Action for Global Health Submission
International Development Committee Inquiry on the Philosophy and Culture of Aid

Action for Global Health (AfGH) is a UK-based network of more than 50 organisations working towards a world where the universal right to health is realised. AfGH acts as the coordinator between the UK government and global health civil society, convening regular meetings and sharing learning from across our network.

1. Introduction

Action for Global Health welcomes this timely opportunity to submit evidence to help shape this inquiry into the culture and philosophy of aid. Global health has long been at the centre of development efforts and accounts for a significant proportion of the ODA budget (varying between 15-20% of total ODA in recent years). In light of the COVID-19 pandemic, it has been elevated further up the political agenda, and the recent Integrated Review indicated that global health security and resilience would continue to be an ODA priority.

As a result of the COVID-19 pandemic, cuts to the ODA budget, and movements for racial justice last year, this has been a critical period of assessment and reflection on the role and delivery of health ODA. As a network organisation, we have held multiple discussions with members and partners on what 'building back better' from the pandemic could look like, what decolonisation and racial justice means in the context of global health and to our sector, and where we should focus our efforts within the chaotic environment within which we are operating, given the increased burdens and challenges faced by our members, in order to be most effective in creating transformational change. We feel that many of these discussions are relevant to the scope and remit of this inquiry, in terms of why the UK provides ODA and the challenges and opportunities for how ODA is delivered. Moreover, we feel that it is vital that we address these discussions in order to deliver positive, long-term change to the use and delivery of ODA.

As such, we would like to put forward the following suggestions for further exploration by the committee:

2. Colonial legacy, the history of aid and decolonisation

Key questions:

- What is the UK's colonial legacy and connections to the history of aid? How did this legacy influence the formation and approaches of development organisations, including within global health?
- How does this legacy continue to influence the approach of UK stakeholders to aid and development to date, in terms of governance structures, balances of power, use of resources and how we communicate about UK aid?
- How can we address and redress these problematic legacies?
- How does the distribution of ODA resources reinforce power imbalances? Should 'value for money' or cost-effectiveness assessments be used in the distribution of resources?

Rationale:

We would encourage the committee to first examine and develop a shared understanding of the UK's colonial legacy and the history of aid. This will ensure that the committee's explorations are rooted in an understanding of the historical context leading to current power and resourcing imbalances, and provide paths of inquiry for addressing the structures, rules and governance systems perpetuating these issues.

This is an area that we have been exploring with our members within the context of global health specifically. These discussions have raised a number of lines of inquiry, across power and governance, resourcing, and language.

We have noted the power imbalances within the governance structures for various global health organisations and multilaterals, including some of our own organisations, in terms of global north/south representation, distribution of decision-making powers and knowledge-sharing/ownership. We have recognised the need to change the formal and informal structures of organisations to centre and shift power to local and community leadership.

We have also been exploring who is involved and consulted in the development of policy, and ways to meaningfully involve key stakeholders within this process. The COVID-19 pandemic has provided an opportunity to review these processes, with the shift to virtual meetings meaning that it is easier to facilitate community voices speaking directly at the table.

We have also been exploring language and narrative – in particular, how we communicate about aid. Our members agreed that often this language is disempowering to local communities, can serve to homogenise contexts (which can serve to undermine and erase the differing issues experienced by varied groups of people) and uses 'othering' language, as if the health challenges we focus on are exclusive to certain contexts or groups (whilst the COVID-19 pandemic has highlighted quite the opposite to be true).

We have also examined how the UK's distribution of ODA resources sometimes continues to reinforce these imbalances. Our *Stocktake Review* of the UK's work on global health found that, in 2018, 93% of health ODA channelled through international NGOs and 95-96% of health ODA channelled through the private sector went to health organisations based in the UK. Whilst organisations based in the UK have a role to play in supporting in-country work in low and middle-income countries, it is essential we ask ourselves whether the current balance of funding is the right one, or whether some of these trends are in fact undermining UK efforts to contribute to global health goals and leave no one behind. Whilst much funding may be channelled from UK-based entities to local entities, there is a need for increased measuring and reporting on the exact percentages and funds reaching local partners. Additionally, the very low direct funding of actors in the global south has obvious implications for development effectiveness principles, including undermining country ownership, and failing to prioritise investment in Southern organisations. Community-based and local health programmes and interventions are critical to sharing trusted, accessible public health information and providing essential health and preventative services.

However, grassroots organisations also need greater support and flexibility from donors, which the current aid rules and restrictions clearly fail to accommodate.

3. **Delivering the universal right to health**

Key questions:

- How is ODA used to deliver the universal right to good health and wellbeing? Is ODA targeted to address health inequalities and leave no one behind? If so, how is this measured? How has COVID-19 impacted progress against these goals?
- How is ODA used to deliver on broader political commitments (such as the 2030 Sustainable Development Goals, the Political Declaration on Universal Health Coverage) and what accountability mechanisms are in place? Are they sufficient?
- What assessments can and should be made of the impact of ODA cuts on the delivery of these health goals?

Rationale:

Even before COVID-19, more than half the world's population did not have access to all essential health services. Recognising the inequalities and weaknesses in health systems globally, the UK committed to the achievement of the 2030 Sustainable Development Goals (including SDG 3 focused on good health and wellbeing). More recently, the UK also signed the Political Declaration on Universal Health Coverage in 2019. Over recent years, the UK has used ODA to contribute towards the achievement of these health goals in a number of ways, from tackling infectious diseases, to strengthening health systems, to investing in health research and development. And yet, the UK Government has not had a public strategy or comprehensive document guiding its work in global health since 2013, raising questions about the targeting and accountability in the use of health ODA.

The pandemic is now further exacerbating health inequalities and weaknesses in health systems globally, vastly impacting the achievement of all health goals – in the short- and long-term. According to a World Health Organization (WHO) survey conducted in July 2020, during the April-June period 36 countries reported disruptions in the provision of antiretroviral (ARV) services, negatively affecting 11.5 million people (45% of global people on ART). Furthermore, the Global Fund to Fight AIDS, TB and Malaria reported that 75% of their Global Fund programmes have reported moderate-to-high levels of disruption to HIV service delivery. More than ever, it is vital that ODA is sustained and targeted, in order to avoid a huge rollback on progress against these health goals for the most vulnerable and marginalised communities. However, the decision to implement significant cuts to the ODA budget is at odds with these commitments and likely to have significant implications for the likelihood of achieving long-term, sustainable development to improve health outcomes.

4. **Global responses to global challenges**

Key questions:

- How is ODA used to support global responses to global challenges, such as the COVID-19 pandemic or the climate crisis?
- How can the UK ensure that their broader policy approaches (beyond aid) are not at odds with these responses?

Rationale:

The COVID-19 pandemic has provided a clear example of a truly global challenge requiring a global response. As the virus spread around the globe, there was a crucial need to share learning across countries and learn from the successes and mistakes of those countries first affected in order to save lives. The pandemic has now led to the deaths of more than 2 million people globally. The virus has exacerbated health inequalities within and between countries, with significant disparities in risk and impact on the basis of age, sex, ethnicity, geography, deprivation, as well as the existence of comorbidities or pre-existing health issues. It has also shown that health is interconnected to every aspect of our lives; we cannot have prosperous societies and economies without healthy populations worldwide.

Through supporting the global coordination role of the World Health Organization and investing in mechanisms such as the ACT-Accelerator to develop COVID-19 technologies, the UK have been able to contribute to the global response to COVID-19. However, the pandemic has also highlighted the need to focus efforts (beyond ODA) on these global challenges, and ensure that broader policies are not at odds with these responses. For example, global vaccine equity goals have recently been hampered by the emphasis on 'vaccine nationalism' domestic policy approaches. Similarly, the decision to make substantial cuts to the ODA budget during a global pandemic, including significant cuts to global health research and programmes, has come under scrutiny and raised concerns.