

The GAVI Alliance and the ‘Gates approach’ to health system strengthening

Katerini T. Storeng^{a,b*}

^aCentre for Development and the Environment, University of Oslo, Oslo, Norway; ^bLondon School of Hygiene & Tropical Medicine, London, UK

(Received 14 November 2013; accepted 7 May 2014)

Lauded for getting specific health issues onto national and international agendas and for their potential to improve value for money and outcomes, public-private global health initiatives (GHIs) have come to dominate global health governance. Yet, they have also been criticised for their negative impact on country health systems. In response, disease-specific GHIs have, somewhat paradoxically, appropriated the aim of health system strengthening (HSS). This article critically analyses this development through an ethnographic case study of the GAVI Alliance, which funds vaccines in poor countries. Despite GAVI’s self-proclaimed ‘single-minded’ focus on vaccines, HSS support is fronted as a key principle of GAVI’s mission. Yet, its meaning remains unclear and contested understandings of the health systems agenda abound, reflecting competing public health ideologies and professional pressures within the global health field. Contrary to broader conceptualisations of HSS that emphasise social and political dimensions, GAVI’s HSS support has become emblematic of the so-called ‘Gates approach’ to global health, focused on targeted technical solutions with clear, measurable outcomes. In spite of adopting rhetoric supportive of ‘holistic’ health systems, GHIs like GAVI have come to capture the global debate about HSS in favour of their disease-specific approach and ethos.

Keywords: global health initiatives; health systems; policy; ethnography; history

Introduction

During the past 10–15 years, a proliferation of parallel and overlapping coalitions, alliances or partnerships working towards different goals has transformed the global health landscape beyond recognition (Rushton & Williams, 2011). An array of global health initiatives (GHIs) now focuses on specific diseases or selected interventions, commodities or services, often through joint decision-making among multiple partners from the public and private sectors, including multilateral agencies, donor bodies, philanthropic foundations and civil society (Buse & Harmer, 2007; Reich, 2002). Such initiatives have assumed dominant positions within global health policy networks (Lee & Goodman, 2002), challenging the authority of the World Health Organization (WHO) as a global health leader (Brown, Cueto, & Fee, 2006). GHIs also control financial resources for health (McCoy, Chand, & Sridhar, 2009; Ravishankar et al., 2009), supported by the ‘new philanthropy’ exemplified by the Bill & Melinda Gates Foundation.

*Email: Katerini.storeng@sum.uio.no

GHIs have been lauded for getting specific health issues onto national and international agendas, stimulating research and development and improving access to cost-effective health care interventions (Buse & Harmer, 2007). The first comprehensive review of GHIs' impact on countries' health systems concluded that, with a few adjustments to the way in which they are run, they may offer critical opportunities to improve 'efficiency, equity, value for money, and outcomes in global public health' (World Health Organization Maximizing Positive Synergies Collaborative Group, 2009, p. 2137).

Critics counter that GHIs are a double-edged sword: while they massively increase the resources available to global health, they also reinforce a business approach to governance and circumscribed, technical solutions to health (Birn, 2005, 2009b). High-volume global funds from such partnerships can also disrupt the policy and planning processes of recipient countries, for instance, by distracting governments from coordinated efforts to strengthen health systems and by introducing 're-verticalisation' of planning, management, and monitoring and evaluation systems (Biesma et al., 2009; Oliveira-Cruz, 2008, p. 2).

Growing evidence that GHIs have a number of unintended negative health system consequences (Biesma et al., 2009; McCoy, 2009) has reinforced the forceful warning made nearly a decade ago that, without greater investment in country health systems, the health-related Millennium Development Goals will not likely be met (Travis et al., 2004). This has fed into growing pressure on GHIs to be more mindful of how they contribute to the 'health system action agenda' (WHO, 2006). It is partly in response to such pressure that a number of the most prominent GHIs – including the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria – have in recent years expanded their disease-specific remit to include support for health system strengthening (HSS) (Hafner & Shiffman, 2013; Marchal, Cavalli, & Kegels, 2009).

In this article, I critically analyse this development through an ethnographic case study of the GAVI Alliance, often referred to as GAVI. Formed as the Global Alliance for Vaccines and Immunization in 1999 with initial funding from the Bill & Melinda Gates Foundation, it brings together the Gates Foundation with the WHO, UNICEF, World Bank, donor governments, international development and finance organisations, pharmaceutical industry and representatives from developing countries with the aim of influencing market mechanisms for vaccine development and procurement (Muraskin, 2005). Despite a self-proclaimed 'single-minded' focus on the provision of vaccines (GAVI, 2013c), from early 2005, the GAVI Board started to widen GAVI support to HSS (Hill, 2011; Naimoli, 2009). Today, so-called 'HSS support' is fronted as a 'key principle of GAVI's mission' and a 'health system goal' is among its strategic objectives (GAVI, 2013c).

Yet, I argue that what is meant by HSS support remains unclear; contested understandings of the health systems agenda abound within the epistemic community around GAVI, reflecting professional pressures and competing public health ideologies. These speak to an enduring tension in the history of international health between vertical programmes, which are often single disease-focused, and horizontal approaches such as primary health care (Cueto, 2004; Mills, 1983, 2005). I demonstrate that GAVI's notion of HSS is far removed, both conceptually and ideologically, from earlier, broader interpretations of health systems, particularly the commitment to publicly funded health systems as part of overall social and economic development that was a cornerstone of the primary health care ideology enshrined in the Alma-Ata Declaration of 1978 (Cueto, 2004; WHO & UNICEF, 1978). GAVI's HSS concept also has little in common with more recent theoretical understandings of health systems as core social institutions (Freedman, 2005) and as potential mechanisms for alleviating social inequalities (Mackintosh, 2001). And it is even narrower than WHO's more functional understanding of HSS, which sees HSS as building

capacity in six critical components or health systems ‘building blocks’ to achieve more equitable and sustained improvements across health services and health outcomes (WHO, 2006). This is significant because, as I show below, ideological tensions and professional pressures operating within the global health field have enabled GHIs like GAVI to embrace rhetoric supportive of ‘holistic’ health systems, while capturing the broader global health debate about HSS in favour of their disease-specific approach and ethos.

Analytical and methodological approach

My purpose here is not to assess the design, implementation, monitoring or outcomes of GAVI’s HSS support. Instead, I approach the debates around GAVI’s health systems goal as part of a contested social process through which different actors negotiate their positions and claims to legitimacy (Mosse, 2005). Analysis of the actors, content and context of policy is central to understanding this process (Walt & Gilson, 1994), but so too is attention to the practices, power struggles and messiness that often characterise the policy process (Shore & Wright, 1997). I treat the idea of HSS not as a given but as a ‘moving target’ (Hacking, 2007) that undergoes permutations in response to changes in global health governance and ideological positions and that, in turn, through changing meanings, influences these elements. I attempt to embed policy discourse within the expert groups or epistemic communities that generate, organise or are organised by its ideas (Mosse, 2011).

Medical anthropologists have been at the forefront of tracing the ‘local’ effects of global health policy (Castro & Singer, 2004; Janes & Corbett, 2009). By contrast, this study is situated within a ‘global’ sphere, comprising transnational expert communities working on research, policy and advocacy within organisations located in centres of global power, although their work is focused on the poorest countries. It thereby contributes to an emerging ethnographic literature on GHIs (Closser, 2012; Kapilashrami & O’Brien, 2012; Storeng & Béhague, 2013).

My analysis draws on fieldwork conducted between 2010 and 2013 in London, New York, Geneva, Toronto and Oslo, and is also informed by extensive participant observation within the global health field over nearly a decade (Storeng, 2010; Storeng & Béhague, 2014). I analysed policy and scientific documents, and observed debates as they played out in research meetings, academic and public lectures, panel discussions and various high-level policy events. These included the First Global Symposium on Health Systems in Montreux, a high-level panel discussion on vaccines in London, and, in Oslo, various international conferences on global health and vaccination research and a high-level meeting on global health between Bill Gates and the Norwegian Prime Minister. I also conducted in-depth interviews with 22 senior-level current and former representatives of GAVI, intergovernmental agencies (UNICEF and WHO) and donor bodies, NGOs and academics in prominent North American and British public health schools, all of whom can be considered to be part of the global health elite.

In order to protect my informants’ anonymity within highly polarised and politicised debates, I have in some cases had to sacrifice on ethnographic details that would have helped to contextualise my informants’ positions. I only identify my informants by name when their statements were made publicly.

The controversy over GAVI’s engagement with health systems

Although GAVI’s strategic plan and public relations materials stress the centrality of HSS to GAVI’s mission, it is no secret that this expansion of GAVI’s remit has been highly

controversial (Hafner & Shiffman, 2013; Hill, 2011; Naimoli, 2009). A senior official I interviewed at the GAVI Secretariat in Geneva even claimed that ‘health system strengthening has probably been the most contentious area *ever* in the GAVI Board’, specifying that the controversy has been driven by ‘very strong camps on both sides’.

The idea of diverting some of GAVI’s vaccine funding to health systems was initially advocated by Julian Lob-Levitt, a British medic and GAVI’s CEO between 2004 and 2010. Along with a small group of like-minded colleagues, he argued that this would be in GAVI’s interest because strong health systems are needed to sustain high vaccination coverage. Lob-Levitt came to GAVI after decades working alongside low-income country governments to strengthen their health systems and, most recently, advising the UK Department for International Development (DFID) on its collaboration with emerging public-private GHIs. Within GAVI, Lob-Levitt quickly became known as a ‘health systems person’, someone who, as one of his former colleagues put it, was acutely aware of ‘the absurdity of vaccine campaigns that consume four weeks to plan, implement and clean up and that, when repeated eight times a year, totally paralyse the health system’.

Lob-Levitt’s health systems advocacy was bolstered by a series of commissioned evaluations of GAVI, which concluded that weaknesses within health systems relating to financing, human resources and infrastructure were hampering the performance of GAVI-supported immunisation programmes (Naimoli, 2009). Some of the issues identified in these evaluations were unavailability of staff, transport and funds for immunisation activities; few and under-trained health workers; and failure to track available data on immunisation coverage and vaccine stock levels (GAVI, 2005). The evaluation team recommended that GAVI expand its support for vaccines to include HSS in order to address these challenges.

The Norwegian and British Governments, both major donors to GAVI and traditionally known to support a health systems approach, backed this recommendation. It was, however, strongly resisted by many powerful actors in the opposing ‘camp’ of GAVI’s Board, including the US Agency for International Development (USAID), senior vaccination experts and, not least, the Bill & Melinda Gates Foundation. Their main concerns included how to define and measure HSS support and, more fundamentally, whether supporting HSS would alter GAVI’s basic mission (cf. Hafner & Shiffman, 2013). The Gates Foundation was ‘a very loud, vocal voice, saying that we do not *believe* in the strengthening of health systems’, said one of GAVI’s strongest health systems proponents, recalling that Bill Gates often told him in private conversations ‘that he is vehemently *against* health systems ... he basically said it is a complete waste of money, that there is no evidence that it works, so I will not see a dollar or cent of my money go to the strengthening of health systems’. According to several informants who had been on the board at the time, private-sector board representatives were surprisingly supportive of the creation of the HSS window, presumably because they saw strong health systems as necessary for creating sustainable markets for their products.

My informants routinely positioned the contrasting ‘for’ and ‘against’ HSS arguments within well-established fault lines between competing public health ideologies. ‘The Atlantic Ocean separates a complete mind-set on HSS’, explained a health systems expert with UNICEF, who had previously worked for GAVI. While a focus on strengthening public sector health services was often considered typically European and particularly Scandinavian, the USA has historically favoured technology-oriented disease-specific solutions, ostensibly reflecting not just a belief in the power of technology but also a preoccupation with surveys and data in order to have ‘an attribution for their dollar’, as a senior UN agency policy adviser explained. This, he claimed, relates to USAID’s

preference for channelling funding through American NGOs rather than through the sector-wide approaches and budget support models many European donors have traditionally favoured. Bill Gates and his foundation were frequently depicted as an extreme expression of the technical bias in US thinking about health systems. ‘They’re obsessed with this’, commented a UK-based vaccine expert with strong global-level policy ties. ‘And I think it is Mr Gates himself who sort of believes that the world can be cured by technology’.

By contrast to this critically minded informant, most of the vaccine experts I interviewed – and not just American ones – shared Gates’ enthusiasm for technological solutions and his scepticism about supporting health systems. ‘Health systems don’t kill people – diseases do’, was an often-repeated maxim in my interviews, frequently followed by the claim that the notion of a health system is too nebulous to be of strategic value. ‘It’s not clear what you are buying into’, a senior UK-based vaccine expert and GAVI Board member told me, and further suggested that the promotion of a health systems focus has actually damaged vertical disease control programmes:

In my opinion, the term ‘health systems’ and the way it has been used, especially by Scandinavians, has been quite detrimental to disease control programmes, because it’s not been clearly defined what it is. To me, for health systems to function, you have to have an environment that has the financing right, that has the policies right. Then to try to inhibit what health systems people call ‘vertical programmes’ is wrong, because they’re all feeding into a system. If you can get a TB drug to people ... those systems should be able to get out other drugs. And it’s a matter of making sure that the systems used by one programme are being used by another. And to invest in ‘health systems strengthening’ is to me a myth.

For Lob-Levitt and those who had been his collaborators, comments such as this one went to the heart of why they felt it was so important to have a dedicated focus on health systems within GAVI. While they acknowledged that disease control systems can indeed have positive catalytic effects for the whole health system, one of these informants explained that one of the biggest problems with GAVI – and indeed other major GHIs like the Global Fund – has been an unquestioned assumption about the positive ‘knock-on’ effects of vertical programmes, coupled with deep-seated resistance to accept that GHIs’ impact on health systems should be monitored alongside progress on their disease-specific goals:

Everyone always says that ‘no, we *do* contribute to strengthening health systems and we do these great things’, but there are no clear measurables, no clear objectives ... If you have a simple objective that is for every global fund [GHI] to sort of say ‘we will be accountable for strengthening and not undermining global health systems and this is how we will measure it whilst getting [disease-specific] results’, that would be an easy thing to do, but none of them will accept it.

As such, he continued, the importance of creating an HSS window within GAVI was as much to introduce ‘more sophisticated thinking’ about how GAVI could not only *strengthen*, but also avoid *undermining*, national health systems.

‘Just posturing’

The GAVI Alliance Board narrowly voted to endorse the health systems goal in 2005, and after a year of consultations, the HSS initiative emerged (Naimoli, 2009). In GAVI’s current five-year strategy, the health systems goal is one of four strategic goals, alongside

the vaccine, financing and market shaping goals. Although most of GAVI's support to countries is still for the purchase of vaccines, up to a quarter of its funding support is now directed to achieving the strategic goal of 'strengthening the capacity of integrated health systems to deliver immunisation'; between 2007 and 2010, GAVI approved \$568 million and disbursed \$315 million for HSS programmes in 53 countries (GAVI, 2013c). In 2011, the board decided to channel all GAVI's cash support for HSS via a single 'funding window' to be delivered through a Health Systems Funding Platform, which was established in cooperation with the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

While some have interpreted these development as evidence of the GAVI Board's willingness to engage with the health systems debates (Hill, 2011), some of my most critical informants dismissed it as 'just posturing' and implied that the board's acceptance of the health systems goal was little more than a public relations exercise to temper the emerging criticism of GHIs' negative impact on health systems.

A former GAVI official insisted that despite the supportive rhetoric, there is actually very little critical engagement with the question of health systems within GAVI, and that findings about the negative effect of GHI practices on country health systems have barely registered within the vaccine community:

I mean people are so single-minded with what they have to get on and do that I don't know that it has any influence ... Like polio – there was concern that polio [eradication] was damaging other services, the evidence was critical, but nothing really changed as a result.

At vaccine-specific events I attended, I was struck by the fact that the issue of health systems was rarely mentioned at all. During a debate in the run-up to a major GAVI replenishment conference in 2011, for example, the only mention of it occurred in the context of praising GAVI for taking it on. This was even touted by one panel member – a prominent public health specialist and chair of the WHO Strategic Advisory Group on Immunisation – as evidence that the previously 'techno-oriented' Gates Foundation 'is also beginning to move towards health systems strengthening'.

Meanwhile, by the time of my fieldwork, members of the original health systems camp had been gradually marginalised within GAVI. When I visited the GAVI headquarters in December 2012, most of the original HSS proponents had actually left the organisation, amidst a rumour that Lob-Levitt had been 'pushed out' as CEO because of his systems advocacy. According to a GAVI official who declared himself sympathetic to Lob-Levitt, after his departure HSS had been reduced to 'a vertical programme within a vertical initiative'. He questioned the sustainability of HSS support given the absence of a strong health system contingent to take the agenda forward; despite a dramatic increase in GAVI's staff in recent years, he could only think of two people (out of about 120 staff) who would claim health systems as their area of expertise. Moreover, he had noted increased resistance to HSS after GAVI's overall funding started to be threatened by the financial crisis affecting donor countries. One of Lob-Levitt's former GAVI associates, who was now working as a consultant to UN agencies in New York, nevertheless predicted that the HSS window would not disappear entirely, if only because it would remain important for external communication and to leverage the support of 'systems-oriented' donors like the UK and Norway, who are very important GAVI funders.

'A square peg in a round hole'

Lob-Levitt and his team originally conceived of GAVI's HSS support as 'flexible support without many strings attached'. However, the negotiations between the 'for' and 'against' camps within GAVI not surprisingly resulted in a compromise position. As critics pointed out, this compromise position reveals a number of inherent contradictions and weaknesses that limit the ability of GAVI's HSS support to contribute to integrated national health systems strengthening strategies. For one critic who had been involved in formulating the original HSS proposal, the HSS window has come to demonstrate that funding health systems through a vertical initiative like GAVI is 'like trying to place a square peg in a round hole'.

To substantiate his claim, he explained that GAVI support is not substantive enough to have a 'real' impact on health systems. Although HSS support constitutes a considerable proportion of GAVI's budget (peaking at \$137 million in 2008 [GAVI, 2013a]), it is a relatively small proportion of total health expenditure in low-income countries, meaning that HSS that is not part of a country's wider national plan and budget will have limited systemic impact. In fairness, GAVI intended its HSS support to complement, not replace, other funding sources. However, a major problem identified by several of my informants is that HSS support appears to be 'crowding out' other, and more flexible, funding for health systems, as donors claim that their support to GAVI also constitutes support to health systems.

As donors claim to be funding health systems through GAVI, they are in effect 'buying into' a very narrow and highly technical vision of what health systems strengthening entails. Within GAVI, HSS support has primarily come to signify a modality for achieving its primary aim, its vaccination goals. Indeed, critics often characterise it as veering towards *immunisation* strengthening support, rather than broader health systems support. It is 'cold chain-focused', said a former GAVI employee, a reference to the challenge of maintaining a 'cold chain' to ensure that vaccines are refrigerated as they are distributed from manufacturers to consumers. Indeed, as GAVI itself puts it, GAVI encourages countries to use HSS funding to target the 'bottlenecks or barriers in the health system that impede progress in improving the provision of and demand for immunisation and other child and maternal health services' (GAVI, 2013a). It is telling that it uses immunisation coverage, rather than a broader set of indicators to monitor HSS performance.

A consequence of this conceptual distortion of HSS has, according to one critic, been that 'most countries [have] used a kind of supermarket approach ... some vehicles there, some refrigerators there, but there weren't very strong health systems strategies behind it'. Independent analyses have similarly pointed to the way in which the GAVI's HSS support has primarily funded selective interventions targeted at bottlenecks in disease-specific programmes, a critique that applies to other GHIs' health systems investments too (Marchal et al., 2009). In this sense, GAVI's HSS strategy fits squarely within what many global health actors have come to refer to as the 'Gates approach' to global health, an increasingly powerful business-oriented, technology-focused public health ideology propagated by Bill Gates and his foundation (see, e.g., Birn, 2005). Though exemplified most clearly by vaccines, the Gates approach impacts on other public health subfields too. For instance, through research and lobbying, the Gates Foundation has encouraged the international maternal health community to focus on 'magic bullets' like antibiotics to prevent maternal deaths, despite maternal health specialists' insistence that general HSS is required to reduce maternal mortality (Storeng & Béhague, 2014).

GAVI has not been blind to the criticisms against it and its current five-year strategy stresses that the Health Systems Funding Platform GAVI joined in 2011 will guarantee ‘a more holistic approach to HSS’ (2013b). However, a GAVI employee, who did not want to be identified, dismissed the platform as ‘conceptually flawed’ because, after the first year, HSS support is partly conditional on performance on set targets for immunisation. As he pointed out, this contradicts the principle of predictable funding enshrined in the Paris Declaration on Aid Effectiveness (OECD DAC, 2005), which GAVI’s major donors have endorsed. Moreover, he explained, because the official UN immunisation estimates used in monitoring are only updated if new surveys are conducted, countries without new surveys in a given year are unable to demonstrate the ‘performance’ needed to qualify for further HSS funding.

Although the HSS strategy is couched in a discourse of aid harmonisation and country ownership (Hill, 2011), critics accused GAVI of increasingly ‘running its own race’. A former GAVI Board member who identified himself as a ‘health systems person’ recalled how he had advocated for easing the reporting burden on countries by requesting that HSS performance be measured using indicators countries already collect, only to be shut down by USAID and Gates, who demanded ‘clearer and more attributable’ indicators tied to vaccination coverage. He felt that it had been ‘impossible to strike a balance and resolve the situation’. Other informants claimed that the rhetoric on country ownership masks that, despite their nominal representation on the board, national government representatives are poorly placed to influence decision-making within an environment what one European board member described as ‘highly intimidating’. A related concern was that the heavy demands governments face when applying and accounting for the use of HSS support divert attention from coherent national health and development plans.

GAVI’s HSS support thus has little in common with broader visions of health systems strengthening. While it espouses a holistic approach, it is far removed from ideologically driven commitment to health systems as part of overall social and economic development. In ignoring the political, social and cultural dimensions of health systems, including the social determinants of health, it reflects poorly the legacy of the 1978 Alma-Ata Declaration on primary health care (WHO & UNICEF, 1978). Although it aligns itself conceptually to WHO’s functional ‘building blocks’ model, a senior WHO official who was one of the model’s architects lamented that GAVI uses the model as a ‘checklist’ rather than as a heuristic for understanding a very complex reality – a tendency she perceived to be particularly troubling because it is permeating beyond GAVI to the broader global health field. A policy analyst who had traced health systems debates through her 40-year long career in international health stressed that although many of the same words are used now as in the 1970s, today’s discourse is articulated within a much more complex governance context and, importantly, within a ‘very specific’ market-oriented ethos.

Capturing the HSS debate

The limitations discussed above suggest that GAVI’s HSS support may not be well placed to make substantive and sustained impact on countries’ health systems. I would argue, nevertheless, that its move into health systems strengthening is highly significant. This significance relates not so much to the actual disbursement or impact of its HSS funds, as to the way GAVI has – along with other GHIs and the private actors who support them – come to capture the debate on HSS in support of its specific ethos and selective approach.

Throughout my fieldwork, I observed numerous examples of such capture, including within the WHO. Historically the champion of comprehensive primary health care, the WHO has in recent years adopted not only a more functional interpretation of health systems, but also much of the business-oriented rhetoric touted by the Gates Foundation and GAVI. For instance, WHO often relies on market metaphors in outlining the expected ‘returns from investment’ from health systems support (WHO, 2006, p. 4). Strikingly, in public discourse, WHO also contributes to turning the critique of the negative impact of GHIs of country health systems on its head, in favour of GHIs. As WHO’s Director General Margaret Chan put it when addressing the High-Level Dialogue on Maximizing Positive Synergies in 2009: ‘Weak health systems are almost certainly the greatest impediment to better health in the world today. They are the central obstacle that blunts the power of global health initiatives’.

Another manifestation of GAVI’s capture of the health systems debate relates to the apparent shift in the way previously systems-oriented donors now approach health systems; there appears to be an erasure of the long-established Atlantic fault-line in thinking on health systems in favour of an ideological convergence around the so-called ‘Gates approach’ to global health. A British public health specialist with senior-level experience from GAVI, for instance, noted that the UK Government has recently ‘moved away from health systems’ after ‘very heavy lobbying from the Gates Foundation and the [Conservative] opposition, and [now] they’re very much more aligned with the Gates line of thinking’. A UK-based vaccine professor with extensive international policy experience noted the same shift in Norway:

All through this whole vertical versus horizontal era, the people from [Norway] ... have been consistent advocates for primary health care. So they have put big dollars into the WHO, they have been the ones to try to support these things as far as I have understood ... [but] things have changed in recent years, especially with Norway. Norway has stepped out of that field and has become a big player. [The] current prime minister [until 2013] Mr Stoltenberg ... he really is committed to this. But he is lined up to some extent with the US type of approach, the Gates approach.

Of course, donors’ embrace of this approach not only reflects ideological convergence, but also the political expediency of funding GHIs like GAVI and – by extension – of funding HSS through GAVI. According to a public health historian I interviewed, as much as sector-wide approaches were touted in the past, public-private GHIs have become the ‘ersatz unified approach to development’. This is itself part of a wider shift that has been taking place since the 1980s, when the WHO started to cede power to new, non-health actors, such as the World Bank, foundations and other private actors (Brown et al., 2006).

As became clear during global health meetings and debates I attended, this shift reflects that donors increasingly perceive that they can more easily exert influence through public-private GHIs than through what they often refer to as the ‘unwieldy’ traditional intergovernmental system of governance. GHIs have acquired a reputation for being more innovative and effective than the WHO, part of what Buse and Harmer (2007) have called the vilification of the public sector by public-private partnerships for health. This attitude was evidenced at the high-level panel debate on vaccines I attended in London in March 2011, when a DFID representative explained that DFID had decided to invest very heavily in GAVI not only because ‘vaccines are clearly cost-effective’, but also because ‘GAVI is an institution that we are confident in’ and that represents ‘a good

buy'. In a veiled denouncement of the WHO's notoriously inefficient bureaucracy, she elaborated:

And what we have to be able to tell the tax payer is that if we put money into an institution, that money will be stewarded well, with *ambitions*. Problems will be sorted and something will come out at the other end.

Such comments suggest that despite being a narrowly focused public-private partnership without a public mandate, GAVI is now often considered a more 'trustworthy' alternative to the traditional, publicly mandated multilateral UN agencies, including the WHO.

A further reason that donors prefer GHIs is that they are incredibly high profile, which makes bilateral aid to these organisations garner attention. The GHIs are also arguably successful, even if only in terms of their narrowly defined goals, making it easy for donors, who are themselves under increasing pressure to demonstrate aid effectiveness, to claim results for their investments. The GHI model fits well with the political cycle because, unlike inter-sectoral action, it produces results quickly. More generally, suggested a senior UK-based public health professor, GHIs' focus on disease-specific, technical-medical approaches is appealing not only because they can be demonstrated to be cost-effective, but also because they offer a seductive solution to problems that appear to be insurmountable, whether extreme poverty or failing or non-existent health systems:

The problems of the developing world are very difficult for people sitting in somewhere like Washington or London to imagine. They sit there and see this sort of mass of problems and think 'that looks altogether too difficult'. That's when someone comes along and says, 'but hey, if we give them all pneumococcal vaccine we'll save 1.3 billion lives instantly. We don't have to do anything else. We can just pay for the vaccines. It's so easy'. It's completely false, but it's easy. So immunisation has been very easy to sell.

While the HSS window may be contested within GAVI, the expanded focus on health systems appears to have actually *enhanced* GAVI's political appeal, at least to its more systems-oriented donors, providing them with further justification for diverting ever-greater proportions of their development budgets to the organisation. With HSS, donors can – and increasingly do – claim that their funding to GAVI also supports health systems. GAVI's HSS window incorporates 'health systems strengthening' within the seductive logic of GHIs by turning it into something technical and making it appear both manageable and measurable. GAVI's clear emphasis on monitoring to ensure 'accountability' for HSS support seemingly helps to overcome the long-touted problem of not knowing 'what you are buying into'. In this way HSS support arguably increases the perceived cost-effectiveness of GAVI even further, representing a win-win situation for donors who are attracted to GAVI's 'comparative advantage' within vaccines, but who are also committed – whether genuinely or rhetorically – to supporting national health systems.

A culture of deference

Despite the apparent convergence around the 'Gates approach' to health systems discussed above, critical voices clearly do exist among both past and present GAVI members, as well as among individuals within bilateral donor agencies, and within the WHO and academic institutions. In private, for instance, many of my informants from across these institutions questioned the legitimacy and capacity of disease-specific GHIs incorporating private-sector actors to set health systems agendas. A number of WHO

officials depicted GAVI's HSS investment as an infringement of WHO's mandate, even claiming that GAVI's inroad into health systems work was part of a broader attempt to usurp WHO's position within global health (cf. Gostin & Mok, 2009). But many of those who privately voiced critical perspectives admitted that they found it very difficult to do so in public. Indeed, published critiques of the 'Gates approach' to public health exemplified by GAVI are rare (exceptions include Birn, 2005; McCoy, 2009).

I would argue that this perceived difficulty is indicative of a professional culture within global health that encourages public displays of consensus around the GHI model and discourages or even stifles open debate. On one level, this culture of deference is indicative of how dependent many actors in the global health arena – from multilaterals like the WHO to elite public health schools and, of course, the governments of poor countries – have become on GHIs, and also the Gates Foundation itself, for funding and prestige. These new global health actors' agenda-setting power is clearly more than just financial, however, and reflects the personal power that Bill Gates has acquired as a global health leader. While public health experts often privately criticised him for being 'incredibly strong-minded' and derided his techno-oriented approach as naive, Bill Gates is also clearly venerated: 'When Bill speaks, people listen', I was frequently told. With Bill Gates at its helm, the Gates Foundation has surrounded itself with what one informant referred to as an 'aura of un-criticisability'. Indeed, one of the few academics to have publicly criticised the Gates Foundation's public health ideology told me how difficult it had been to find a scientific journal willing to publish this critique. Gates' reputation for being 'not very good at listening' has encouraged a non-confrontational approach within the global health arena that extends even to actors within GAVI; a former GAVI employee and HSS proponent recounted how he and his colleagues used to 'roll down the HSS posters' when Bill Gates came to visit the GAVI headquarters in Geneva because he is known to 'hate this part' of GAVI's work.

Such lack of open, critical debate not only results from professional deference but also reflects the value placed within the global health field on disease-specific technical knowledge relative to health systems expertise, which suffers from low-scientific status and has even been said to have an 'image problem' (cf. Travis et al., 2004). Disease-specific specialisation is encouraged throughout the global health career trajectory, from training, recruitment and funding acquisition to publishing. 'People make their lives around single diseases', said a self-proclaimed health systems expert with UNICEF's immunisation department, adding that he is the only one in his department without the name of a disease after his title. He further claimed that there is 'huge reluctance to deal with the health system within the immunisation community. People don't want to take it on, they are not familiar with it and don't see it as part of their expertise'. Moreover, many global health leaders are trained in biomedicine, a discipline that is on many levels inimical to health systems thinking (Gilson et al., 2011). A senior WHO official and physician admitted that she had been forced to 'unlearn thinking like a doctor' in order to be able to work on health systems issues. While health systems advocates generally arrived at their position off the back of extensive exposure to country health systems, the new generation of global health professionals tends to move straight from elite education in North America and Europe to global health organisations, with little or no exposure to low-income country health systems. In fact, concluded the UNICEF official cited above, 'people have become too accustomed to their elite lifestyle of cocktail parties and fancy dinners to really want to get their hands dirty'.

Conclusion

GAVI has received much public praise for its foray into health systems support. Its own website stresses how HSS support has helped boost access to immunisation and other health services in countries ranging from Afghanistan to Cambodia, through interventions like in-service training programmes for health workers, establishment of health centres and public information campaigns (GAVI, 2013a). Publicly, GAVI appears to have successfully propagated the idea that vertical investment or funding can be a good way to achieve ‘horizontal’ aims like HSS.

Hafner and Shiffman (2013) analyse GAVI’s HSS support as one manifestation of a more general recent growth in global political priority for health systems strengthening. They depict this trend as a new wave of ‘horizontal’ after a long period of ‘verticality’ in the history of global health. By contrast, my ethnography suggests that GAVI’s health systems support actually has more in common with past waves of verticality, continuing the incursion into global health of neoliberal principles and market metaphors and a preponderance of technical solutions to health problems. Within GAVI, the notion of HSS has been gradually narrowed or even distorted, increasingly meaning little more than strengthening the components needed to achieve disease-specific goals (cf. Marchal et al., 2009). ‘HSS’ has taken on a distinct and even reified meaning typical of the techno-managerial paradigm within global health. This is indicative of the fact that we are, as historian Anne-Emmanuelle Birn (2009a) argues, living in an age shaped by new actors and values in the international health field who emphasise demonstrating value for money through evidence of cost-effectiveness. According to one of the former GAVI officials I interviewed, these principles have become so pervasive that ‘the approach now among those supporting health systems is to work within the disease-specific approach’.

Recently, global health leaders have implied that the decades-long vociferous debate about vertical versus horizontal approaches to health can be resolved by taking a ‘diagonal’ approach to public health (see, e.g., Ooms, Van Damme, Baker, Zeitz, & Schrecker, 2008). However, this article demonstrates that the debate on horizontal and vertical approaches is alive and well within elite global health professional communities, even if power struggles and ideological tensions have been silenced by global-level proclamations of consensus and the creation of new, high-profile initiatives for health systems strengthening. While the vertical versus horizontal debate is often dismissed as a stagnant and old debate, I would argue that efforts to dismiss its importance simply buy into the unquestioned authority of GHIs to set the global health agenda. This is a debate that ‘does matter’, as several of my informants agreed, especially at the country level, where the preponderance of disease-specific funding often occurs at the expense of other, more flexible types of funding, with potentially substantial impacts on countries’ ability to develop and implement coherent national health plans (McCoy, 2009).

While GHIs’ support for HSS has often been seen as a positive development, this article supports the view that support of health systems is often instrumental, not intrinsic (Hafner & Shiffman, 2013; Marchal et al., 2009; McCoy, Jensen, Kranzer, Ferrand, & Korenromp, 2013). I would argue that the most important effect of the creation of GAVI’s HSS window has actually been to maintain – or even strengthen – the power of GHIs like GAVI to set the global health agenda. It has contributed to removing debates about health systems from the political realm, recasting them as technical debates about health care and product delivery systems. HSS is presented as a technical solution and is articulated within an internally foolproof logic of cost-effectiveness and ‘saving lives’ that is politically appealing and difficult to challenge (cf. McCoy et al., 2013), and which is itself part of

a broader trend in global health to eschew complexity. Embracing HSS has also contributed to silencing critics of GAVI's narrow focus on vaccines. In the process, the 'Gates approach' has been reinforced within the broader global health community, while alternative public health paradigms have been marginalised. HSS support also justifies the shift in donor support away from publicly mandated institutions. Incorporating HSS within the remit of disease-specific GHIs thus, ironically, serves to legitimise some of the very practices – private financing, disease-based initiatives and a narrow focus on measurable health outcomes – that have arguably contributed to decimating poor countries' health systems.

Acknowledgements

I would like to thank all those who participated in interviews and informal discussions, and those who facilitated my access to the global health debates that provided data for my analysis. I would also like to thank the other authors in this special issue, who provided much useful feedback on earlier versions of this article during two workshops in Oslo, and especially Sidsel Roalkvam and Arima Mishra, my project collaborators. Thank you also to my three anonymous reviewers for their very useful comments and suggestions.

Funding

This research has been funded by the Norwegian Research Council's Global Health and Vaccination Research programme (GLOBVAC) as part of a larger research project, Health systems strengthening within vaccination programmes: an ethnographic study (project number 196382).

References

- Biesma, R. G., Brugha, R., Harmer, A., Walsh, A., Spicer, N., & Walt, G. (2009). The effects of global health initiatives on country health systems: A review of the evidence from HIV/AIDS control. *Health Policy and Planning, 24*, 239–252. doi:10.1093/heapol/czp025
- Birn, A. E. (2005). Gates's grandest challenge: Transcending technology as public health ideology. *Lancet, 366*, 514–519. doi:10.1016/s0140-6736(05)66479-3
- Birn, A.-E. (2009a). The stages of international (global) health: Histories of success or successes of history? *Global Public Health, 4*(1), 50–68. doi:10.1080/17441690802017797
- Birn, A. E. (2009b). The stages of international (global) health: Histories of success or successes of history? *Global Public Health, 4*(1), 50–68. doi:10.1080/17441690802017797
- Brown, T. M., Cueto, M., & Fee, E. (2006). The world health organization and the transition from "international" to "global" public health. *American Journal of Public Health, 96*(1), 62–72. doi:10.2105/AJPH.2004.050831
- Buse, K., & Harmer, A. M. (2007). Seven habits of highly effective global public-private health partnerships: Practice and potential. *Social Science & Medicine, 64*, 259–271. doi:10.1016/j.socscimed.2006.09.001
- Castro, A., & Singer, M. (Eds.). (2004). *Unhealthy health policy: A critical anthropological examination*. New York, NY: AltaMira Press.
- Closser, S. (2012). 'We can't give up now': Global health optimism and polio eradication in Pakistan. *Medical Anthropology, 31*, 385–403. doi:10.1080/01459740.2011.645927
- Cueto, M. (2004). The origins of primary health care and selective primary health care. *American Journal of Public Health, 94*, 1864–1874. doi:10.2105/AJPH.94.11.1864
- Freedman, L. P. (2005). Achieving the MDGs: Health systems as core social institutions. *Development, 48*(1), 19–24. doi:10.1057/palgrave.development.1100107
- GAVI. (2005). *Alleviating system wide barriers to immunization: Issues and conclusions from the second GAVI consultation with country representatives and global partners*. Oslo: Norad.
- GAVI. (2013a). *Health system strengthening support*. Retrieved from <http://www.gavialliance.org/support/hss/>
- GAVI. (2013b). *The health systems goal*. Retrieved from [http://www.gavialliance.org/about/strategy/phase-iii-\(2011-15\)/health-systems-goal/](http://www.gavialliance.org/about/strategy/phase-iii-(2011-15)/health-systems-goal/)
- GAVI. (2013c). *What we do*. Retrieved from <http://www.gavialliance.org/about/mission/what/>

- Gilson, L., Hanson, K., Sheikh, K., Agyepong, I. A., Ssengooba, F., & Bennett, S. (2011). Building the field of health policy and systems research: Social science matters. *PLoS Med*, 8(8), e1001079. doi:10.1371/journal.pmed.1001079
- Gostin, L. O., & Mok, E. A. (2009). Grand challenges in global health governance. *British Medical Bulletin*, 90, 7–18.
- Hacking, I. (2007). British academy lecture 2006: Kinds of people, moving targets. *Proceedings of the British Academy*, 151, 285–318.
- Hafner, T., & Shiffman, J. (2013). The emergence of global attention to health systems strengthening. *Health Policy and Planning*, 28(1), 41–50. doi:10.1093/heapol/czs023
- Hill, P. (2011). The alignment dialogue: GAVI and its engagement with national governments in health system strengthening. In S. Rushton & O. D. Williams (Eds.), *Partnerships and foundations in global health governance* (pp. 76–101). London: Palgrave Macmillan.
- Janes, C. R., & Corbett, K. K. (2009). Anthropology and global health. *Annual Review of Anthropology*, 38, 167–183. doi:10.1146/annurev-anthro-091908-164314
- Kapilashrami, A., & O'Brien, O. (2012). The Global Fund and the re-configuration and re-emergence of 'civil society': Widening or closing the democratic deficit? *Global Public Health*, 7, 437–451. doi:10.1080/17441692.2011.649043
- Lee, K., & Goodman, H. (2002). Global policy networks: The propagation of health care financing reform since the 1980s. In K. Lee, K. Buse, & S. Fustukian (Eds.), *Health policy in a globalising world* (pp. 97–119). Cambridge: Cambridge University Press.
- Mackintosh, M. (2001). Do healthcare systems contribute to inequalities. In D. A. Leon & G. Walt (Eds.), *Poverty, inequality and health: An international perspective* (pp. 175–193). Oxford: Oxford University Press.
- Marchal, B., Cavalli, A., & Kegels, G. (2009). Global health actors claim to support health system strengthening: Is this reality or rhetoric? *PLoS Medicine*, 6(4), e1000059. doi:10.1371/journal.pmed.1000059.s002
- McCoy, D. (2009). Global health initiatives and country health systems. *Lancet*, 374, 1237–1237. doi:10.1016/S0140-6736(09)61778-5
- McCoy, D., Chand, S., & Sridhar, D. (2009). Global health funding: How much, where it comes from and where it goes. *Health Policy and Planning*, 24, 407–417. doi:10.1093/heapol/czp026
- McCoy, D., Jensen, N., Kranzer, K., Ferrand, R. A., & Korenromp, E. L. (2013). Methodological and policy limitations of quantifying the saving of lives: A case study of the Global Fund's approach. *PLoS Med*, 10(10), e1001522. doi:10.1371/journal.pmed.1001522
- Mills, A. (1983). Vertical vs horizontal health programmes in Africa: Idealism, pragmatism, resources and efficiency. *Social Science and Medicine*, 17, 1971–1981. doi:10.1016/0277-9536(83)90137-5
- Mills, A. (2005). Mass campaigns versus general health services: What have we learnt in 40 years about vertical versus horizontal approaches? *Bulletin of the World Health Organization*, 83, 315–316.
- Mosse, D. (2005). Global governance and the ethnography of international aid. In D. Mosse & D. Lewis (Eds.), *The aid effect: Giving and governing in international development* (pp. 1–36). London: Pluto Press.
- Mosse, D. (Ed.). (2011). *Adventures in Aidland: The anthropology of professionals in international development*. New York and Oxford: Berghahn Books.
- Muraskin, W. (2005). *Crusade to immunize the world's children*. Los Angeles, CA: USC Marshall Global BioBusiness Initiative.
- Naimoli, J. F. (2009). Global health partnerships in practice: Taking stock of the GAVI Alliance's new investment in health systems strengthening. *International Journal of Health Planning and Management*, 24(1), 3–25. doi:10.1002/hpm.969
- OECD DAC. (2005). *Paris declaration on aid effectiveness: Ownership, harmonisation, alignment, results and mutual accountability*. Paris: Organization for Economic Development.
- Oliveira-Cruz, V. (2008). Financing primary health care. *id21 insights*, 12, 1–2.
- Ooms, G., Van Damme, W., Baker, B. K., Zeitz, P., & Schrecker, T. (2008). The 'diagonal' approach to Global Fund financing: A cure for the broader malaise of health systems? *Global Health*, 4(6). doi:10.1186/1744-8603-4-6
- Ravishankar, N., Gubbins, P., Cooley, R. J., Leach-Kemon, K., Michaud, C. M., Jamison, D. T., & Murray, C. J. (2009). Financing of global health: Tracking development assistance for health from 1990 to 2007. *Lancet*, 373, 2113–2124. doi:10.1016/S0140-6736(09)60881-3

- Reich, M. R. (Ed.). (2002). *Public-private partnerships for public health*. Cambridge, MA: Harvard Center for Population and Development Studies (Distributed by Harvard University Press).
- Rushton, S., & Williams, O. D. (Eds.). (2011). *Partnerships and foundations in global health governance*. London: Palgrave Macmillan.
- Shore, C., & Wright, S. (1997). Policy: A new field of anthropology. In C. Shore & S. Wright (Eds.), *Anthropology of policy: Critical perspectives on governance and power* (pp. 3–34). London: Routledge.
- Storeng, K. T. (2010). *Safe motherhood: The making of a global health initiative* (PhD dissertation). University of London, London.
- Storeng, K. T., & Béhague, D. P. (2013). Evidence-based advocacy and the reconfiguration of rights language in safe motherhood discourse. In A. Mold & D. Reubi (Eds.), *Health rights in global context: Genealogies and anthropologies* (pp. 149–168). London and New York: Routledge.
- Storeng, K. T., & Béhague, D. P. (2014). Playing the “numbers game”: Evidence-based advocacy and the technocratic narrowing of the Safe Motherhood Initiative. *Medical Anthropology Quarterly*, 28, 260–279. doi:[10.1111/maq.12072](https://doi.org/10.1111/maq.12072)
- Travis, P., Bennett, S., Haines, A., Pang, T., Bhutta, Z., Hyder, A. A., & Evans, T. (2004). Overcoming health-systems constraints to achieve the Millennium Development Goals. *Lancet*, 364, 900–906. doi:[10.1016/S0140-6736\(04\)16987-0](https://doi.org/10.1016/S0140-6736(04)16987-0)
- Walt, G., & Gilson, L. (1994). Reforming the health sector in developing countries: The central role of policy analysis. *Health Policy and Planning*, 9, 353–370. doi:[10.1093/heapol/9.4.353](https://doi.org/10.1093/heapol/9.4.353)
- WHO. (2006). *Opportunities for global health initiatives in the health system action agenda*. Geneva: Author.
- WHO & UNICEF. (1978). *Declaration of Alma-Ata international conference on primary health care, Alma-Ata, USSR, 6–12 September 1978*. Geneva: World Health Organization.
- World Health Organization Maximizing Positive Synergies Collaborative Group. (2009). An assessment of interactions between global health initiatives and country health systems. *Lancet*, 373, 2137–2169. doi:[10.1016/S0140-6736\(09\)60919-3](https://doi.org/10.1016/S0140-6736(09)60919-3)