Policy Brief **13**

September 2020

The political economy of pandemic prevention and preparedness in Africa

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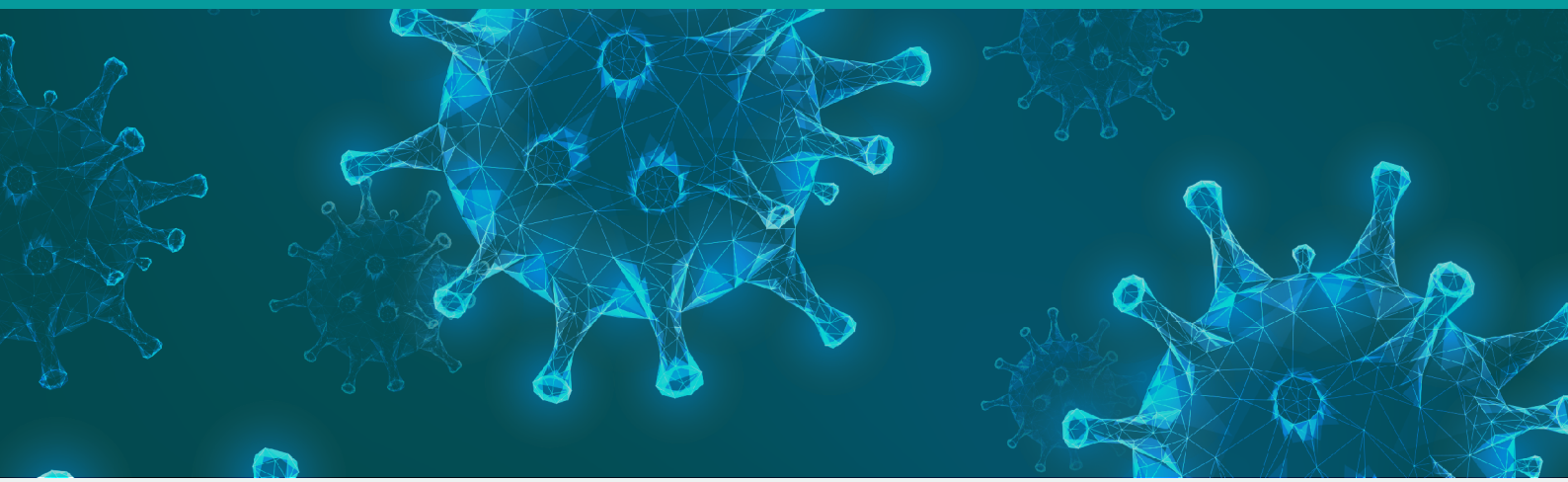


Key Messages

- The huge cost of the COVID-19 crisis have revealed a global failure to learn lessons from previous health crises, and to invest sufficiently and consistently in the public goods of pandemic prevention, preparedness and response. This health security agenda has been seriously neglected in Sub-Saharan Africa, which is in a particularly weak position to respond to the present crisis and future pandemics.
- Based on research conducted for the UK Foreign, Commonwealth and Development Office (FCDO) funded Tackling Deadly Diseases in Africa Programme (TDDAP), this Policy Brief suggests that the neglect of the health security agenda in Sub-Saharan Africa is above all a political economy problem best understood in terms of the political incentives facing leaders, institutionalised power relations and the collective action problems shaping health security systems and international funding.
- Based on analysis of these interlocking problems, this Policy Brief makes the following recommendations:

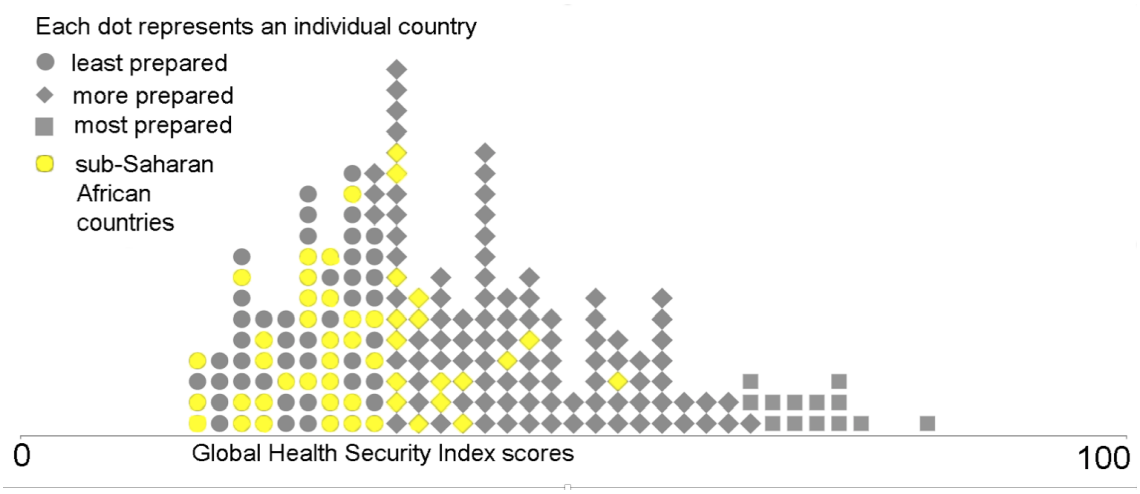
1. Make use of the political moment of the COVID-19 crisis to draw attention to the urgency of strengthening pandemic preparedness and prevention in Africa.
2. Strengthen incentives facing political leaders in African countries to invest in health security.
3. Strengthen societal pressure on governments to invest in health security.
4. Develop more realistic approaches to promoting intersectoral coordination that work with the grain of existing institutions.
5. Adopt a do no harm principle in international health financing.
6. Give special attention and additional resources to address health security threats emerging in situations of fragility and conflict need, using approaches adapted to the local context.

Background

As COVID-19 continues to destroy lives and livelihoods, one crumb of comfort is that the crisis may lead to more concerted global and national action to prevent and prepare for any future pandemic. But the evidence from previous infectious disease crises is not encouraging. Public and political attention tends to follow the curve of the epidemic, switching from widespread panic at the early stages and until the peak of the outbreak to a long period of complacency and neglect when the crisis recedes. COVID-19 has exposed us to immense human and economic cost – and revealed that there has generally been a global failure to learn lessons from previous crises, and to invest sufficiently and consistently in the global public goods of pandemic prevention, preparedness and response. What explains this massive policy failure?

During the early phases of the COVID-19 crisis, political attention was focused on the developed world, but the disease is now spreading fast in the developing world, including sub-Saharan Africa where systems for disease prevention, preparedness and prevention are particularly weak. While some capacity exists in sub-Saharan Africa, there has been serious underinvestment in developing the necessary functions to provide health security, as revealed by low scores achieved by African countries on the Global Health Security Index (Figure 1) and the World Health Organization-led Joint External Evaluation (JEE). This creates massive epidemiological risks for the countries concerned, the African continent and the global population as a whole. Why has the health security agenda in sub-Saharan Africa been so seriously neglected?

Figure 1 Global Health Security Index scores for all countries and Sub- Saharan Africa



Source: Data Downloaded from https://www.ghsindex.org on 8 July 2020

Why is health security neglected?

Based on analysis during the inception phase of the FCDO-funded Tackling Deadly Diseases in Africa Programme (TDDAP), we identify four main factors that explain the neglect of the health security agenda in sub-Saharan Africa: 1) financial constraints, 2) capacity constraints, 3) behavioural and psychological biases and 4) political economy.

The first two are evidently serious issues but ought to be resolvable, given the relatively low cost of health security systems compared with the cost of pandemics, and the availability of financial and technical assistance through development cooperation and multilateral organisations.

Psychological and behavioural barriers blind both political leaders and citizens to epidemic risks and include several well-researched phenomena, such as normalcy bias (it won't happen), herd instinct (no one else seems worried), optimism bias (it won't happen to me) and exponential myopia (it won't get that big) (see the blog by Tim Harford).

While all of these factors are significant, our research for TDDAP suggests that the failure to invest sufficiently in pandemic prevention and preparedness in sub-Saharan Africa is above all a political economy problem, best understood in terms of the political incentives facing leaders, institutionalised power relations and the collective action problems shaping health security systems and international funding.

From research in the six TDDAP countries (Chad, Cameroon, Côte d'Ivoire, Niger, Mali and Uganda), we identified five political economy problems that appear to be particularly undermining pandemic prevention and preparedness:

1. Weak political incentives to invest in health security.

Across the TDDAP countries, there is evidence of other priorities, inside and outside the health sector, squeezing out vital investment in health security. Health security tends to lose out to more politically attractive, visible and vote-winning types of expenditure, most notably curative health services targeted at urban constituencies and cutting ribbons on new infrastructure. More fundamentally, politicians are not rewarded for preventing health crises that do not happen. When epidemics do arise, politicians are often blamed for lack of preparedness and for mismanaging the response. But these costs are unlikely to enter their prior political calculations because there is no certainty that a serious disease outbreak will happen while they are in office.

2. Weak societal pressure on governments to invest in health security.

Although epidemics generate mass fear and panic, remarkably little public and media attention is given to health security risks between epidemics. In the six countries studied under TDDAP, very few civil society organisations engage with health security issues, particularly at the level of policy advocacy and monitoring of government performance. Private sector representative bodies rarely raise the issue of disease outbreak risks as a threat to business and fail to advocate for effective health security as part of an enabling investment climate.

3. Institutional fragmentation.

Effective health security requires an integrated approach to managing human, animal and environmental health risks, in particular to address the threat of zoonotic diseases. All TDDAP countries have adopted the integrated 'one health' model but in practice the structures linking ministries responsible for human, animal and environmental health are weak, in particular at central level. Inter-institutional rivalry, power struggles over leadership of cross-ministerial structures and a variable level of commitment to cross-disciplinary working undermine collective action. There is more evidence of collaboration between human, animal and environmental health professionals at local level, as well as community-level institutions taking an integrated approach to health security. However, the mechanisms linking central government, local government and community structures are typically weak and do not enable effective exchange of information and joint action.

4. Dysfunctional international funding systems.

The international architecture of health financing has had perverse effects on the ability of recipient countries to build strong and sustainable health security systems. A key issue is the prevalence of disease-specific vertical funding, which has enabled significant progress in delivering frontline programmes to combat major communicable diseases but has arguably undermined the cross-cutting functions of the public health institutions that are required for preventing and preparing for a wide range of possible health threats. There appears to be a lack of interest in funding civil society actors to engage in advocacy and accountability work around health security (see point 2 above). For the Sahelian countries covered by TDDAP, it is also notable that international health partners have played the leading role in epidemic response, inviting a moral hazard situation whereby government has withdrawn from health security and expects international actors to fill the gap. Although this responds to a lack of government capacity and can be justified on humanitarian grounds, there is a concern that the situation has become self-perpetuating. Government has little incentive to develop epidemic response capacities, and the international health partners have little incentive to give up a role that justifies their presence and continued funding.

5. Limited state control over territory and borders.

The Sahelian countries covered by TDDAP are currently experiencing serious security crises, which are resulting in loss of government control over territory and borders and preventing effective disease surveillance and response and the control of points of entry through which pathogens are imported. This has exacerbated health security risks (e.g. links between population displacement and disease transmission) and undermined state capacity to respond, by limiting physical access to insecure areas and reducing fiscal space. In these settings, health security crises are driven by the factors causing physical insecurity and conflict, in particular ideological struggles and the weakness of the political settlement and social contract.

Recommendations

These five problems are very difficult to address because they are interlocking and deeply embedded in institutions and power structures. There are some grounds for optimism that the COVID-19 crisis will stimulate renewed international cooperation, funding and technical assistance to support sub-Saharan African countries to strengthen their health security systems. However, such assistance will not be effective (and could prove counterproductive) unless these five fundamental political economy problems are fully recognised and adequately addressed. We suggest that the following points may be useful to governments, donors and international health partners in guiding more effective strategies to strengthen pandemic preparedness and prevention.

1. Make use of the political moment of the COVID-19 crisis to draw attention to the urgency of strengthening pandemic preparedness and prevention in Africa.

COVID-19 may make it easier than in the past to mobilise resources and technical assistance because it will be possible to argue more convincingly that international assistance is in the mutual interest of the beneficiary country and the donor (global public goods argument). There are some positive examples of previous epidemics where affected countries have used the crisis effectively to strengthen preparedness systems (e.g. SARS in South Korea and Nipah Virus in Kerala, India).

2. Find ways to strengthen incentives facing political leaders in African countries to invest in health security.

The COVID-19 crisis has created incentives for politicians to act in the short term, but how can this be sustained and extended to generate more investment in long-term pandemic preparedness and prevention? Part of the answer is to use international pressure more effectively. For example, more publicised use of performance measurements such as the JEE can lead to peer pressure on countries by revealing strong and weak performers. The inclusion of measures of pandemic preparedness in international credit ratings could also be promoted, to give investors clearer information on risks and to incentivise governments to invest in health security in order to reduce borrowing costs. Another part of the answer is to find ways to promote investments in health security systems that are more politically attractive and less politically costly. For example, so long as they are not disrupted by misinformation and mistrust (a big if), government-led vaccination campaigns may play well with voters. The recruitment of community health agents as part of disease surveillance systems can bring status and financial rewards to the recruits while also helping extend state presence and authority. The key is to find initiatives that are attractive to politicians, play well with voters and are good for health security.

3. Strengthen societal pressure on governments to invest in health security.

There is potential for a broadening of the social contract (the implicit bargain between state and society on what government is expected to provide) to include pandemic prevention and preparedness. This may be politically feasible because wealthy and influential groups (elites) cannot isolate themselves from epidemic risks, and may put pressure on government to invest in preparedness and prevention that benefits elite

and non-elite groups alike. There are interesting and underutilised options with regard to helping strengthen societal pressure, including research and advocacy on the costs of infectious disease outbreaks; supporting civil society and business associations to engage in advocacy and accountability initiatives around health security; promoting media coverage of prevention and preparedness; and including these topics in civic and public education curricula.

4. Develop more realistic approaches to promoting intersectoral coordination that work with the grain of existing institutions.

While an integrated approach to health security is essential to tackle zoonotic and environmental health risks, there has been too much focus on pushing idealised institutional models (e.g. the One Health Platform, the National Action Plan for Health Security) that assume well-functioning institutions, the free flow of information and the absence of power relations and collective action problems. A more realistic approach is to work with existing structures and to seek to improve their functioning on an incremental basis. For example, if cross-sectoral collaboration is working better at a decentralised or community level, then it may make sense to focus support on these levels and to address coordination failures in central government on a slower and more step-by-step basis.

5. Adopt a do no harm principle in international health financing.

International health financing and aid management practices have created distortions that risk undermining efforts to build sustainable health security systems. Providers of health financing need to refrain from using types of financing and project delivery that undermine government ownership of health programmes, that establish parallel structures that are not well integrated with national health systems (e.g. some types of vertical programmes) and enable government to withdraw from delivering on its public health responsibilities. In situations of low government capacity, international health partners will continue to play a key role in financing and delivering services, but this needs to be part of a long-term plan that is directed by national authorities and is consistent with building sustainable and effective health systems. Coordinated donor funding of the National Action Plan for Health Security can be an important first step.

6. Give special attention and additional resources to address health security threats emerging in situations of fragility and conflict need, using approaches adapted to the local context.

Greater international attention is required to address the closely connected threats of conflict and infectious disease outbreaks affecting fragile states, particularly in the Sahel and Central Africa. Approaches to promoting health security in these regions need to adopt a multisectoral approach to confronting the complex and interlinked problems of weak government capacity and presence, limited state legitimacy, low levels of trust and rampant misinformation, as well as direct attacks on health facilities and health workers. In these contexts, a health security strategy needs to be linked to broader approaches to addressing the causes of conflict, rebuilding state capacity and legitimacy, improving the conduct and performance of security services, generating trust, disseminating accurate information and promoting social inclusion.

About this Policy Brief and The Policy Practice

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September 2020