide development actions worldwide for the next 15 years. Of the 17 SDGs, Goal 3 aims to "ensure healthy lives and promote well-being for all at all ages." Given the cross-sectoral relations among the SDGs, Goal 3 should not be analyzed in isolation. Nevertheless, even without taking into account the other 16 goals and their 156 targets (which should be viewed as social determinants of health), the 13 targets under Goal 3 signal a shift in global health priorities from narrow and discrete goals to more broad-based and inclusive ones. Among the MDGs, for example, combating HIV/AIDS, malaria, and other diseases was one of the three goals explicitly devoted to health, yet it is now only one of the 13 targets for fulfilling SDG Goal 3.

The SDGs are highly relevant to low- and middle-income countries (LMICs) in the North America region, many of which are struggling to fulfill their pre-existing commitments while adapting to new health challenges. Mexico, for example, has achieved sustained progress in bringing down child, maternal and infectious disease-related mortality over the last three decades. However, urgent action is needed to attain SDG-related targets in non-communicable diseases (NCDs) and fatal injuries.[2] In the Caribbean, high maternal mortality and a high HIV/AIDS prevalence rate continue to pose challenges to improvements in health. With an adult HIV/AIDS prevalence rate of 1.1%, the Caribbean remains the second most-affected region in the world.[3] As far as maternal mortality is concerned, the 37% drop between 1990 and 2013 – from 300 to 190 maternal deaths per 100,000 live births – places the region significantly off-track with regards to the MDG target of a three-quarters reduction by 2015. Three Caribbean countries (Trinidad and Tobago, Grenada, and the Dominican Republic) are on track to register an increase in maternal deaths per 100,000 live births.[4] Even worse, the region is experiencing an epidemiological transition that has resulted in the rise of NCDs becoming the primary health challenge as the region enters the post-MDG era. Deaths caused by NCDs now account for 70% of all deaths in the region.[5]

That said, the SDGs are not just aimed at LMICs; every country, regardless of its income level or development assistance, is expected to meet the goals and targets set out in the new development agenda. Fulfilling all of these targets poses challenges, even for the

United States (US) and Canada, two of North America's high-income countries. According to a new study, 38% of those who make less than $22,500 a year reported being in poor or fair health, while only 12% of those making more than $47,700 a year reported health troubles, making the United States a world leader in health inequality.[6] Canada, too, faces problems in in-country disparities in healthcare access and quality, with Canada's northern, indigenous, and immigrant populations experiencing far different health outcomes than the southern-based, non-indigenous populations. This seems to be ironic for a country that is purportedly supportive of the SDGs, but has little concrete evidence of a domestic implementation or monitoring plan.[7] Of the 13 targets included under Goal 3, almost all targets have been only partially met. The United States, for example, only began to move toward covering large segments of its uninsured population (16.3% of the total population in 2010) with the Patient Protection and Affordable Care Act (ACA, also known as Obamacare). Despite the drop in the uninsured population ever since, Obamacare is bedeviled by poor performance and other problems.[8] Now as President Trump threats to repeal the ACA, the program faces a very uncertain future.

ADOPTION OF THE SDGS AND IMPLEMENTATION IN PROGRESS

Adopting the SDGs was a politically inclusive process that involved governmental and non-governmental actors at both the national and international levels. Many countries in the North American region were closely involved in the process. Following the United Nations Conference on Sustainable Development (Rio+20), 14 countries from the Latin American and Caribbean Group (including Mexico, Bahamas, Barbados, Nicaragua, Haiti, and Trinidad and Tobago) shared the six seats in the working group that was tasked with preparing a report on a set of SDGs addressing the social, environmental, and economic dimensions of sustainable development. In addition, representatives from three countries in the region (Cuba, Mexico, and the United States) served on the United Nations (UN) High-level Panel on the Post-2015 Development Agenda.

Regional bodies have also been actively involved in identifying specific areas of focus for SDG implementation. In June 2015, participants at a symposium convened by the Caribbean sub-regional headquarters of the Economic Commission for Latin America and the Caribbean (ECLAC) identified 12 of the 17 proposed SDGs as shared priorities for addressing the sub-region's SDG needs. Most of the goals are either directly related to SDG 3 or considered social determinants of health.[9] Later on, ECLAC established the Forum of the Countries of Latin America and the Caribbean on Sustainable Development as a mechanism to follow up and review the implementation of the SDGs at the regional level. Mexico was among the 22 countries that undertook voluntary reviews to be presented at the High-Level Political Forum on Sustainable Development in July 2016. Three Caribbean countries (Bahamas, Dominican Republic, and Jamaica) are expected to present in 2018.[10]

Unlike the MDGs, country ownership characterizes the implementation of the SDGs, not just in the sense that countries will rely less on donor funding than domestic funding,[11] but that they will be given space to identify their own national priorities within the broad sustainable development framework. As David Nabarro, the UN secretary-general's special adviser on the 2030 Agenda for Sustainable Development, noted, the SDGs are "owned by world leaders on behalf of their people," and "the accountability is between national governments and their people, with the people having the right to expect that the goals will be addressed in their own countries and to demand this of their leaders".[12] While ratification of the SDGs has officially committed countries in the region to fulfill the health-related SDG targets, implementing these targets requires a more fundamental domestic policy change that can only be achieved by effectively mobilizing domestic resources and political leadership.

Initial implementation efforts have varied across sub-regions. Many LMICs have recognized that the SDGs represent a clear opportunity to pursue more coherent and effective public policies around issues of governance, the economy, and healthcare. In aligning national development objectives with the Sustainable Development Goals and targets, Mexico has set up political leadership for implementation at the highest level; included SDG information in the activities and speeches of officials at all levels of government; put in place a national committee for SDG monitoring; and engaged civil society and the academic and private sectors in defining national SDG indicators.

But in high-income countries such as the United States and Canada, national plans for a domestic approach seem almost absent even though their foreign aid sectors are more involved and abreast of the SDGs. Like Mexico, the United States government initially showed interest in pursuing the SDG agenda. Under the leadership of chief negotiator Tony Pipa, the United States played an important role in shaping the SDGs. The then-U.S. President Barack Obama indicated that the goals were relevant at home by saying that "we recognize that our most basic bond – our common humanity – compels us to act... we reaffirm that supporting development is not charity, but is instead one of the smartest investments we can make in our own future."[13] With the ratification of the SDGs, the United States has been exploring how the SDGs can be applied domestically. Philanthropy has led the implementation efforts. It is estimated that the philanthropic sector will contribute at least $364 billion towards the implementation of the SDGs by 2030.[14] The United States was the first high-income country to join four other nations as pilot countries in the SDG Philanthropy Platform, which brings together foundations and philanthropists from around the world to build partnerships between philanthropic organizations, UN agencies, civil society organizations, and the private sector to achieve the SDGs. Of the more than $100 billion of U.S. foundation SDG funding for 2010 to 2015, more than 25% goes toward the fulfillment of Goal 3.[15]

Still, SDGs are barely discussed or acknowledged domestically. When asked what America would do differently once it signed on to the SDGs, Tony Pipa indicated that there was no need to change the domestic development agenda because, "The SDGs are reflective of the agenda that President Obama and his administration have been pursuing domestically."[16] As a result, most of the implementation efforts, if any, seem to transpire at the international level. Not surprisingly, the U.S. Agency for International Development (USAID), which oversees development assistance, is the lead agency implementing the SDGs, focusing on working with other countries to build local capacity and partnership, and bridging the local funding gap. But even such limited implementation efforts are being undermined by the new administration. In a rare twist, those who felt disenfranchised and dispossessed in the United States expressed their anger by voting for Mr. Trump in November 2016, who after taking the presidency, vowed to undermine action against some important SDG goals (e.g., Goal 13 on climate change, Goal 7 on clean energy, Goal 5 on gender equality) and Goal 3 targets such as universal health coverage. In April 2017, President Trump announced he was withholding $32.5 million in funding earmarked for the UN Population Fund (UNFPA), an agency that promotes family planning in more than 150 countries.[17] This was followed by the unveiling of the proposed budget from the new administration that the United States would cut $2.2 billion from global health spending. The budget, if approved, would slash programs to combat HIV/AIDS in the world's poorest countries by 17%.[18]

High-level leadership on SDG implementation at home appears absent in Canada, too. In spite of the welcome references to the SDGs in policy rhetoric, no clear, concrete, and bold steps to advance the SDGs within Canada have been taken by its government leaders.[19] A whole-of-society approach that engages with the three levels of government, indigenous authorities, civil society, the private sector, and Canadians remains absent, even though think tanks stressed that "Canada's success in tackling global sustainable development cuts

across stakeholders, disciplines and ministries."[20] Canada also failed to volunteer to appear before the meeting of the High-Level Political Forum in 2017 to present a voluntary national review on how it is implementing Agenda 2030.[21]

WHY THINK TANKS AND ACADEMIC INSTITUTIONS ARE RELEVANT IN THE POLICY PROCESS

In most countries in the region, public policy processes occur in a context of diffuse decision-making, where state and non-state actors seek to influence public choices. Compared to individual citizens, well-structured non-governmental organizations (NGOs) are generally in a better position to influence public policy-making. But think tanks and academic institutions (TTAIs) are no ordinary NGOs. They have the resources and capabilities to accelerate health-related SDG implementation in the region by pushing for changes in the three stages of the policy process: agenda setting, policy formulation, and policy implementation. Based on John Kingdon's model of agenda setting, the impact of TTAIs may be felt in three policy streams: problem recognition, policy proposal generation, and politics.[22]

Table 1. TTAIs in agenda setting

	Problems	**Policies**	**Politics**
Process	Defining a given condition as a problem	Diffusion of ideas; generation of proposals	Swing in national mood; change in administration and public opinion
Active participants	Media, TTAIs (specialists), bureaucrats pressure groups	Academics, TTAIs (specialists)	Parties, politicians, pressure groups, TTAIs
Consensus building	Persuasion	Persuasion	Bargaining

In the problem-recognition stream, TTAIs are considered active participants because they, like media outlets, can help policymakers learn about conditions and redefine a given condition as a problem. While the media tends to emphasize focusing events (such as a major acute disease outbreak) in this stream, TTAIs can rely on research and publications to persuade policymakers to pay attention to a particular issue. They are also instrumental in generating policy proposals and pushing for the diffusion of policy ideas that they favor. With the emergence of new 'do' tanks (for example, research-cum-advocacy organizations), they can also become proactive in policy advocacy, including lobbying decision-makers and influencing public opinion to change the direction and flow of politics. This is where we see the rise of what Kingdon calls 'policy entrepreneurs,' or people who are willing to invest their resources in return for the future adoption of policies they favor.

To the extent that policy formulation is about developing effective and acceptable courses of action for addressing what has been placed on the policy agenda, TTAIs have more say in the analytical phase (namely, policy alternative specification) than in the political phase (that is, policy enactment). Through presentations, conferences, congressional hearings, media interviews, the circulation of papers, and conversations, they help to dilute the policy primeval soup and narrow down the set of conceivable alternatives. Policy design will certainly affect policy implementation, or the process by which policies

enacted by government are put into effect by the relevant agencies. Here, again, TTAIs may play a role by providing feedback on the outcome of policy implementation.

HOW TTAIS HELPED SHAPE THE HEALTH-RELATED SDGS: THE CASE OF THE COUNCIL ON FOREIGN RELATIONS

Even before the new development agenda was unveiled, TTAIs in the region had already been actively involved in addressing health-related issues. Most schools of public health or medicine carry out teaching and research functions. As a leader in integrated public health research and teaching in Latin America, the National Institute of Public Health of Mexico (INSP) aims to generate and disseminate reference knowledge and provide state-of-the-art training in human resources to develop evidence-based public policies. In addition, many standalone or university-affiliated research institutes – such as the U.S.-based Institute for Health Metrics and Evaluation (IHME) and the National Institute of Hygiene, Epidemiology and Microbiology in Cuba – are devoted to health research. IHME, for example, assembled a consortium of more than 1,800 researchers in more than 120 countries to collect data on premature deaths and disability from more than 300 diseases and injuries in 188 countries, based on age and sex, from 1990 to 2013. By enabling decision-makers to compare the effects of different diseases and to learn how disease burden shifts over time, the Global Burden of Disease (GBD) study plays a crucial role in evidence-based health policymaking. The GBD has helped transform health care policy in numerous countries, and has greatly influenced research, policy, and education. In May 2016, for example, a Mexican lawmaker cited GBD estimates to propose new additions to the General Ecological Balance and Environmental Protection Law and pushed for the creation of a National Council to champion Mexico's environmental protection actions.[23]

Unlike IHME, health programs run by independent think tanks focus on policy-oriented research and outreach. Established in 2007, the Center for Health Policy at the Brookings Institute aims to develop policy recommendations and practical solutions that help achieve innovative and affordable healthcare in the United States. The Global Health Policy Center of the Washington-based Center for Strategic and International Studies (CSIS) has played a key role in shaping U.S. global health efforts over the past decade by working directly with policymakers, partnering with experts of developing countries, and convening high-level task forces on health issues. With growing global health challenges, the 21st century saw the proliferation of TTAIs dedicated to global health studies. The Consortium of Universities for Global Health (CUGH) has 146 member institutions. It organizes an annual conference, which has become the leading academic global health conference in the world.

Among these TTAIs, the Council on Foreign Relations Global Health Program aims to provide independent, evidence-based analysis and recommendations to help policymakers, business leaders, journalists, and the general public better understand the health-related SDGs. In recognition of efforts to design a new framework for development beyond 2015, it organized a workshop in November 2012, *Sustaining Healthy Development: A Workshop on the Post-MDGs Agenda for Global Health*. Through keynote speeches, panel discussions, and presentations, the workshop sought to draw lessons from the implementation of the MDGs, examine the changing geoeconomic, demographic, and epidemiological landscape since 2000, and evaluate objectives and strategies moving the global health agenda forward. Using the Council's convening power, the workshop attracted participants from the UN system, NGOs, foundations, the private sector, think tanks, and U.S. government agencies to discuss the status of health in the Post-2015 Development Agenda.

In 2012, the author of this paper was selected by the Asian Development Bank (ADB) to participate in the Asia-Pacific regional consultations for the UN Post-2015

Development Agenda. This led to the publication in September 2013 of the ADB working paper *Health in the Post-2015 Development Agenda for Asia and the Pacific*.[24] The Council has also been active in shaping the content of the SDG health agenda. As early as 2010, it held a roundtable meeting on non-communicable diseases, with speakers including Rachel Nugent and Derek Yach. These efforts culminated in the release of an independent task force report focusing on NCDs in LMICs.[25]

Equally importantly, the Council has been actively calling for universal health coverage to be included in the post-2015 health agenda. In 2011, it launched its roundtable series focusing on universal health coverage, which led to the publication of a policy report, *The New Global Health Agenda*, in April 2012.[26] Publications and associated meetings have received significant media attention and have encouraged greater discussion within the global health and development communities on how to improve health systems, particularly universal health coverage. Ultimately, the initiative increased understanding about and support for universal health coverage, and eased the translation of universal health coverage from an abstract goal into an achievable and valuable framing goal for the Post-2015 Development Agenda.

Furthermore, the Council has taken the initiative of bridging the knowledge gap that had limited the ability of many governments to engage in the universal health coverage debate. From June to October 2015, the Council held three roundtable meetings, focusing respectively on the healthcare workforce, financing, and implementation issues. By marketing each meeting to a select group of UN mission staff, government officials, international development experts, business leaders, global health scholars, and Council members, the project highlighted the importance, complexities and challenges of implementing universal health coverage. Publications from the project, shared among policymakers and thought leaders from a diversity of disciplines, have helped inform the final stages of the SDG implementation processes.

Needless to say, the Council is not the only TTAI that is involved in shaping the health-related SDG agenda. Many other TTAIs, including FIOCRUZ, the Graduate Institute's Global Health Centre, the Center for Global Development, the CSIS Global Health Policy Center, and the Brookings Institute, have made important contributions to the process. Academic institutions have also been instrumental in influencing agenda setting and developing a monitoring framework with targets and indicators for the SDG health goals. IHME, for example, not only helped identify the targets to be included in SDG 3 (through the GBD study), but also developed tools to monitor progress toward achieving the SDGs.[27] In Canada, Dr. Michael Brauer, a professor at the University of British Columbia's School of Population and Public Health, helped raise awareness about the problem of air pollution in the country.[28]

The case study supports the aforementioned model on the role of TTAIs in SDG-related agenda setting. TTAIs overall are active in all policy streams: problems, policies, and politics. Through research and outreach activities, they can reframe a condition into a problem, generate policy proposals, and influence public opinions. Instead of being direct negotiators in the consensus-building process, though, they seem to be more interested in persuading than bargaining with policymakers to accept their preferred policy ideas.

WHAT TTAIS CAN OFFER IN THE IMPLEMENTATION OF THE HEALTH-RELATED SDGS

While TTAIs in high-income countries have played a key role in identifying and advocating for the expanded presence of health in the post-2015 framework, they have generally been absent in contributing to the implementation of the health-related SDG in their own countries. The debate in the United States and Canada has focused on what they can do for others, rather than what they can do for themselves. The Council on Foreign Relations report on non-communicable diseases, for example, focuses on the NCD threats in and from

developing countries and the importance of U.S. leadership in helping these countries address NCDs.[29] In December 2015, the CSIS Global Health Policy Center launched the Task Force on Women's and Family Health. The task force brings together a distinguished and diverse group of leaders from the U.S. Congress, academia, foundations, the global health community, and the private sector to "chart a bold vision for the future of U.S. leadership to support the health of women and families around the world." In Canada, although scholars recognize the importance of substantively embracing and implementing the SDGs in contributing to Canada's own sustainable development, they admitted, "our applied research and think tank systems are weak" in leveraging a whole-of Canada approach to addressing global challenges. [30] This is not surprising given that, for a long time, the two countries have been used to being the primary sources of international development financing, as well as development-related ideas and policy advisors for the LMICs. The presumption is that neither the United States nor Canada has major development issues to address domestically. When Canadian Prime Minister Trudeau asked government agencies to deliver on "helping the poorest and the most vulnerable, and supporting fragile states by supporting the implementation of the 2030 Agenda for Sustainable Development," for example, he was referring to how Canada could help others, not how it would implement the SDGs at home.

But there are, indeed, development gaps that decision-makers in the United States and Canada must confront. In terms of Goal 3 targets, these gaps are concentrated in the following areas: universal health coverage (in the United States), NCDs and their risk factors, and substance abuse. Even in areas where SDG targets have been met, such as maternal and child health and universal health coverage (for Canada), the results are not as good as those of many other wealthy nations. The gaps become even more glaring when we take into account all related goals/targets in an inter-sectorial way (e.g., reducing inequality, tackling climate change, ensuring inclusive and equitable quality education). It is therefore important for TTAIs in the two high-income countries to raise awareness about these issues and to help elevate them from the public agenda to the governmental agenda.

Given the scale of the challenges and the resource constraints faced by LMICs, the role of TTAIs in priority setting becomes even more crucial. Here, TTAIs can help to set out a comprehensive set of recommendations that are of greatest relevance and importance to LMICs in the North America region, where epidemiological data all point to the need to improve universal health coverage, reduce maternal mortality, and address the NCD threat. Interestingly, Caribbean countries, in rolling out their SDGs, have focused on the impact of the environment on health. In January 2016, about 40 environmental health professionals from 17 Caribbean countries took part in the Caribbean Environmental Health Conference, aiming to address the threat to health and the environment from climate change. With the SDG framework in mind, the meeting offered a platform for evaluating the impact of the third phase of the Caribbean Cooperation in Health Initiative (CCH III), and the development of the next phase, CCH IV.[31] This was followed by the first Caribbean Sustainable Development Forum in Aruba in February 2017, which focused on climate change mitigation and adaptation.

In addition to priority setting, TTAIs can play a key role in articulating a clear set of minimum core obligations for countries to fulfill, which the existing SDG health targets fail to offer. This involves prioritizing where to start. A survey conducted by the New America Foundation, GreenHouse (a Chicago social innovation group), and the Organization for Economic Cooperation and Development (OECD) sought to find the best, most logical sequences in which to tackle the SDGs. Interestingly, "Ensure access to safe, effective and affordable health care, medicine and vaccines" was ranked Number 3 among the top 20 SDG options in sequence.[32] Still, a lack of sufficient operational definitions for the SDGs and their targets is a major concern for the implementation efforts. In March 2016, the UN Statistical Commission's Interagency and Expert Group on SDG Indicators (IAEG-

SDGs) approved 230 indicators for the SDG agenda, including 25 indicators for SDG 3. Still, there is much room for improvement. For example, SDG 3.3 unrealistically proposes ending epidemics of all communicable diseases. Moreover, little or no baseline data exists for these indicators in many poor countries, which further compromises the operationalization of the SDG targets. Here, TTAIs can play a pivotal role, particularly in terms of cooperating with poor countries, building reliable baseline data, and developing operationalized indicators to measure progress. For example, in achieving targets of reducing child and maternal morbidity by X%, TTAIs may use a numerical target per 1,000 live births to replace X%, given the widely varying baselines used by different countries and the need for all to reach a globally acceptable standard.[33]

TTAIs can also play an instrumental role in generating policy proposals or action plans for a national strategy to implement the health-related SDGs. Central among these efforts is the push for an integrated and synergistic approach to achieving the targets. This is because many health-related issues cut across a significant number of SDG areas. Tackling NCDs in the region, for example, cannot be separated from dealing with pollution and other risk factors (for example, smoking and obesity) and the establishment of universal health coverage – even without considering other social determinants of healthcare. Similarly, in order to reduce maternal mortality, several issues, including obesity-related complications and a lack of access to affordable, quality healthcare, must be taken into account. Also, by participating in the design of indicators to measure progress towards SDG 3, TTAIs can work with civil society organizations to hold the government accountable for meeting the targets domestically.

TTAIs can influence policymaking by applying evidence-based research tools to specific areas of implementation. In Mexico, for example, a comprehensive healthcare model called CASALUD is being used to improve the care, control, and prevention of non-communicable diseases.[34] Drawing on clinical, epidemiological health economics and other information and methodologies, the health technology assessment (HTA) approach can be quite useful for informing policy and decision-making in healthcare, especially on how to best allocate limited funds for health interventions and technologies in promoting universal health coverage. While translating HTA into policy can be a highly complex business, TTAIs should aim to make it more relevant for health policy in North America.

As Ilona Kickbusch, director of the Graduate Institute's Global Health Centre, noted in the meeting on TTAIs in Rio de Janeiro in November 2016, SDG implementation should be accelerated through better governance for health at different levels. A national strategy is important, but turning it into action requires engaging state (provincial) and local actors. This is especially true in countries where local governments and grassroots institutions carry most of the responsibility for delivering healthcare. The SDGs would provide a unique opportunity for TTAIs to forge partnerships with local governmental actors in the implementation process.

In October 2015, a core team of local experts from the University of Baltimore's College of Public Affairs and Merrick School of Business, the University of Maryland's National Center for Smart Growth Research and Education, and an international non-governmental organization (INGO) called Communities Without Boundaries International came together to brainstorm how to put the SDGs into action. Through this initiative, experts from academic institutions work with key technical specialists from city agencies, civil society organizations and non-profit organizations have proposed a list of feasible and quantifiable sustainable development targets that could be considered for incorporation into future city strategies.[35] While the partnership is not health-focused, it can serve as a model for other U.S. cities planning to build locally grounded strategies to tackle the health-related SDGs.

Finally, TTAIs can help leverage the strength of the private sector in implementing health-related development goals. Some business leaders have complained that, for many

years, the World Health Organization (WHO) leadership has demonized the private sector, blaming the latter for the rise of non-communicable diseases. But, overlooking the role of the private sector is neither desirable nor feasible. Given the resource constraints faced by all countries in achieving their health-related SDG targets and their reduced reliance on donor support, public–private partnerships in financing and delivering health services have become even more important. Involving for-profit private actors (such as pharmaceutical companies) risks undermining public interest, but this should not deter policymakers from including the private sector in efforts to achieve the health-related SDG targets. Indeed, evidence suggests that when the public and private sectors work together, not only does universal health coverage become more affordable, but overall health outcomes improve.[36] This very issue was addressed by a dialogue organized by strategy consulting firm Rabin Martin, the Johns Hopkins Institute for Applied Economics, Global Health and the Study of Business Enterprise, and the Graduate Institute's Global Health Centre in Geneva. The dialogue led to the publication of a report, *Advancing universal health coverage as a cornerstone of the SDGs: What is the role of the private sector?*, which outlined how the private sector is already helping countries move forward in the journey toward universal health coverage, and pointed to important lessons learned on how to expand opportunities for future partnerships to accelerate progress.

CHALLENGES FACED BY TTAIS IN INFLUENCING IMPLEMENTATION EFFORTS

Because implementation involves putting policy into practice, TTAIs, in maximizing their policy impact, may venture onto the political stage of policy formulation, and may even become directly involved in local implementation efforts. Moving from 'think' tanks to 'do' tanks may allow the new research-advocacy TTAIs (for example, the Center for American Progress, New America Foundation) to play a greater role, but this also presents challenges for traditional, mainstream TTAIs, which value independent research and do not want to be viewed as policy lobbyists or activists. But even traditional think tanks can impact the politics of policymaking while maintaining their neutrality. In June 2016, with support from the Rockefeller Foundation, the Global Health Program at the Council on Foreign Relations launched a roundtable series titled 'The Next Director-General of the World Health Organization," which drew attendees from UN agencies, NGOs, the private sector, academic institutions, and U.S. government agencies to scrutinize the new election process, examine previous elections and directors-general, and consider what sort of individual is suitable to lead the WHO. Even though it did not advocate a particular candidate, the roundtable series helped attendees understand the key issues and debates in the election process. When asked to express their confidence in the new election process's ability to produce an exceptional leader for the WHO, roundtable attendees expressed, on average, far less confidence than the remainder of respondents who were not in attendance. Similar efforts have been made by the Graduate Institute's Global Health Centre (under the leadership of Professor Ilona Kickbusch) and Chatham House's Centre on Global Health Security (headed by Dr. David Heymann).

Major challenges exist in this process. Among others, tightening budgets have limited the ability of TTAIs to influence the SDG implementation process. TTAIs, especially think tanks, often rely on funding that is dependent upon their proven impact on policy process. Potential donors focusing on value for money nowadays prefer to support projects that can demonstrate immediate and measureable results, but have less interest in big ideas or macro policy issues. Also, as the largest private funder in global health, the Bill & Melinda Gates Foundation is increasingly interested in supporting TTAIs that can promote its own funding priorities, such as women's health and polio eradication. While this may contribute to SDG implementation, it runs the risk of distorting the fulfillment of SDG 3, in that only those issues favored by the foundation receive priority when it comes to implementation.

The credibility and impartiality of TTAIs may also be undermined when they are asked to lobby government actors to promote the donors' agenda.

Another challenge is the issue of access to decision-making and multilateral forums. In order to maximize their impact on the implementation process, TTAIs in the region will need to be more aggressive in reaching out to a new set of actors at the local, regional, and global levels. The shift to a Trump presidency, with its inclination to trust the president's own instincts and not to overthink things, makes the job even more difficult for traditional or leftist TTAIs to influence top-level decision making in the United States. Gaining access may also be constrained by technical and resource gaps, which may limit TTAIs' ability to engage in the debate and deliberations over reaching the SDG targets. While politicians and decision-makers are responsible for making institutional and financial arrangements to facilitate such access and make it more effective, gaining access should not be achieved by sacrificing independent analysis in exchange for saying or doing what the government wishes in the decision-making process. To maintain independence in its research, the Council on Foreign Relations, for example, strictly forbids the direct acceptance of funds from any government actor.

There is also concern about conflicts of interest when TTAIs seek funding from foreign governments and the private sector (for example, the pharmaceutical industry). Given that the issue of access to affordable and effective medicine highlights the tension between public health and intellectual property rights, taking money from the pharmaceutical industry runs the risk of undermining public interest and the credibility of the research organization involved. Accepting funding from foreign governments raises similar concerns. Reading two *New York Times* articles about think tanks from 2014 and 2016,[37] one can easily draw the conclusion that "think tanks are frequently not objective, neutral arbiters of information, but corporate- and government-funded agenda-promoters with an academic veneer to give the appearance of impartiality."[38]

A network of TTAIs at the regional and global levels can facilitate access and help overcome such funding and capacity gaps. Firstly, implementing the health-related SDGs involves building multi-stakeholder and multi-sectoral synergies.[39] Many health-focused TTAIs in the region are staffed mainly by scientists, epidemiologists, physicians, or other researchers with a public health background. While their expertise is critically important, in order to build capacity to influence key policy sectors and actors, we need to involve lawyers, diplomats, mediators, economists, anthropologists, and political scientists, as well as experts in agriculture, trade, intellectual property, and human rights. A network of TTAIs may not only facilitate knowledge sharing between multidisciplinary researchers, but may also make it more likely that partnerships across sectors will be developed, thereby mitigating the gap in skills and resources faced by many TTAIs.

Secondly, the principle of inclusiveness enshrined in the SDG adoption and implementation processes has reshaped the relationship between the Global North and the Global South. Given the common challenges faced by developed and developing countries in achieving SDG 3, experiences from other countries can inform and inspire North American countries in their pursuit of the health-related goals. Southern TTAIs, such as FIOCRUZ, are already playing an active role in supporting the UN Technology Facilitation Mechanism (TFM) toward the implementation of the SDGs. As the Council on Foreign Relations report on NCDs notes, initiatives launched by LMICs to integrate nutrition and the promotion of a healthy diet into primary care – such as those pioneered in Ethiopia and Honduras – may have relevance to the United States; efforts made by developing countries to experiment with lower-cost chronic care models may also help slow the soaring rise in health costs in the United States.[40] Through this network, Southern TTAIs can individually, or in partnership with Northern TTAIs, identify problems and targets, develop indicators, and specify policy alternatives for the purpose of implementation. This can be conducted at the regional level, through organizations such as the Pan-American Health Organization or

International Development Research Centre, or at the global level, through International Geneva, which boasts the proliferation of organizations in the fields of global health, trade, human rights, the environment, and sustainable development.

CONCLUSION

In implementing health-related SDGs, North America faces unique challenges, no less because the region is a combination of LMICs (Mexico and the Caribbean) and high-income countries (the United States and Canada). The universal and inter-sectoral nature of the SDG health agenda highlights the failure of countries in the region, including the United States and Canada, in meeting the health-related SDG goals and targets. Through research and outreach, TTAIs in the region have played a key role in placing the health-related SDG framework in place, but their role remains limited in the implementation stage. TTAIs in the United States and Canada pay relatively less attention to implementation issues at home. They can be mobilized for setting health-related implementation priorities, identifying core obligation for countries to fulfill, applying evidence-based research tools to specific areas of implementation, and leveraging the strength of the private sector. To that end, greater efforts should be made to ease their budget constraints, lower the barriers for them to gain access to SDG-related decision making, and minimize conflicts of interest between TTAIs, on the one hand, and the private and government sectors, on the other. A network of TTAIs at the regional and global levels would be necessary to facilitate access and reduce funding and capacity gaps.

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[1] There are varying interpretations and definitions of North America. Broadly defined North America contains all Caribbean and Central America countries, Bermuda, Canada, Mexico, the United States of America, as well as Greenland. This paper will focus on Canada, the United States, and Mexico, which make up the largest part of the continent, although it also touches upon the Caribbean countries.

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The Role of South Asian Health Policy Research Institutions in Accelerating the Implementation of the Sustainable Development Goals

Saadiya Razzaq

This paper intends to investigate, through available literature and web searches, the role of policy research institutions in South Asia in accelerating the monitoring and implementation of health-related SDGs. It is argued that SDGs are not only relevant, but also critical for the region, and policy research institutions are playing their role in evidence generation, knowledge sharing, and policy research. As they are facing the challenges of donor dependency, financial constraints, and the law and order situation, among other things, it is therefore suggested that a network of health policy research institutions be formed at the regional or global level with regional chapters to facilitate their role in accelerating the growth on SDGs. If supported and facilitated enough in terms of resources, capacity building, and independence in research, these institutions can be vital players toward the attainment of SDGs.

The Relevance Of The SDGS To South Asia

Sustainable Development Goal 3 (SDG 3) focuses on healthy lives and well-being for all, while leaving no one behind, which is quite an ambitious agenda. So far, discussions around the SDGs in many countries – at national and regional levels through discussions and forums – have focused on goals and indicators, and it is still unclear in some countries how the roles and responsibilities of different actors and stakeholders will be distributed to achieve the SDGs. This paper aims to explore the role of health policy institutions in South Asia in accelerating the implementation of health-related SDGs and to identify the factors influencing the work done by these bodies.

Today, we are confronted by a series of global health issues, including 65.3 million displaced people worldwide[1] who face challenges in accessing healthcare facilities; the health effects of climate change;[2] antimicrobial resistance;[3] a global shortage of 7.2 million doctors, nurses, and midwives;[4] mental health issues faced by Ebola survivors[5] and victims of gender-based violence;[6] and natural disasters.[7] Similar challenges are being faced by the South Asia region.

The southern part of the Asian continent is comprised of eight countries, namely Afghanistan, Bhutan, Bangladesh, India, Pakistan, Maldives, Nepal, and Sri Lanka. The region is bordered by the sea to the south and the Himalayan Mountains to the north. South Asian civilization began as early as 2500-1500 BC, and is also known for the Indus civilization that thrived in the region around the Indus River.[8] The Early Modern Period (1526-1858) in South Asia was known for the rise of Mughal Empire in 1526 and ended with the fall of the empire in 1857. The empire, considered the most powerful, lasted seven generations. It established highly organized administrative systems and spread from Samarkand and the Punjab (now India and Pakistan) to Kabul (now Afghanistan). This period was followed by colonial rule, which started in the 16th century and ended in the 20th century. Vasco da Gama was the first European to arrive in South Asia, followed by the Portuguese and then the Dutch, who mainly ruled Ceylon (now Sri Lanka) for 137 years. The British captured Calcutta and Madras (now India) and continued to rule the sub-continent until 1947. In August 1947, colonial rule ended in the sub-continent, and Pakistan and India

achieved independence.[9] In 1971, East Pakistan separated from West Pakistan and emerged as an independent state, now known as Bangladesh.

Figure 1: Map of South Asia

Currently, South Asia is the world's fastest-growing region,[10] but capital inflows have declined, inflation is increasing, and remittances from Middle Eastern countries are decreasing. It is important to note that the economic growth in the region has facilitated decline in poverty rates, improving the health status of the population. Still (as of 2012) 19% of the population lives below the poverty line (measured at $1.90 per day).

Despite significant social, economic, geographic, linguistic, and political diversity, the countries of South Asia face common health issues and challenges. The SDGs are not just relevant to the region – they are of critical importance. South Asian countries had made good progress on some of the MDG targets, such as poverty eradication, gender equality in primary education, reducing tuberculosis, increasing forest cover and protected areas, reducing carbon dioxide emissions, and increasing access to safe drinking water. However, most of the targets on maternal and child mortality, sanitation, and reducing the proportion of underweight children remain a challenge[11]. Notably, the MDG targets that could not be achieved are all related to health.

South Asia a population of 1.7 billion[12] – nearly a quarter of the world's population, and 40% of the world's extreme poor,[13] which poses serious health-related accessibility and affordability challenges. This situation is further aggravated by the lack of healthcare services, including lack of healthcare professionals. In South Asia, the literacy rate among youth (aged 15-24) is 83.5%; the infant mortality rate (per 1,000 live births) is as high as 42; under-five mortality rate (per 1,000 live births) is 53; prevalence of underweight children under five is 31%; maternal mortality ratio (per 100,000 live births) is at 182; the incidence of tuberculosis (per 100,000 people) is 220; and only 45% of the population has access to the improved sanitation facilities.[14] Most of the countries in the region face a triple burden of disease, including ongoing infectious diseases, persistent non-communicable diseases and chronic diseases, as well as a growing burden of injuries – mainly road injuries (among top ten causes of death).[15] In addition, a host of compounding factors exacerbate the

situation, such as the social determinants of health, demographic transitions and urbanization, including growing informal settlements and slums.

Table 1 shows a range of health indicators for different countries in the region. Population growth, at 2.8%, is highest in Afghanistan, which also has the lowest life expectancy at birth of 60.5 years. Immunization for measles is as high as 99% in the Maldives and Sri Lanka, but other countries trail behind. The percentage of births attended by skilled birthing staff varies across the region, from 39% in Afghanistan to 99% in the Maldives. Access to improved sanitation is still a matter of concern across the region. Maternal mortality and under-five mortality remains high in some countries, especially in Afghanistan where measles, mumps, and rubella is at 396 per 100,000. High out-of-pocket expenditure for health services is prevalent across South Asia ranging from 64% of total health expenditures in Afghanistan to 18% in Maldives and, by international standards, there is also a shortage of needs-based health staff.[16] These issues stress the need for a coordinated and integrated approach by all the countries at the national and regional levels to improve the health status of the region's people, and the SDGs provide the very framework for moving forward.

Table 1: Health indicators in South Asia

Indicators	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Population Growth (Annual %)[b]	2.8	1.2	1.3	1.2	2	1.2	2.1	0.9
Urban Population (% of total)[y]	27.1	35.0	39.4	33.1	46.5	19	39.2	18.4
GDP Growth (Annual %)[b]	1.5	6.6	3.3	7.6	1.5	3.4	5.5	4.8
Life Expectancy at Birth (Years)	60.5	71.8	69.8	68.3	78.5	69.2	66.4	74.9
Immunization, Measles (% of Children Ages 12-23 Months) [b]	68	88	97	87	99	85	61	99
Births Attended by Skilled Health Staff (% of Total)	38.6***	41.2*	74.6**	52.3 [z]	98.8***	55.6*	52.1*	98.6 [z]
Improved Water Source (% of Population with Access) [b]	55.3	86.9	100	94.1	98.6	91.6	91.4	95.6
Improved Sanitation Facilities (% of	31.9	60.6	50.4	39.6	94.9	45.8	63.5	95.1

Population with Access) [b]								
Mortality: Under-five (Per 1,000 Live Births) [b]	91.1	37.6	32.9	44.7	8.6	35.8	81.1	9.8
Mortality Rate, Neonatal (Per 1,000 Live Births)[y]	35.5	23.3	18.3	27.7	4.9	22.2	45.5	5.4
Mortality Rate, Infant (Per 1,000 Live Births)[y]	66.3	30.7	27.2	37.9	7.4	29.4	65.8	8.4
Maternal Mortality Ratio Per 100 000 Live Births [a]	396	176	148	174	68	258	178	30
Out-of-Pocket Expenditure as % of Total Health Expenditure [a] (2014)	63.9	60.9	25.3	62.4	18.3	47.6	56.3	42.1
Per Capita Total Health Expenditure at Average Exchange Rate (USD)[a] (2014)	57	30.8	88.8	75	1165.1	39.8	36.1	127.3
External Resources for Health (% of Total Expenditure on Health)[y]	23	11.8	6.4	0.9	0.4	1.3	12.6	8
Risk of Impoverishing Expenditure for Surgical Care (% of People at Risk)[y]	83.1	79.1	61.5	67.3	8.8	44.2	87.5	62.8
Risk of Catastrophic Expenditure for Surgical Care (% of People at Risk)[y]	92.8	73.6	37.7	59.6	23.2	58	74.8	75.2
Health Physicians[a]	0.2**	0.3***	0.2**	0.7***	1.4 [z]	-	0.8 [z]	-

Workforce per 1000 Population	Nurses/ Midwives [a]	-	0.2****	0.9***	-	5.0 [z]	-	0.5 [z]	-
	Dentists [a]	0.004**	0.02*****	-	0.09****	0.08 [z]	-	0.06 [z]	-
	Pharmacists [a]	0.047**	-	0.01****	0.5***	0.6 [z]	0.1*****	-	0.03***
Cause of Death, by Injury (% of Total)[y]		18.1	7.8	9.5	11.1	10.7	11.7	8.6	12.6
Number of Infant Deaths[y]		67399	97478	335	946304	58	16144	350600	2620
Cause of Death, by Non-communicable Diseases (% of Total)[y]		42.3	66.9	67.8	60.8	78.4	64.5	56.4	79.7
Literacy Rate, Adult Female (% of Females Ages 15 and Above)[y]		23.873849 87	58.313640 59	55.118190 77	62.984718 32	98.855079 65	54.750518 8	42.727169	91.708648 7
Literacy Rate, Adult Male (% of Males Ages 15 and Above)[y]		51.472679 14	64.642593 38	71.147178 65	80.935546 88	99.795532 23	75.809776 31	69.570220 9	93.616668 7

*Note: [a] = WHO, 2015; [b] = World Bank, 2015; * = Data for 2014; ** = Data for 2013; *** = Data for 2012; **** = Data for 2011; [z] = Data from 2007–2010*
Source: WHO presentation at the South Asian Regional Consultation on Health Policy Research Institutions, 5 December 2016; y = Health Nutrition and Population Statistics (http://databank.worldbank.org/data/reports.aspx?source=health-nutrition-and-population-statistics#)

Goal 3 relates specifically to health, but many other goals also have a major impact on health, though they relate to the environment, poverty, nutrition, hunger, sustainable production and consumption, climate change, agriculture, and education. The goal of ensuring healthy lives for all depends not only on health sector development, but also on progress in other sectors. So, achieving all the targets and effectively monitoring progress toward the indicators is imperative to ensure healthy lives and well-being for all, as well as the achievement of all 17 SDGs. This interdependence requires an inter-sectoral and multi-sectoral approach toward the attainment of health-related SDGs. The health-related SDGs cannot be achieved if the social determinants of health are ignored; therefore, it is required to work in collaboration with other sectors and departments by adopting a health-in-all policy approach. Healthy life and wellbeing is not limited to the provision of health care services, rather, it necessitates improvement in sanitation facilities, provision of safe drinking water, promotion of hygiene, improved education and literacy, women's empowerment, and social protection mechanisms, among others, as these have a direct impact on the health status of the population. If the integrated approach toward health were to be adopted, it would require collective efforts by all the relevant stakeholders, and thus, a multi-sectoral approach is a must. Unfortunately, the governance structure in South Asian countries is designed in a way that every department or ministry is working in isolation, so adopting a multi-sectoral approach is a challenge.

TRANSFORMATIVE POLICY ACTIVITIES IN THE REGION

To make progress toward achieving the SDGs, efforts are under way throughout the region at different levels, including government, civil society, policy research institutions, and other stakeholders. In Bangladesh, the sector-wide approach (SWAp),[17] adopted by the Ministry of Health and Family Welfare (MOHFW), aims to improve the health status of the population. In Pakistan, an SDG unit has been set up in the Planning Commission at the federal level, whereas separate units in planning departments at provincial levels are underway to promote an integrated approach toward developing policies and programs around health. The government has also internalized the Sustainable Development Goals as national goals, which represents a major policy shift.[18] In addition, Pakistan's National Health Vision 2016–2025[19] aims to build coherence into federal and provincial efforts to consolidate progress; facilitate synchronization for commonality across international reporting and international treaties; facilitate coordination for regulation, information collection, surveillance, and research for improved health systems; and provide a foundational basis for charting and implementing the SDGs in partnership with other sectors.

In Afghanistan, the country's 2015–2020 health policy focuses on governance, institutional development, public health and health services provision, as well as human resource management to improve the health sector devastated by decades of war and conflict.[20] India's 2015 health policy focuses on equity, universality, patient-centered care and quality of care, inclusive partnerships, accountability, learning and adaptive systems, and affordability.[21] In Sri Lanka, the National Health Strategic Master Plan for 2016–2025 focuses on issues such as health administration and human resources for health, curative services, preventive services, rehabilitation services, and healthcare financing to promote the health status in the country.[22]

Similarly, policy research institutions are also striving to generate evidence and produce research on issues of prime importance, with the hope that this may result in effective policymaking in their respective countries.[23] A detailed study is being conducted in seven South Asian countries, namely Afghanistan, Bhutan, Bangladesh, India, Pakistan, Nepal, and Sri Lanka – led by the Sustainable Development Policy Institute in Pakistan with the support of the International Development Research Centre in Canada to understand the role of stakeholders in promoting health related SDGs. The report will provide insights into the policy research institution and contextualize its work on SDGs. Hopefully; the report will be available by end of this year.

WHY POLICY RESEARCH INSTITUTIONS ARE RELEVANT FOR THE IMPLEMENTATION OF THE SDGS AND TO WHAT EXTENT THEY ARE ALREADY ENGAGED

McGann (2008)[24] defines think tanks as "public policy research, analysis and engagement institutes that generate policy-oriented research, analysis and advice on domestic and international issues that enable policy makers and the public to make informed decisions about public policy issues. Think tanks may be affiliates or independent institutions and are structured as permanent bodies, not ad hoc commissions (page 7)." Based on this definition, think tanks will have to play a leading role in providing evidence-based policy interventions to ensure that universal health care is achieved. It is also important to note that there are many other factors that affect policies, such as the political and economic situation of the relevant country. Think tanks also have an important role in synthesizing available information and evidence and analyzing it through different lenses, including human rights, gender, social justice, and equity.

Without the research, it is unrealistic to expect improvements in the health system or the development of new initiatives. This crucial role – of producing research, generating

evidence, and devising policy guidelines, as well as synthesizing existing research and best practices and informing policy on what works and what does not – is also being performed by academia. The relevance and role of these institutions will be analyzed in the following section.

Making progress on 13 targets and 25 indicators (including additional targets) is not an easy task and requires significant resources. It is estimated that developing countries will need to spend nearly $2.5 trillion per year[25] to achieve the SDGs. In addition to financial resources, a multidimensional matrix of non-financial resources – like global dialogue frameworks and agreements, global data compiling and monitoring, and South–South cooperation – needs to be accomplished for the implementation of the Sustainable Development Goals.[26] In addition, policy research institutions can play their role in identifying the ways to fill this financial gap along with contributing through evidence generation.

Think tanks and policy research institutions have an important role to play in providing these non-financial resources as they engage themselves with their respective governments by providing evidence-based policy advice, producing progress reports on development goals, and forecasting the future development trajectory.[27] Similarly, they have the potential to bring civil society, governments, and intergovernmental organizations together for collective and concerted efforts to achieve the SDGs.[28]

A study of civil society organizations (CSOs) in South Africa revealed that CSOs played an important role in articulating needs and promoting good governance in relation to the implementation of the MDGs. It is therefore of crucial importance to recognize the potential role of CSOs in the global development agenda through effective engagement in policy development and implementation of the SDGs.[29] Another study on six health policy institutions – including non-governmental organizations (NGOs), academia, and government-owned institutes around the world – indicated that health policy institutions can play a critical role in evidence-based policymaking, provided they have some degree of independence, an enabling policy environment, and sufficient finances.[30]

While narrowing down the focus from all 17 SDGs to the health-related SDGs, knowledge building and sharing, capacity building, and innovation appear as the three most important areas where think tanks and health policy analysis institutions can contribute toward the translation of commitments to better health for all.[31] All three are interlinked and are equally important.

The slow diffusion of knowledge[32] warrants the need for systematic knowledge sharing and dissemination. Knowledge sharing will remain futile unless the recipients of knowledge have the technical capacity to make use of that knowledge.[33] The lack of technical capacity by governments to monitor and implement the SDGs has resulted in calls for capacity-building initiatives.[34] Here, think tanks can contribute by assessing the needs and suggesting mechanisms to fulfill these needs. The existing pool of knowledge will have to be continuously reinforced with innovative ideas that provide solutions to key challenges, such as achieving universal health coverage in resource-limited settings, controlling non-communicable diseases with inter-sectoral policies, and using technology for community-based health care system accountability. Policy research institutions can play their role through conducting analyses of best practices, causes of failures of different initiatives, and determinants of policy implementation.

LANDSCAPE OF HEALTH POLICY RESEARCH INSTITUTIONS IN SOUTH ASIA

As research and literature – albeit limited – has indicated, health policy institutions (whether think tanks, research institutes, or academia) can play a very important role in the implementation of the SDGs as mentioned above. They can not only produce evidence on progress in implementing the SDGs, but they can also play an important catalytic role in

formulating policies and strategies for the health sector. They also give a voice to the community, particularly the poor and vulnerable, and engage them in participatory research.

Research suggests that health policy institutions around the world exercise significant policy influence and capacity-building. For example, Heartfile in Pakistan was the first organization in the region to develop the Non-Communicable Diseases National Plan in collaboration with the Pakistani government. The recommendations given by the Sustainable Development Policy Institute (SDPI) Pakistan to the National Economic Advisory Council were adopted by the government and reflected in the Federal Budget 2015-16. The community health worker model in Bangladesh by BRAC is another good example that is being replicated by other countries. Similarly, other think tanks have also contributed to policy development, though it is quite difficult to track their impact, as there are many other factors that simultaneously influence policy decisions.[35] The author of this paper has analyzed the role of health policy institutions in South Asia in achieving the goal for healthy lives, and mapped health policy institutions in the region – including think tanks and academia – that will help identify avenues of partnership among themselves, both within the ambit of South–South development cooperation, as well as with other international development organizations and donors who can work within the context of a triangular partnership or involving other institutions from the Global North. There are few examples of South-South cooperation like SAARC – the South Asian Association for Regional Cooperation – which works at the government level, but is now not as functional as it should be due to rifts between some countries in the region. Another example is Southern Voice, which is a network of think tanks in the Global South, including organizations from South Asia, and is working toward the SDGs (before 2015 it was working on MDGs). The think tank initiative by IDRC is another good example of networking among South Asian think tanks, and consists of 14 think tanks from the region. Currently, a very limited literature is available on the role of policy research institutions in South Asia.

For the purpose of analysis, a comprehensive web research was conducted and 43 health policy institutions were identified in the South Asia region. This web based research very much depended on the availability of online information about these institutions, and thus does not represent the size or population of a respective country. These institutions include think tanks, research institutes, NGOs, government-owned think tanks and research institutes, and university-based research institutes (which have not been disaggregated into public and private universities). Of the 43 organizations in South Asia, most of the institutions are based in India, followed by Pakistan, Nepal, Sri Lanka, and Bangladesh. Research identified only one organization in Afghanistan, while no organizations in Bhutan or the Maldives were identified.

The health policy institutions were analyzed by type of institution, functions, and work related to the health sector. For the sake of analysis, these institutions were categorized into three broad categories. Think tanks, research institutes, and non-governmental organizations represent 70% of the 43 organizations identified; think tanks and research institutions affiliated with governments account for 12%; and academic research institutes make up 18% of the total. Of the 43 institutions, 21 work exclusively on health issues, while the remaining 22 are working on multi-sectoral issues, including health.

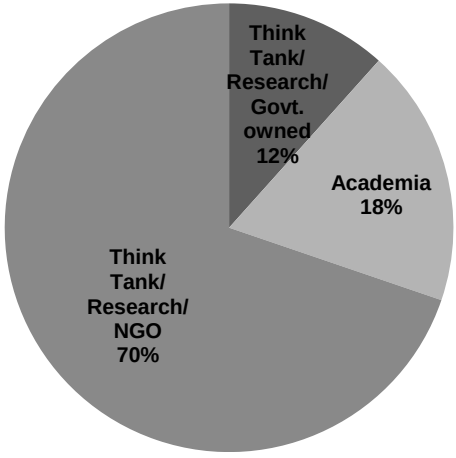
The health policy research institutions under study carry out a diverse range of activities and work related to the health sector, including developing research outputs, monitoring and evaluation, consultancy-based research, project implementation and management, policy briefs, conducting dialogue and workshops on health policy issues, capacity building and training activities, advocacy, community engagement, and evidence generation. Their work was categorized into four broader groups for further analysis, namely: (A) Research and analysis, (B) Policy advice and advocacy, (C) Training and

capacity building, (D) Implementation/project management. Figure 2 shows the type of work carried out by the different institutions.

Table 2: Country Wise Number of Institutions in South Asia (Understudy)

Countries	**No. of institutions**
Pakistan	7
India	17
Nepal	6
Bangladesh	5
Sri Lanka	6
Afghanistan	1
US based (working on India)	1
Total	43

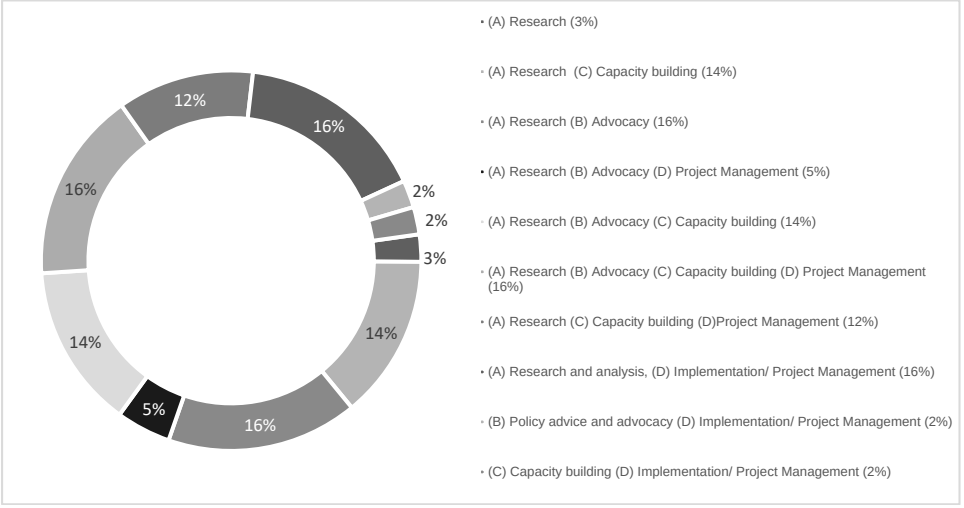
Figure 2: Type of Organizations



According to the analysis, most of the organizations not only produce research, but are also involved in capacity building and advocacy activities. Only 3% of institutions generate research output, while 4% of these organizations do not specifically conduct research, but are involved in capacity building, training, project management, and advocacy-related activities. The remaining institutions are involved in a range of activities, including research, policy advice, and capacity building. The thematic areas of activities conducted by these institutions include (see Figure 4) but are not limited to, tobacco control, tuberculosis (TB), malaria, non-communicable diseases, other communicable diseases (in addition to TB and malaria) maternal and child health, health system strengthening, health financing, aging, and human resources for health. In research, the dominant thematic areas are health system strengthening and maternal and child health, followed by population,

nutrition, and health financing. Regarding advocacy, health promotion and health systems strengthening (HSS) are dominant areas. Capacity building activities are being conducted mainly in the areas of population and HSS, while most of the projects being implemented are related to maternal and child health.

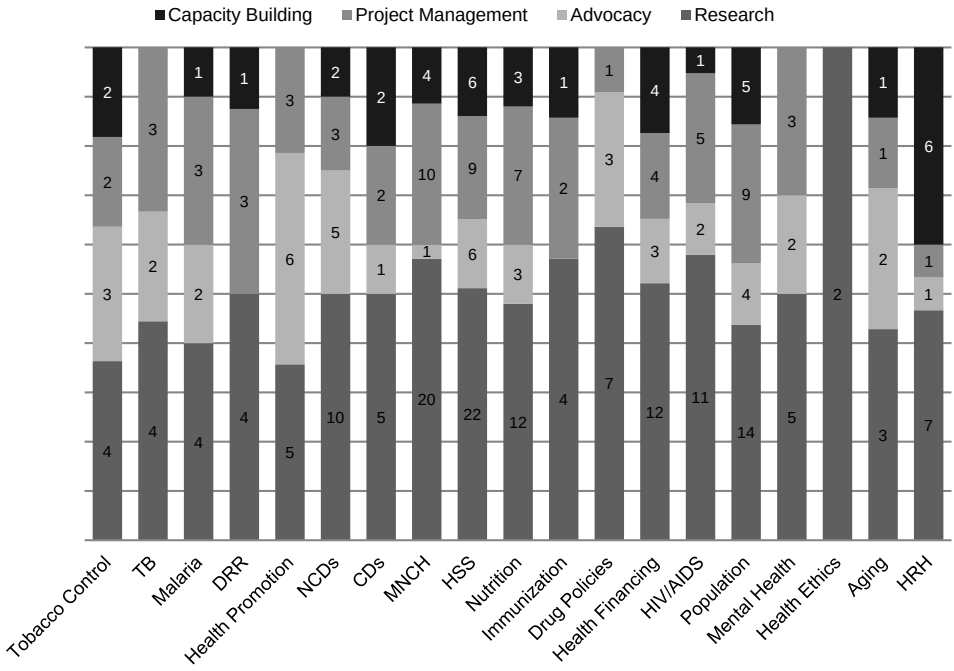
Figure 3: Type of Work Done by Health Policy Research Institutes



To get an idea of the quality of work carried out by health policy institutions, the 'Global Go-To Think Tank Index Report 2016[36] was also reviewed. Of the 55 top domestic health policy think tanks listed in the report, six were from South Asia, and they all featured in the bottom 26. Of these six, five were from India and one was from Sri Lanka. The rankings for the top 35 global health policy think tanks featured only two South Asian institutions, from India and Sri Lanka, ranked 25th and 27th, respectively. This implies that think tanks in other countries, like Pakistan, Nepal, Bhutan, Afghanistan, and Bangladesh need to either enhance the quality of their work or improve their communications strategy, as the real reason for their absence from the rankings can only be determined from further investigation. These organizations may form a network to raise their collective voice or start exchange programs to be heard across borders.

To analyze the structure, governance, funding, and other aspects of these policy institutions, further investigation is required, possibly involving case studies from selected institutions. Case studies would be useful in providing an insight into the working model and strategies used for influencing the policy arena in individual countries, as the relationship between government and policymakers can vary, depending on local political, social, and administrative practices. The case studies would also facilitate a further examination of national, regional, and global collaborations, highlighting types of networks and partnerships, as well as the impact on research and policy advice. Some examples include the Think Tank Initiative, the Southern Voice network, the South Asia Economic Summit, the Health Economic Evaluation Network, and the Alliance for Health Policy and Systems Research.

Figure 4: Number of Health Policy Research Institutions by Area of Work



THE POTENTIAL ROLE OF POLICY RESEARCH INSTITUTIONS

The role of health policy institutions (based on a literature review and analysis of institutions' websites) suggests that these organizations can play a critical role in generating research and policy advice, providing advocacy on health-related issues, holding governments accountable over SDG progress, and giving a voice to poor and vulnerable groups in society. This is achieved through advocacy and research - an example of which is the Indian Institute of Dalit Studies (IIDS) focusing on marginalized groups. Organizations also support and facilitate service delivery, monitor SDG implementation, evaluate health programs and initiatives, and enhance coordination and partnerships within the regional and at the global level to ensure healthy lives and promote well-being for all.

One important issue emerging from the analysis so far is that very few health policy institutions (like SDPI Pakistan and the Observe Research Foundation in India) are working on health-related data. Data is of vital importance to achieving the SDGs, and it is essential that standardized, timely, quality, and disaggregated data is available for planning, monitoring, and implementation purposes. Health policy institutions in South Asia need to strengthen this aspect of their output.

There is a potential role for health policy research institutions to provide evidence for policymaking. Investing in operational research is another area where health policy research institutions can play a role by applying innovative techniques and technologies. Regional collaboration is also important, as it enables organizations to learn from one

another and share experiences and best practices, especially as health is a cross-cutting issue.

Policy research institutions can also play a collaborative role with government by providing direct and indirect support through knowledge sharing and policy advice, and by highlighting the positive effects of public decisions on the health sector in terms of service delivery and coverage.

Pakistan's Sustainable Development Policy Institute (SDPI), in collaboration with Canada's International Development Research Centre (IDRC), hosted the first South Asian Regional Consultation on Health Policy Research Institutions in the Pakistani capital, Islamabad, on December 5, 2016. Around 50 participants from 27 organizations in the region attended the meeting. The participants were keen to move forward on the 2030 Agenda for Sustainable Development. These institutions (SDPI, Pakistan Institute of Development Economics and the Social Policy and Development Centre; Center for Policy Dialogue, Bangladesh Institute of Distance Education and the International Centre for Diarrhoeal Disease Research Bangladesh; Nepal Public Health Foundation; IIDS and the Indian Council for Research on International Economic Relations; Sarvodhya and the Institute of Policy Studies of Sri Lanka; and others – a complete list can be found in the consultation report) are already contributing toward sustainable development in their respective countries, and will continue their efforts. These institutions represent a reference point from which to progress plans for greater coordination and collaboration at the national, regional, and global levels.

CHALLENGES BEING FACED BY POLICY RESEARCH INSTITUTIONS

It is also important to note that there are some critical factors behind the success of policy research institutions, such as innovative ideas, academic thinking, support for the institutions, and institutional credibility. Government support for policy institutions is also an important factor.

Policy research institutions[38] face a range of challenges, including security, law and order (particularly in conflict-affected countries and areas), lack of data availability (open data access is limited and disaggregated data is not available), donor dependency, and a lack of good governance. Because of financial constraints and donor dependency, it can sometimes be difficult to conduct independent research[39] - this issue is being faced by almost all the policy research institutions that were present at the regional consultation.

HOW CAN THE NETWORK OF POLICY RESEARCH INSTITUTIONS SUPPORT THE SDGS PROCESS?

There is growing recognition that public health problems can only be solved by applying research findings to policy and practice, which is a role that policy institutions can fulfill through providing research and analysis on priority and emerging issues.

One important issue that emerged from discussions during the first South Asian Regional Consultation on Health Policy Research Institutions was the need to conduct multi-sectoral and multidisciplinary research and data collection for the SDGs. This not only requires resources and expertise, but it also involves collaboration and coordination among different stakeholders at the national, regional, and global levels for compiling the required capacities and conducting multi-disciplinary research. The main outcome of the regional consultation was an agreement on the need to establish a regional network of think tanks and academic institutions to achieve the goal of healthy lives and well-being for all.

A collaborative network of policy research institutions is not only important for the implementation of the SDGs, but also vital given the current state of the health sector (as discussed above) in South Asia. The realization of SDGs also depends on financial resources,

course correction as per monitoring of activities, and strong commitment from government, among others. But to identify the problem and suggest the solution is only half of the work that can be done by these policy research institutions. This network/forum can be helpful in not only conducting the research, but also identifying the root causes of poor health status that may underlie the lack of ineffective policies or poor governance/implementation mechanisms. It may be something else, but the exercise itself would facilitate the sharing of common experiences along similar themes.

One of the practical measures a policy research institutions network could take would be to conduct a survey among policy institutions about the challenges they face, what their strengths are (that they can then bring to bear on these challenges), and where they need additional resources. In this regard, SDPI Pakistan is leading a study on policy research institutions in South Asian countries in the context of their role in accelerating the growth on SDGs with the support of IDRC, which will be available by the end of this year.

If such a network were to be established, it could support the process of accelerating the implementation and monitoring of the SDGs at the national, regional, and global levels. Besides, it may be connected to preexisting networks (if any) that support SDGs work at national, subnational, or regional levels from different aspects. Following the consultation and a review of the limited literature, there are a few key areas where a network could support institutions in achieving the desired goals; namely enhancing coordination and collaboration at the national, regional, and global levels, increasing opportunities for capacity building, standardizing data and research, institutional development, and improving the quality of research.

For this reason, emphasis needs to be placed on institutional development, accountability, quality research, evidence generation, relevant and up-to-date training, and the involvement of policy research institutions at different levels and forums in formulating policy for the attainment of the SDGs. Innovation, knowledge sharing, monitoring and evaluation, narrowing the gap between the North and the South, and enabling more partnerships are among the chief areas where a network of policy research institutions can provide support.[40]

If engaged and utilized to their full potential, policy research institutions have much to contribute to the attainment of the SDGs. But it is necessary to steer those efforts in the right direction and support them in improving the quality, coordination, and institutionalization of research and evidence generation.

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Health SDGs and Europe: The role of regional think tanks

Oriana Ramirez-Rubio and Gonzalo Fanjul[1]

The Sustainable Development Goals (SDGs) are a new opportunity to propel Europe's role in the fulfillment of global health aspirations, such as ending preventable diseases and achieving universal health coverage (UHC). However, they also represent an international responsibility for Europe to address its own health challenges and inequalities, which are considerable in areas such as noncommunicable diseases and mental health and in health risk factors such as obesity and environmental changes. In the atomized and somewhat messy agenda of the SDGs, think tanks and academic institutions can underpin this process by informing the design of national plans, encouraging implementation and making institutions accountable for their commitments. This paper briefly reviews the work of European policy research institutions (both formal policy-oriented think tanks and assimilated centers within academic institutions) in this field and suggests some avenues for their enhanced involvement in the SDG debate.

THE RELEVANCE OF SDGS FOR THE REGION AND THE RESPONSE OF INSTITUTIONAL ACTORS

In the distribution of obligations defined by the Millennium Development Goals (MDGs, 2000–2015), the group of most developed regions was confined to the role of donor and policy 'stimulator'. The SDGs take a different perspective. On the one hand, the 2030 Agenda is far more comprehensive and takes an integrated approach to the different targets. On the other hand, it extends the responsibility of the core commitments to developed regions that were distanced from the previous agenda beyond their role as donors, and which will now be evaluated on the basis of both the social advances in their particular context and their contribution to the common goals.

The role of European countries[2] in the health-related objectives is an illustrative example of this new approach. This sector has a central place in the 2030 Agenda through SDG 3 ("Ensure healthy lives and promote well-being for all at all ages"), which includes the unfinished work of the MDGs (women, children, and infectious diseases in the context of extreme poverty). But it is also dependent on at least 13 other targets that cover a wide spectrum of global health issues, including core health concerns for the European region such as noncommunicable diseases, urban health, equitable access, and sustainability.

The combined list of issues contained in the different goals and targets provides a challenging landscape for the region. In the last century, Europe has made major advancements in most health targets, especially those already covered by the MDGs. When it comes to SDG 3, most European countries have comfortably exceeded the existing targets for maternal and infant mortality, as well as for the incidence of infectious and waterborne diseases (although preparedness and emergency response for emerging diseases and outbreaks, such as Zika and Ebola, continues to be a priority for the region).[3]

Despite this success, a closer look indicates considerable room for improvement in at least three key areas: noncommunicable diseases (cardiovascular pathologies, diabetes, cancer, and chronic respiratory diseases); mental health, including substance abuse and outcomes such as suicide; and health risk factors, such as child overweight and obesity (implicitly related to SDGs 2 and 3), tobacco use, and environmental health (SDG 11). Using a combination of existing sources, the table below provides a snapshot of Europe's starting point in the SDG challenge.[4] A more limited reference could even be made to infectious diseases: while the bulk of this agenda is still focused on poor countries' concerns, it could

be argued that the increasingly relevant antimicrobial resistance is a universal cause for concern.

Beyond the ranking of individual goals, two cross-cutting elements stand out as highly relevant for the European case. The first is the role of inequity as an obstacle to the right to health (referred to in SDG 3 and implicitly covered in SDG 10). In all European Union (EU) countries, poor people and vulnerable communities tend to report a higher percentage of unmet needs for medical care than wealthier people, due to either financial, geographical, or administrative reasons. Several countries, hard hit by the economic crisis, have cut their health spending since 2009 (Greece, Croatia, and Italy, among others).

On average, over 75% of health spending is publicly financed across EU countries, but in some countries, out-of-pocket expenses represent a much higher share than in others.[5] Dealing with the challenge of achieving truly universal access to healthcare will require a profound reconsideration of redistribution policies, as well as a much more disaggregated information system, as this paper will explain later.

The second element to be considered is related to the interactive nature of the different SDGs. As pointed out by Nilsson et al (2016), "implicit in the SDG logic is that the goals depend on each other – but no one has specified exactly how."[6] The health sector is no stranger to this logic. Health impact assessments and the "Health in All Policies" approach, for instance, are becoming a useful tool for informing policies in other sectors – such as urban development and planning – upon which depend critical health determinants like air and noise pollution, the lack of green spaces, and sedentary behaviors (SDG 11).[7]

Box 1. Who is monitoring the SDGs data in the European region?

National statistical systems are responsible for monitoring the goals and targets included in each of the national SDG implementation plans. These, in turn, report to the United Nations Statistical Commission, which provides the most up-to-date, aggregated status of the whole process.

Overall, this process is proving to be slow and cumbersome, making it difficult to compare countries with each other. As a result, various international initiatives (covering Europe as well as other regions) are gaining traction as reliable sources of data for the health sector:

- The Sustainable Development Solutions Network (SDSN) report:[12] This report contains a prototype of a single Global SDG Index, with SDG Dashboards based on the three traffic light colors – red, yellow, and green – at the country level. It is limited to the 149 of the 193 UN member countries with adequate data coverage.

- WHO's *Monitoring Health for the SDGs*:[13] The *World Health Statistics* series is WHO's annual compilation of health statistics for its 194 member states. *World Health Statistics 2016* focuses on the proposed health and health-related SDGs and associated targets.

- The Global Burden of Disease Study:[14] Funded by the World Bank and the Bill and Melinda Gates Foundation, and based at the Institute of Health Metrics and Evaluation (University of Washington), the Global Burden of Disease Study (GBD) is the most comprehensive worldwide observational epidemiological study to date. Drawing on the GBD, the report provides a measurement of 33 of the 47 health-related SDG indicators and introduces an overall health-related SDG index for 188 countries, from 1990 to 2015.

Other illustrative examples include the impact of intellectual property rules on access to medicines[8] and the conflict between migration policies and the right of all individuals to health.[9] The latter, in particular, has been part of the public debate for years in many European countries, and gained increased attention during the recent economic and migrant crises.[10] In Spain, for instance, an April 2012 decision by the national government to exclude irregular migrants from the full coverage of public health was followed by a public outcry and the decision of a number of regional governments not to implement the norm in their own regions.[11]

The following table provides a snapshot of the classifications contained in the different indexes:

Table 1. Health-related SDG indicators in European countries

Country	Health-related SDG index (GBD) 0–100*	Non-MDG index (GBD) 0–100*	Health SDG index (Sachs) 0–100**	Life expectancy for both sexes (WHO), years	Healthy life expectancy at birth (WHO), years
Iceland	85	79	78.41	82.7	72.7
Sweden	85	80	84.53	82.4	72
Andorra	83	77			
Finland	82	76	87.11	81.1	71
Netherlands	82	76	91.64	81.9	72.2
Spain	82	74	88.84	82.8	72.4
UK	82	78	84.72	81.2	71.4
Ireland	81	75	84.96	81.4	71.5
Luxembourg	81	75	85.94	82	71.8
Norway	81	74	89.04	81.8	72
Germany	80	73	87.27	81	71.3
Malta	80	74		81.7	71.7
Belgium	79	73	86.52	81.1	71.1
Cyprus	79	73	82.5	80.5	71.3
Denmark	79	73	86.82	80.6	71.2
Italy	78	70	84.26	82.7	72.8
Portugal	78	70	83.87	81.1	71.4
Switzerland	78	72	98.05	83.4	73.1
France	77	70	84.81	82.4	72.6
Greece	76	68	85.23	81	71.9
Slovenia	76	68	87.19	80.8	71.1
Austria	74	66	86.41	81.5	72
Czech Republic	74	66	88.96	78.8	69.4
Estonia	74	68	81	77.6	68.9
Hungary	73	66	79.08	75.9	67.4
Slovakia	73	66	81.76	76.7	68.1

Poland	72	66	79.35	77.5	68.7
Croatia	70	64	84.65	78	69.4
Latvia	69	63	77.27	74.6	67.1
Lithuania	68	62	80.07	73.6	66
Albania	67	65	72.06	77.8	68.8
Montenegro	67	61	75.61	76.1	67.9
Macedonia	66	62	77.49		
Serbia	65	60	75.04	75.6	67.7
Bulgaria	64	57	74.93	74.5	66.4
Bosnia and Herzegovina	63	57	72.8	77.4	68.6
Romania	63	58	73.09	75	66.8
Moldova	62	58	70.44		

** According to its authors, the overall health-related SDG index "is a function of the 33 health-related SDG indicators (referred to as the health-related SDG index)." They also point out that two related indexes were constructed: "one reflecting the SDG health-related indicators previously included in the MDG monitoring framework (referred to as the MDG index) and one reflecting SDG health-related indicators not included in the MDGs (referred to as the non-MDG index)."*[15,16]

*** According to the source, this index was elaborated by "selecting the arithmetic mean to aggregate within each SDG. Every variable within an SDG is given equal weight. This implies that the relative weight of an indicator in a particular goal is inversely proportional to the number of indicators available for that goal." The relevant SDG in this particular case is #3.* [17]

HOW ARE EUROPEAN GOVERNMENTS RESPONDING TO THE SDG CHALLENGE?

By February 2017, only a handful of European countries (Estonia, Finland, France, Georgia, Germany, Montenegro, Norway, Switzerland, and Turkey) had voluntarily reported their progress towards the SDGs or the adoption and articulation of the 2030 Agenda in their policies and social dialogue. Eleven more countries (Belarus, Belgium, Cyprus, the Czech Republic, Denmark, Italy, Luxembourg, Monaco, Portugal, Slovenia, and Sweden) are planning to report in 2017, and Ireland in 2018.[18] Others, like Spain, have yet to announce a date.

The reality of the European case is that most of the region is well advanced in the objectives related to social development, as can be expected from mature welfare states, but two important caveats remain. First, health-related rights are not written in stone. The response to the economic and financial crisis has resulted in policy regression in the form of co-payments, the exclusion of patients, and weaker social protection.[19] Second, the fulfilment of important health-related targets will require nothing short of a complete reversal in some of Europe's existing policies, in areas such as income redistribution, the protection of marginalized populations, waste management, and the protection of biodiversity and marine environments.[20] These are the SDGs where red warnings are concentrated for European countries in SDG Dashboards for OECD countries.[21]

National and regional civil society has started to engage in consultation processes and unilateral initiatives intended to underpin the SDG policy momentum. SDG Watch Europe, for instance, is "a new, EU-level, cross-sectorial civil society organization (CSO) alliance of non-governmental organizations (NGOs) from development, environment, social, human right, and other sectors. Its goal is to hold governments to account for the

implementation of the 2030 Agenda for Sustainable Development."[22] Many other national platforms are also involved in an array of participatory initiatives.

The role of the EU and its common institutions deserves a separate mention. In November 2016, the European Commission (EC) published a communication on "next steps for a sustainable European future."[23] In this document, the EC declares it is fully committed to being a front-runner in the implementation of the 2030 Agenda and the SDGs, together with its member-states, and it reports on the steps it will take to incorporate the 2030 Agenda in the economic, social, and environmental dimensions of its sustainable development policies, as well as governance within the EU and globally. When it comes to health, the EU aims to complement action by member-states with an ambitious plan in the form of legislation and programs focused on public health, health systems, and environmental health issues.

How much of this is mere rhetoric remains to be seen. Despite the ambitious communication described above, health, in itself, does not feature among the ten declared priorities of the EC in the current president's term, either on an internal or an external front.[24]

THE ROLE OF THINK TANKS AND ACADEMIC INSTITUTIONS

European think tanks and academic institutions have already played an important part in the design of the SDGs, providing leverage for their launch and technical assistance for their policy and statistical development. They are now being called upon to continue this commitment through an active role in the implementation phase, where their monitoring and evaluation capacity may prove critical for the complex policy challenges ahead.

Table 2 provides a sample of some of the most important institutions currently involved in this debate. Most were active in the participatory processes that took place in their own countries, but some are also engaged in broader networks that share knowledge and activities. This is the case with the Network of Global Health Policy Think Tanks[25] and the SDSN mentioned above, consisting of national and sub-regional chapters that, among others, cover health-related SDGs.

Table 2. SDGs and European global health think tanks[26,27,28]

Think tank	**Actions regarding SDG 3 and beyond**
Global Health Centre, the Graduate Institute, Geneva, Switzerland	Measuring and monitoring implementation of the SDGs (indicators, data quality, role of big data) Member of the UN Partnerships for SDGs platform Member of the SDG Hub at the Maison de la paix
Overseas Development Institute (ODI), UK	Policy analysis, advocacy, progress monitoring

	Member of the SDG Action Campaign
Barcelona Institute for Global Health (ISGlobal), Spain	Research projects on main SDG health and related targets Creating evidence-based tools (for example, urban health impact assessment tool) Policy analysis and advocacy National and global networking
Global Health Lab, International Centre for Evidence in Disability (ICED), London School of Hygiene & Tropical Medicine, UK	Creating evidence-based tools Policy analysis
Institute of Tropical Medicine, Antwerp, Belgium	Participated in regional debates
Centre on Global Health Security, Chatham House, UK	Policy analysis (engaging leading thinkers in a process of dialogue, research, and analysis on the future of global health governance) Mapping of main stakeholders
SDSN in Germany, Italy, Spain, and Turkey, as well as networks in northern Europe and the Mediterranean region	Various activities related to sustainable development, teaching, and education, and applied research. This work is carried out in collaboration with a number of national private and public institutions.
WEMOS, The Netherlands.	Global Networking Advocacy
Institute for International Cooperation and Development Studies (UPV/EHU), Spain	Teaching, research, and education activities. Implementation of International Cooperation Projects in Latin America's countries.
Medicus Mundi Network International	Global Networking. Analysis and Debate of Global Health

While the aim of this paper is not to provide an analysis of these institutions' work, the following are some of the main areas covered in seminars, papers, and communication materials:

- The challenge of interdependency in SDG implementation, which confronts research organizations as much as governments, with the limits of clustered knowledge generation and implementation.
- How do we complete and integrate the inherited agenda? From the unfinished business of the diseases of the poor to the implementation of climate change agreements within the SDG framework.
- The governance of global health in the context of a new road map that reorders previous commitments and brings additional stakeholders to the table.
- The challenge of a multi-level agenda where local and national targets will have to coexist with a global commitment to health public goods.
- The challenge of data generation, both in terms of existing gaps and homogenization difficulties.
- The historic target of universal health coverage (UHC), both as a means and an end in the SDG agenda.
- The question of what equity means when it comes to global health, and what we need in order to address equity in policies, programs, and finances.
- Abundant sectoral material regarding the many areas where research organizations are involved, such as specific diseases, analysis of health systems, and aid policies.

In the atomized and somewhat messy agenda of SDG implementation, research institutions can play a critical role in helping to ease the process and provide the knowledge and external accountability that will help public and private actors walk the talk. The next two sections focus on this added value and provide some ideas to take it forward.

WHAT ROLE CAN THINK TANKS AND POLICY-ORIENTED ACADEMIC INSTITUTIONS PLAY IN ACCELERATING THE IMPLEMENTATION OF HEALTH-RELATED SDGS?

One thing that is clear when it comes to the formidable challenge of implementing the SDGs is that we will need as many hands and capacities as possible. The public, private, and non-profit sectors do indeed play a distinct and complementary role in defining the plans, in their implementation, and in their subsequent evaluation and adjustment. In this context, there is a particularly relevant role for think tanks and policy-oriented centers within academic institutions,[29] which are uniquely placed to address the global and multidisciplinary nature of the targets involved. This is even more the case if they are able to join forces through creative and efficient implementation networks.

The following are five key areas where think tanks could play a role in the correct implementation of the health-related SDGs:

1. Engaging in debates around the definition of national plans and indicators

The practical complexity of the 2030 Agenda is best reflected in the definition of national strategies and the specific indicators derived from them – a process that is proving burdensome in many cases. As we explain above, at the time of writing, almost a year and a half after the SDGs were formally launched, only nine European countries had formally presented their specific plans, and even these were incomplete in terms of priorities, indicators, budgets, and calendars.

Think tank experts and academics can be very helpful in this regard. The German government, for instance, has turned its National Sustainable Development Strategy into the strategic framework for the implementation of SDGs. This strategy is complemented by a periodic report from the Federal Statistical Office, which serves as a progress report. As the German government acknowledges in its formal submission, frequent consultation (five public dialogues) with a group of actors, including academic and policy analysts, has been a determining factor in the success of the process.[30]

2. Data gathering, qualification, and reporting

A fundamental component of the previous element is the definition of the data required to monitor and evaluate the implementation of the SDGs. Even for sophisticated statistical systems, such as those in European countries, the breadth and complexity of the new agenda will inevitably create a number of needs in terms of defining new indicators, data gaps, the organization and management of information, and reporting mechanisms. As the World Health Organization (WHO) put it in its commentary on the implementation of SDGs in the European region, "The SDG era will intensify the need for strengthened national and subnational systems for integrated monitoring, including of health programs and performance."[31]

In this regard, it is worth acknowledging the role that the SDSN is playing in order to "accelerate joint learning and help to overcome the compartmentalization of technical and policy work" in the implementation of the SDGs. This network has engaged in the production of shadow reports that inform and stimulate the official statistical work. The starting point was worrisome: as of June 2014, the complete World Bank Western Europe, Eastern Europe, and Central Asia regions had a percentage of indicators data coverage of between 39% and 48%, and an average reporting frequency of 1.8 to 2.5 years.[32]

3. Monitoring, evaluation, and adjustment of commitments

Once national and regional SDG plans are in place, there is a critical need to guarantee a proper implementation of their contents by monitoring and evaluating them, not least because of the possible adjustments they will require. Through their existing analytic platforms or through the creation of new coordinated tools, think tanks and academic institutions are obliged to inform the process and provide it with the necessary accountability. This is a role that must be played out before the whole of society, but which can prove particularly useful in terms of parliamentary control and reporting to independent supranational institutions.

The Overseas Development Institute, a UK-based think tank, has contributed to this effort by creating the SDG Targets Tracker database, which covers 11 goals, including SDGs 2, 3, 6 and 7, which are directly related to health, in 75 countries, including 12 European nations.

The Deliver2030.org website also offers an interesting example of the role that think tanks can play in monitoring the commitment of public institutions. Coordinated by the British think tank Overseas Development Institute, this hub of information concerning progress in the implementation of the SDGs offers news, updated data, commentary, and other useful resources per country.

4. Providing a local, national, and international perspective, as well as an interdisciplinary approach

A distinctive added value of some think tanks and universities working on global health lies in their comprehensive view, both in terms of geography and in their interdisciplinary approach.

For those institutions involved in issues such as noncommunicable diseases, innovation and access to medicines, health inequities, the impact of global warming on health, and global health governance, the possibility of establishing limited clusters to their analysis is simply a non-starter. Leading institutions in each of these areas are part of extended networks that cover the local, national, and international layers of these debates, both within the European region and with other geographical areas of the world.

Take the example of urban planning, environment, and health, one of the key areas of research at the Barcelona Institute for Global Health (ISGlobal). Spurred on by the idea that "cities can be leaders in tackling problems such as high air pollution and noise, heat island effects, lack of green space, and sedentary behavior", a team of medical researchers, urban policy experts, and communicators is working together to inform and influence the decisions of a range of municipalities, the Spanish government, and the European institutions in order to extract the most out of the opportunity offered by the SDGs (2 and 11, even more than 3). If ISGlobal were to restrict its field of action to the policies of a single player, such as the central state, then not only would its knowledge and experience be wasted, but its effectiveness in achieving some of the objectives set out in Agenda 2030 would also be seriously undermined.[33]

5. Public pedagogy and dissemination, including best and worst practice

A final area where think tanks can play an important role is in the explanation and dissemination of information about the SDGs. Despite the official fanfare, the current global development agenda remains a mystery for many people, including many in the academic community and in the very official institutions that will be responsible for its implementation. The challenge, therefore, is internal as much as external. On the one hand, the scientific and policy communities must embrace the opportunities offered by the SDG agenda, not least through the important public and private financing sources that have been opened up in this area.[34] On the other hand, however, they should also be aware of their responsibilities in

terms of the successful implementation of the SDGs, as we have explained throughout this paper.

Externally, think tanks and academic institutions can be instrumental in providing public opinion and decision-makers with an accessible explanation of the 2030 Agenda and the risks and opportunities it presents. Some of the most fundamental debates driving public and political discussions in the European region – from the impact of austerity on health policies to the cost of hepatitis C treatment and the role of Europe in the world – can be framed within an agenda that is intended to spur governments into action.

There is no shortage of initiatives in this regard. The last few years have seen a range of national and international events focused on the design and implementation of health-related SDGs. The Overseas Development Institute, the Global Health Centre in Geneva, and various others have been particularly active in engaging scientific and policy actors in this debate and informing the policy community and the relevant institutions. The SDSN has launched the SDG Academy,[35] which facilitates understanding of the different goals and the process towards their achievement.

WHAT OBSTACLES NEED TO BE OVERCOME TO UNLEASH THE POTENTIAL OF THINK TANKS' CONTRIBUTIONS?

There is no shortage of technical, political, or organizational difficulties when it comes to the implementation of SDGs and the role that think tanks can play. We have grouped these challenges into four key areas, which are certainly not exclusive to the European region, but which could present certain particularities.

The first is related to the breadth and interdisciplinary nature of the health agenda. As it has already been pointed out, the relevance of the SDGs for global health goes far beyond Goal 3, and could easily be identified across the complete agenda, both in terms of final and intermediary objectives. Some are explicit – such as nutrition and obesity (Goals 2 and 3), air quality (Goal 11) and new models of pharmaceutical innovation (Goal 9) – but it would be difficult to argue that some of the more instrumental goals (Goal 10 on inequality and Goal 17 on partnerships, for example) are alien to any effective and long-lasting global health agenda.

Just as importantly, however, none of these objectives can be worked out in isolation from the others. As we have already mentioned, there is a diversity of interactions, both positive and negative, within the goals, which makes it impossible to work in clusters and reinforces the "indivisible whole" approach. Very few global health institutions in Europe (and elsewhere, for that matter) provide this kind of comprehensive view, a gap that can only be filled through intensive coordination.

The second obstacle is geographical diversity. European think tanks and academic institutions working on the SDGs will have to resolve the complexities derived from a truly global agenda. The institutional, political, financial, technological, and natural differences of the global health debate in the diverse regions of the world make it very difficult to find a common approach.

Take the example of UHC, which is arguably one of the main added values of the new development road map. While protection against financial risk or catastrophic spending seem easy to understand everywhere, the WHO's definition of UHC includes widely debated components, such as "access to quality essential health-care services." The implications of such an agenda in terms of defining specific national objectives (the construction of basic schemes in Africa versus the threat of austerity to public health

systems in Western Europe, for instance) pose considerable challenges for think tanks working in this area.

Thirdly, we have already referred to data and information gaps. The lack of reliable data to define, monitor, and evaluate SDG indicators is already proving to be a challenge. A number of national implementation plans have established statistical improvements as one of their priorities, but this is a complex and burdensome task. Any analyst willing to work on SDGs will certainly be ballasted by this fact.

Finally, research institutions will have to face a disabling political environment. Even though less than two years have passed since the SDGs were formally approved at the UN General Assembly, the political context in which this agenda will have to be implemented has become more hostile and disabling. Aid policies, cooperation, and the leverage of the international community are now at stake, not just in the United States, but also in many other regions of the world. Europe, in particular, faces a perfect storm, where the protracted economic crisis, the influx of refugees, and the resurgence of nationalism threaten the political relevance of the SDGs and the appetite of public and private actors to enforce them. Moreover, European institutions such as the EC lack the necessary leadership to guarantee the kind of coherent, coordinated approach that the 2030 Agenda requires from member states.

Global health think tanks and academic institutions will most likely suffer from these uncertainties, both in terms of an enabling policy environment and the availability of funds related to these priorities.

CONCLUSION

Everything that has been described above suggests that only through a comprehensive and coordinated approach will we be able to overcome the obstacles in the path towards the SDGs and extract the most out of the process. In our view, it is precisely this that the Network can offer. By bringing together the capacities, thematic expertise, and geographical presence of this diverse range of research institutions, this network of think tanks can provide tangible added value in a number of key areas that requires little explanation:

- underpinning knowledge generation and dissemination
- providing spaces for institutional coordination and collaboration
- stimulating policy innovation and experimentation, both in terms of the specific policies, interlinkages, and the institutions best suited for SDG implementation
- signaling and facilitating financing opportunities for individual organizations or, most probably, the resulting consortiums

Important as all of this is, however, it is far from enough. In the context of a "post-truth" society, where scientific arguments and proved facts rarely constitute the basis for public debate, think tanks and universities should consider their responsibility to break through the bubble of experts and high-ranking officials and reach the broader public. In this respect, this coalition of organizations provides a combination of talents that could well serve one or more of the following purposes:

- Establishing complicity with mainstream and social media in informing the public debate: A number of recent initiatives – such as online news and views service 'The Conversation,"[36] and the Global Development[37] and Planeta Futuro[38] websites, originating from the UK's *The Guardian* and Spain's *El País* newspapers

respectively – point the way forward for new forms of scientific dissemination in every corner of the SDG spectrum. Using these channels, and creating new ones as needed, should form part of our contribution.

- Identifying creative ways to pursue this public pedagogy: Seminars and experts' meetings can get us so far. A modern conversation in a flooded information market requires new forms of storytelling and the stimulation of creativity. The Global Festival of Ideas for Sustainable Development –co-organized by a consortium of NGOs, cities, think tanks and multilateral organizations- is an inspiring example in this regard.

- Establishing creative alliances and improbable partnerships: We do this more and more often in our own areas of expertise and with our own stakeholders, but there is much room for improvement if we work together to intensify collaboration with private companies, technological innovators, cities, and all the other actors that can play a critical role in the implementation of the health-related SDGs.

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[1] The authors would like to thank Evangelina Martich for her helpful assistance in the elaboration of this paper.

[2] While the WHO European region includes the Russian Federation and other neighboring countries (Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkey, Turkmenistan and Uzbekistan), we have decided to take only those within the European Union. Additionally, statistics provided by the *SDG Index and Dashboards* use the OECD countries as a subgroup, where most European countries are certainly included. The European Union uses statistics for its member states and associated states.

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What approaches can schools of public health take to engage in global health?
Reflections on the implications of a conceptual synthesis.

Donald C Cole, Suzanne Jackson and Lisa Forman

Schools of Public Health (SPH) have been integral to public health system development at different jurisdictional levels, including global. With different histories, they have adapted to the shifting landscape of globalization, health determinants, research opportunities and public health responses. Informed by literature, web searches and our own experiences, we synthesized four broad approaches to SPH engagement in global health: technical, humanitarian, social justice and entrepreneurial. We describe their nature, common organizational forms, and the research, education and service-practice activities which exemplify each approach. We acknowledge potential heterogeneity within approaches and the difficulties of drawing boundaries between them. For fiscal, operational and historical reasons many SPH often straddle approaches, adopting a portfolio approach to engagement in global health. In the neo-liberal context faced by SPH, pressures to engage through the technical and entrepreneurial approaches may create tensions among members of SPH. Explicitly noting approaches in existing activities and new opportunities, and discussing their implications may inform dialogue as SPH decide on their priorities. We encourage colleagues in SPH globally to share experiences of making decisions on these and other approaches and their consequences for SPH, their faculty, staff, partners and students.

INTRODUCTION

It has been well argued that "schools of public health (SPHs) are ... essential to the nation's health, security, and well-being"[1] given their traditional core missions of conducting basic research in disease etiology, prevention and control, and of training a range of health professionals in public health.[2] High income countries (HIC) established SPH in the 19th century, middle (and later lower income) countries (LMIC) founded SPH in the 20th century, with Brazil's and other LMICs rapid expansion of SPH activities particularly exemplary.[3] At the same time, 'global health' has emerged as a major focus of research and education across a range of cognate academic disciplines in HICs. Yet this trend for SPH to go global' raises significant conceptual and ethical questions and strategic choices, complicated by the often contrasting definitions of 'global health' as a field of research, education and practice.[4] Indeed, the multi-disciplinary and multi-sectoral drivers of the increasingly vast project of global health reproduces divergent conceptions of the actors, subjects, methods and even intended outcomes of global health activities.

Historically, some HIC SPH joined with basic science, clinical, and other departments to play a key role in 'tropical medicine' research in colonized countries, incorporating large scale vaccination and control programs and health care training.[5] This expansion was aided by HIC philanthropic organizations like the Rockefeller Foundation, which established over 25 SPH in the early 20th century as part of its public health mission internationally.[6] With the shift from 'tropical medicine' into 'international' and now 'global' health, other disciplines like international relations, political science, law, engineering, and business have appropriately contributed to both scholarship on determinants and actions affecting the health of populations in LMICs.[7] Against a backdrop of changing geo-politics, international public private partnerships, economic change driven by transnational corporations, globalization, civil society activism, and the projection of higher education institutions internationally,[8] a wider range of university, funder, and public health organizations have joined debates about the meaning of 'global' health,[9] the nature of the

discourse on global health,[10] and what 'should' be done in global health.[11] While our aim here is not to reiterate these debates in detail, we draw on them in our consideration of the role of SPH in global health below.

SPH have led important discussions on "The Changing Landscape of Global Public Health".[12] SPH have been actively involved in LMIC- HIC collaborations,[13] capacity development regionally,[14] and innovations such as global health diplomacy training.[15] Amidst the global ambitions of their own countries and regions, with the competing interests of different social actors who involve themselves in the contested terrain of public health, each SPH has a particular historical trajectory, funding mix and opportunity context which have shaped its choices of national, regional and global health activities.

In our own experience, we have found troubling the lack of clarity among actors involved in our Canadian SPH on the rationale, nature and implications of global health activities. As core faculty members at the University of Toronto's Dalla Lana School of Public Health (DLSPH), with diverse disciplinary backgrounds (medicine, health promotion, and law), we have participated in global health planning, events and streams of research,[16] education and service with our SPH. We have discerned several key approaches SPH take to global health (see Table 1) which partly parallel the ways that SPH approach public health in general and that universities as a whole address global health.[17] In this paper, we reflect on these broad approaches and the implications of emphasizing one or more of them, hoping to encourage discussion among SPH colleagues about the choices SPH face.

Table 1. Four approaches to global health at schools of public health (SPH)

Technical	▪ Emphasis on generation of new knowledge through research. ▪ Applied in surveillance, disease prevention and guideline development, as per collaboration with the World Health Organization. ▪ Education on methods for understanding and responding to substantive public health problems of lower & middle income countries (LMIC).
Humanitarian	▪ Drawing on notions of charity, aims to alleviate suffering and save lives. ▪ Applied in large scale emergencies, disasters, or crises, as per collaboration with the ▪ International Committee of the Red Cross and non-governmental humanitarian organizations. ▪ Education includes certificates and masters' degrees in humanitarian assistance.
Social Justice	▪ Core value linked to critical global health ethics, solidarity and human rights. ▪ Applied in analyses of structural determinants like macro-economic and trade policies and their consequences for health status and care, as per participation in the Peoples' Health Movement. ▪ Education oriented around social justice, human rights and global health ethics courses, certificates and graduate programs.

Entrepreneurial	▪ Stimulates new ventures including sourcing resources and taking risks. ▪ Applied through public-private partnerships, production as well as distribution, market-based mechanisms and integrated innovation (Grand Challenges), often around technology. ▪ Education through multi-disciplinary courses on innovation for health.

APPROACHES

An approach embodies ways of understanding and prioritizing particular activities with implications for how global health is understood, practiced, and taught.[18] To characterize each approach, we drew upon literature, web searches (English, Spanish & French), and our experiences. In addition to those organizations specifically named as SPH, we included foundations, institutes, and faculties which conduct a mix of research, training and service for national (and international) public health purposes, in keeping with the definition used by the Association of Schools of Public Health in the European Region (ASPHER, 2013).[19] We sought examples of SPH partners and engagement in global health, including public health practice, the equivalent of Farmer and colleagues' clinical services for clinical faculties.[20] We paid particular attention to the nature of partnerships[21] and the kinds of education with associated competencies.[22] Here we describe and exemplify key features of each approach, recognizing the diversity within and overlaps across the approaches themselves (see Heterogeneity and Boundaries section below.)

Technical Approach

Historically, the technical approach capitalized on discoveries in microbiology, infectious diseases prevention and epidemic control primarily to support European colonial regimes. A prime example of the technical approach is how over the last 70 years, SPH have collaborated extensively with the World Health Organization to elaborate public health guidelines for infectious and non-infectious disease control.[23] The technical approach underlies one of the top 20 TED Talks by Hans Rosling which shows how all countries are moving towards longer lives and higher incomes on average, largely due to scientific and technological improvements.[24] With the technical approach comes a strong belief that scientific and technical developments are benefiting all countries and, following the current trajectory, that global health problems will be a thing of the past.[25]

Organizationally, the technical approach is mirrored in SPH visions and missions. For example, the Johns Hopkins Bloomberg SPH is "dedicated to the education of a diverse group of research scientists and public health professionals, a process inseparably linked to the discovery and application of new knowledge, and, through these activities, to the improvement of health and prevention of disease and disability *around the world*."[26] With this approach, partnerships are firmly rooted in grants for science and capacity strengthening, becoming a major source of support for research and training in LMIC SPH. Research under the technical approach can include laboratory-based biological research where HIC expertise is focused on issues faced in LMIC, such as descriptive research on the distribution of exposures, specific disease burden and causes of HIV among vulnerable populations.[27] It can also include studies of the impact of technical interventions such as TB control in health facilities.[28]

In education, this approach is exemplified by specialized MPHs and full doctoral programs emphasizing competency in technical skills with application in LMICs. Inclusion of "global health" in HIC programs may involve primarily international placements where

the HIC student uses technical knowledge and skills to address a LMIC health issue like maternal-infant nutrition and diarrhea in an Afro-Colombian and Mestizo population in Colombia.[29] Service can be part of integrated action research projects involving specific interventions, such as preparation for influenza epidemics in South East Asia.[30] Capacity-strengthening in this approach tends to lend the technical scientific and epidemiological expertise of HIC to solving problems in LMIC with the aim of bringing skill levels to HIC standards of competencies. For example, the US Centers for Disease Control advertise for only four types of positions, all adopting a technical approach – epidemiologist, public health advisor, health scientist, and medical officer.[31]

Humanitarian Approach

Historically, humanitarianism was associated with the International Committee of the Red Cross/Red Crescent (ICRC) in its role of intervening impartially during war, extended to large scale emergencies or disasters as 'problems of human suffering' and 'crises of humanity'.[32] In its contemporary manifestation, humanitarianism involves actions designed to alleviate suffering and save lives, drawing from notions of charity, philanthropy and related forms of responsibility.[33]

Organizationally, SPH have collaborated with humanitarian organizations such Médecins Sans Frontières, Dignitas and others. SPH pursue humanitarian research agendas, such as the "*Public Health* in *Humanitarian* Crises Group" at the London School of Hygiene and Tropical Medicine. It is "concerned with tackling the unique public health challenges posed by these crises, through a combination of research and consultancy, teaching, advice to policy-makers and communication."[34] Educationally, Johns Hopkins and the ICRC not only run joint training, but have produced a Public Health Guide Book for responses in emergencies. Responding to both the needs of humanitarian organizations and the interest of students in humanitarian response, Johns Hopkins, Columbia University and other SPH offer both certificates and masters' degrees, emphasizing public health among the core competencies in disaster management and humanitarian assistance.[35]

Many incoming students to graduate programs such as our own (DLSPH) have had initial health service experiences internationally with humanitarian organizations. In their placements, students work with humanitarian organizations,[36] developing materials or evaluating programs. In their doctoral studies, students have participated in humanitarian responses in situations of emergencies and operational research.[37] Special events have been co-sponsored by humanitarian organizations (e.g. Partners in Health forum with Paul Farmer, summer 2014). As such, humanitarian organizations are key stakeholders in the global health landscape, partners in SPH research, training, and public outreach, and employers of SPH graduates.

Social Justice Approach

With historical roots in 19th century social medicine, social justice can be viewed as a core value or foundation of public health.[38] Deeply concerned with growing inequities in social-ecological determinants of health, and their upstream causes in international trade and global politico-economic structures,[39] the approach embraces critical global health ethics and human rights more generally.[40]

Organizationally, some SPH recognize the fractured economic and political history prompting this approach and include it in their name (e.g. St. Louis University College for Public Health and Social Justice).[41] The social justice approach aims to foster more horizontal relationships across country income divides and across academia and social movements - as exemplified by the combination of research and advocacy in the People's Health Movement (*www.phmovement.org/)* which includes SPH members from around

the globe. Such partnerships emphasize co-learning on mechanisms to address the social determination of health.[42]

Similarly research focuses on upstream determinants like Canadian mining operations in LMIC and their impacts on local communities.[43] University of Toronto DLSPH research activities have emphasized promotion of health equity among Canada's northern/indigenous communities,[44] and among populations in the Americas.[45] Faculty have researched and written on the right to health, including reproductive care and access to medicines, as part of the broader use of human rights to advance health globally.[46]

Some SPH orient their entire educational programs around social justice at the masters and PhD levels, emphasizing these aspects of public health competencies.[47] Similar strengths are emerging in human rights approaches including programs,[48] certificates,[49] and a suite of course offerings.[50] Explicit global health ethics training has been a key strength of the DLSPH Joint Centre for Bioethics educational offerings.[51]

Beyond the usual academic service activities, the social justice approach includes actions, such as students running symposia and participating in protests against the cutbacks in funding of health services to refugees in Canada. It links with solidarity, a key value for global health ethics and public health,[52] as exemplified by the hosting of public health scholars forced into exile and SPH support of national programs of international solidarity.[53]

Entrepreneurial Approach

Economists originated notions of entrepreneurship as the process of identifying and starting a new venture, sourcing and organizing the required resources, taking risks and receiving rewards associated with the venture.[54] The entrepreneurial approach has sometimes been a part of technological developments associated with SPH, such as the Connaught laboratory vaccine production facilities, which incubated flu vaccines to meet public health demand globally.[55] More recently, entrepreneurship has been linked with innovation, most markedly in the development of national Grand Challenges programs in the US, Canada, Brazil, Israel, and Peru, amongst others, where combinations of business, technical and social innovations are advocated as solutions to major LMIC health problems.[56]

Examples of the entrepreneurial partnerships with SPH abound, such as the Brazilian Fiocruz SPH engagement in mixed public-private research and development of biologics, and 'Lab-on-a-Chip' development as a point-of-care diagnostic tool in malaria endemic areas with public health laboratories and private companies.[57] At a different scale, agriculture-for-health projects linked SPH work with small farmers to modify production methods and food preparation, improving their nutritional health of themselves and their communities.[58] Application of the entrepreneurial approach can involve partnerships with multiple private, for-profit partners such as the Duke Social Entrepreneurship accelerator.

Some SPH education programs now explicitly foster entrepreneurial goals and competencies. The Yale SPH is part of Innovate Health Yale in order to "encourage[s] public health advances by harnessing the power of entrepreneurship."[59] The Harvard Global Health Institute includes a course on Entrepreneurship and Venture Capital in Healthcare, noting that "biotechnology, medical device, and health care service investments have represented between 25 to 30 percent of all venture capital funding**".**[60] In a joint graduate course at the University of Toronto's DLSPH, "students from multiple disciplines (engineering, management, public health and social sciences) work together – using participatory methods with an international partner – to address a locally relevant challenge.... The final deliverables ... include: a prototype of the end product, a business plan, a policy analysis, and analysis of impact on global health."[61] The entrepreneurial

approach of this course is animated by the fact that a team of its graduates obtained Grand Challenges funding for their idea of a workplace breast-milk preservation system.[62]

HETEROGENEITY & BOUNDARIES

Before proceeding to implications, we pause briefly to consider problems inherent in our approach classification. As is the case for most typologies applied to domains of activity by organizations, our parsimonious set of approaches may inappropriately 1) subsume important heterogeneity or 2) demarcate boundaries where overlap is common.

First, for each broad approach, some colleagues may object that we do not sufficiently appreciate the heterogeneity involved. Diverse cognate approaches are apparent within the approaches: for example, we are aware of the variety of technical work conducted at SPH, some of which may be regarded as more methodological (such as ways of modelling epidemics or estimating burden of illness), while others are more applied (such as public health intervention research on policy changes to shift determinants of health in Brazil).[63] Similarly, small scale social entrepreneurs may be uncomfortable being grouped with entrepreneurs engaged in technology development with large private corporations, given the differential equity focus. For example, small farmer agriculture-nutrition-health development projects are distinct from large scale food security promotion efforts working with a range of biotech companies, processors, and international marketing firms on new fortified crops.

Second, the boundaries between these approaches are not clear-cut. Many would argue that similar values such as benevolence and compassion imbue both humanitarian and social justice approaches. Social or policy entrepreneurs are key players in human rights work to imagine different forms of social organization and global health governance, and may distance themselves from for-profit sector entrepreneurial traditions. Further, any one academic may work with a portfolio of activities, including more methodological, technical work, and more applied humanitarian service or social justice activism, as part of their engaged scholarship.

IMPLICATIONS

As academic organizations, SPH are in no way monolithic. As noted initially[64] , we can expect divergences in how SPH faculty conceive, portray, and practice not only public health but also global health, as manifested at a summit which our SPH co-sponsored, in which content spanned these approaches.[65] As universities promote cross-campus interdisciplinary work, units and members of SPH become more involved with colleagues from other faculties. For example, members of our SPH include those who interact with clinical departments and medical specialty training programs (technical), with international refugee organizations (humanitarian), with the critical development community (social justice), and/or with business and engineering faculties (entrepreneurial). While these interactions potentially offer a rich interdisciplinarity to global health research and practice, the lack of coherence amongst diverse global health related activities can result in tensions between colleagues advocating contrasting approaches.[66] For example, those adopting a primarily social justice approach argue that the technical approach does not sufficiently consider the differential effects that public health interventions may have on existing health inequities,[67] and that the humanitarian approach has become "[c]harity medicine for the global poor".[68] In contrast, those adopting technical approaches argue that social justice approaches such as human rights risk being overly individualistic in ways that subvert population health outcomes and democratic allocations of limited resources.[69] Further, none of the approaches alone can likely come to grips with the massive consequences of global change and the substantial responses needed to fully promote 'planetary health'.[70] To

respond to such global health challenges, some adjustment of the different approaches can come through interactions among faculty, as observed in social justice rooted colleagues persuading those emphasizing entrepreneurship to emphasize social entrepreneurship alongside product development with commercial interests.

Despite limits in our application of concepts of neoliberalism[71] , neoliberal policies will likely continue to impact universities and SPH[72] with continued scarcity of public resources. For substantial investments in SPH, private resources will continue to be sought. The funding pressures may favor technical and entrepreneurial approaches, promote self-censorship among faculty, skew criteria for what is accepted as 'science' and scholarship in promotions, and reduce student exposure to a wider array of approaches. Given the nature of private support and the potential conflicts-of-interest associated with links to the corporate for-profit sector,[73] guidelines for receiving donations and grants may be needed. A group from the Canadian Coalition for Global Health Research has developed a set of questions to ask around global health research funding[74], which might be tailored by and for SPH and their range of activities. Explicitly identifying the diversity of approaches that can be adopted in global health, noting their differences, contextualizing current engagements and new opportunities for research, education and service in the dominant context of neoliberalism and globalization,[75] and discussing their implications, should be helpful for members of SPH when they decide individually and collectively their strategic directions, their chosen activities, and their priorities for investment of SPH resources, from whatever sources.

DIRECTIONS

We recognize that this conceptual piece needs empiric support. This support could include comparative historical work tracing both the continuities and disjunctures in SPH development of their mix of approaches to global health. Comprehensive examination of activities and associated funding among SPH using our conceptual framework would also be helpful, using country, region or continent directories, similar to that on health services research across East African SPH.[76] Associations of SPH may want to develop indicators of the approaches, in order to assess their relative importance in curricula and inform choices on competencies to be emphasized in their global public health educational programs.

In the meantime, when it comes to setting priorities for investment, setting out academic plans and seeking resources, we would urge members of SPH to collectively reflect upon their approaches using our conceptual framework. Such clarification should assist debates on future directions for global health research, education and practice in the public health community globally and foster greater clarity about the potential trade-offs inherent in the choices which SPH and their members make.

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Friend or Foe? Citizen Perception of Foreign and Non-State Actor Participation in the Health Sector in Africa

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The past decade has been characterized by a dramatic scale-up of development assistance for health, which has raised questions about who is responsible for health, how to hold non-state actors accountable for their activities and whether development assistance is producing more harm than good. Little is known about how citizens perceive various actors in global health, including their own leaders. This study examines citizen attitudes towards different global health actors using Afrobarometer surveys from 20 African countries (2008-2009). Results show that although there is variation across countries, citizens mostly view international actors as helping their countries and make few distinctions in terms of their degree of help. The study also finds that individuals who view their governments' handling of the country in a positive light are less likely to view foreign/non-state actors positively. These results suggest that the pessimistic view of many scholars about the low contribution of development assistance to improved health and development outcomes does not seem to be borne out in the average citizens' views of international organizations and non-state actors.

INTRODUCTION

Over the past decade, global attention to health and health system issues in low and middle income countries has increased significantly, including a dramatic scale up of development assistance for health (DAH), most markedly towards HIV/AIDS. Disbursements of DAH reached $31.3 billion in 2013 up from just over $10 billion in 2000.[1] The amount of DAH has remained steady in the face of global austerity brought on by the economic crisis even as foreign aid has declined overall.

The increased attention to health has also brought new players into the development field and new revenue sources including revenue from non-state actors. Although the largest channel of DAH remains US bilateral agencies at 23.7%, non-governmental organizations (NGOs), and the Global Fund provided the second and third largest amounts of DAH at 15.7%, and 12.9% of the total, respectively.[2] In addition to traditional bilateral donors, since 1990, NGO global health expenditure has at times outpaced total development assistance for health and combined NGOs also spend more annually than any one major multilateral agency.

This massive scale-up of funding for global health and the increasing role of foreign and non-state actors in health service provision in low and middle income countries has raised questions about who is responsible for health and about how to hold non-state actors accountable for their activities. The scale-up of global health programs has also raised anew existing post-colonial tensions and fault lines between Western aid and national development programs.

Little is known about how citizens perceive various actors in global health. Qualitative evidence from the continent suggests an uncomfortable ambivalence towards foreign actors, on the one hand crediting these actors with addressing the continent's unmet health needs, but on the other hand, with skepticism towards their motives.[1]

[1] See, for instance, some of the case studies in the special issue of Global Public Health on HIV Scale-Up and the Politics of Global Health: http://www.tandfonline.com/doi/abs/10.1080/17441692.2014.880727#.VNvHGIe-U2w

Furthermore, certain African leaders have tried to reassert their own authority, issuing appeals to nationalism in their responses to domestic health threats.[3] To what extent does the increasing presence of non-state actors in service delivery undermine support for the state? Or, if non-state actors are unpopular or perceived as doing more harm than good, could they bolster support for the state? Do attitudes depend on how personally individuals are affected by aid?

Using data from Round 4, Afrobarometer surveys in 20 African countries (described further in the methods section) collected between 2008-2009, this study examines citizen attitudes towards different global health actors. Round 4 of the Afrobarometer asks questions about how much different international actors (e.g., UN, US, international donors and NGOs, multi-national corporations) as well as domestic non-state actors (e.g., NGOS and civic organizations) help the country and whether they exert too little or too much influence.

The paper proceeds as follows. First, the paper reviews the evolving relationship between Western non-state actors and African states, a history marked by unequal power and situates the global health aid apparatus in this ongoing history. Second, the paper reviews different theories about the motivations behind the provision of development aid. While much empirical research has explored why aid is given by donors, much less research has analyzed how aid is viewed by recipients and how the perceived source/reasons for aid may influence attitudes towards it- both at an elite and citizen level. The paper then poses various hypotheses about how attitudes towards external actors might differ depending on the actor and the relationship between attitudes towards aid and perceptions of the efficacy of the state. The paper then lays out a series of empirical tests to answer these questions.

How citizens perceive non-state actors providing DAH is important to understand for a number of practical as well as academic reasons. First, many non-state actors providing DAH, particularly global NGOs, are believed to be extrinsically motivated by principled values and see their mission in these terms.[4] However, for aid to be effective and beneficial to recipients (the ostensible goal of development assistance), programs must be embraced by the populace and not viewed as a form of neo-colonial domination. Yet, increasingly the non-state provision of aid is being criticized for its lack of sustainability,[5,6] its inability to foster grassroots participation even when it tries,[7] and its undermining of state capacity building.[8,9] In addition to this practical concern, this research also raises a more academic, structuralist concern- that the current aid architecture creates and perpetuates subjects rather than citizens and deprives both African governments and African publics of agency by undermining state capacity and nation building. We analyze attitudes towards different non-state actors from the vantage point of the average citizen across a range of African countries.

A HISTORY OF MISTRUST: THE WESTERN DEVELOPMENT AID APPARATUS AND AFRICAN PUBLICS' PERCEPTIONS OF EXTERNAL ACTORS

Tensions between Western bearers of development assistance and African publics have been visible since independence. In the immediate post-colonial period, developing countries tried to achieve economic independence from the global North through a variety of different development strategies. During the Bretton Woods negotiations in the immediate post-WWII period, independent developing states sought and failed to ensure that development would be assured the same priority as reconstruction.[10] Developing countries argued for the right to protect their infant industries through trade restrictions and other modifications to the free trade regime, which had previously benefited advanced industrial economies as they developed economically. Being denied this right, developing states turned inward and adopted import substitution strategies to promote industrialization and put an end to neo-colonial economic exploitation.[11] Developing states, finally a numerical majority in

multilateral institutions in the post-war period, banded together to create the Group of 77 (G77) as a counterweight to the G-7 industrialized superpowers to represent the economic interests of the global South at UN forums. This movement culminated in the call for a new international economic order (NIEO) in the wake of the economic crises of the 1970s. This movement was ultimately undermined largely by the fragmenting of the developing world between the newly industrializing and emerging economies in East Asia and Latin America and poverty stricken African countries that remained aid dependent. Thus, efforts to build South-South cooperation, though highly popular in the developing world, ultimately faltered and continued dependence on Western aid became ensconced.[2]

With the failure of genuine South-South cooperation, the system of bi-lateral development aid that developed between Western advanced industrial countries and poor African states post WWII served as a useful tool for dividing the loyalties of African leaders and African publics, contributing to ongoing tensions between the Western development apparatus and African publics. With the onset of the Cold War, international development aid became a valuable political instrument to win the loyalty of newly decolonized countries as well as a useful way for colonial powers to retain links with their former colonies. [12] Beyond aid, direct foreign intervention into national politics through the support of (often brutally autocratic) leaders with loyalties to the West, arguably further weakened African trust of Western development partners.

Multi-lateral aid, such as support from international financial institutions (IFIs), the United Nations (UN) and the World Health Organization (WHO), though touted as a means of offering superior a-political, technical assistance, shares a fraught history with Africa, particularly aid delivered through international financial institutions, which since the 1980's have been viewed as vehicles of Western liberal development orthodoxy. [13] The structural adjustment period of the 1970s and 1980s left a particularly sour note in the consciousness of African publics and elites. The IMF's Structural Adjustment Programs (SAPs) required specific institutional changes and public policies (e.g., privatization of public health services and implementation of cost recovery schemes) at a time when African countries were in the midst of a debt crisis. [14, 15] Likewise, the lack of local engagement in large-scale infrastructure programs supported by the World Bank led to criticisms that these projects disenfranchised local populations. [16] In paternalistic fashion, structural adjustment policies put African leaders (purposefully) in a bind- adopt harsh and unpopular policies, or leave money on the table and continue in economic decline- also a losing proposition. Thus, African leaders, some perhaps true believers, others more likely converts, [17] were forced to accept reforms regardless of public opinion. As Sachs (1996) describes:

> *"Since independence, African countries looked to donors—often their former colonial rulers and to the international financial institutions for guidance on growth. Indeed, since the onset of the African debt crisis of the 1980s, the guidance has become a kind of economic receivership, with the policies of many African nations decided in a seemingly endless cycle of meetings with the IMF, the World Bank, donors and creditors... Africa is constantly berated for its poor politics and bad economic ideas, though much of the mischief has come from outside."* [18]

Globalization critics have targeted SAPs charging that they increased rather than decreased poverty and foreign debt. [19] The degree to which African publics blame SAP policies for Africa's poor economic performance and perceive SAP policies as motivated by external

[2] For a good review of this history, see Spero, J.E., Hart, J.A. (1997). The Politics of International Economic Relations. 5th Edition. St. Martins Press: New York, NY

forces or internal policy decisions of leaders remains blurry, though some scholars blame SAP policies for the further the de-legitimatization of the African state. [20]

After decades of criticism, the IFIs have tried to redeem their image, embracing poverty reduction, rather than growth per se, as their ostensible development goal, going more grassroots and local in their lending approach, and at least rhetorically embracing participatory approaches to development. [21] However, it is not clear what irreparable damage may have been done to their reputation or to Western donors more broadly from earlier lending approaches or the credibility of their revised approach.

Multi or trans-national corporations (TNCs) have likewise received criticism for their promotion and exploitation of loose labor standards in countries. Detractors of the globalization of production worry that governments will engage in a "race to the bottom" in economic and social policies in order attract foreign direct investment, leading them to favor the interests of international firms over those of workers. [22] Moreover, reminiscent of dependency theory, are concerns that TNCs repatriate their profits to the "core" countries where the corporations are officially housed. As part of this race to the bottom dynamic, some developing countries have adopted export processing zones that specialize in the manufacture of goods for export where jobs may be labor intensive and poorly remunerated, labor rights are often restricted, and that serve as tax havens restricting the government's ability to tax corporations to provide basic public services. While critiques of TNCs are common, little is known about whether the public in developing countries views transnational businesses as a source of opportunity or a threat.

More recently, the BRICS countries (Brazil, Russia, India and South Africa) have emerged as potential renewed sources of South-South aid and technical assistance. The motivations of these countries are not well studied and the actual amount of aid being given, including for health, likely underestimated. [23] Both India and Brazil have used their economic might to tackle unequal global trade regimes that hinder access to anti-retrovirals and other essential medicines. Brazil issued compulsory licensing and parallel importing to ensure access to essential medicines even in the face of potential sanctions and global opposition. [24] South Africa tried to do the same, though has ultimately relied largely on donated AIDS medications. [25] India is well known as the Pharmacy of the World for its production and export of generic medicines, though more recently has been compelled by the WTO to comply with TRIPs agreements. [26] Exact estimates of aid generally, and health aid more specifically, from these countries to African countries is hard to come by.[23] Gomez refers to this dynamic as the politics of receptivity and resistance- BRIC countries with significant economic might at times strategically engage in partnerships with the donor community while at other times resisting donor advice on AIDS prevention and treatment and join international movements aimed at building a more equitable treatment access trade regime. [27]

Current estimates suggest that China is a leading contributor of aid to Africa and ranks highly among the bilateral health donors to Africa. However, in terms of its health assistance to Africa, China appears to have very different health priorities compared with those of DAC donors – with much more emphasis on health-system projects and much less emphasis on disease-specific programmes.[23] More generally, China has invested more heavily in infrastructure and revenue creation projects compared with Western donors. Although in rhetoric China justifies its intervention in Africa as a counterweight to Western aid bringing economic growth, in reality, China is viewed skeptically by certain African leaders and tensions between African and Chinese emigrant populations in certain countries are mounting. [28] The West, in turn, has been critical of China's willingness to trade with autocratic leaders, largely reflecting China's philosophy on the relationship between economic and political development. [29]

Thus, one could imagine several different ways that African publics might view China and other BRIC countries: 1. In a primarily positive light, as motivated by altruistic

agendas and common cause, given their middle positions in the global economic order (most particularly South Africa, which serves as a self-appointed regional leader); 2. In a negative light (especially for China) in supporting governments that the public themselves do not support; 3. Ambivalently- neither seeing them as a major help nor hindrance.

A second type of multi-lateral assistance includes the aid of global non-governmental organizations and their domestic counterparts, local grassroots organizations. The "associational revolution" of the 1990s made NGOs the "favored child" of the development community promising to elude patronage and corruption and bring increased participation to the development process. [30] A trend driven by the twin poles of neoliberal economics and liberal democratic theory (e.g., Habermas'- the "public sphere"), NGOs have increasingly been viewed as the preferred channel of service provision in developing countries.[30] Transnational non-governmental organizations and activist networks have been credited with successful campaigns that have drawn global attention to domestic problems, including domestic public health threats like HIV/AIDS.[25] Transnational activists have been especially effective in linking domestic causes to international audiences thereby bringing needed support to domestic political causes.[4] The global AIDS treatment action movement serves as a case in point. South African activists, particularly the Treatment Action Campaign (TAC) were able to successfully build a transnational movement through its 'moral legitimacy' and use of 'struggle symbolism', effectively borrowing tactics from AIDS and anti-apartheid activism a decade prior and thereby securing increased access to antiretrovirals both in South Africa and across the African continent.[25]

However, an increasing literature base is pointing to the dark side of civil society, citing NGO's lack of accountability and popular representation, and more broadly for weakening the state by siphoning off resources and capacity building opportunities as well as needed human capital.[30] While transnational activist networks have been successful at using moral suasion to garner attention to neglected health issues, it is increasingly recognized that the priorities identified by international NGOs may not match the priorities of the median African citizen, but rather reflect only a select group of domestic activists-often the most vocal and already well-funded. For instance, TAC succeeded in its appeals for treatment access at least in part through the linkages it sustained between South African and Northern AIDS activists that combined the gay rights cause with AIDS activism, drawing on 'shared human rights based discourse to combat homophobic and AIDS-related discrimination' (pp. 75–76). [25] This approach of forging ties based on a shared gay rights agenda would be unlikely to work in other parts of Africa where gay rights are more contested and even within South Africa, the framing of AIDS as a gay rights issue may be too divisive to give the issue much traction. In fact, across Africa, the framing of AIDS as a "Western, homosexual" disease has provided cover for politicians to sidestep attention to HIV.[33] Movements to address female genital mutilation have similarly elicited culturally relativist responses that place a wedge between priorities deemed important by TANs and African citizens/elites, further instantiating mistrust. When African publics are asked their own priorities, the economy and unemployment are their top concerns. [31] HIV and health more broadly do not figure prominently in the equation, even in heavily AIDS affected countries.' [32]

In addition to a lack of popular representation, unlike governments, which can be held accountable through formal mechanisms (the sovereign state is considered the ultimate duty bearer in international law and in theory is accountable through elections in representative democracies), there are no such formal mechanisms to hold NGOs to account, nor is there any formal obligation on the part of NGOs to continue providing services. Global health projects have been particularly prone to working through non-governmental entities rather than providing general budget support to the state thereby siphoning off capacity building opportunities. An increasing amount of aid in the global

health field is delivered through non-state actors with contributions from organizations such as the Gates Foundation and the Global Fund rivaling aid from bi-lateral donors and multi-lateral organizations providing them with disproportionate influence. Non-state actors such as Gates and the Global Fund are also more likely to provide aid directly to non-governmental actors thereby bypassing interactions with the state. [33]

In response to the subversion of African agency by international actors and economic interests, African leaders have attempted to build pan-African institutions closer to home to support African development. The African Union was formed in May 2001 in order to bring together the numerous sub-regional institutions to pursue continent-wide co-operation and integration and to serve as a conflict mediator and as a platform for African states to participate more effectively in the international market and in international trade negotiations. However, critics of the AU see this institution as a manifestation of the power of three individuals- Olusegun Obasanjo, Thabo Mbeki, and Muammar Ghaddafi- who came together to form the AU to suit their foreign policy interests. [34] Furthermore, as a regional leader, South Africa has a number of significant inconsistencies, which demonstrates contradictions between the country's self-interest and its interest in pan-Africanism. For example, Mbeki's 'quiet diplomacy' on Zimbabwe, his denialist position on HIV/AIDS, and his domestic xenophobia contradict his purported support for an African renaissance. [35] Some of these inconsistencies have undermined the country's international credibility and at times over-shadowed its considerable achievements. Likewise, Nigeria's inability to control domestic terrorism, particularly brought to light in the wake of the kidnapping of hundreds of school girls by the Boko Haram, has raised questions about the power of the country internally and externally.

In sum, in spite of the multiplicity of non-state actors working in Africa (and the relative weakness of African states vis-a-vis these actors), surprisingly little research documents how African publics feel about these external influences. Though there is some evidence that leaders posture to be more appealing to Western development agencies [36] and that donor priorities do not match public priorities,[31] little is known about how citizens perceive various actors in global health.

WHY DO DONORS GIVE AND WHY IT MATTERS FOR CITIZEN ATTITUDES TOWARDS EXTERNAL ACTORS (AND ULTIMATELY AID EFFECTIVENESS)

How African publics view the motivations behind development aid may influence how they view external actors. A considerable amount of scholarly debate in the international relations literature concerns whether countries give bi-lateral aid for altruistic reasons (liberal perspective) or out of self-interest (realist perspective). [37] Although Africa lacks intrinsic strategic significance to the West, traditionally, the realist view on development aid has predominated, especially during the Cold War where the containment of communism served as a realist justification for the allocation of aid to countries lacking inherent strategic imperative. In the post-cold War period, the liberal view that bi-lateral donors provide aid on humanitarian grounds has received renewed credibility given that aid to Africa has continued and in fact increased even though containing the spread of communism is no longer an imperative (although arguably this has been replaced with aid aimed at containing the spread of radical Islam). [38] In addition, the constructivist shift in the international relations literature, with a focus on the transnational activism of multi-lateral NGOs, has brought attention to the power of principled ideas and values as altruistic motives behind development assistance.[4]

Health aid, like aid more broadly, can be framed in both strategic and altruistic terms. On the one hand, as demonstrated acutely with the recent Ebola pandemic, the containment of infectious disease provides a strong strategic incentive to invest in health and development abroad. Similarly, justification for AIDS aid was framed in strategic terms

as a means of preventing regional destabilization and conflict in heavily AIDS affected countries. [39,40] Fears of contagion and destabilization notwithstanding, health assistance has largely been framed in humanitarian terms.

For instance, in terms of bilateral health aid, the President's Emergency Plan for AIDS Relief (PEPFAR), George W. Bush's $15 billion investment in HIV treatment and prevention, was framed as a form of humanitarian assistance. [41] Indeed, PEPFAR was explained by the Bush administration as being grounded in Bush's philosophy of compassionate conservatism and broader attempts to rebrand and humanize the Republican party and appeal to its Christian conservative base.[33] More cynically, PEPFAR can be viewed as a public relations move to draw attention from the highly unpopular wars in Iraq and Afghanistan. Global AIDS activists were critical of certain provisions in PEPFAR that seemed to be based more on Christian conservative values than science- i.e., that 30% of prevention funds were required to go to abstinence-only campaigns and the so-called anti-prostitution pledge, which stipulated that organizations receiving PEPFAR funds could not promote or advocate for "the legalization or practice of prostitution," and requires organizations to adopt a policy "explicitly opposing prostitution and sex trafficking." [42] However, while international NGOs have been critical of these aspects of PEPFAR, these elements may actually be supported and preferred by African publics and African leaders who often share similar Christian conservative values. The Ugandan government, for instance, has been particularly vociferous in promoting and enforcing PEPFAR's abstinence agenda and rejecting the promotion of condom use largely on moralistic grounds. Most controversially, in 2004, the Museveni government issued a nationwide recall of condoms with the brand name Engabu, based on disputed claims that they were of poor quality. [43]

On the other hand, one element of PEPFAR that served to alienate African publics was the stipulation that AIDS drugs needed to be FDA approved, thereby generating a built-in preference for more expensive, US-based, name brand drugs over generic medications. In 2005, in a seeming act of defiance, the governments of Uganda, Nigeria, Ethiopia and Tanzania demanded that any drugs purchased on the part of PEPFAR had to have WHO approval and would not accept FDA approval.[33] An additional critique of PEPFAR has been the fact that much of PEPFAR funding has been channeled through international NGOs (including faith-based organizations) and academic institutions, and little funding has gone to African governments or even to local NGOs in spite of the rhetoric of community participation embedded in PEPFAR grants.[33] Thus, African publics may support some of the moral motivations that have guided PEPFAR funding even while rejecting or questioning the economic motivations behind it. More broadly, given the seemingly self-interested motivation of bilateral aid, it is likely that African publics view bi-lateral aid and international health aid work in a skeptical light.

In contrast with bilateral aid, multi-lateral aid provided through international NGOs is theoretically more genuinely motivated by principled ideas and values since non-state actors, in theory, have moral rather than strategic interests in Africa. To the extent this is true, international NGOs should be viewed more positively by African publics. However, the fact that bilateral aid may be channeled through NGOs as in the case of PEPFAR, and the potential value incongruence between Western NGOs and local African populations may generate skepticism. In addition, international NGOs may be seen as overshadowing or taking the place of local NGOs, and their sustainability, and therefore public trust, may be questionable. While Multilateral international organizations like the UN and WHO should be viewed in a more positive light than bi-laterals (since they represent all nations, in theory), even these organizations may suffer from legitimacy issues. For instance, vaccination campaigns by international organizations may be perceived as a pretense for false flag operations, such as the Hepatitis B vaccination program that was used to capture Osama bin Laden. [44] Similar suspicions about polio vaccination efforts in Northern Nigeria have led to declining vaccination rates and a resurgence of the disease. [45]

Who to Blame for Failed Development Projects: Donors? The State?

Overall, this discussion gives rise to the question of who to blame for failed development projects and specifically who do African publics blame? The disappointingly low return on investment from development assistance in Africa has brought recent scholarly attention to the underlying reasons for these limited gains. In spite of billions of dollars spent annually on development assistance, almost a billion people still live on a dollar a day and millions die annually of preventable illnesses. [7] According to Deaton (2013), the total amount of bilateral development assistance from all developed countries in 2011 was $133.5 billion, which is equivalent to $0.37/day for each poor person (p.272).[7] This does not include the additional set of assistance available through non-governmental sources. In spite of this large deluge of funds, poverty has reduced little.

The exact cause of this failure to launch is contested. In one version of the story, corrupt African governments are to blame and international development assistance exacerbates this dynamic. Donors give to countries and not people. If development funds could be given directly to people in need, this would likely reduce poverty as a form of direct income assistance that would allow for household investment.[7] However, in reality, development assistance gets channeled through governments, leading to a vicious circle of corruption, market distortion, and further poverty. In fact, the aid apparatus often serves to keep corrupt dictatorial regimes in power. Pogge (2005) [46] argues that the international resource payments, borrowing, treaty, and arms privileges that Western powers have extended to repressive rulers are quite advantageous to them, providing them with the money and arms they need to stay in power.

Increasingly, in an effort to bypass corrupt governments donors have begun to develop micro-projects that aim to cut out the middle men. Randomized experiments aim to identify effective programs (as opposed to providing general budget support) that can be effectively scaled up with little government involvement in order to avoid collaborating too closely with repressive regimes. [47] Programs including PEPFAR and the Global Fund have attempted to fund grassroots organizations directly and involve the local NGO sector more in decision making processes.[44, 48] Proponents of microlevel development projects see this as a means of fostering grassroots community participation and as a strategy that will simultaneously ensure better project outcomes, solidify citizen support of donor and non-governmental organization (NGO) initiatives, and reinforce the broader development ideals of good governance, civil society and accountability.[8, 49]

However, in a second variant, it is this very micro-targeting that is to blame for poor development outcomes. Too much "small thinking" loses sight of the ultimate goals of aid, which is to make countries self-sufficient.[9,63] This camp suggests that capacity-building, not program implementation, should be the focus of development assistance and that bypassing government only serves to further undermine state capacity.[9]

Given these conflicting elite views of the purpose of development assistance, the root question addressed in this analysis is therefore, who do African publics blame for underdevelopment? Their governments? International influences? To what extent do African publics endorse pan-African, post-colonial skepticism of international actors versus pro-Western attitudes? How might African attitudes towards external actors affect the efficacy of global aid programs?

Some testable hypotheses from the above observations include the following:

- With more principled and humanitarian motivations, international NGOs should be viewed more positively than bi-lateral donors, or international financial actors. However, grassroots organizations should be viewed as more of help than

international NGOs since their values should align more closely with the people they serve.

- Multi-lateral organizations that represent the African continent (i.e., the African Union and ECOWAS) will be viewed in a primarily positive light by a majority given that they are distinctly regional organizations with the interest of the continent more in mind.
- Among bilateral donors, those representing the global South and regional leaders (e.g., Brazil, China, South Africa, Nigeria) should be viewed more positively than donors from the global North (e.g., US, EU, former colonial powers).
- Due to their fraught history with the continent, international business/finance will be viewed negatively on average.
- Public support for external actors should depend on support for one's own leadership and their response to health threats.
    - If the public perceives their government to be doing a poor job handling development issues at home, support for non-state actors should be higher. Conversely, if a citizen perceives country leadership to be doing a good job, he/she will be more likely to see external actors as exerting too much influence.

METHODS

Data

Using data from Round 4 Afrobarometer surveys in 20 African countries collected between 2008-2009, this study examines citizen attitudes towards different global health actors. Afrobarometer is an African-led, non-partisan research network that conducts public attitude surveys on democracy, governance, economic conditions, and related issues across more than 30 countries in Africa and are repeated on a regular cycle. All Afrobarometer surveys employ multistage cluster sampling to ensure national representation and all interviews are conducted face-to-face. Data from the Afrobarometer surveys are publicly and freely available at the Afrobarometer website: http://www.afrobarometer.org/about.[3]

Round 4 of the Afrobarometer asks questions about how much different international actors (e.g., UN, US, international donors and NGOs, multi-national corporations) as well as domestic non-state actors (e.g., NGOS and civic organizations) help the country and whether they exert too little or too much influence. Round 4 was collected in 20 African countries and N-size and response rates are summarized in **Table 1**. Though there are a total of 5 rounds of Afrobarometer, only Round 4 collects information on citizen attitudes towards donors and other non-state actors. This limits the analysis to cross-sectional associations.

Dependent Variables.

Several questions included in Round 4 are relevant to the present study. *Non-state actors help or hurt country*? First is a set of questions that asks how much various non-state actors help a respondent's country with response options ranging in a likert scale from no help to help a lot. These questions take the general form of the following:

> ***"Question:*** In your opinion, how much do each of the following do to help your country, or haven't you heard enough to say?"

[3] : The author has no affiliation with the Afrobarometer survey.

The question is posed about the following actors: African Union, ECOWAS, International donors/NGOs, International business/finance, US, China, former colonial powers, South Africa, Nigeria, EU.

Influence of non-state actors on countries. A second set of questions asks about how much influence three specific types of non-state actors have on the country (international donors/NGOs, international business/finance and civic organizations and NGOs- presumably domestic). The question is posed as follows:
"Do you think that each of the following has too little, too much, or about the right amount of influence over your government?"
Respondents can choose among the following categories: Far too little, Somewhat too little, About the right amount, Somewhat too much, Far too much, Don't know.

Next, the study uses multivariate analysis to assess whether the attitudes of African publics towards non-state actors vary by their perception of the state. Specifically, if the public feels the state is handling various policy issues well, then they will be more likely to view non-state actors as intervening too much and not being helpful. Conversely, if citizens perceive the state as corrupt, they will be more likely to see non-state actors in a positive way as helping the state and exerting too little influence.

To conduct these multivariate tests, the study combines information from several measures to build a scale capturing perception of state efficacy and perception of state corruption. A battery of questions on the Afrobarometer asks how the government is handling various issues (e.g., alleviating poverty, managing the economy, corruption, health services, education, etc.- see Appendix for full set of questions). These questions are combined and responses divided into quartiles of individuals who believe the government is handling the country very well, somewhat well, not very well and not well at all. Likewise, the survey asks a battery of questions about how many individuals in different offices (e.g., presidency, parliament, tax collectors) are involved in corruption. Combining information from these batteries of questions, a dichotomous variable is derived of individuals that view the state officials as mostly corrupt or not very corrupt. These measures are then correlated with perceptions of non-state actors to assess whether citizen's perceptions of their own government's performance is associated with their attitudes towards non-state actors.

Control Variables

Years of education and interest in public affairs. Citizens that are more highly educated and have an interest in public affairs will be more likely to have strong opinions about international actors than those with less education or that are not interested in public affairs. On the one hand, we expect more educated individuals to be more critical of international actors due to their greater knowledge. However, for certain actors, they may have a more positive view, for instance, towards international business, which they may see as bringing jobs and promoting growth. More educated/aware individuals may also have a more cosmopolitan outlook having traveled more or had more interactions with outsiders and therefore view foreign actors more positively. We control for level of education (coded as none, primary, secondary, tertiary or higher+) and whether someone reported being very interested in public affairs (1 if yes, 0 for other categories).

Urban residence. Residents of urban areas may also be more attuned to politics, or, because of the well-known urban bias [50, 51, 52] in development in Africa, have different political interests than rural residents. It is not clear to what extent the urban bias (the idea that leaders give more public goods to urban residents to quell disaffection in this relatively more powerful group) extends to non-state actors or perhaps whether donors are more likely than governments to privilege rural areas. Nonetheless, we control for urban residence to adjust for this potential bias.

Gender. We also control for whether an individual is male or female. Development projects may be more geared towards helping women, for instance, reproductive health projects, and women may therefore have more direct contact with international development assistance for health. Microcredit and conditional cash transfer schemes have been particularly targeted towards women and questions have been raised over how this targeting of women may emasculate men. [53]

Analysis. This study first examines variations in weighted responses to the dependent variables to determine whether there are any generalizable trends across countries. Next, in multivariate analysis, the study tests whether positive assessments of non-state actors (e.g., that they help rather than hurt and exert the right amount or too little influence) are associated with negative assessments of the performance of the state and perceptions that the state is corrupt adjusting for control variables.

For the multivariate analysis, only five non-state actors were selected for the regression in terms of whether actors help or hurt representing different types of actors (the UN, the AU, China, US and former colonies). For the analysis of the degree of influence of different actors, all three types of actors were included (international donors/NGOs; International business/Finance; Civic Orgs). Each of the outcome measures was recoded as a dichotomous variable and logistic regression models adjusting for clustering at the country level were run. Analysis was conducted in STATA version 12 using the xtlogit command.

RESULTS

Overall, respondents viewed most foreign actors as having helped their respective countries. Majorities or pluralities across countries viewed various actors as helping their country somewhat or a lot (see Table 2). International donors/NGOs, the UN and the US were viewed most positively with 53-54% of respondents viewing these actors as helping their countries. One exception to this overall positive assessment of external actors was Nigeria, which 18% of respondents viewed as not having helped at all and 40% did not know if Nigeria had helped, though in two countries (Benin and Liberia), 67% of respondents viewed Nigeria as helping some or a lot. Substantial proportions reported not knowing how much each actor helped.

In spite of generally widespread assessments that external actors are helpful on the whole, when asked whether certain actors exert too much or too little influence, responses were quite divided (see Table 3). Twenty-four percent of respondents felt that international donors/NGOs either exerted too much or too little influence, and 20% about the right amount. Likewise, for international business/investors 24% believed they had too little influence and 22% too much. Domestic civic organizations and NGOs were slightly more popular, with 26% believing they had too little influence and 20% too much. For each type of actor, the largest category were those individuals who did not know how much influence different actors exert/how much they help suggesting either that respondent's attitudes were not well formed or that they lacked adequate information to make an assessment.

There was a wide variation across country responses, however, which makes generalizing about overarching attitudes towards various non-state actors impossible. This heterogeneity in attitudes towards different external actors suggests that there is no one overarching African experience. A few cases stand out for having particularly high or low assessments of external actors' degree of helpfulness and influence. Lesotho reported very high assessments of the helpfulness of various actors, particularly international donors/NGOs (65% reported they help a lot); however, at the same time, nearly 70% of the public believed they exerted too much influence on the country. Conversely, Liberia and Zimbabwe stand out in that the public in those countries view external actors, particularly international donors/NGOs as being helpful but unlike Lesotho feel that these external actors exert too little influence in their countries.

Results from the multivariate analysis both support and diverge from hypotheses (see **Tables 4 & 5**). On the one hand, as support for government handling of country problems increases (% believe government is handling various issues well/very well), so too does endorsement of the belief that non-state actors exert too much influence. For instance, compared with those who think the government is not handling the country's problems well, those who believe the government is handling problems very well are 60 percent more likely to believe that international donors and NGOs exert too much influence. Similar results apply for international business/finance and domestic civic organizations.

However, contrary to hypothesis, individuals who think that most or all government officials are corrupt are more likely to agree that non-state actors exert too much influence. In other words, in spite of viewing the state as corrupt, individuals believe that non-state actors exert too much influence.

Those who were highly interested in public affairs and more educated individuals were more likely to agree that non-state actors exert too much influence over the country and being male had the same effect. Age was not consistently associated with higher endorsement of the belief that non-state actors have too much influence, nor was living in an urban area.

DISCUSSION AND CONCLUSIONS

Overall the study revealed a wide heterogeneity of attitudes towards different non-state actors, which begs for further deep-dive analysis. The case of Lesotho stands out in particular where a large majority believes that various bi-lateral and multilateral actors help their country a lot, yet at the same time they believe that they exert far too much influence on the country.

Lesotho, though not a PEPFAR country, has received a tremendous amount of donor and technical support for its response to AIDS. It is a small state, with a highly literate populace, and an exceedingly high HIV infection rate, which may have offered its citizens more direct contact with donor projects (and the problems of sustainability and ownership these projects bring) than other larger countries. Qualitative evidence from Lesotho suggests a strong ambivalence towards external donors and particularly the pseudo-participatory mechanisms employed to generate local ownership of these initiatives.[8]

The reverse attitude seems to be the case in Liberia and Zimbabwe where citizens view international donors as very helpful but unlike Lesotho feel that these external actors exert too little influence in their countries. This suggests an unmet demand for more direct non-state intervention in their countries. Notably African institutions and bilateral partners were not necessarily viewed in a more positive light than Western donors/actors (particularly Nigeria, which was fairly uniformly not viewed as helpful except in two closely neighboring countries).

In spite of the heterogeneity across countries, some broad generalizations that can be drawn from the analysis include the fact that, on average, individuals that believe the government is handling his/her country's affairs well are more likely to think that non-state actors exert too much influence. Surprisingly though, the main justification given by non-state actors for bypassing the state - corruption- does not dissuade respondents from believing that non-state actors exert too much influence. Put another way, a belief that the state is corrupt does not translate into African publics supporting more influence of non-state actors.

More educated/informed individuals and males were more likely to view external actors in a negative light. This could be due to the fact that more educated individuals are less likely to have directly benefited from the services of non-state actors and may be more aware of the harried history of intervention from external actors. On the other hand, one might have expected more educated/informed individuals to be more cosmopolitan in their

worldview, or more pro trade openness and therefore more supportive of certain international actors.

What to make of these findings? These results suggest that the pessimistic view of many scholars about the contribution of development assistance to improved health and development outcomes does not seem to be borne out in the average citizens' views of international organizations and non-state actors. Most view these actors as primarily helping their countries, though with a degree of skepticism towards whether they are too involved in national affairs. While citizen views could be inaccurate, there is doubtless helpful value in examining citizen opinions about non-state actors and incoming foreign aid. These views can serve as important markers for these agencies to consider in the design, staffing and operations of programs at the local level. Both from a normative perspective and outcome oriented perspective, the process of incorporating of citizen preferences into development programs has the potential to increase the legitimacy of programs, increase transparency and accountability and make for more successful program buy-in. For instance, researchers have attributed the failure of HIV prevention campaigns to reduce multiple partnerships and risky sexual practices to the inability of foreign donors to foster grassroots movements to change behavior and local norms. [54] By contrast, the success at ending the practice of female circumcision in certain countries in West Africa has been at least partially attributed to the ability of grassroots campaigns to foster of local citizen-led declarations against harmful traditional practices. [55] Advocates of discursive democracy view citizen input as the only legitimate means of formulating and implementing public policy. [56] Others remain skeptical of the necessity or benefit of involving citizens who may not wish always with to be involved in the details of every policy and view citizen participation at times as a guise for increased task shifting onto unpaid volunteer labor.[7]

Clearly, having the support of locals is desirable, but how should global development actors incorporate citizen demands? Is there a cost and downside to being overly responsive to local demands? How can development assistance be channeled in such a way that it will benefit ordinary citizens and contribute to good, and not corrupt, governance practices? These questions cannot be answered with the current data, but are important for development agencies to consider.

Limitations and Further Analysis. This study has several notable limitations that constrain inferences that can be drawn from the data analysis. First, because only Round 4 collects information about citizen attitudes towards non-state actors, we cannot examine how these attitudes have changed over time. The results are best thought of as a snapshot of attitudes at a very particular juncture in the African development aid apparatus. It is important to bear in mind that the period 2008/9 when the survey was fielded was in some respects the pinnacle of health aid to Africa, but at the same time a critical turning point just after the economic crisis when talk of reductions in DAH were at a peak. It was also immediately following the election of Barack Obama as US president and many questions about the fate of PEPFAR as a funding mechanism hung in the balance.

Additional limitations include the fact that questions were at times worded in a double barreled manner, collapsing together all multi and bi lateral donors and NGOs into a single category (i.e., international donors/NGOs). In particular, it is not possible to parse out attitudes towards international NGOs per se from other types of donors, even though there is reason to believe that there should be heterogeneity in attitudes towards different types of international NGOs (i.e., religious vs secular) and towards the motivations of bi-lateral donors versus international NGOs. The NGO world is a large universe in which some organizations operate better than others, and where many organizations work on the back lines and not on the community front lines and thus citizens would not have much direct experience to judge these organizations on. The lack of specificity in the survey questions points to the need for further elaboration in future rounds of the Afrobarometer of the myriad of different actors involved in development assistance and questions that can assess

whether individual respondents have received aid. No question specifically addresses the divisive history of the IFI technical assistance across the continent. Furthermore, although health aid has been a major form of aid in recent years, constituting a large piece of the aid pie, it is not possible to distinguish through these questions attitudes towards health aid from attitudes towards other types of aid. Limiting the analysis to AIDS affected (and PEPFAR vs non-PEPFAR AIDS affected countries) can attempt to capture the effect of health aid specifically, but it is not possible to isolate this effect entirely.

Furthermore, the questions related to perceptions of how government is handling various issues does not necessarily get at deeper attitudes about what roles and responsibilities the public believes is the purview of the state versus non-state actors. It is likely, for instance, that the public may conflate state projects/activities with activities performed by non-state actors. This distinction is difficult to parse out both empirically and conceptually. Finally, the scales derived for questions to capture state efficacy and corruption could be better specified through factor analysis or some other data reduction technique. Nevertheless, the analysis lends some tentative insight into the attitudes of African publics towards non-state actors, which is an angle that has been quite neglected in academic debates about the causes and effects of development assistance. The heterogeneity of attitudes across the continent also suggests that each country has a unique story to tell.

CONCLUSIONS

Though there is a good deal of variation across countries, preliminary results find that across countries, citizens mostly view international actors as helping their countries and make few distinctions among these actors in terms of their degree of help. Citizens are also fairly torn about whether the degree of influence of foreign actors is too little, too much or about the right amount (20-25% in each category). Individuals who believe the state is handling its affairs well are more likely to think that non-state actors exert too much influence on their country. However, viewing the state as corrupt does not translate into more support for non-state actors. A few exceptions to this rule warrant further investigation. These results lend support to the idea of an uncomfortable ambivalence of African publics (and African leaders) towards foreign and non-state actors, on the one hand helping with unmet health needs, and on the other hand intruding on the roles traditionally provided by the state.

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Table 1: Summary, country sample size

	Country	Total	Response Rate
West Africa	Benin	1,200	62.3%
	Burkina Faso	1,200	69.8%
	Cape Verde	1,264	94.2%
	Ghana	1,200	72.9%
	Liberia	1,200	93.7%
	Mali	1,232	83.1%

	Nigeria	2,324	89.9%
	Senegal	1,200	80.8%
East Africa	Kenya	1,104	73.4%
	Tanzania	1,208	85.5%
	Uganda	2,431	86.5%
Southern Africa	Botswana	1,200	72.0%
	Lesotho	1,200	87.0%
	Madagascar	1,350	96.9%
	Malawi	1,200	89.4%
	Mozambique	1,200	72.2%
	Namibia	1,200	74.3%
	South Africa	2,400	59.4%
	Zambia	1,200	74.9%
	Zimbabwe	1,200	75.1%

Table 2: % Reporting External Actor Help some/a lot

		African Union	ECOWAS	UN	International donors/NGOs	International business /investors	Nigeria	South Africa	China	US	Former colonial power	EU
West Africa	Benin	35%	38%	40%	50%	51%	67%	34%	54%	49%	50%	43%
	Burkina Faso	46%	48%	51%	58%	55%	34%	38%	55%	57%	53%	50%
	Cape Verde	25%	30%	48%	45%	41%	13%	18%	70%	72%	67%	60%
	Ghana	41%	43%	52%	52%	44%	27%	26%	46%	61%	54%	0%
	Liberia	48%	71%	80%	66%	48%	67%	38%	69%	78%	NA	66%
	Mali	50%	51%	58%	64%	61%	28%	31%	67%	64%	63%	52%
	Nigeria	38%	44%	46%	42%	41%	NA	26%	38%	46%	41%	39%
	Senegal	26%	29%	31%	45%	42%	11%	13%	52%	40%	43%	32%
East Africa	Kenya	32%	38%	61%	58%	46%	12%	19%	46%	65%	59%	52%
	Tanzania	41%	33%	61%	59%	45%	15%	26%	44%	68%	59%	54%
	Uganda	31%	34%	60%	61%	35%	11%	13%	22%	49%	45%	41%

Southern Africa	Botswana	46%	59%	54%	53%	46%	18%	59%	64%	61%	58%	50%
	Lesotho	57%	71%	65%	76%	68%	27%	77%	68%	66%	53%	45%
	Madagascar	54%	40%	68%	71%	71%	28%	37%	47%	54%	58%	51%
	Malawi	20%	25%	25%	26%	20%	8%	21%	32%	35%	35%	31%
	Mozambique	39%	41%	44%	44%	40%	15%	37%	49%	47%	36%	41%
	Namibia	60%	71%	79%	65%	60%	27%	62%	48%	64%	54%	57%
	South Africa	30%	35%	41%	37%	40%	14%	NA	26%	29%	26%	24%
	Zambia	28%	36%	51%	50%	36%	10%	24%	51%	47%	36%	33%
	Zimbabwe	44%	57%	59%	80%	29%	10%	77%	45%	57%	39%	32%
	Total	**39%**	**43%**	**53%**	**54%**	**45%**	**20%**	**31%**	**47%**	**54%**	**45%**	**41%**

N=27,713; Weighted estimates

Table 3: % Reporting Degree of Influence of External Actors Too Much

		Influence of International donors and NGOs too much	Influence of international businesses and investors too much	Influence of civic organizations and NGOs too much
West Africa	Benin	13%	16%	12%
	Burkina Faso	29%	27%	19%
	Cape Verde	13%	12%	11%
	Ghana	16%	15%	17%
	Liberia	18%	12%	11%
	Mali	40%	38%	32%
	Nigeria	14%	15%	15%
	Senegal	15%	16%	6%
East Africa	Kenya	23%	19%	22%
	Tanzania	27%	23%	19%
	Uganda	28%	25%	20%
Southern Africa	Botswana	16%	15%	17%
	Lesotho	69%	64%	60%
	Madagascar	28%	30%	17%
	Malawi	14%	12%	10%
	Mozambique	38%	36%	33%
	Namibia	30%	32%	31%
	South Africa	18%	20%	20%
	Zambia	28%	25%	17%
	Zimbabwe	14%	10%	12%
	Total	**24%**	**22%**	**20%**

N=27,713; Weighted estimates

Table 4: External actors exert too much influence by how well the country is handling issues

VARIABLES	1 Internat Donors/NGOs, too much influence	2 Internat Bus/Finance, too much influence	3 Civic Orgs, too much influence
Government Handling Country Well/Badly Quartiles			
Not well (ref)	0	0	0
Somewhat well	1.326***	1.393***	1.441***
	-0.0739	-0.0785	-0.0856
Well	1.507***	1.514***	1.592***
	-0.0734	-0.0749	-0.0826
Very well	1.653***	1.637***	1.901***
	-0.0857	-0.0862	-0.103
Corruption (most/all public officials corrupt)	1.313***	1.199***	1.188***
	-0.0518	-0.048	-0.0487
Very interested in public affairs	1.437***	1.537***	1.460***
	-0.0519	-0.0565	-0.0552
Urban	1.048	1.025	1.042
	-0.0404	-0.0402	-0.0418
Education			
None (ref)	0	0	0
Primary	1.422***	1.398***	1.350***
	-0.0664	-0.0668	-0.066
Secondary	1.606***	1.669***	1.436***
	-0.0951	-0.1	-0.088
Tertiary	1.875***	2.019***	1.354***
	-0.159	-0.171	-0.123
Higher	1.999***	1.671***	1.339***
	-0.15	-0.129	-0.107
Age			
18-34 (ref)	0	0	0
35-49	1.112***	1.056	1.003
	-0.0449	-0.0436	-0.0428
50-65	0.987	0.971	1.008
	-0.0566	-0.0565	-0.0596
65+	0.869	0.773***	0.858
	-0.0793	-0.0729	-0.0806
Male	1.150***	1.192***	1.140***
	-0.0408	-0.043	-0.0422
Constant	0.0684***	0.0845***	0.0655***
	-0.00772	-0.0092	-0.00772
Observations	19,680	19,677	19,675

Standard errors in parentheses, *** p<0.01, ** p<0.05, * p<0.1

Table 5: Non-state actors help a lot by how well the country is handling issues

VARIABLES	UN helps a lot	AU helps a lot	China helps a lot	US helps a lot	Former colonies help a lot
Government Handling Country Well/Badly Quartiles					
Not well (ref)	ref	ref	ref	ref	ref
Somewhat well	1.505***	1.402***	1.423***	1.331***	1.369***
	-0.0786	-0.0888	-0.0815	-0.0695	-0.0779
Well	1.715***	1.592***	1.530***	1.528***	1.509***
	-0.0786	-0.0878	-0.0771	-0.0697	-0.0755
Very Well	1.946***	2.372***	1.637***	1.770***	1.889***
	-0.0946	-0.133	-0.0862	-0.0852	-0.0984
Corruption (most/all public officials corrupt)	1.183***	1.008	1.135***	1.251***	1.215***
	-0.0432	-0.0413	-0.0445	-0.0456	-0.0474
Very interested in public affairs	1.335***	1.434***	1.470***	1.454***	1.391***
	-0.0456	-0.0553	-0.0537	-0.0491	-0.0501
Urban	1.168***	1.051	1.132***	1.047	1.004
	-0.0419	-0.043	-0.0438	-0.0375	-0.0388
Education					
None (ref)	ref	ref	ref	ref	ref
Primary	1.917***	1.722***	1.563***	1.713***	1.679***
	-0.0835	-0.0865	-0.0734	-0.0736	-0.0784
Secondary	2.334***	1.867***	1.763***	1.890***	1.882***
	-0.129	-0.119	-0.106	-0.104	-0.113

Table 5: Non-state actors help a lot by how well the country is handling issues continued

VARIABLES	UN helps a lot	AU helps a lot	China helps a lot	US helps a lot	Former colonies help a lot
Tertiary	2.531***	1.821***	1.549***	1.997***	1.881***
	-0.205	-0.168	-0.137	-0.163	-0.167
Higher	2.909***	2.071***	2.029***	2.042***	2.207***
	-0.207	-0.174	-0.163	-0.148	-0.168
Age					
18-34 (ref)	ref	ref	ref	ref	ref
35-49	1.038	0.972	1.001	1.035	1.045
	-0.0396	-0.0428	-0.0417	-0.0395	-0.0431
50-65	1.033	0.961	1.009	1.107*	1.155**
	-0.0553	-0.0588	-0.0577	-0.0583	-0.0645
65+	0.961	0.983	0.822**	0.925	1.106
	-0.08	-0.0907	-0.0724	-0.0755	-0.0941
Male	1.248***	1.238***	1.341***	1.235***	1.188***
	-0.0414	-0.0473	-0.0485	-0.0408	-0.0423
Country (included but not shown)					
Constant	0.0837***	0.0898***	0.166***	0.130***	0.131***
	-0.00851	-0.00986	-0.0158	-0.0123	-0.0128
Observations	19,692	19,663	19,692	19,689	18,633

*** p<0.01, ** p<0.05, * p<0.1

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Is improving global public health compatible with saving the climate? Exploring the discourses of health and climate change

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INTRODUCTION

The climate change discourse holds that burning of fossil fuels leads to climate change. Therefore, emissions must be reduced in order to avoid climate change. Further, it holds that climate change deteriorates global public health. Acting on climate change is thought to prevent negative health outcomes. Parallel to the discourse of climate change, there is an ongoing discourse on global health. We take the moral imperative to provide all humans with appropriate healthcare, food, housing and other key elements to live long and healthy lives, to be the basis of the global health discourse.

In short, we see two discourses: the climate change discourse, arguing that emissions from fossil fuels must be reduced to protect the health of the people and the planet, and the health (national and global) discourse, which advocates for more resources to healthcare or other goods that contribute to better health outcomes.

In this study, we ask if there is a conflict between the climate change and global public health discourses, and whether it is possible that the negative climate effects of healthcare delivery and appropriate living standards have been underplayed in the public debate. To put it bluntly, is improving global public health compatible with saving the climate? Rather than looking for scientific data supporting one view or another, we are interested in studying the discourses.

The impact of climate change on people's health have been well documented. In the foreword of the UN World Commission on Environment and Development (WCED) report from 1987, Gro Harlem Brundtland calls for action against climate change in order to secure "our children's fundamental right to a healthy, life-enhancing environment".[1] The links between environmental stress (i.e. the "plausible and serious probability" of climate change[i]) and disasters disproportionally affecting the poor, such as droughts and floods, air pollution, infectious diseases, hunger and stunting are laid out. More recent reports documenting the negative effects climate change can have on human health include the Lancet Report from 2009[2] and the Fifth Assessment Report the Intergovernmental Panel on Climate Change (IPPC)[3] from 2014.

On an institutional level these findings have also led to new initiatives. In 2009, the American Centers for Disease Control and Prevention (CDC) established a climate and health programme. In 2014, the World Health Organization (WHO) organised its first ever global conference on climate change and health. The conference marked the importance of public health issues in the climate change debate prior to the 21st Conference of the Parties of the UN Framework Convention on Climate Change (UNFCCC), which resulted in the Paris Agreement, the first legally binding global climate agreement since 1992.[4] The agreement does not go into detail regarding specific climate related health impacts, but points to the co-benefits on health of mitigating climate change. "The right to health" is mentioned twice in the 31 pages of the text of the agreement.[5]

Global health issues have gained both increased political attention and funding in the past decades.[6] Today, a magnitude of national, regional, global, public and private organisations and initiatives are involved in improving global public health.

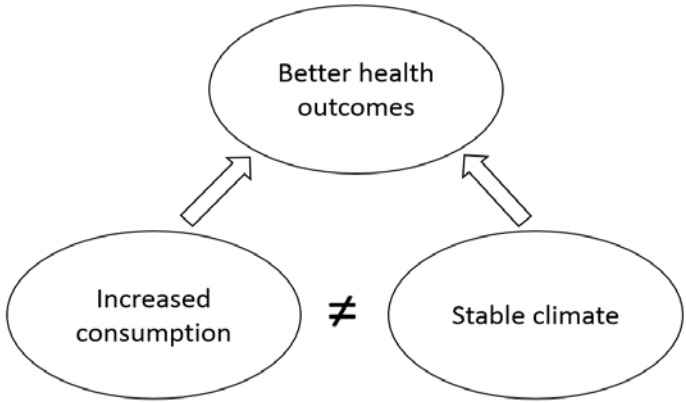
In national and global health discourse it is argued that more resources spent on healthcare is a prerequisite for improved health outcomes.[7][8][9] Improved healthcare at a global level with increased utilisation of medical goods and services will likely cause increased emissions (see Figure). Research shows that 3% and 8-10% of UK's and US's carbon footprint respectively comes from the health sector, mainly stemming from hospitals and the pharmaceutical industry.[10][11][12] If the U.S. healthcare industry was a country, it would

rank 13th in the world for greenhouse gas (GHG) emissions. The largest contributors to emissions by expenditure category were Hospital Care (36%), Physician and Clinical Services (12%), and Prescription Drugs (10%).

As developing countries spend more on healthcare[13] total emissions from the global health sector might increase. Although there is hope in new technologies, it is hard to imagine how the health and life expectancy of those worst off[14] can improve significantly without an increase in consumption of food, housing, transport and other material goods. Evidence suggests that increased CO_2 emissions correlate with increases in life expectancy, population growth and Gross Domestic Product,[15] and that while high life expectancies are compatible with low carbon emissions, high incomes are not.[16] On the other hand, some claim that increased carbon emission is not a prerequisite for economic growth.[17] Experts have proposed solutions to potential problematic relationships between consumption, health and climate, such as sustainable development,[18] innovative engineering and financing mechanisms[19] as well as investment to reduce poverty and health inequality.[20]
Over the past decades, the world's most populous country, China, has lifted 500 million people out of extreme poverty,[21] seen an increase of 8 years in life expectancy at birth (13 in the past four decades),[22] and become the major driver of global carbon emissions.[23] The example from China shows that development or poverty reduction might result in both increased life expectancy and hefty CO_2 emissions.

We are puzzled by the questions of whether and how global public health can be improved without accelerating climate change. When the climate and global health discourse are compared, a rather complex picture emerges: Climate change harm people's health. At the same time, achieving good health for all might cause climate change.

Figure 1: Relationship between consumption, climate and health. Increased consumption and stable climate are both thought to improve health outcomes. Increased consumption is however thought to be incompatible with a stable climate. Model developed by the authors.



In this study we set out to explore if there is a conflict between the current climate change and health discourses. In the methodology section we briefly introduce Foucault's work on discourse as his analysis of discourse serves as a basis for this paper. Our discussion is based on the findings from the analysis of text and interviews.

METHODOLOGY

We understand discourse as "an ensemble of ideas, concepts and categories through which meaning is given to social and physical phenomena, and which is produced and reproduced through an identifiable set of practices".[24] This study is inspired by Foucault's seminal works on discourse.[25] Foucault demonstrated how phenomena that often are portrayed as natural, universal and unchangeable, really are reproductions of social practices that vary. One might say that Foucault is not interested in the deeper meaning or truth of a statement, but rather in how a statement can reproduce or challenge the current discourse. Foucault argues that power is relational, and where there is power there is resistance. Challenging a discourse is likely to pose resistance. Foucault is interested in how one discourse relates to another (interdiscourse), and how elements from one discourse might be imported from another discourse (recontextualisation). When studying a statement in a foucaultian tradition, not only what is said or written holds importance; what is *not* said or written can be just as important.

For those looking for a clear definition of what a discourse is, or a strict method of how to perform a discourse analysis, Foucault offers little help.[26] Foucault gives a perspective rather than a methodology when it comes to understanding and studying discourse. Inspired by some elements of Foucault's extensive work we set out to study what we see as the current discourses of global public health and climate change.

The method of this study is twofold, comprising of a review of government statements and interviews of stakeholders in the public debate on global public health and climate change. Being based in Norway with access primarily to Norwegian stakeholders and government data, this is the material on which we have based this study. Feedback from five informants were obtained. The first informant (hereafter, informant 1) was a politician and member of the standing committee on energy and the environment of the Norwegian Parliament, providing inputs from a climate change policy perspective. The second informant (informant 2) was the head of a Norwegian association for health professionals, providing inputs mostly from a health policy perspective. The third and fourth informant (informant 3, informant 4) were researchers with experience from global health and climate change policy research. The fifth informant was head of a Norwegian environmental organisation (informant 5).

First, we wanted to get an overview of the extent to which global health figures in the climate change discourse, and how climate change figures in the global health discourse. In the review of government statements, we screened speeches and editorials held by government officials and published on the website of the Norwegian government (www.regjerningen.no) between 2014 and 2016 under the topics of "health and social care" and "climate and environment".

Second, we wanted key stakeholders to reflect upon the two discourses and the relationship between them. Informants were selected based on selective sampling and interviews were conducted either face to face or by email correspondence in February 2015. We then studied their responses (transcripts or informants' written responses). We were interested in whether they saw a conflict between the discourses and how the discourses related to each other. In particular, we aimed to explore the recontextualisation of "health" in the climate change discourse. We studied whether our informants reproduced or challenged the discourses, and reflected on what the they did *not* say or write.

FINDINGS

Government statements

Reviewing speeches and editorials on the topic of climate and environment by Norwegian ministers, revealed that out of a total of 118 cases, reference to the health effects as related

to climate change was made 11 cases, 8 of which were held by the Ministry of Climate and Environment officials, and three which were held by Ministry of Foreign Affairs (MFA) officials. Out of the three cases, two were held in English. A similar review of speeches and editorials on the topic of health revealed that four out of 146 cases made reference to climate change impacting health, of which three were held by MFA officials and one was held by the Ministry of Health (MH). All four cases were held in English.

The health and climate references focused on health effects of climate change disproportionately affecting poor people in developing countries. Negative health effects of air pollution were frequently mentioned. Challenges related to health and climate in regard to food production and consumption were included in two speeches and editorials. One speech focused on climate change within the post 2015 agenda and the sustainable development goals. The notion of a conflict between global public health and climate change could not be traced in the speeches.

Interviews

Responses to the idea of a conflict between the discourses

Informants 1, 2, 3 and 5 rejected the notion of a conflict between the discourses and did not find it relevant to discuss climate and health as rivals. They said that health care consumption need not be compromised to mitigate climate change. Informant 2 found it difficult to identify with the idea of a conflict, and said this was due to never having been exposed to the idea. Informant 4 did see a conflict between the discourses.

Informants 1, 2 and 3 believed that fuel-efficient solutions would solve problems of both climate change and adverse health outcomes. Informants 2 and 5 called for a greener production of healthcare services. Informants 1 and 2 listed several adaptations aimed to improve both climate and health, including clean cookstoves and traffic regulations. Informant 3 also argued the need to find solutions that were mutually beneficial for the climate and for global public health.

Informants 1 and 2 did however highlighted the idea of a conflict between food production policy and climate change policy, with the view that organic farming can have a positive impact on health outcome but a negative impact on the climate, while scaled, industrial food production might have a positive impact on the climate but a negative impact on health outcomes. Informant 2 argued that Norwegians cared little about the health effects of climate change, but cared more about their diet and potentially harmful food contents. “People are more concerned with their own health than with the climate”, the informant concluded.

Informant 5 replied that a conflict between health and climate change discourse seemed “constructed”, and pointed to the win wins for both health and the climate from decreased emissions. “The fact that hospitals run on fossil fuel can be solved”, he wrote. We did not receive further feedback from this informant.

Informant 4 identified with the idea of a conflict between the health and the climate change discourses and said that the conflict was not being communicated in the public as it would be “politically uncomfortable and therefore is avoided”. He argued that health is more important than climate change to politicians, since people in general are very occupied with their own health. “People’s actions reveal that they care little about the climate”, the informant said. “The fear of Chinese and Indians all driving cars is present in the debate, however cutting back on health care and standards of living are not, because it is too sensitive”, the informant argued.

When asked to give their view on the link between health, climate change and global demography, informant 1 argued that better health outcomes would result in population decrease, which would hinder climate change and improve health outcomes. He also highlighted the need for Western countries to change to sustainable energy forces and said that "keeping people in poverty is not a solution". The informant did not believe that providing modern health care for all would damage the climate and pointed to the potential of technological innovation to eliminate 80 per cent of emissions globally.

Informant 2 argued that the effects of climate change seem too distant for Norwegians. The informant said that climate change generally is dealt with as something that happens elsewhere and which is not a problem for people's health in Norway.

Interdiscourse and recontextualisation

Informants 2 and 3 stated that there were little or no mutual discourse between the health and climate discourse, and informant 2 highlighted that this communication between the discourses were particularly lacking in the domestic public debate.

Informant 4 said that the health discourse politically is often more powerful than the climate discourse, arguing that "people will always be occupied with their own health". Informants 1, 2, and 3 did not want to give more weight to one discourse than the other. When asked about the importance of health in the climate change discourse 10 years down the line, none of the informants saw health as a key element in the climate change discourse.

Reproduction of the discourses

All of our informants reproduced both the health and the climate discourse in their responses. However, with regard to public health and consumption, informant 3 indicated that "less is sometimes more", and informant 2 pointed to the overuse of medicines, both challenging the call for more resources. Informant 4 challenged the climate change discourse at a local or national level, saying that "it does not matter what we (*i.e. Norway*) do, except perhaps by setting an example". The informant claimed that the policies by populous states will determine the degree of climate change.

DISCUSSION

Interdiscourse and recontextualisation

The review of speeches and editorials indicates that the linkages between global public health and climate change most often figure on the international scene, and is less frequently addressed in the national context. Further, the links are almost exclusively addressed by ministries of climate and environment, and of foreign affairs.

In the speeches negative health effects of air/ particle pollution are referred to relatively frequently. We are not sure why this is, but one explanation might be that polluted air impacts public health relatively directly and quickly ("here and now"), and might be seen as more easily conveyed than the negative effects of global warming. The absence of climate change in the Norwegian domestic discourses of health might be due to the fact that negative health effects of climate change are not a current threat to the health of Norwegians. Our findings suggest that this link is first and foremost treated as part of Norwegian foreign affairs. Informants echoed these findings by indicating that the absence of interlinkages between the climate change discourse and the health discourse is particularly prominent in domestic debates.

Reinforcing and challenging a conflict between the discourses

Informants' reactions to the idea of a conflict varied from total rejection to full embrace. Several observations draw our attention. We are not quite sure how to interpret the reactions to the idea of a conflict. Perhaps they suggest that the thought of the two discourses in relation to each other is foreign to most people, even provocative. The spectrum of reactions is interesting as it might reflect the boundaries of the discourse. Their reactions also meant that discussing the discourse, rather than informants' own opinions, became difficult.

Related challenges

While most informants did not identify with the potential conflict, two informants voiced the issue of conflicting interests within food production, climate change policy and health policy. We believe that the idea of a food production and climate conflict can be seen to embody much of the same dilemma as the idea of a global public health and climate change conflict, namely, how to provide the world's population with food and proper healthcare without harming the climate. Why is it that the idea of food production and climate change conflict appears to be much more acceptable to two of our informants than the idea of a conflict between health and climate change? One answer to this can be that there has been relatively high coverage on dilemmas regarding global food production and health in the Norwegian media and public life, and we also found references to this in the government statements. It could also be that unhealthy food is conceived as a more immediate health threat in Norway, whereas effects of climate change on health seem distant both in time and place.

The unspoken

When negotiating the allocation of resources, competing policy goals are translated into political priorities. Based on the notion that healthcare consumption leads to emissions, and emissions cause climate change, it was interesting that none of the informants raised the issue of prioritisation. The majority of informants (1, 2, 3 and 5) voiced an optimistic future that could accommodate both healthy humans and a healthy planet. In particular, informants 1, 2 and 5 expressed a strong faith in new technology that will replace fossil fuels.

Citing John Balbus at the National Institute of Environmental Health Sciences when speaking to The New York Times in 2012, "Tying things that are good for sustainability to short-term benefits for vulnerable kids with asthma, and children in general, presents a potentially strong policy motivator", and a "potential spoonful of sugar for the bitter medicine of climate change policy".[27] As such, the connection between climate change and health is useful as it helps people reflect on how climate change impacts them directly. However, the idea that health outcomes could also serve as a surrogate for climate change outcomes was not echoed by the informants. None considered the recontextualisation of health into the climate change discourse as significant.

Given most informants rejected the idea of a conflict between the discourses it was difficult to discuss the discourses rather than opinions. For instance, we asked the informants to link the discourses to agendas, and to outline the main determinants for good health and climate change prevention. Both proved difficult. One explanation could be that

four out of five did not find the idea of a conflict interesting or relevant. Another could be that the questions should have been posed differently. Wearing Foucault's glasses, a third explanation could be that we might be touching upon a regime of power, which embodies certain rules of exclusion, of what it is possible to talk about and what is not.

LIMITATIONS

There are several limitations to this study. First, the study had a limited number of informants and the analysis would have benefited from richer data had more informants been interviewed. Second, only a certain type of Norwegian official documents was assessed systematically, and written communication from other stakeholders were not included in the assessment. Future studies could increase the number of informants and statement sources to explore this topic further. Third, there is little empirical research conducted to support our findings. This calls for more empirical studies to test the relationship between healthcare and climate change. By basing our findings on informants based in Norway exclusively, we might have framed rather local versions of global discourses.

"Everything is connected to everything", Brundtland famously said.[28] This study has aimed to explore how the climate change discourse and the global public health discourse are connected, or perhaps disconnected. Our findings suggest that the discourses are just partly interlinked and by and large live separate lives.

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