The era of global health: The policies, the actors, and the dynamics

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Issue topic

What does global health mean for health care?

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Introduction to the topic

The era of global health: The policies, the actors, and the dynamics

The last time that Politique africaine published an issue dedicated to health was in December 1987.[1] This special report aims to fill that thirty-plus-year gap, acknowledging the considerable changes that have recently come about in public health in Africa. There has been a profound transformation in the configuration of health policies in Africa in the three decades since the previous special report on the topic, and it is this shift that provides the empirical basis for the present special report. The five articles within this volume reveal the ruptures caused by the globalization of health policies, each taking one specific issue as its starting point: universal health coverage through digital technology; performance-based financing (PBF); the fight against diabetes; universal access to antiretroviral treatment; and the supply of antimalarial drugs. In this introduction and throughout this special report, we scrutinize the development of global health,[2] its stops and starts, its logics and contradictions. We will begin this introduction with a historical examination of the changes that have accompanied these developments, and we will then highlight three important factors that will allow us to analyze them: the ideologies behind global health; the dynamics of what has been described as the "return of the state in Africa" in the early twenty-first century; and the markets that exist alongside these new policies.

1. Didier Fassin and Émile Le Bris, eds., "Politiques de santé," Politique africaine 28 (1987).
2. In the original French version of this text, as well as in the title of this special report, we retained the English expression "global health" to reflect the fundamentally anglophone influence of this new era of public health that has emerged on a global scale since the turn of the millennium.

The shift toward global health in the early 2000s

One central issue has been at the root of the series of developments that have taken place in the field of health since the late 1990s: the AIDS pandemic. The shock of the epidemic and the human cost of the disease in sub-Saharan Africa led to an international response, with a major turning point in the early 2000s.[3] The creation in 2002 of the Global Fund to Fight AIDS, Tuberculosis and Malaria (hereinafter the Global Fund) in response to calls made by the secretary-general of the United Nations, Kofi Annan, was symbolic of this change. This new transnational actor in the field of international public health is generally held up as one of the principal embodiments of our passing into the era of global health.[4] Global health is indeed closely associated with the emergence of new institutions and new actors, including philanthropic foundations such as the Bill & Melinda Gates Foundation, and new types of interventions led by public-private partnerships.[5] Another important element of these changes is the considerable growth in the resources provided. Between 2002 and 2018, the Global Fund invested $27 billion in the fight against AIDS, malaria, and tuberculosis,[6] and the Gates Foundation has a bigger annual budget than the World Health Organization (WHO).[7] Beyond financial matters, and in collaboration with the actors involved, one key factor in global health is the definition of new health policy priorities. "Global Health can be understood as the outcome of the permanent and reciprocal influence between international relations and health problems."[8]

3. Fred Eboko, Repenser l'action publique en Afrique: du sida à l'analyse de la globalisation des politiques publiques (Paris: Karthala, 2015); Vinh-Kim Nguyen, "La santé mondiale et l'éradication du sida," in Penser global: Internationalisation et globalisation des sciences humaines et sociales, ed. Michel Wieviorka, Laurent Lévi-Strauss, and Gwenaëlle Lieppe (Paris: Éditions de la Maison des sciences de l'homme, 2014), 211–17.

4. Stéphanie Tchiombiano, "Public Health, Private Approach: The Global Fund and the Involvement of Private Actors in Global Health," Face à face: Regards sur la santé 15 (2019), https://journals.openedition.org/faceaface/1418, accessed March 3, 2020.

5. Auriane Guilbaud, Business partners: Firmes privées et gouvernance mondiale de la santé (Paris: Presses de Sciences Po, 2015).

6. "Results & Impact," The Global Fund, https://www.theglobalfund.org/en/impact/, accessed March 3, 2000.

7. $5 billion, compared with $4.4 billion for WHO in the 2016–17 financial year. See WHO, Budget Programme 2016-2017 (Geneva, World Health Organization, 2015); and Léa Lejeune, "La Fondation Bill & Melinda Gates, une puissante machine humanitaire," Challenges, June 26, 2015, https://www.challenges.fr/challenges-soir/la-fondation-bill-melinda-gates-une-puissante-machine-humanitaire_77808, accessed March 3, 2020. While WHO of course also has an influence on the drafting of technical standards and recommendations, this financial statistic is nonetheless remarkable.

8. Celia Almeida, Fred Eboko, and Jean-Paul Moatti, "Global Health: What Are We Talking About?," Face à face: Regards sur la santé 12 (2013), http://faceaface.revues.org/936, accessed March 3, 2020.

Public health actors define global health in relation to what they consider to be relatively new epidemiological data. The executive committee of the Consortium of Universities for Global Health explains that "the rapid increase in speed of travel and communication, as well as the economic interdependency of all nations, has led to a new level and speed of global interconnectedness or globalization, which is a force in shaping the health of populations around the world."[9] This new era simultaneously represents a continuation of and a break from the notion of "international health," which developed as part of the post-1945 world order alongside the newly created World Health Organization and was intended as a means of dealing with health matters at a supranational or multilateral level. The shift that took place at the start of the 2000s involved more than just supervision upstream of the decision-making process; it ushered in a global approach to dealing with health matters. Global health transcends national borders and links people and other living species together beyond states, continents, or regions, making particular health problems supposedly central for the whole world, in the name of security imperatives and humanitarian values.[10]

In the quest to make sense of these new realities, the number of social science publications on the topic of global health has grown exponentially.[11] The analyses that the social sciences have provided on health issues in Africa have become increasingly politicized since the 1980s, especially in francophone academia. It was anthropology that blazed the trail. In his introduction to the 1987 issue of Politique africaine, Didier Fassin opened up the field of health to political questions: "Health is also, and primarily, a daily political matter for all those involved, whether as patients, therapists, or decision makers."[12] Thus, in the 1990s, political science followed the path set out by

9. Jeffrey P. Koplan et al., "Towards a Common Definition of Global Health," The Lancet 373, no. 9679 (2009): 1994.

10. Guillaume Lachenal, "The Dubai Stage of Public Health: Global Health in Africa Between Past and Future," Revue Tiers Monde 215, no. 3 (2013): 53–71.

11. See, among many others, Laëtitia Atlani-Duault and Laurent Vidal, eds., "La santé globale, nouveau laboratoire de l'aide internationale?," Revue Tiers Monde 215, no. 3 (2013); Almeida, Eboko, and Moatti, "Global Health"; Paul Farmer et al., Reimagining Global Health: An Introduction (Berkeley: University of California Press, 2013); Juan Garay, Laura Harris, and Julia Walsh, "Global Health: Evolution of the Definition, Use and Misuse of the Term," Face à face: Regards sur la santé 12 (2013), http://faceaface.revues.org/936, accessed March 3, 2020; João Biehl and Adriana Petryna, eds., When People Come First: Critical Studies in Global Health (Princeton: Princeton University Press, 2013); Joshua K. Leon, The Rise of Global Health: The Evolution of Effective Collective Action (New York: State University of New York, 2015); Benjamin Mason Meier and Lawrence O. Gostin, eds., Human Rights in Global Health: Rights-Based Governance for a Globalizing World (Oxford: Oxford University Press, 2018).

12. Didier Fassin, "Avant-propos," Politique africaine 28 (1987): 4. Translator's note: Unless otherwise stated, all translations of cited foreign-language material in this article are our own.

anthropology, concentrating initially on issues around AIDS.[13] Adopting an understanding that differed from that offered by public health, mentioned above, these researchers tended to treat global health as an "arena" in which various actors intervene according to specific logics and objectives, where questions of power and economic concerns are of particular importance.[14]

Indeed, a number of actors and financial mechanisms that were "partly free of the boundaries and authority of governments"[15] appeared, including the Global Fund and the Bill & Melinda Gates Foundation, as already mentioned. Other examples include Gavi, the Vaccine Alliance, created in 2000, and Unitaid, a Franco-Brazilian initiative set up in 2006.[16] These new actors joined older established bodies, including nongovernmental organizations (NGOs) and bilateral and multilateral institutions, some of which expanded their activity from the start of the 2000s. These included the World Bank[17] and American cooperation programs such as the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI). In the face of budgetary and institutional difficulties in the 1990s, WHO repositioned itself as a strategic planner of global health initiatives, coordinating several partnerships between different types of actors. Gro Harlem Brundtland, director-general of WHO from 1998 to 2003, was the chief

13. See, in particular, Jean-Pierre Dozon and Didier Fassin, "Raison épidémiologique et raisons d'État: Les enjeux socio-politiques du SIDA en Afrique," Sciences sociales et santé 7, no. 1 (1989): 21–36; Jean-Pierre Dozon and Didier Fassin, eds., Critique de la santé publique: Une approche anthropologique (Paris: Balland, 2001); Marc-Eric Gruénais et al., "Le sida en Afrique: un objet politique?," Bulletin de l'Apad 17 (1999), https://journals.openedition.org/apad/476, accessed March 3, 2020; Claude Raynaut, "Comment évaluer les politiques de lutte contre le sida en Afrique?," in Jean-François Baré, ed., L'évaluation des politiques de développement: Approches pluridisciplinaires (Paris: L'Harmattan, 2001), 317–54 ; Fred Eboko, "Politique publique et sida en Afrique: De l'anthropologie à la science politique," Cahiers d'études africaines 178 (2005): 351–87.

14. Almeida, Eboko, and Moatti, "Global Health"; Biehl and Petryna, When People Come First; Vinh-Kim Nguyen, "Anthropology and Global Health," in The Ashgate Research Companion to the Globalization of Health, ed. Ted Schrecker (Farnham, Surrey: Ashgate, 2012), 79–96; Didier Fassin, "That Obscure Object of Global Health," in Medical Anthropology at the Intersections: Histories, Activisms, and Futures, ed. Marcia C. Inhorn and Emily A. Wentzell (Durham, NC: Duke University Press, 2012), 95–115.

15. Pierre Lascoumes and Patrick Le Galès, "Introduction: L'action publique saisie par ses instruments," in Gouverner par les instruments, ed. Pierre Lascoumes and Patrick Le Galès (Paris: Presses de Sciences Po, 2005), 22.

16. Dominique Kerouedan and Joseph Brunet-Jailly, eds., Santé mondiale: Enjeu stratégique, jeux diplomatiques (Paris: Presses de Sciences Po, 2016); Fred Eboko, "La lutte internationale contre le sida, chantier d'une gouvernance mondiale de la santé publique," Questions internationales 43 (2010): 76–78.

17. Theodore M. Brown, Marcos Cueto, and Elizabeth Fee, "The World Health Organization and the Transition from 'International' to 'Global' Public Health," American Journal of Public Health 96, no. 1 (2006): 62–72.

architect of the organization's transition.[18] The questions raised by these new dynamics are of especially acute importance in Africa because of the economic fragility of most of its countries and the resulting power of transnational actors.[19] The logics of these actors, the ideologies driving them, and the relationships they maintain between one another and with the national actors in the African countries where they are active have now become subjects of research in the social sciences.

Our goal here is not to call into question the progress that has been made on various health issues. The establishment of the Global Fund undoubtedly led to a series of breakthroughs in the treatment and prevention of HIV/AIDS, and subsequently tuberculosis and malaria.[20] The Global Fund is estimated to have saved 22 million lives, around 70 percent of them in Africa, where AIDS-related mortality is reported to have fallen by 30 percent by the tenth anniversary of the Fund's existence.[21] The prevalence of the disease fell in twenty-two sub-Saharan African countries from 2000 to 2010, and there has been a significant increase in the number of people on antiretroviral treatment (ART). Significant progress has also been observed in the mortality figures for malaria, although these seem to have plateaued since 2015.[22] In the era of global health, the new global governance of health has undoubtedly had positive effects in Africa. However, our task is to analyze the reconfiguration of this world of public health since the start of the 2000s and to highlight, beyond the advances in health care itself, the political and ideological issues generated by this reconfiguration, as well as

18. Ibid.; Marcos Cueto, "A Return to the Magic Bullet? Malaria and Global Health in the Twenty-First Century," in Biehl and Petryna, When People Come First, 30–53; Eboko, Repenser l'action publique.

19. Eboko, Repenser l'action publique. For the sake of convenience, we use the expression "transnational actors" in this text to encompass the various different types of extra-national actors currently involved in public health in Africa, including bilateral institutions (various cooperation services), multinational institutions, such as the World Bank and the Global Fund, NGOs, foundations, and public-private partnerships.

20. Kerouedan and Brunet-Jailly, Santé mondiale; Fred Eboko, "Background and Evolution of an International Solidarity Instrument," Face à face: Regards sur la santé 15 (2019), https://journals.openedition.org/faceaface/1438, accessed March 3, 2020.

21. "Results & Impact," The Global Fund, https://www.theglobalfund.org/en/impact/, accessed March 3, 2020.

22. World Health Organization, World Malaria Report 2019 (Geneva: World Health Organization, 2019).

the contradictions that have arisen and the limits of these health policies,[23] while recognizing the role of other key players such as states and "epistemic communities."[24] We will develop these themes using three elements of analysis. Starting with the field of global health as it has developed since the early 2000s, this introduction will look at health policies targeting infectious and communicable diseases. But this is a fast-moving field, so, beyond these initial themes, our attention will turn—albeit in a variable way—to other health issues and arrangements, such as universal health coverage (UHC), currently a much-highlighted topic.[25] Thus, the three elements of analysis that we propose below appear to us to be relevant (beyond the issue of communicable infections)[26] in examining the various health policies that are currently being pursued by actors in the field of global health.

Global health, its ideology and its tools: Vertical programs, technical solutions, and new public management

The undeniable progress that has been made in combating diseases, with the support of the Global Fund, has given rise to rich, if contradictory, debate. Criticisms have generally highlighted the fact that "vertical" programs—those targeted at a particular disease or service, which generally have their own mode of governance and specific infrastructure and are "vertically funded, managed, delivered and monitored"[27]—have penal-

23. This special report thus marks a continuation of the studies that have been carried out on development projects in Africa for nearly three decades (on their harmful effects, misuse, failures, etc.). See Jean-Pierre Olivier de Sardan, Anthropologie et développement: Essai en socio-anthropologie du changement social (Paris: Karthala, 1995), and, more recently, Tom De Herdt and Jean-Pierre Olivier de Sardan, eds., Real Governance and Practical Norms in Sub-Saharan Africa: The Game of the Rules (London: Routledge, 2015); and Dominique Darbon, "Des administrations africaines paradoxales: entre pratiques locales plurales et régimes d'aide incertains," Quaderni 87 (2015): 37–50.

24. In the strict sense according to Peter M. Haas: a community of experts who convert their knowledge into public policy. See Peter M. Haas, "Introduction: Epistemic Communities and International Policy Coordination," International Organization 46, no. 1 (1992): 1–35.

25. See Jean-Pierre Olivier de Sardan and Valéry Ridde, eds., Une politique publique de santé et ses contradictions: La gratuité des soins au Burkina Faso, au Mali et au Niger (Paris: Karthala, 2014); Céline Deville, Fabienne Fecher, and Marc Poncelet, "L'Assurance pour le renforcement du capital humain (ARCH) au Bénin: processus d'élaboration et défis de mise en œuvre," Revue française des affaires sociales 1 (2018): 107–23.

26. At the time of writing this introduction, the coronavirus crisis has highlighted the fact (if it were necessary) that global health has by no means dealt with the issue of epidemics and communicable diseases.

27. Rifat A. Atun, Sara Bennett, and Antonio Duran, When Do Vertical (Stand-Alone) Programmes Have a Place in Health Systems? (Copenhagen: WHO/European Observatory on Health Systems and Policies, 2008).

ized so-called "integrated" policies, according to which funding, organization, and management are "integrated" into the health system as a whole. These criticisms highlight how vertical programs have upset the balance of healthcare systems.[28] These disagreements between experts have given rise to various works on the topic and, ultimately, to a WHO working group on the impact of global health initiatives (GHIs) at the turn of the millennium. This group, which includes researchers from both the Global North and the Global South, framed a counterargument around the contention that:

> The disease-specific investments by GHIs have produced fortuitous or planned benefits for the general strengthening of systems.[29]

The article by Jessica Martini, Annick Tijou Traoré, and Céline Mahieu reveals the severity of some of the criticisms regarding noncommunicable diseases, which are not the highest priorities for global health. The example of diabetes in Mali shows community organizations taking care of patients, but without being able to free up and accelerate the political response to the disease. In analyzing the configuration of the actors involved, the apparently isolated work of the various associations and health professionals serves to highlight the comparative strength of the programs established under the global health approach, which involve transnational actors and significant funding, and which have so far focused on a number of infectious and communicable diseases. Several examples illustrate the marginalization that this has caused for diseases whose response does not lie in a large-scale transnational initiative, despite the available knowledge and the pharmaceutical and therapeutic innovations that have been made. This has particularly been the case for hepatitis and cardiovascular diseases, whose prevalences and

28. See Randall M. Packard, A History of Global Health: Interventions into the Lives of Other Peoples (Baltimore: Johns Hopkins University Press, 2016); Valéry Ridde and Jean-Pierre Olivier de Sardan, "The Implementation of Public Health Interventions in Africa: A Neglected Strategic Theme," Médecine et santé tropicales 27, no. 1 (2017): 6–9. The weakness of health systems in the era of global health became very apparent when the Ebola epidemic arose in West Africa in 2014–2015, hitting certain countries harder than others. See Donna A. Patterson, "Le virus Ebola: un révélateur d'inégalités biomédicales et une intervention internationale hétérogène" ("Ebola: Inequalities in Biomedical Capacity and International Response"), Anthropologie et santé 11 (2015), https://journals.openedition.org/anthropologiesante/1914, accessed March 4, 2020; Emmanuel N'koué Sambiéni, Nouratou Danko and Valéry Ridde, "La Fièvre Hémorragique à Virus Lassa au Bénin en 2014 en contexte d'Ebola: une épidémie révélatrice de la faiblesse du système sanitaire" ("The Lassa Virus Hemorrhagic Fever in Benin in 2014: An Epidemic that Reveals the Weakness of the National Health System"), Anthropologie et santé 11 (2015), https://journals.openedition.org/anthropologiesante/1772, accessed March 4, 2020.

29. World Health Organization Maximizing Positive Synergies Collaborative Group, "An Assessment of Interactions Between Global Health Initiatives and Country Health Systems," The Lancet 373, no. 9681 (2009): 2162.

diagnostic and therapeutic tools are known.[30] Amid the plethora of initiatives that took place in the 2000s, noncommunicable diseases such as diabetes (examined in the case of Mali by the three authors mentioned above), as well as communicable diseases such as hepatitis, have revealed global health's soft underbelly. These conditions have been allocated very few resources compared with the three more lethal diseases (AIDS, malaria, and tuberculosis) that have been the targets of global programs, or the so-called neglected tropical diseases that have also featured on the global health agenda, albeit not so high up.[31] As explained above, global health is currently tending to address health issues that go beyond infectious and communicable diseases, in connection with today's major, well-publicized global issues.[32] As well as universal health coverage, which we have already mentioned, these include antibiotic resistance and wider environmental issues under the "One Health" approach.[33] The fact remains that the policies developed in this area broadly remain vertical in nature, involving significant funding and leaving other health issues that still merit some attention to one side.

In addition to the question of vertical programs, two further aspects that could be said to form the global health ideology have been the focus of criticism from the social sciences. The first of these, sometimes described as the "magic bullet" policy, consists in making technical solutions available to populations (including seemingly basic yet potentially expensive items such as mosquito nets, diagnostic tests, and measuring tools), as well as supplying medicines, but without setting precise goals for improving healthcare systems or widening access to care for individuals.[34] The second aspect regularly criticized by the social sciences is the tendency to focus on quantitatively measured effectiveness above all else. Jean-Benoît Falisse addresses

30. Fanny Chabrol, "La longue éclipse des hépatites virales en Afrique: Ethnographie à l'hôpital à Yaoundé," Émulations 27 (2018): 15–32; Aimé Bonny et al., "Cardiac Arrhythmias in Africa: Epidemiology, Management Challenges, and Perspectives," Journal of the American College of Cardiology 73, no. 1 (2019): 100–9.

31. See the "unlikely" partnership formed in the era of global health between the NGO Médecins Sans Frontières (MSF) and pharmaceutical firms under the Drugs for Neglected Diseases initiative (DNDi). Set up in 2003 by MSF and the Institut Pasteur, along with four other research institutes in Brazil, India, Kenya, and Malaysia, the partnership brings together WHO, universities, pharmaceutical firms, governments, and civil society. See https://www.dndi.org/about-dndi/.

32. See Soraya Boudia and Emmanuel Henry, eds., La mondialisation des risques: Une histoire politique et transnationale des risques sanitaires et environnementaux (Rennes: Presses universitaires de Rennes, 2015).

33. See "One Health," World Health Organization, https://www.who.int/features/qa/one-health/en/, accessed February 2020.

34. On policies for tackling malaria, see Cueto, "A Return to the Magic Bullet?"; Carine Baxerres et al., "Le paludisme à l'ère de la santé globale, entre retour des velléités d'élimination et permanence des bricolages populaires," in Guérir en Afrique: promesses et transformations: Anthropologie comparée, ed. Alice Desclaux, Aïssa Diarra, and Sandrine Musso (Paris: L'Harmattan, publication pending).

this by examining the question of performance-based financing (PBF) based on the example of free health care for mothers and babies in Burundi. He highlights the constraints imposed by global health institutions, referring to "the power of procedures."[35] Falisse offers a contextualized critique of New Public Management in health policy in Africa, even though it has been generally successful in this particular case. This management model, which transfers practices from the private sector to the public sector, represents the alpha and the omega of health programs funded by international organizations.[36] The situation that Falisse describes falls between the imposition of management norms and an ideology of rationalizing costs and improving efficiency. His article shows how this procedural framing can be relativized by the facts, with health staff devoting part of their working time to "monitoring and evaluation" visits, such that the fantasy of these management practices being necessary or genuinely effective can be laid bare. Recent and ongoing work on universal health coverage has generally revealed similar pitfalls.[37]

Focusing on the ideology of global health, social science researchers have undertaken a critical, targeted analysis of these health programs and strategies based on the "politics of simple solutions" founded on figures and performance indicators, in such a way that measurement and evaluation become ends in themselves, rather than a means to an end. The article by Martini, Tijou Traoré, and Mahieu amplifies this criticism in the case of diabetes. The disease's complexity, its long-term implications, and the necessarily qualitative support that must be provided for patients' behavioral changes make the disease poorly suited to the quest for short-term measurable results. As Jean-François Bayart points out, health was not the first area where New Public Management was implemented in Africa. Indeed, it became one of

35. Stéphanie Tchiombiano, Olivier Nay, and Fred Eboko, "Le pouvoir des procédures: Les politiques de santé mondiale entre managérialisation et bureaucratisation: l'exemple du Fonds mondial en Afrique de l'Ouest et du centre," in L'État réhabilité en Afrique: Réinventer les politiques publiques à l'ère néolibérale, ed. Emmanuel Grégoire, Jean-François Kobiané, and Marie-France Lange (Paris: Karthala, 2018), 105–124.

36. From the late 1970s, so-called developed countries adopted a "new public management" approach in public policy in order to overcome the inefficiency of public organizations. The Organisation for Economic Co-operation and Development (OECD), the IMF, and the World Bank went on to promote this approach on a global scale. See Emmanuel Abord de Chatillon and Céline Desmarais, "Le Nouveau management public est-il pathogène?," Érudit 16, no. 3 (2012): 10–24. For a critique of new public management in French hospital policy, see Pierre-André Juven, Une santé qui compte? Les coûts et les tarifs controversés de l'hôpital public (Paris: PUF, 2016).

37. Olivier de Sardan and Ridde, Une politique publique de santé; Deville, Fecher, and Poncelet, "L'Assurance pour le renforcement du capital humain."

the chosen areas for this approach after other sectors, following structural adjustment programs (SAPs).[38]

The return of the state in Africa: States facing global health

Analyses of global health have tended to consider African states as "low capacity states,"[39] with a "passive adherence"[40] to international recommendations. These studies have not generally examined the role of states in depth, nor have they analyzed how the measures taken have impacted societies—a point that has been made by some researchers.[41] Yet, the way in which different states have become involved in the tangle of partnerships that accompany aid initiatives reflects the historical trajectories and particular characteristics of each state.[42] Political science research has helped to underline the individual specificities of different African states,[43] and this special report aims to extend this by assessing a range of situations that call into question the "poly-governance" of public policy in Africa. This question is discussed in the contribution by Falisse and in the article by Martini, Tijou Traoré, and Mahieu. Further useful illustrations are found in the articles by Charlotte Pelletan and Jessica Pourraz, which deal with similar topics (state regulation of local pharmaceutical manufacturing). These writers analyze, from different perspectives, the clash between global norms and the history of national industrial policy, in South Africa and Ghana respectively. The arenas they describe reveal some rarely discussed situations in the field of health in Africa, where political, economic, and infrastructural history leads to clashes with prescribed international standards (Jessica Pourraz on Ghana) or with the state's desire to regulate a web of pharmaceutical companies (Charlotte Pelletan on South Africa), even after all the debates sparked

38. Jean-François Bayart, "Moment d'historicité et situation historique en Afrique subsaharienne," Revue française de science politique 66, no. 3–4 (2016): 557; Jean-François Bayart, Ibrahima Poudiougou, and Giovanni Zanoletti, L'État de distorsion en Afrique de l'Ouest: Des empires à la nation (Paris: Karthala, 2019), 49–53.

39. Andrew Lakoff, "Two Regimes of Global Health," Humanity 1, no. 1 (2010): 64.

40. Eboko, Repenser l'action publique, 139.

41. Laëtitia Atlani-Duault and Laurent Vidal, "The Era of Global Health: Forms, Figures, and Agendas for International Aid," Revue Tiers Monde 215 (2013): 7–16; Jessica Pourraz, "Réguler et produire les médicaments contre le paludisme au Ghana et au Bénin: une affaire d'État? Politiques pharmaceutiques, normes de qualité et marchés de médicaments," (PhD dissertation, École des hautes études en sciences sociales, Paris, 2019).

42. See "L'État rhizome: réseaux et intégration politique," in Jean-François Bayart, L'État en Afrique: La politique du ventre (Paris: Fayard, 1989), 270–80.

43. See Tarik Dahou and Vincent Foucher, eds., "Le retour du politique," Cahiers d'études africaines 178, no. 2 (2005); Grégoire, Kobiané, and Lange, L'État réhabilité en Afrique.

by the iconoclastic proclamations of the country's heads of state in the post-Mandela era.

Indeed, President Mandela himself admitted that he had done less to tackle the AIDS crisis than he would have liked, and his successors have not always had a positive input on the matter.[44] By contrast, the urgency of the response by South African industrial actors is striking in the context of the regulatory tendency imposed by what Charlotte Pelletan refers to as the "soft power" of the authorities. South Africa bears witness to the complexity of the links between health indicators and the economic, social, and political factors that allow countries to maintain their equilibrium. While it is a fact that South Africa is the country with the greatest number of people living with HIV in the world, Pelletan shows how South Africa's industrial response to AIDS is unmatched anywhere else in Africa. The country's response has relied on an economic fabric that is rare in Africa, thanks to which South Africa, along with Botswana, now has the highest proportion of HIV-positive patients receiving antiretroviral treatment in the form of triple therapy. On Ghana, Jessica Pourraz shows how, despite strongly supporting the infrastructure of the pharmaceutical industry since independence, the state has come face to face with global health policies that are reliant on importing medicines, rather than developing the domestic industry. Quality standards and the managerial operation of transnational programs have prevailed over Ghanaian economic and industrial interests. Despite this, amid this unequal yet dynamic situation, the government has built up some room for maneuver and has at last sought to bolster its pharmaceutical production through alternative alliances and partnerships.

When the structural adjustment programs (SAPs) came to a close at the end of the 1990s, a range of transnational actors joined states in various fields of public policy.[45] The cursor of public policy is shifting according to the issues, sectors, and historical circumstances, and states must identify the most effective combination of relationships for each policy. Global health actors are convinced that theirs is the priority sector, whereas political science

44. President Thabo Mbeki called into question the link between HIV and AIDS in April 2000. See Didier Fassin, "Le sida comme cause politique," Les temps modernes 620–1, no. 4–5 (2002): 312–31. Mbeki's successor, Jacob Zuma, stated during his 2006 trial, where he was accused of raping a young HIV-positive woman while deputy president, that he had taken a shower following sexual intercourse to lower the risk of infection. See Adrien Barbier, "Afrique du Sud: les casseroles judiciaires de Jacob Zuma," Le Monde Afrique, February 15, 2018, https://www.lemonde.fr/afrique/article/2018/02/15/justice-sud-africaine-les-casseroles-de-jacob-zuma_5257591_3212.html, accessed March 4, 2020.

45. This is what Fred Eboko conceptualized using the notion of a "matrix of public policy in Africa," which may be characterized by the repeated involvement of bilateral and multilateral actors, NGOs, and private partnerships alongside public authorities. See Eboko, Repenser l'action publique.

puts all the issues faced by public authorities into perspective in order to understand their choices. This special report represents one illustration among many of the continual tension between global health and public authorities—between policy and politics.[46] It helps to explain the field of possibilities for health policy in connection with other areas. By taking into account the bijective relationship between donors and public authorities, we can avoid the stereotypes of actions being forced through or of failed African states.

On April 27, 2001, in Abuja, Nigeria, African heads of state pledged to increase public health expenditure to at least 15 percent of their respective national budgets. However, by 2019, the Abuja Declaration was being adhered to by only seven countries: Rwanda (18.8%), Botswana (17.8%), Niger (17.8%), Malawi (17.1%), Zambia (16.4%), Burkina Faso (15.8%), and South Africa (15%). However, given the economic and demographic disparities between these countries, as well as within some countries such as Nigeria, what does the overall figure of 15 percent actually represent for the most impoverished of them? One observer in Burkina Faso sardonically but succinctly pointed out that "15 percent of nothing is nothing."[47] It should also be borne in mind that, when the heads of state signed the Abuja Declaration, almost all of them were emerging from a drastic austerity regime that had weakened all social sectors (health and education in particular), and they were facing a multitude of political and economic issues. On the day when the declaration was signed, the secretary-general of the United Nations, who took part in the meeting, launched the idea for the Global Fund, which became a reality less than a year later, in January 2002.[48] In other words, when they were signing the document, the African leaders knew that they would benefit from subsidies for tackling three diseases that were undermining the health of their respective populations, and without any immediate trade-offs. The Fund and its associated pledges did not have any equivalent at the time—for education, agriculture, security, infrastructure, or indeed any other sector. Why, then, would these leaders have respected this commitment? It seemed highly likely that, given what Kofi Annan promised at the Abuja conference, this double bind would be manifested in goodwill on the part of African heads of state, including on strategy. When petitions and appeals for the Abuja commitment to be upheld were repeatedly launched by global health actors,

46. Dominique Darbon, "Peut-on relire le politique en Afrique via les politiques publiques?," in State, Power, and New Political Actors in Postcolonial Africa, ed. Alessandro Triulzi and Maria Cristina Ercolessi (Milan: Fondazione Giangiacomo Feltrinelli, 2004), 175–200.

47. Remark heard at the offices of an international organization in Ouagadougou, April 2014.

48. See Fred Eboko et al., "Gouvernance et sida en Afrique: instruments de l'action publique internationale, l'exemple du Fonds mondial," Mondes en développement 170, no. 2 (2015): 59–74.

they revealed a closed world whose completely legitimate priorities masked the multiplicity of factors that African states have to manage and address.

The markets of global health

One common reason why global health has drawn criticism from the social sciences, although it is not always sufficiently substantiated or specifically explained among other associated processes, is that there is a commercial dimension, or even a profit-driven one for certain actors, to the policies that global health promotes.[49] Marine Al Dahdah fully addresses this issue in her article, showing how the development of mHealth (the use of mobile phones for delivering health policy), in conjunction with mMoney (the use of mobile phones for accessing banking services) set up by private economic actors, has paved the way for new markets under the cover of health care. Al Dahdah thus demonstrates the shift from infrastructure and competences linked to care (hospitals, medical staff, access to care) to infrastructure and competences linked to the profitability of a digital platform—in other words, a transition from a public service principle to a market logic. Her study highlights the fact that, in this era of global health, transnational, national, and civil society actors are joined by private actors, whose primary objective is economic profitability. In the context of a "return to growth" among African states, these actors and the interests they represent for Africa should not be ignored.[50]

These global health markets can easily be brought into play for the technical solutions, such as those previously highlighted, that are prioritized as part of these health policies (e.g., mosquito nets, medicines, diagnostic tests, product quality testing, authentication measures, condoms). But the producers and distributors of such items should always be identified. The potential economic interest, for certain actors, of global health policies has mostly been highlighted in relation to medicines and pharmaceutical firms, as such products always feature in these policies: for example, mass treatment with the aim of eradicating specific diseases (such as helminthiasis

49. See Section 3 ("Markets") of Biehl and Petryna's When People Come First.
50. African states have experienced an average growth of around 5 percent over the last decade. There was a slight drop in 2014, when growth fell to an average level of 4.2 percent, following a slowdown in some international investment because of fears over Ebola and a drop in commodity prices. See United Nations Economic Commission for Africa and African Union, Economic Report on Africa 2011 (Addis Ababa: United Nations Economic Commission for Africa, 2011).

and trachoma)[51]; early intervention ("test and treat") and an "HIV prevention revolution" in the case of AIDS[52]; and intermittent preventive treatment for children and pregnant women to tackle seasonal malaria in the Sahel. This criticism is especially leveled at the so-called "pharmaceuticalization" of society.[53] Even beyond medicines, there is a whole economy around global health, incorporating technical tools, as well as consultants, providers, "recipients," and other "implementing partners," typically in the private sector.[54] Again, the identities of these actors and of those funding the policies should always be sought.

Thus, through global health markets, the goal is to bring certain solutions front and center (a type of medication, rapid diagnostic tests, a piece of technology) and to use the private sector, its many and heterogenous actors, and the dynamics they create, in order to utilize market mechanisms to achieve declared public health goals (such as lowering morbidity and mortality among vulnerable populations).[55] This raises the question—as posed in Marine Al Dahdah's article—of whether these objectives are in fact the means rather than the end.

Thanks to the contributions of the five articles in this special report, the elements of critical analysis of health policies in the global health era are thoroughly dissected through a specific set of questions taking into account the particular trajectories of five African states: South Africa, Kenya, Burundi, Mali, and Ghana. This set of articles hence contains examples

51. Kelley Cosby Sams, "The Elimination of Blindness: An Ethnographic Exploration of the Fight Against Trachoma in Niger" (PhD dissertation, University of South Florida, Tampa, 2013); Baxerres et al., "Le paludisme à l'ère de la santé globale."

52. This involves broadening the use of antiretrovirals to several other contexts for prophylactic purposes, so as to reduce the transmission rate as much as possible. See Alice Desclaux, "Les effets microsociaux des antirétroviraux: prophylaxie de la transmission mère-enfant du VIH et individualisation au Burkina Faso," Autrepart 63, no. 4 (2012): 161–77.

53. João Biehl, "Pharmaceuticalization: AIDS Treatment and Global Health Politics," Anthropological Quarterly 80, no. 4 (2007): 1083–1126; John Abraham, "Pharmaceuticalization of Society in Context: Theoretical, Empirical and Health Dimensions," Sociology 44, no. 4 (2010): 603–22; Simon J. Williams, Paul Martin, and Jonathan Gabe, "The Pharmaceuticalisation of Society? A Framework for Analysis," Sociology of Health and Illness 33, no. 5 (2011): 710–25 ; Alice Desclaux and Marc Egrot, eds., Anthropologie du médicament au Sud: La pharmaceuticalisation à ses marges (Paris/Marseille: L'Harmattan/IRD éditions, 2015); Johanne Collin and Pierre-Marie David, eds., Vers une pharmaceuticalisation de la société? Le médicament comme objet social (Québec: Presses de l'université du Québec, 2016).

54. Jean-Paul Gaudillière, "Un nouvel ordre sanitaire international? Performance, néolibéralisme et outils du gouvernement médico-économique," Écologie & politique 52, no. 1 (2016): 107–24; Pourraz, "Réguler et produire les médicaments contre le paludisme."

55. The SHOPS project (Sustaining Health Outcomes through the Private Sector), for example, was set up by USAID in several African countries in the late 2010s. The project was expanded and is now known as SHOPS Plus. See https://www.shopsplusproject.org/, accessed January 2020. See also Yuyang Mei, "Neoliberal Optimism: Applying Market Techniques to Global Health," Medical Anthropology 36, no. 4 (2017): 381–95.

that underpin the notion of diversity of situations in Africa, specifically in the field of health, in Southern, Central, East, and West Africa. The articles also cover a wide range of questions that are currently being addressed by global health, albeit to varying degrees: infectious diseases (such as AIDS and malaria), chronic diseases (such as diabetes), healthcare funding (universal health coverage), the functioning of healthcare facilities (through performance-based financing), and the supply of medicines (the manufacturing and/or import of antiretrovirals and artemisinin-based combination therapies). Each of these contributions assesses the innovations that have appeared, albeit not without tensions between the different actors involved, and the re-emergence of old causes, the combination of which has defined the dynamic and fluctuating nature of global health.

This special report calls on us to speak of Africa and of health in the plural. Indeed, an analysis of health policies in Africa reveals a diversity of situations and trajectories that can be seen in a new light through the paradigm of global health, its actors, its dynamics, and its goals—both explicit and implicit. This volume allows us to address the ruptures, the advances, the promises, the failures, the successes, and the performative political discourses specific to global health. These new languages participate in a form of hegemony—that of a humanitarian, security-based, and speculative approach whose foundations and effects must be examined, along with its unthought-of aspects. Each of the articles in this special report illustrates this point. Finally, this collective work marks a continuation of the renewed assessment of public policy in African contexts, revisiting the classic paradigms of policy analysis. The African states that we examine, with their plethora of actors and in the context of globalization, provide an empirically fertile ground without parallel in the contemporary world.[56]

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56. See Dominique Darbon and Olivier Provini, "'Penser l'action publique' en contextes africains: Les enjeux d'une décentration," Gouvernement et action publique 7, no. 2 (2018): 9–29; Dominique Darbon et al., "Un état de la littérature sur l'analyse des politiques publiques en Afrique," Papiers de recherche/Research Papers 2019-98, Agence Française de Développement (2019); Philippe Lavigne Delville, ed., "La fabrique de l'action publique dans les pays 'sous régime d'aide'," Anthropologie & développement 45 (2017).

What does global health mean for health care?

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