

# Africa Health R&D Week 2022

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Financing for health R&D as a critical component of public health in Africa is not clearly articulated. In principle, the region's governments acknowledge health as a productive sector contributing to socioeconomic growth and development. There is also the consensus that domestic funding of health research and development (R&D) is necessary to ensure alignment of research agendas with national and regional health priorities. The annual **Africa Health R&D Week** was inaugurated as a forum to rally advocacy addressing barriers to Africa's health transformation through health research, development, and innovation. From November 8-11, 2022, global health advocates, media, policymakers, program implementors, researchers, and funders engaged in discussions on key issues and trends influencing domestic resource mobilization for health R&D on the continent.

Day 1 featured discussions on end-to-end visibility of health research funding for impact with a keynote talk on accountability as a strategy to increase domestic resource mobilization (DRM) delivered by Dr. Ogwel Ouma, the acting director of Africa Centers for Diseases Control (CDC). Professor Geoffrey Setswe, managing director for the Implementation Research Division at The Aurum Institute and member of South Africa National AIDS Council (SANAC) spoke on the impact of budget allocations to health R&D on Africa's health. The Coalition to Accelerate and Support of Prevention Research (CASPR) DRM Advocacy champion in Dr. Parfait Uwaliraye, the head of planning, monitoring and evaluation and health financing in Rwanda's Ministry of Health, spoke on his country's experience in tracking health research funding sources. Professor Christian Happi, director of the African Center of Excellence for Genomics of infectious Diseases, Nigeria, spoke on governance and transparency in health systems towards translation of research to policy and practice. The presentations culminated in a moderated discussion chaired by Dr. Joyce Wamicwe, head of research and innovation at the Ministry of Health in Kenya.

On Day 2 conversations focused on the debt burden and illicit financial flows/progressive taxation. A key presentation on debt relief or cancellation as a strategy to raise domestic resources for health R&D was given by Jaime Atienza Azcona, UNAIDS director for equitable financing. Acting Executive Director of Tax Justice Chenai Mukumba spoke about the role of tax reforms and the impact of illicit tax flows on resource mobilization for health and Amanda Banda, co-lead for the Coalition to build Momentum, Power, Activism, Strategy and Solidarity (COMPASS) led a discussion with advocates on the role of advocacy in securing debt relief towards increased financing of health care and health research.

During Day 3 conversations on domestic resource mobilization of health R&D, Frances Ilika, director of health systems at Palladium spoke on innovative approaches to DRM for health, giving insights from the HIV Policy Plus project in Nigeria. Linda Mafu, the head of civil society and political advocacy at the Global Fund shared examples of advocacy initiatives to unlock DRM for health R&D by the Global Fund advocacy network. Advocates shared experiences on advocacy at a national level including Walter Chikanya, director at Zimbabwe Community Health Intervention Research speaking on influencing health R&D financing trends in Zimbabwe, and Atuswege Mwangomale, head of Sikika's Health Program spoke about advocacy for increased financing of health in Tanzania. Dr. Robert Karanja, co-founder and chief innovation officer of Villgro Africa, shared perspectives on engaging the private sector in DRM for health R&D.

Conversations on the fourth and final day centered around global health equity, decolonization of R&D to fund Africa health R&D, featuring fireside chats on empowering the African research enterprise in a more equitable way for the benefit of African citizens by Vuyiseka Dubula, director of the Africa Centre for HIV/AIDS Management, Stellenbosch University, and Dr. Agnes Binagwaho, vice chancellor of the University of Global Health Equity. The week closed with a panel discussion featuring Dr. Al Haji N'jai, senior scientist and lecturer at University of Sierra Leone; Dr. Nadia Sam-Agudu, associate professor of pediatrics at the University of Maryland; Tian Johnson, head of the African Alliance; and Yvette Raphael, co-founder and co-director of Advocacy for Prevention of HIV and AIDS in Africa.

This document is a summary of the issues discussed during the four-day event as well as recommendations on advocacy and practical steps to increase resources for health R&D in Africa, ensuring that the research conducted is responsive to the continent's health systems and needs.

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# End-to-end visibility for financing of health R&D in Africa

There is need for a comprehensive and transparent approach to tracking the flow of financial resources for health and R&D initiatives in Africa, from the initial funding source to the ultimate beneficiaries of these resources.

## Introduction

Research and development (R&D) pipelines for diseases that disproportionately affect African countries are inadequate (Simpkin, 2019). According to a report in the Global R&D Funding Forecast for 2016, the total investment in health R&D by African countries was estimated to be around US\$1.9 billion – only 1.1% of the global investment in health R&D – most of the funding originating from external sources including official development assistance and global health funding agencies. This is despite the continent representing 15% of the world's population. African governments' reliance on external sources of investment in health R&D puts at risk the progress towards achieving universal health coverage and building sustainable health systems.

While the advocacy for increased domestic funding for health gains traction in Africa, the prioritization of funding for health R&D as a critical component of public health is not clearly articulated. In principle, the region's governments have acknowledged health as a productive sector contributing to socio-economic growth and development and that domestic funding of health R&D is necessary to ensure alignment health priorities<sup>1</sup>.

The COVID-19 pandemic has taught us many lessons, including the need for local R&D underpinned by robust funding to ensure timely access to lifesaving global health interventions. Addressing the vitality of R&D in our health systems now is vital for future pandemic preparedness, as well as for generating our own health products and prioritizing diseases that are most prevalent and pose the highest burden to the continent.

## Realizing Africa's potential for global health self-reliance

Currently, Africa's pharmaceutical manufacturing represents only 3% of global production, while we import around 70% of the medicines we use. In terms of vaccines, Africa produces just 1% of locally used vaccines, importing 99% despite accounting for 25% of the global vaccine consumption. This situation

highlights a significant opportunity for growth of vaccine and pharmaceutical manufacturing on the continent.

It is essential for African countries and institutions to invest strategically in research and development and support local enterprises and researchers. The African Vaccine Acquisition Trust and the Partnership for African Vaccine Manufacturing are mechanisms used by the African Union intended to foster such support, as well as the African Continental Free Trade Area agreement, which will serve to increase the opportunities for return on investments in health R&D.

## Accountability: a strategy to increase domestic resource mobilization

Addressing the challenge in delivering on commitments made to sustainably finance health R&D must begin with the acknowledgment of the multiple commitments made on the continent and globally.

The Abuja Declaration in 2001 called for allocating 15% of national budgets to health care, which remains unfulfilled as very few countries have achieved this target. Similarly, the Africa Union commitment in 2007 for investing at least one percent of GDP into research and development, and the Bamako Call to Action in 2008, which called for allocating two percent of National Health budgets to health research, remain unachieved. To translate the declarations of intention to sustainably fund health R&D into action, there is need for greater accountability.

What gets measured gets done. Thus, a robust mechanism is necessary to measure commitments and communicate each country's reality to establish the habit of decision-making and implementation. Governments often fail to prioritize past commitments due to changes in administration. Such a mechanism will serve as a starting point for every new administration, whether national or continental, forcing them to appreciate past decisions and implement them. It is crucial to document and communicate all research and development progress to foster increased support for health R&D that reflects our health priorities.

<sup>1</sup> Risk Ranking and Prioritization of Epidemic-Prone Diseases – Africa CDC: <https://africacdc.org/download/risk-ranking-and-prioritization-of-epidemic-prone-diseases/?ind=1700468611867&filename=RISK-RANKING-AND-Prioritization-of-Epidemic-Prone-Diseases-1.pdf&wpdmdl=13252&refresh=65668879c03fd1701218425>

## Rwanda: Importance of data in monitoring the research agenda

In Rwanda, the government has established a data system to capture health resources across various sectors, including research. Data collection from all partners, including the private sector, academia, civil society organizations (CSOs), and governments has been institutionalized and is done on a regular basis. By tracking all budget and expenditure activity, the government can monitor trends including priority areas, diseases, geographical location, and implementing agencies and ensure alignment of R&D efforts with the country's research and development goals.

Supported by this data, the Rwanda Ministry of Health's national health research subcommittee can make informed decisions on strategic investments in health R&D, and this guides the approvals of research proposals prior to submission to the Ethics Committee.

The information gathered in this way is shared with the research and implementing communities to promote ownership and understanding of the importance of reporting data in line with the country's priorities.

This system has been implemented since 2017 and has contributed to enhancing research review processes and incentivizing health R&D. Reliable research data aligned with national priorities can inform policymaking, requiring support from stakeholders to convince leadership to invest more in research.

## End-to-end contribution to sustainable financing of health R&D

It is crucial for African leaders to take ownership of the health research agenda and establish an Africa-centered approach to problem-solving. Policy and regulatory frameworks should evolve in tandem with the prevailing R&D landscape to ensure that research is relevant and supports policy formulation. Governments also have a role in providing the necessary infrastructure and institutional strengthening support for the R&D ecosystem. This includes strengthened intellectual property laws and regulations that ensure local innovators and innovations are well recognized, valued, and protected.

Increased partnership between the private sector and local institutions will ensure that cutting-edge research benefits the population. The startup ecosystem in Africa is thriving but needs to expand from the focus on fintech to include life sciences innovation. Incentives such as tax breaks and startup support can contribute to such a paradigm shift and towards greater investment in health R&D by the private sector, which remains largely untapped.

Researchers have a role in making their science accessible to the private sector and the government to encourage increased investment. By aligning research with national priorities, being accountable for their productivity, and participating in the national budgeting process, the research community can play their part in ensuring a well-funded health R&D pipeline. The research community can also play a vital role in creating public demand for local R&D products.

While the push for local development and manufacturing of vaccines and health products is gaining momentum, it is not sustainable for every country to have its own stand-alone R&D initiative. Strong leadership that aligns national and continental priorities and supports regional hubs of excellence for vaccine development and production is necessary. Breaking down knowledge silos, sharing expertise, harmonizing oversight processes and opening up markets is critical for a robust and sustainable R&D ecosystem. Furthermore, cross-border collaborative research enables pooling of resources and curbs the waste of duplicated efforts.

Africa's future is tied to its people's health security. A committed and intentional approach to investing in health R&D is key to achieving better health outcomes for its people.



# The impact of the debt burden on financing health R&D in Africa

Debt hinders a government's ability to invest in health research, impacting domestic resource mobilization. Although it is often overlooked in resource mobilization, it is important to advocate for debt relief and cancellation in order to increase funding for health research.

The debt burden borne by many African countries could have a significant impact on the financing of health research and development (R&D) on the continent. Perennial servicing of huge loans diverts resources away from health R&D, limiting the ability of African countries to build their health research capacities and infrastructure. The heavily indebted African countries are more reliant on foreign aid or loans to finance their health R&D, reducing the control they have over the research agenda, as well as increased vulnerability to external factors such as changing donor priorities or economic conditions. Addressing debt sustainability issues is therefore crucial to ensuring availability and access to health care and scientific innovation on the continent.

In the decade between 2000 and 2010, African countries made economic and social progress, but the average tax collection was only 18% of gross domestic product (GDP), compared to the Organization for Economic Cooperation and Development countries, which collect 35-40% of GDP, and between 25% and 30% of GDP in other developing regions. Meanwhile, new loans, bond issuances, bank loans, and multilateral loans to African countries grew at a rate of 10% annually, resulting in a continuous increase in debt, even as tax collection remained flat. When tax collection is low, governments may be perceived as less reliable and may need to pay higher costs for new loans, further increasing the level of debt. Other factors affecting Africa include the "Africa premium" that causes Africa to face higher costs for new debt compared to other countries.

African governments' debt repayments were approximately 5% of revenue in 2010, rising to 12% by 2017. The debt challenges being faced by African countries at the time of publishing this brief began before the global economic crises occasioned by the COVID-19 pandemic of 2020-2022 and the Ukraine war in 2022. Should it continue, debt repayments could reach an average of over 18%, above 2000 levels, affecting countries' public budgets and further limiting their capacity to spend on different needs. Following the global economic shocks of the COVID-19 pandemic and the Russian invasion of Ukraine, many countries have experienced a limited capacity on health spending. In 41 countries, health spending is projected to remain lower than 2019 levels, indicating reduced investment in critical areas. Only slightly over one-third of the countries globally are projected to increase government spending by 2027, most of them high-income or high-middle-income. Such trends presented in the World Bank report highlighting a forthcoming health financing crisis widen the existing economic divide.

There is a link between the severity of debt crisis, limited access to relief, and the severity of global health impacts. In 73 countries, for every US\$10 in revenue, only one dollar was spent

on health while the rest went towards foreign debt repayments. This pattern extends beyond Africa, with debt repayments exceeding health investments in 37 countries.

## Addressing the debt crisis to increase funding for health R&D

To increase resources for countries, the focus ought to be on growing domestic revenues, closing tax loopholes, and implementing progressive taxation. There is a need to support allocation of resources towards health spending, despite competing needs. This requires both international and domestic reforms:

1. We should push for Special Drawing Rights (SDR)<sup>2</sup> reallocation to low-income countries, and advocate for some of those funds to be invested in health.
2. Debt cancellation must be provided to countries in distress or at high risk, and new systems for fast debt renegotiation must be established.
3. We also need to explore measures to swap resources from debt to health and climate, such as The Global Fund's debt swap initiatives.
4. We need fair rules on intellectual property for all pandemic-related vaccines, treatments, and prevention, especially as new prevention medicines are being developed. It is crucial to guarantee equal access without long delays or high prices.
5. We need additional Official development assistance (ODA) and non-ODA countries' cooperation in devising and adopting innovative funding instruments.
6. Multilateral action is needed to address the impacts of the COVID-19 pandemic on financing and resource mobilization.
7. Health institutions must be included in decision-making processes for financing, which normally happens in Parliament or with the Finance Ministry and the International Monetary Fund.
8. We need to build space for health to be part of the political dialogue and engage with advocates, civil society, and policy experts. Advocacy, essential partnerships, and influencing are crucial to securing funds in budgets since it is a highly political process. It is important to build these efforts strongly for the future of health financing.

<sup>2</sup> <https://www.imf.org/en/Topics/special-drawing-right#:~:text=The%20SDR%20is%20an%20international,provide%20a%20c>



## Addressing illicit financial flows influence on resource mobilization in Africa

Recent reports on illicit financial flows show that Africa has lost \$1 trillion, and that over \$50 billion is lost annually. While it is often declared that the government doesn't have enough resources, with \$50 billion lost annually, it's clear that there is potential to increase the tax base and provide the resources needed for health.

Governments tend to tax individuals heavily while neglecting to tax multinational companies and other big players. Addressing this issue will open access to additional resources. While the need for solutions that will enable debt cancellation are

paramount, there is scope to improve finance, tax, and debt disciplines. The focus on small taxes, rather than addressing illicit financial flows, does not generate sufficient revenue.

## Conclusion

While it is not easy to push for change, progress has been made in securing debt relief, fair taxation, and new financing. There are alliances such as the Tax Justice Network in Africa<sup>3</sup> that continue to push for the prioritization of efficiency in investments, public financial management, and government accountability to both international partners and their citizens.

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<sup>3</sup> Tax Justice Network Africa (TJNA) <http://www.taxjusticeafrica.net>

# Innovative approaches to domestic resource mobilization

How do we engage the private sector in domestic resource mobilization, and what innovative strategies could advocates employ to increase investment?

Sustainable financing of health research and development (R&D) in Africa is critical for an enabling environment that supports the creation of contextually relevant products for our public health tools that suit our communities' needs. Although Africa bears 25% of the global disease burden, less than 1% of global health expenditure originates from the continent. Majority of African countries spend below the recommended US\$86 per capita on health, despite having committed to allocate 15% of their national budgets to health in the Abuja Declaration<sup>4</sup>. Subsequently, less than 2% of the

4 Nyamugira AB, Richter A, Furaha G, Flessa S. Towards the achievement of universal health coverage in the Democratic Republic of Congo: does the Country walk its talk? *BMC Health Serv Res.* 2022 Jul 4;22(1):860. doi: 10.1186/s12913-022-08228-3. PMID: 35787277; PMCID: PMC9254687.

medicines and vaccines consumed on the continent are manufactured locally<sup>5</sup>, and less than 2% of global research output originates from the continent. While some African countries have been successful in dedicating more taxes to health and health R&D, this remains a challenge where a larger part of the population is in the informal sector and beyond the tax base. General taxation alone is insufficient to fund government interventions including health R&D .

5 Saied AA, Metwally AA, Dhawan M, Choudhary OP, Aiash H. Strengthening vaccines and medicines manufacturing capabilities in Africa: challenges and perspectives. *EMBO Mol Med.* 2022 Aug 8;14(8):e16287. doi: 10.15252/emmm.202216287. Epub 2022 Jun 27. PMID: 35758210; PMCID: PMC9358391.

## CASE STUDY

### Nigeria Health Policy Plus project

The most populous country in Africa with over 53% of the population below the poverty line, Nigeria is characterized by inequitable access to healthcare, a highest out-of-pocket spending and a low insurance coverage. In close to six years from 2015, the U.S. funded Health Policy Plus project supported the government in mobilizing over \$18 million in additional domestic resources for health. They also supported the development of a national HIV policy to raise an additional \$662 million over the next five years (from 2021) and implemented health insurance reforms that ensure increased access to priority health interventions, including HIV/AIDS, cardiovascular disease, and malaria.

The Health Policy Plus project (HPP) supported evidence generation to change the perspective that the government did not need to spend money on HIV/AIDS, and that it was the sole responsibility of donors. Assessments were conducted of expenses incurred despite free services; obstacles in funding HIV/AIDS treatment, care and research; local manufacturing capacity for HIV/AIDS commodities; and the funding sources for necessary interventions. The evidence was used in developing policies for sustainable HIV/AIDS financing, including the National Agency for the Control of AIDS' domestic resource mobilization and sustainability strategy for 2021- 2025. The policy is being implemented in many states, including Lagos. Additionally, a policy blueprint that guided the integration of HIV/AIDS into health insurance in Nigeria as developed to ensure that HIV/AIDS was prioritized in the country's plan to expand health insurance coverage.

### Success factors

The underpinning focus of the project was sustainability, ensuring stable and predictable funding even with changes in government. Local ownership was prioritized and facilitated through capacity building at for evidence-driven decision-making and strategy at all levels of government and citizen involvement, transparency, and accountability in policy development and implementation. A multi-sectoral approach was taken with technical working groups comprising ministries of finance and health, parliamentarians, private sector, implementing partners, and civil society organizations institutionalized in the health financing unit within the Ministry of Health's department of planning, research, and statistics. The unit had a dedicated budget to drive research and track budgets used for state health accounts. The improved relationship between the health sector actors and the Ministries of Finance and parliament resulted in increased understanding of the importance of investing in health, improved accountability, and transparency.

### Lessons learned

1. The importance of aligning with existing government health financing policies: HPP aligned with Nigeria's Basic Healthcare Provision Fund policy.
2. The role of evidence in decision-making: the project was able to generate evidence through participation, inclusion, and interaction across key sectors.
3. The need to build trust and strengthen capacity at individual and organizational levels.

## Innovative financing

Innovative financing and the efficient use of mobilized resources is needed to increase the investment in health R&D. A mix of public financing, prepayment mechanisms, innovative financing, and external financing can be employed with the goal of achieving financial self-sufficiency in the health sector.

## Advocacy to promote domestic resource mobilization

One approach to domestic resource mobilization involves leveraging different entry points for advocacy. Global high-level platforms can raise visibility of progress towards domestic resource mobilization and be used by leaders to hold each other accountable. At the regional level, conversations at the African Union and annual leadership meetings can be focused on accountability and reporting on resource mobilization and allocation to health. Engagements with parliamentary networks during budget-making processes facilitate strategic input, follow-up, and holding governments accountable to their commitments. Civil society play a key role in such advocacy and can strengthen their capacity to engage through understanding of budget processes and strategies for advocacy.

## Private sector involvement

The challenge of Africa's 1.3 billion people bearing a disproportionate share of the global disease burden can be viewed as market opportunities. This should guide targeted investment in health R&D. While it remains unclear how investments in R&D are made across multiple sectors in Africa, estimates show financial technology (Fintech) receiving a lion's share of investment with some going to agriculture and the

least to health. Lessons for health R&D can be drawn from the Fintech sector's focus on market shaping rather than just technology push. Viewing health as a key economic driver and a better understanding of the health market needs can contribute to a strong value proposition that is competitive and sustainable. This will require policy interventions that influence research environment, innovation adoption, access, distribution, and affordability.

Venture capital investment in the health sector is a potential alternative source of funding for R&D. In 2021, Africa received about \$5 billion in venture capital investment (less than 1% of the global total) with the health sector only accounting for 10%. Regardless, there are already strong biotech startups targeting the health sector emerging, such as 54Gene from Nigeria and Mawingu Biotech from Ghana.

Innovative financing models like impact bonds that can support industrial cluster development can be applied to stem the hidden threat of capital flight. Local manufacturers should extend their focus to building a knowledge-intensive pharma industry that translates health R&D outputs into innovative products and services. The risks of loss on investments need to be mitigated including through acquiring advanced market commitments. Impact bonds (outcomes-based contracts using private funding from investors to cover the upfront capital required for a provider to set up and deliver a service) can be used to attract impact investors who take on the heavy risk, allowing the government to succeed without spending any revenue generated by companies and the industry, and foreign exchange gains. Success in engaging the private sector optimally calls for reimagining an indigenous African pharma sector, rather than taking the easy path of the export processing zones model.

### CASE STUDY

## Zimbabwe: How can advocates promote innovative domestic resource mobilization approaches?

Zimbabwe's health system has been in decline over the past decade, worsened by COVID-19 challenges in 2021. Despite consistent funding to the health sector, the country experienced a decline from US\$321 million to \$96 million in 2019 due to macroeconomic struggles, particularly devaluation of the local currency.

In 2021, advocacy from civil society and partners led to an increase in the fiscal budget. Civil Society Organizations (CSOs) such as the Advocacy Core Team in Zimbabwe have engaged key policy and decision-makers to increase funding allocated to health. The CSOs leveraged existing platforms such as parliamentary networks, national financing dialogues, and budget consultations. Additionally, they employed tactics such as petitions, priority papers, and roundtables with key parliamentarians. Civil society engagement was underpinned by community literacy and awareness. These efforts resulted in an increment in health funding towards the Abuja Declaration and we are preparing for the next national financing dialogue in 2023. The country's allocation to health currently stands at 12.7% against the Abuja Declaration goal of 15%.

The role of advocacy in budget processes been recognized to the extent that a social contracting system has been adopted whereby 3% is levied on workers to facilitate funding from the national coffers for CSOs in every province. To ensure sustainable health financing, CSOs are advocating for public expenditure tracking services that allow monitoring of allocation and disbursement of funds, including emergency funds such as those for COVID-19. In addition to accountability in the use of resources, the CSOs see need for accountability in the use of research to inform policy and practice.

# Global health equity: Decolonizing R&D to fund Africa's health

## Why decolonizing the research and development pipeline enterprise is critical to the advancement of global health equity

The impacts of colonization, systemic racism, and inequities in resource mobilization for research remain an impediment to globally equitable access and manufacturing capacity for vaccines and medicines. There is an urgent need to decolonize the health research and development (R&D) pipeline to advance global health equity.

The decolonization agenda in the global health space acknowledges that global health research perpetuates existing power imbalances and aims to identify concrete ways in which teaching and research can overcome its colonial past and present.<sup>6</sup>

### Addressing R&D power imbalances

A starting point for the decolonization of global health is the decolonization of academic publishing spaces where dissemination of 'acceptable' knowledge is enabled.<sup>7</sup> The number of first or final author papers that an individual has is used to gauge their prominence in the field and is often a key consideration in the qualification to receive funding or recognition. However, outputs from large, multi-partner clinical trials disproportionately attribute scientists from high-income countries despite significant contributions from researchers in lower income countries. The limit to the number of authors and author positioning in a publication perpetuates the perception that global health research is 'driven' by scientists based in high-income institutions, and the idea that what is done in these countries has more value than research led by institutions in lower middle-income countries. As a result, research leadership is largely attributed to scientists from high income countries (75%)<sup>8</sup> (75%) yet these countries only make up 17% of the global population.

This bias is carried on further through the location and orientation of global health programs in high-income countries, creating content based on their history and priorities. Furthermore, limited access to these programs for low-income countries in the form of visa requirements and costs, further exacerbates this issue. The net result is the expectation that knowledge generated by high-income countries is superior and a reluctance to learn from low- and middle-income countries, as was the case with the success in controlling the COVID-19 pandemic with few or no vaccines in middle-income African countries. Rather than acknowledge the success, excuses were made, such as claims that the virus couldn't survive in hot climates.

The expectation in collaborative research for high-income countries to lead research, manage funding, and determine research priorities brings on an added layer of imbalance. Often, funding for such research is directed towards the high-income country groups to facilitate studies in middle- or low-income countries, rather than supporting local experts and facilitating their leveraging of other experts as and when needed. Lastly is the Hertillan effect, where data from experts in low- and middle-income countries that face various barriers to publishing their own work is used by those with the means, resulting in their recognition as the sole expert.

### Global health practice — is it what we preach?

Global health is defined by global cooperation. In reality, as evidenced during the COVID-19 pandemic, countries pursued a nationalistic approach with high-income countries breaking the commitment to ensure 70% of the global population including low- and middle-income countries access COVID-19 vaccines through the COVAX mechanisms. On the local manufacturing and self-reliance front, high-income countries were unwilling to share intellectual property (IP) rights for vaccines developed and opposed the TRIPS waiver recommended by South Africa and India.<sup>9</sup> The result was a global shortage of vaccines felt acutely in low- and lower middle-income countries.

Pharmaceutical companies have been known to make astronomical profits from drugs developed using taxpayer money. Global health practice must prioritize equity at both national and international levels. Differentiation in standards of care for high- and low-income countries due to cost implications should be countered by efforts to ensure effective drugs are accessible to all. For example, effective treatment for multi-drug resistant tuberculosis, which is emerging in low-income countries, is beyond the reach of many, leading to a high death rate. Lastly, the term "cost effectiveness" is often used to judge the value of a health program based on a country's GDP, resulting in the perception that investing in health care in a low-income country is a lower priority. Biases of what is acceptable must be addressed, such as accepting lower quality care for low- and middle-income countries.

6 Lawrence DS, Hirsch LA. Decolonising global health: transnational research partnerships under the spotlight. *Int Health*. 2020 Nov 9;12(6):518-523. doi: 10.1093/inthealth/ihaa073. PMID: 33165557; PMCID: PMC7651076.

7 Khan SA. Decolonising global health by decolonising academic publishing. *BMJ Global Health* 2022;7:e007811. doi:10.1136/bmjgh-2021-007811

8 Khan SA. Decolonising global health by decolonising academic publishing. *BMJ Global Health* 2022;7:e007811. doi:10.1136/bmjgh-2021-007811

9 Amin, T., & Kesselheim, A. S. (2022). A global intellectual property waiver is still needed to address the inequities of COVID-19 and future pandemic preparedness. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 59, 004695802211248. <https://doi.org/10.1177/00469580221124821>



## Experiences of institutional racism

As a clinician scientist focused on infectious diseases in African children, I aim to generate evidence that guides clinical and public health policies. Before medical school, I wanted to root my research in African history, practices, and context. However, I realized that decolonizing medicine and research was crucial because of the lasting effects of colonization. I have experienced injustices, such as being held to a higher standard than my peers, which led me to question my ability to succeed.

**Nadia A. Sam-Agudu, M.D., Associate Professor, University of Maryland, School of Medicine**

Medicine as a career has only become accessible to black and non-white South Africans after independence. In my experience, during anatomy classes, students of color were only permitted to learn from cadavers of black people, while white students were allowed to learn from both black and white cadavers.

**Leonard Solai, Vice President – Product Access and External Affairs and Community Engagement, IPM South Africa**

Studying science in the U.S. made me realize the impacts of slavery, racism, and colonialism globally. The lack of representation of people who look like me in grad school motivated me to create an organization called Project 1808, which focuses on capacity building and mentoring students towards a decolonization pathway.

**Dr. Alhaji N'jai, founder of Project 1808 and Associate Professor, University of Sierra Leone**

## A new global health paradigm

To decolonize global health, we must decolonize our thinking as this affects everything from global health education to research and partnerships. Institutions in high-income countries must be purposeful about addressing systemic and scientific racism. The current research landscape demands conformity, but if scientists the world over do not insist on telling their own stories, using their indigenous knowledge and being part of the published data, we will continue to perpetuate the colonization. There is a need to collectively examine who holds power and how they use it — this is an invitation to self-reflection and discomfort, encouraging sincere allies to confront their own role in colonization.

## What role can Africa play in decolonizing global health?

We need to decolonize global health R&D because the current system does not support equity and justice. The current flow of knowledge and resources favors a culture of power and marginalization. This aspect of global health education, R&D, and health care must be addressed as relevant indigenous knowledge systems are understood and integrated into the empirical body of knowledge. There is a need to develop industrial and technological thinking that builds on local knowledge, especially in the fields of tropical medicine where the knowledge exists in Africa but is not being utilized. Experience with the COVID-19 pandemic demonstrated that indigenous knowledge and research as well as traditional medicines have role in global health.

An honest appraisal of the health R&D ecosystem is necessary to address power dynamics in global health research partnerships. Researchers from low- and lower middle-income countries, as well as other minority groups should endeavor to create spaces for others. Fair and transparent engagement of communities in research must be demanded in tandem with the requirement for community researchers' inclusion and recognition in dissemination. There must no longer be an undervaluation of the contribution by Africa to the global health R&D space. Learning institutions must train and produce technical skills that are responsive to Africa's health research agenda. Intra-African research collaborations and funding must be encouraged to build locally relevant capacity.

Africa needs to be intentional about building a commercial sector for research and development to boost local production. The absence of domestic investment in research and development in Africa contributes to disempowerment of African researchers and research institutions. Africa must prioritize funding for research and development to grow its own economy and improve universal health care coverage. Without new products coming from Africa in the next decade, economic growth will not be possible, and targets for treating everyone with essential medicines will not be met.

## Conclusion

In conclusion, there is a need to reform the current health R&D ecosystem in Africa and governments must be held accountable for the transformation of research and innovation in Africa. If the continent cannot develop new products in the coming decade, its ambition for economic growth and universal healthcare coverage is in jeopardy.