

## 4.1 Final Publishable Summary Report - Go4Health

### Executive Summary

The Millennium Development Goals (MDGs) have been credited with focusing attention on health development issues and thus contributing to the improvement of global health. The goals and governance for global health (Go4Health project) aimed to formulate New Health Development Goals (NHDGs), and propose new governance for global health that will allow the achievement of these goals in the post MDG era. To achieve these twin objectives it generated and disseminated scientific evidence on how the post-2015 development agenda could address the health MDGs' main shortcomings, including the public health concern that they contributed to the increased verticalisation of global health interventions and the human rights concern of increasing global health inequity. Go4Health committed to proposing NHDGs, embedded in a supportive global social contract. It also committed to engaging actively with the post-2015 policy process and relevant key actors, from high level global policy leaders to marginalized communities, so as to contribute to better understanding of the impact of different actors' priorities on the policy process.

Following extensive research, publication and review of results and consultations with global and local actors, Go4Health advocated that "Realizing the right to health" become the post-2015 health and development goal, – and include two targets, "universal health coverage anchored in the right to health" and "a healthy social and natural environment". This goal and two targets guided subsequent Go4Health analysis. The value and resonance of this broad approach was evident when the post-2015 MDG negotiations fused with the Sustainable Development Goals (SDG) negotiations, thus affirming the importance of an aligned global development agenda that addresses both the social and natural environment.

These developments pushed Go4Health to examine two key issues, how health will be integrated into this larger sustainable development discussion and how the realisation of social human rights, like the right to health, is an essential precondition for the achievement of one of the three pillars of sustainable development, namely social sustainability. We used these considerations to guide our analysis of the proposed and final SDG goal on health, "Ensure healthy lives and promote well-being for all at all ages" (SDG 3). Our analysis focused on eight key themes that emerged from our initial research and consultations; 1. Governance, 2. Domestic Financing, 3. International Financing, 4. Health and Environment, 5. Access to Medicines, 6. Community Participation, 7. Universal Health Coverage and 8. Accountability.

By using these eight key issues to examine the health-related SDG targets and priorities for implementation, from a rights based perspective and outside a rights frame, the added value of the rights framework for advancing global health equity becomes clearer. Our research demonstrates that an extensive reworking of global health governance and global health financing is needed so as to overcome gridlock and competition among (inter-) national health actors. The fundamental importance of participation and accountability in the rights-based

approach, key findings reaffirmed by our research, leads us to conclude that for the post-2015 agenda to realise its goal of “leaving no one behind” a rights- based approach can provide useful guidance on both global health governance reform and priorities for implementation.

## Project context

In 2000, world leaders adopted the Millennium Declaration and agreed that the subsequent Millennium Development Goals (MDGs) would guide global development policy until 2015, at which point a new global agreement would enter into force. The Goals and Governance for Global Health (Go4Health) project responded to the European Commission call on *“Setting health-related development goals beyond 2015,”* which is part of the *“Coordination and Support Actions Across the [Health] Theme.”* Go4Health was tasked with helping *“ensure that the health-related development objectives for the period after 2015 are based on the best scientific evidence available and address the main shortcomings of the current MDGs.”*

Goals and governance are the essential elements of a social contract, which is a political philosophy concept underpinning the relationship between citizens and governments: together, citizens agree on a set of goals, and accept an authority empowered to take the necessary measures to achieve those goals. The Millennium Declaration can be understood as an emerging global social contract. The Millennium Declaration’s preamble sets forth a bold vision for a common humanity, advancing global responsibilities without diminishing national responsibilities: *“We [heads of States and Government] recognize that, in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level.”* It is a contract between governments, and between citizens of the world.

The key aim of the Go4Health project was to advance and improve on the concept of a global social contract as first articulated in the Millennium Declaration; proposing a set of New Health-related Developments Goals (NHDGs) and a governance structure centred on a framework of common but differentiated responsibilities. Specifically, we aimed for the NHDGs to strike a *“balance between horizontal and vertical approaches to healthcare”*; it should indicate *“an improved system for global health innovation”*; and should *“be measurable, achievable and sustainable,”* while effectively accounting for *“the constraints of developing countries for improving health outcomes themselves.”*

Go4Health combined the findings of four different research streams (each the subject of a Work Package -WP) and made sure there was cross-fertilisation among these streams:

1. MDG & Innovation - analysis and dialogue with governments providing assistance
2. Essential Health Needs- formulation and dialogue with communities and civil society
3. National & International Responsibilities Allocation - dialogue with governments requiring assistance
4. Global Governance of Health - analysis and dialogue with multilateral actors

The links between these research streams and the formulation of the NHDGs was based on the following assumptions:

Assumption 1. The NHDGs will not represent a rupture with the Millennium Development Goals (MDGs) agenda, but will build on the MDGs process and agenda. It is therefore essential to critically analyse the strengths and weaknesses, the achievement and the shortcomings of the MDGs process. This analysis will cover classical public health aspects such as improvements with respect to mortality and morbidity, coverage, and cost-effectiveness, but also achievements with respect to the underlying policy objectives such as equity, accountability, solidarity and shared responsibility. Likewise, new internationally agreed solutions for health innovation (and successful sharing of the benefits of health innovation) are likely to build upon solutions that are already being proposed. We call this the ‘MDGs & Innovation analysis’ research stream.

Assumption 2. The NHDGs will be linked to the emerging international consensus on Universal Health Coverage (UHC). The Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions on ‘The EU Role in Global Health’ explicitly embraces *“the challenge of universal health coverage,”* while the accompanying Commission Staff Working Document on ‘Contributing to universal coverage of health services through development policy’ mentions *“Insufficient and uneven progress towards the health MDGs”* as one of the main reasons to aim for universal health coverage. However, turning the UHC concept into measurable, sustainable and achievable goals will require a more precise formulation of the definition used by the World Health Organisation (WHO): *“Universal coverage of health care means that everyone in the population has access to appropriate promotive, preventive, curative and rehabilitative health care when they need it and at an affordable cost.”* To be convincing, the formulation of what we will call ‘Essential Health Needs’ (EHNs) should build on extensive consultations with the key stakeholders: the communities whose health is most severely compromised. And to achieve universal health coverage requires not only more clearly defining its scope, but also establishing the mechanisms and processes required to ensure that coverage extends to the poorest and most marginalized populations, to enable communities to hold governments and health services accountable for providing these services, and to ensure that communities have a role in developing the policies that will deliver these EHNs. We call this the ‘EHNs formulation’ research stream.

Assumption 3. We need new goals, but we need governance too. This aspect has been reinforced as the first priority for action in the new 2011 EU communication *“Increasing the impact of EU Development Policy: an Agenda for Change”*. While the MDGs succeeded in generating political consensus on and mobilising resources towards agreed goals, they were less successful at clarifying responsibilities for achieving them. For example, the MDG target about sharing global health innovation – *“In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries”* – is particularly ambiguous about the allocation of responsibilities. To be achievable and sustainable, the NHDGs will have to be embedded in an agreement that allocates responsibilities, national (states towards their inhabitants) and international (the international community towards states needing assistance). We call this the ‘National & International Responsibilities allocation’ research stream.

Assumption 4. Governance not only requires allocation of responsibilities, but also organisations and mechanisms to ensure accountability. Uneven progress towards the health MDGs may be due, at least in part, to the uneven creation of organisations, institutions and regimes for supporting the achievement of the MDGs. For example, MDG6 benefitted from the Global Fund to fight AIDS, Tuberculosis and Malaria, while, until recently, no similar organisation existed for MDG4 or MDG5. To be achievable and sustainable, the Global Governance of Health must be better understood, and will likely need to be modified. We call this the 'Global Governance of Health analysis' research stream.

Throughout the project, we ensured cross-fertilisation among the research streams outlined above, creating an interdisciplinary think-tank, representing leading research and civil society institutions across the globe with close links to health policy development at the national and international level. We also maintained our commitment pursuing a right to health-based approach while remaining attuned to the political realities that could influence decisions to embed the NHDGs in a global social contract that will clarify national and international responsibilities and propose improvements in global governance of health.

The Go4Health Consortium pursued an intensive dialogue with all key stakeholders, such as national and international policy makers, international organisations, and civil society, and especially with a selection of communities that will be most impacted by the NHDGs (e.g. in Bangladesh, Uganda, Zimbabwe and Guatemala) , throughout the project.

**Our main objectives included:**

- **General objective: To propose NHDGs, embedded in a supportive global social contract.**
- **Specific objective 1: To critically analyse the MDG approach, its achievements and shortcomings, including the present incentive systems for MDG-related health innovation.**
- **Specific objective 2: To formulate a set of goods and services that corresponds with the NHDGs, which should be guaranteed to every human being as entitlements under the human right to health.**
- **Specific objective 3: To affirm and further elucidate the national responsibility for providing these goods and services, and to clarify the international responsibility in relation to the national responsibility.**
- **Specific objective 4: To critically analyse and propose changes to the present global governance of health, such that it holds governments and others more accountable for their responsibilities, enhancing the likelihood that the goals will be achieved.**

To achieve these objectives each research stream (WP) committed to the following specific objectives:

## **WP 1 - MDG and Innovation**

1. To analyse the current MDG approach with respect to its specific targets and underlying policy objectives such as access to health care, health systems, sustainability, equity, gender equality, local ownership, and empowerment; and to analyse the present incentive structure for health innovation and alternatives proposed.
2. To organise a continuous consultation and communication process on a framework for the NHDGs with stakeholders and policy makers on global and European level, with particular attention to the European Commission's DG DEVCO (Development and Cooperation) and other EU institutions.
3. To develop a concept for new and revised development goals based on evidence and advice gathered through the above mentioned MDG analysis and stakeholder consultation, and as derived from WP2, WP3 and WP4, with a particular focus on the shortcomings of the present health innovation system.

## **WP2 - Essential Health Needs (EHNs)**

1. Based on communities' own expectations and assessment of needs, to determine health care goods and services, and other underlying determinants of health that should be guaranteed to every human being as entitlements.
2. To identify communities' expectations and demands in relation to their participation in public policy development, implementation and monitoring, and the mechanisms they suggest for holding authorities and other duty bearers accountable.
3. To elicit from communities suggestions as to mechanisms and processes that will ensure the right to health for marginalised and vulnerable individuals and communities.
4. To translate findings from diverse communities into a coherent set of right to health expectations that will inform work of other WPs in determining national and international responsibilities and global governance for health.
5. Gather and analyse views of civil society organisations regarding the right to health expectations of the communities they represent, to further inform work of other WPs on responsibilities and governance.

## **WP3 - Allocation of National & International Responsibilities**

1. Assess how national and international responsibilities for health have been allocated (or not) in treaties and non-binding international instruments (e.g., declarations, resolutions), in constitutions, in case law (mostly about national responsibility), in previous international efforts to improve health, and in relevant literature.
2. Assess real and perceived "*constraints of developing countries for improving health outcomes themselves*" with a particular focus on national financing capacity, but also on affordability of medicines, availability of human resources, and right to health shortcomings in such areas as equity, participation, and accountability.
3. Identify gaps in MDG process.

4. Examine the development and definition of the minimum core concept in international human rights law, including through reviews of international human rights law and policy, literature reviews, and interviews with key drafters of the Maastricht Principles and General Comment 14 on the right to health.
5. Identify weaknesses in present practice of international assistance, in terms of volume and longer term reliability of international assistance, its contributions to greater equity, accountability of international assistance to local populations, and inclusive country ownership including participation of communities and marginalized populations in determining uses of assistance.
6. Identify weaknesses and gaps in present national practices to improve health equity, ensuring the accountability of health services to populations, and inclusive participatory processes in developing, monitoring, and evaluating health policies and practices.
7. Compare EHNs as developed in WP2 with costing estimates that have already been made, trying to affirm or infirm the validity of these estimates.
8. Determine domestic health funding targets consistent with the right to health and its requirement to expend the maximum of available resources towards economic, social, and cultural rights, while avoiding taxation levels that would further impoverish already poor people.
9. Determine international health funding targets that will ensure universal health coverage for all people.
10. Determine obligations with respect to equity, participation, and accountability in national and international health policies, processes, and funding.
11. Provide a conceptual framework for applying the principle of shared responsibilities as formulated in the Millennium Declaration on complex issues like health innovation (responsibility for encouraging and rewarding the development of medicines most needed by the communities whose health is most affected) and migration of health workers (responsibility for training and retaining health workers, and possibly compensation).

#### **WP 4 - Global Governance of Health**

1. To summarize current institutional structures that support the achievement of the MDGs and challenges and opportunities these create for the future.
2. To propose changes to the present Global Governance of Health such that it holds governments and others more accountable for their responsibilities, enhancing the likelihood that the NHDGs will be achieved.
3. To clarify where in the Global Governance of Health landscape responsibilities for ensuring the affordability and accessibility of both new and existing essential medicines, building local research and production capacity, and ensuring financing of future research and development efforts should be discussed and agreed upon.

## Main Results

The EC funded Go4Health Project was launched on 1 September 2012 and ended on 29 February 2016. Its main objective was “Formulating new Goals for global health, and proposing new Governance for global health that will allow the achievement of these goals.” To achieve this objective, throughout the three and a half years of the Project, partners first focused on researching and developing a Go4Health position on the new health goals and the governance needed to achieve these goals. The results of these efforts appear in the two Go4Health reports from September 2013, “Realizing the right to health for everyone: the health goal for humanity” and December 2014, “The health-related development goal in the post 2015 negotiations: the right to health - buoyed or drowning in sustainable development?”. In parallel, Go4Health partners published different outputs from this research in peer-reviewed journals. After developing the Go4Health position, partners focused on publishing their work in peer reviewed journals, engaging in dissemination activities and contributing to a wide-range of different types of discussions on the post-2015 process. The focus on publishing research output is reflected in the numerous (over 35) peer-reviewed academic publications. This report on results will focus on the two key reports developed by Go4Health and the main themes that emerge in the numerous published articles, both peer and non-peer reviewed over the course of the Project. The dissemination and network building are addressed in detail in the impact section.

To understand the significance of the Go4Health Project, and its ongoing impact, it is first necessary to provide some background for understanding the significance of these results. Therefore, first we reflect on the objectives and deliverables identified in the Description of Work (DOW) and, where possible, identify the contributions from each work package (WP) to realising the envisaged results. It is important to bear in mind that Go4Health aimed for cross-fertilisation of research and results from different WPs so it is difficult to attribute responsibility for many of the results to any one partner, for example in publications with authors from several WPs. The value of this highly collaborative approach is evident in the volume of publications arising through cross-learning and sharing of experiences.

The Go4Health Project was comprised five interlinked work packages (WPs):

### **WP 1 - MDG and Innovation, analysis and dialogue with governments providing assistance**

Lead Partner: Universitätsklinikum Heidelberg, Germany

Other Partners: London School of Hygiene and Tropical Medicine, UK

### **WP2 - Essential Health Needs (EHNs) formulation and dialogue with communities and civil society**

Lead Partner: Georgetown University, USA

Other Partners: MEDICO International, Germany; CEHURD, Uganda; BRAC, Bangladesh; CEGESS, Guatemala

**WP3 - Allocation of National & International Responsibilities allocation and dialogue with governments requiring assistance**

Lead Partner: University of Nairobi, Kenya

Other Partners: University of Toronto, Canada

**WP 4 - Global Governance of Health analysis and dialogue with multilateral actors**

Lead Partner: University of Edinburgh, UK and University of Queensland, Australia

**WP 5 – Internal management, coordination and dissemination**

Lead Partner: Institute of Tropical Medicine, Belgium

The Go4Health DOW identified one general objective and four specific objectives which guided all research:

General objective: To propose New Health Development Goals (NHDGs), embedded in a supportive global social contract.

Specific objective 1: To critically analyse the Millennium Development Goals (MDG) approach, its achievements and shortcomings, including the present incentive systems for MDG-related health innovation.

Specific objective 2: To formulate a set of goods and services that corresponds with essential health needs, which should be guaranteed to every human being as entitlements under the human right to health.

Specific objective 3: To affirm and further elucidate the national responsibility for providing these goods and services, and to clarify the international responsibility in relation to the national responsibility.

Specific objective 4: To critically analyse and propose changes to the present global governance of health, such that it holds governments and others more accountable for their responsibilities, enhancing the likelihood that the goals will be achieved.

Below we shall address how inputs from the specific objectives contributed to realising our general objective, “Propose NHDGs, embedded in a supportive global social contract” (deliverable five, milestone two). The finalisation of this 2014 Report is entitled ‘ The health-related development goal in the post 2015 negotiations: the right to health - buoyed or drowning in sustainable development? (Available from <http://www.go4health.eu/publications/>) was the starting point for the Project’s key contribution to the post-2015 discussions. The 2014 Report reflected the combined input of Go4Health partners and their commitment to develop the key themes in this Report.

## The Go4Health Reports

To understand the importance of the 2014 Report requires we review the research and analysis that required the collaboration and cooperation of all Go4Health partners. During the first phase of Go4Health, (September 2012 – September 2013), the Consortium partners identified key elements for the NHDGs and a supportive global social contract, based on evidence from the four different research streams/WPs.

Concretely, at the first Go4Health workshop in Entebbe, Uganda, in September 2012, the road map for the Go4Health project was developed (deliverable one). Each WP group committed to gathering evidence in line with the relevant research stream, and presented it in a way that is relevant for the other WPs, including through internal briefs (deliverable two). The result was a schematic overview of gaps and tensions in progress towards universal health coverage (UHC). For WP2 this work included consultations with marginalised communities, in Bangladesh, Guatemala, Zimbabwe and Uganda. Consultations were necessary as there is insufficient evidence on communities' views in the academic literature.

The second internal project workshop, organized by WP1 in Heidelberg saw partners build on the internal reports prepared by each WP (deliverable two). In light of the feedback from Go4Health related research, and following debate, at an internal Go4Health workshop in March 2013 in Heidelberg, Go4Health partners agreed that “Realizing the right to health” should become the post-2015 health and development goal, – and that it should include two targets, “universal health coverage anchored in the right to health” and “a healthy social and natural environment”. We advocated that the right to health should be understood as a right to health protection, including two components: a right to health care and a right to healthy conditions. However, to respond to the legitimate expectations of the communities with which we consulted, we argued that these components need to be infused with the essential principles of the right to health: progressive realization, non-discrimination, cost-effectiveness, participatory decision-making, prioritization of vulnerable or marginalized groups, minimum core obligations, and shared responsibility.

The results stemming from these deliberations and ongoing interaction between WPs contributed to our report which outlined the first proposal of NHDGs, embedded in a supportive global social contract in September 2013 (deliverable three): ‘Realizing the right to health for everyone: the health goal for humanity’, available from: <http://www.go4health.eu/publications/>. A Spanish version, ‘Realizando el derecho a la salud para todos: Salud para toda la humanidad’ is also available. This report was presented to the public at a satellite session during the 8th European Congress of Tropical Medicine and International Health (ECTMIH) in September 2013 in Copenhagen, Denmark (<http://ectmih2013.org/go-4-health/>). In this report, we followed the structure of the four specific objectives, corresponding with the four WPs. Under the two sub-goals we proposed (healthcare and healthy environment), we reported the expectations from communities (WP2), the requirements of international human rights law (WP3), and the situation under the present MDGs (WP1). The findings of WP4 (global governance) are reported under a separate section.

After September 2013, (Phase two of the project – September 2013-September 2014) the original work plan foresaw returning to the different constituencies for feedback. However, it became apparent that a major change in the MDGs reformulation process saw the Sustainable Development Goals (SDGs) formulation process taking over from the MDGs reformulation process, so we had to adapt to these circumstances. Furthermore, early feedback convinced us that it would make more sense to consider targets and indicators in the community questionnaire – not only the goals that we had proposed. We therefore decided to create a working group on targets and indicators. The results were presented in Antwerp at a Go4Health internal workshop in March 2014. The second round of community consultations therefore started in March 2014, rather than in October 2013, and the first draft of the Second report on the NHDGs embedded in a social contract was ready for comment in September 2014, instead of April 2014.

In September 2014 we presented the first draft of the Second report on the NHDGs at a multi-stakeholder conference (including civil society, academia, EC -and German government representatives) in Berlin. On the basis of this feedback and taking into consideration the findings of other groups we finalised the agreement on NHDGs and supportive global social contract in December 2014 (milestone two and deliverable 5). This report is entitled ‘The health-related development goal in the post 2015 negotiations: the right to health - buoyed or drowning in sustainable development? (The Second Go4Health Report) Available from <http://www.go4health.eu/publications/>

The Second Go4Health Report summarises progress on the post-2015 negotiations, noting that in December 2014 many important questions remained unanswered. Our report focused largely on the Open Working Group (OWG) ‘final’ proposal of July 2014 which contained 13 health targets – nine of them (3.1 – 3.9) addressing outcomes, four (3.a – 3.d ) addressing ‘means of implementation’ – under the umbrella health goal to “Ensure healthy lives and promote well-being for all at all ages. We asked, “would the 13 health targets be reduced to fewer, more comprehensive and integrated targets?” We observed that, previously (prior to the publication of the OWG proposal) that some of the key stakeholders appeared to support a more comprehensive approach. For example, the European Commission (EC) Communication – of obvious importance for Go4Health – of June 2014, “A decent Life for all: from vision to collective action”, proposes a more comprehensive integrated health goal, with only four sub-goals and a prominent role for Universal Health Coverage (UHC). In addition, the “Common African Position on the Post 2015 Development Agenda”, developed by the African Union (AU), also proposes “Universal and equitable access to quality healthcare”, rather than a series of issue-specific targets. Last but not least, the communities of marginalised people we consulted expressed a clear preference for a goal that is flexible and responsive to their needs, rather than a series of targets approved at the global level that may or may not correspond with their most urgent needs. For more details see: <http://www.go4health.eu/wp-content/uploads/WP2-August-2013-FINAL-Light.pdf>

Therefore, rather than a further elaboration of our original proposal, our Second report on the NHDGs (our overall objective) examined the seven main tensions we identified when comparing

the OWG proposal with the EC and the AU proposals. (see above). The report is based primarily on our analysis of feedback on our original proposal gathered from extensive stakeholder consultations with diverse groups, including EU member state representatives and marginalised communities, to explain why these tensions exist, and why they were important for the ongoing post-2015 health goal negotiations. Ultimately, once the OWG framework was agreed the diplomats negotiating the SDGs were not willing to reopen the negotiations, and moved forward with finalizing the conditions and language in this framework. Thus, although from 2012-July 2014 UHC had been a leading, well-supported contender to assume the role of 'new health development goal', following the finalization of the OWG framework, it emerged as one of the health SDG targets, not the umbrella goal many had lobbied for.

During the final phase of Go4Health (September 2014-February 2016), team members were prolific publishing over twenty peer reviewed publications, engaging in numerous dissemination events, continuing and expanding engagement with civil society and expert groups and expanding the Go4Health network. Part of the expansion of the network was due in part to the renewed focus on global health governance in light of the global response to Ebola. The results from this period were guided by decisions taken at the Go4Health internal workshop in Antigua, Guatemala. The consensus was that the final SDG outcome document would closely resemble the OWG proposal and that it would be most likely be adopted by the General Assembly in New York in September 2015. It was further agreed that further research and analysis would be guided by the Go4Health proposal that universal health coverage be anchored in the right to health. This required that the Go4Health team examine:

1. How health will be integrated into the larger sustainable development discussion
2. How the realisation of social human rights, like the right to health, is an essential precondition for the achievement of one of the three pillars of sustainable development, namely social sustainability

Eight key entry points for addressing these two questions guided research, analysis, writing and dissemination. They emerged from the first two years of research, analysis and engagement with the post-2015 process.

1. The process of global health governance
2. Financing for health the role of the international community
3. Financing for health the role of the national government
4. Health and the environment
5. Access to medicines
6. The role of community participation
7. How to define and advance Universal Health Coverage
8. What type of accountability?

## Results – Publications

In December 2014, Go4Health Partners agreed to us these eight themes to guide their work, and to focus on understanding developments in relation to these topics in light of the overarching objectives for this period, namely tracking the emerging priorities for implementation (deliverable 6) and the global governance required to achieve these. As the Go4Health Consortium was comprised mainly of academic partners (seven) and civil society partners (three) its academic output was prolific generating (by 29 February, 2016) over fifty publications (thirty six peer reviewed academic publications) in diverse fields and published in public health journals, legal journals and medical journals. Please note that several Go4Health publications are still being peer-reviewed.

The bulk of Go4Health research and thinking on these eight key themes can be found in the numerous peer reviewed articles published throughout the project and listed in annex one (also see [www.go4health.eu](http://www.go4health.eu)). The section below summarises Go4Health thinking on the eight themes.

## **Results – Summary of findings**

### **1. Global Health Governance**

The international response to the Millennium Development Goals initiated a series of global changes, now integral to the narrative of Global Health Governance, with impacts at multilateral, bilateral and regional levels, with the EU acting as a global leader. It seems likely that the SDGs will have a different pulling force from the MDGs because they are much broader in scope and more comprehensive. Whether they will be as influential is hard to predict at this time. Thus, focusing attention on the current global health governance structure, and how it is evolving, are of key importance to understanding the advance of the SDGs. WP 4 team members have used an international relations perspective and incorporated a rights analysis, working with WP 3, into their work on global health governance. This addresses whether and how SDG implementation will replicate the impact of the MDGs in terms of global policy, governance and interventions for health and development.

### **2. Financing (international)**

In examining the role of international financing for advancing health rights in the post-2015 agenda we focused on one key question: how would international public financing for the health SDG look different if the health SDG were phrased and framed as an operational agenda to realize the right to health? In answering this question WP3 focused on three key financing issues; volume, reliability and alignment. First we examine the question from a rights based perspective and second compare this with the current approach.

Under international human rights law, states have the primary duty to fulfil the rights of those within their borders.

While we cannot state that realising the right to health demands precisely the international financing target set forth by the Chatham House Working Group on Health Financing, we can confirm that the realization of the right to health requires a kind of agreement, under which all states – wealthy and poor – make reciprocal commitments about domestic and international financing, of which the order of magnitude would be in line with the targets set forth by the Chatham House Working Group on Health Financing.

Shared responsibility is fundamental to a rights-based approach to health and if we apply this principle to international public financing for health it can also help address some of the problems associated with reliability and alignment. A rights-based and shared responsibility grounded compact could help clarify the conditions under which states would qualify for international public financing. While it seems likely that wealthier countries will try to prioritize infectious disease control efforts and addressing global health risks, as the global response to HIV and Ebola demonstrate, it seems unlikely that they will succeed in establishing a compact based on reciprocal commitments that do not follow domestic needs, such as for maternal and child health or the growing burden of Non-Communicable Diseases (NCDs)

### **3. Financing (domestic)**

This research, undertaken by WP3, addresses the on-going debate on the limits of domestic or national responsibility for realising social rights, and the right to health in particular, and what should be expected of national governments vis à vis funding.

In discussing international human rights, states and scholars make numerous references to the limited resources that are available. It is therefore clear that at the domestic level there is a need for a clear and well set out health strategy framework to improve health services and health care. The paradigm of limited resources and the ensuing complications arising from the use of all these diverse financing mechanisms, fails to recognize the new data that has emerged on the failure of taxation. In particular, it does not address the failure of Multinational Corporations (MNCs) to pay their fair share of tax, not to only developing but also developed countries.

Go4Health research affirms that participation is crucial towards the realisation of the right to health of individuals and communities. Through relying on its own resources a state would be able to put in place infrastructure and provide access to essential medicines required by its population. The financing of this infrastructure and provision of essential medicines will then be done through a system that is based on domestic resource mobilisation and participation of its population. The participatory approach becomes especially important in situations of conflict where refugees and migrants across borders were not taken into consideration previously in the fiscal planning not just for health but the entire social services system.

A further key challenge to domestic financing of health firstly is that health concerns vary over time, region and communities. While malaria may be a problem in one country, diabetes may be prevalent in another. Different diseases have different costs for medication and care; health concerns also have different costs because of purchasing power parity; and as result, there can be no way in advance to exactly quantify spending. In addition, allocation within a domestic state should take place at the various tiers of government, federal, state/county and constituency as well as village level to ensure geographical spread without concentration in specific regions within a state.

In order to finance the right to health and Universal Health Coverage (UHC), there must be clarity on what is included in the basket of goods and services in order that a state can both plan and also allocate adequate resources to cater for it. WP3 has advanced work on this but further research is needed. The legal framework for this is set out in the International Covenant on Economic, Social and Cultural Rights (Covenant) and other treaties that have over the years been expressed in legislation at the domestic level. However there remains a lack of clarity firstly on what is included in the right to health, as health concerns vary over time and place. Secondly, on how much should as a result be allocated annually to ensuring a healthy domestic population.

There is no clarity provided internationally as to when a state should be a donor and when a recipient but in the spirit of community and joint development of the globe all states ought to contribute money for international co-operation and assistance based on their ability in order that each at minimum assists their neighbours and develops the global community of nations. Further, an international template on implementing common but differentiated responsibilities can be found in the 1997 Kyoto Protocol and the Framework Convention on Climate Change Agreement, finalised in Paris in December 2015.

The end aim or goal of a domestic health financing framework should be “health for all” which takes into consideration not just fiscal support but satisfaction of peoples’ needs while recognising the resource limitations and prioritization. However domestic health financing should benefit not just from state allocations but also international co-operation and assistance. With respect to international co-operation, according to an ever increasing number of reports on this matter, the volume and scope of international financial flows, illicit capital flight, tax evasion and tax avoidance is vast. This suggests there is clearly a need to address international taxation rules so as to improve national tax collections efforts, especially from multi-national corporations. This objective stands in contrast to the recent discourse that focuses on increasing forms of domestic taxation and overburdening an already exhausted individual tax base.

#### **4. Health and the environment**

As it became clear that the SDG and post MDG process were merging, the prospects for a more holistic approach to addressing health and the environment appeared strong. This optimism, and the benefit of this holistic approach, was reflected in the 2015 Lancet Commission on Health and Climate Change which noted that *“The central finding from the Commission’s work is that tackling climate change could be the greatest global health opportunity of the 21st century”*. However the final reality is not as promising. While the global health community, including WHO, rightly emphasis the synergies and co-benefits for the health as well as the environment agenda (“greatest health opportunity”), it appears that there are also political motives behind this move as climate change has become a dominant global theme and health has lost its prominence, that it enjoyed in the MDG context.

In assessing how this process has played out WP 1 colleagues note that “there are strategic considerations that health, and funding for health may be best served by linking it to the environment and climate change agenda. It is, however, difficult to argue for universal health coverage from an environment perspective, as the implementation of UHC is unlikely to contribute substantially to the achievement of lower carbon emissions. Thus, we propose to build the argument for *both*, a healthy and sustainable environment, as well as UHC on their foundation in human rights, rather than the co-benefits, which exist in some, but by far not all areas of health care.”

Thus, to truly advance a holistic health and environment agenda the importance of a rights-based agenda has become more evident. However, the SDGs, like the MDGs are a political

declaration which evidence intention to act, but the consequences of inaction for a country's government remain minimal. The appetite for binding accountability mechanisms has not increased.

## **5. Access to medicines**

If we understand UHC as access to health care and to a healthy living and social environment it is clear that access to essential medicines is a key component of UHC. WP 3 research on access to medicines framed this issue as a human rights issue highlighting deficiencies in the harmonisation of different legal regimes.

In comparison to the MDGs, global policy has progressed since then, with the medicine goal in the SDGs (SDG 3) calling for states to: "Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all."

The SDG goal is markedly broader and more ambitious than its counterpart in the MDGs, encompassing both innovation of new medicines and access to existing medicines, incorporating both communicable and non-communicable disease, and explicitly citing the Doha Declaration in affirming the right to use TRIPS flexibilities to the full. These inclusions suggest that the global perspective on access to medicines has shifted considerably since the MDGs were formulated in 2001. However, despite this progress we believe that there has been negligible impact on the primary barriers to access, namely affordability. In fact, these barriers, TRIPS-plus intellectual property rights are not only expanding through bilateral and regional free trade agreements, but are getting stricter, with TRIPS flexibilities being limited and even eradicated and the global movement of generic medicines through international borders being continually obstructed under measures to eradicate counterfeit medicines.

WP3 further argues that the full use of TRIPS flexibilities may be the primary solution on the table to increase accessibility but it is a poor solution from a human rights perspective. It is notable therefore that the 2012 UN Commission on HIV and the Law has recommended that WTO members urgently suspend TRIPS for essential drugs for low and middle-income countries, and that the UN secretary general convene a new body to recommend a new intellectual property regime for drugs. The recently established United Nations Secretary-General's High-Level Panel on Access to Medicines, set up in response to this demand, will provide an important testing ground for promoting an intellectual property system, which doesn't just enhance protection of the public interest as an externality to its ethos of advancing trade interests. It has the potential to locate the intellectual property regime within the broader system of international law and as such responsive to the requirements of international human rights law.

## **6. Community participation**

The research on community participation in the post-2015 process produced some of the guiding lines for Go4Health engagement with questions about the process of goal setting and governance. The importance of unpicking what participation really means, including how it is interpreted and relates to the right to health, remained key issues throughout the project.

The importance of people's participation; People's participation is integral to improving health system responsiveness (through identifying local priorities, developing and implementing public policies, and establishing accountability mechanisms) and has been recognised for decades. However, it was not until the World Health Organization's 'call back to Alma-Ata' in 2008 that participation was put forth as one of four policies that would lead to health systems strengthening. While SDG 16 includes an important target on participatory decision-making at all levels, this target is not linked to the role that the public should play in the development of national strategies to implement the SDGs. If this link between participatory decision making and the development of national implementation strategies was made; we could say that such strategies would aim towards building a norm that is grounded in the right to health, one that highlights the central role that meaningful participation from the local level can and should have.

The importance of clear guidelines and financial incentives for fostering inclusiveness; for participation policies and schemes to be successful, they need to have clear guidelines and financial incentives that allow stakeholders from vulnerable groups to be included and to have a voice. Studies show that participation that takes place within a well-funded and simple structure allows more voices from community-level stakeholders to inform policy at higher levels. Through these structures, local stakeholders can shape global or national policies to reflect the context and the needs of the people. Communities and civil society organizations (CSOs) in Brazil, Guatemala, Uganda and India, and in many other countries around the world, have been able to establish meaningful participation processes that have contributed to improved access and quality of health services. However, these have mostly been local successes; there are few national and global-level spaces for participation. Even at the local level, vulnerable and marginalized communities continue to be routinely excluded from making decisions on the policies that affect their communities and their lives.

The synergistic relationship between the right to health and participation; The right to health brings with it a requirement for engaging people in the decisions that affect health policy, and emphasizes the need to raise the voices of excluded and marginalized populations. In turn, meaningful participation that contributes to the redistribution of decision-making power in democratic spaces helps to guarantee the right to health. Because people need to be able to impact policy and engage with local and national-level authorities, developing open communication lines and participation structures that connect the local, the national and the

global level (multi-level governance) is among the great challenges of the new global development agenda.

The obstacles to genuine participation in global processes, including accountability; The SDG review processes are intended to be gender-sensitive and respect human rights, but the voluntary nature of these processes raises serious questions of implementation for countries not already committed to human rights. Many believe that for societies, perhaps especially in “fragile” societies like Guatemala, Uganda and Bangladesh, and so many others around the world, achieving social justice, inclusion, and equitable social and economic development – and the promise of the SDGs – requires improving the balance of power through democratic means. Yet these shortcomings need not continue to exist. Powerful and effective forms of participation that go beyond the district level are as possible as they are necessary, and the dialogues with communities and civil society organizations that Go4Health has engaged shows that this can be an obtainable reality. For the SDGs to succeed where the MDGs did not, particularly by reaching the poorest and most marginalized populations, they need to include the voices of stakeholders from the local, national and global levels because achieving goals in contexts of deep-rooted inequality and marginalization requires going beyond the simple provision of services. And although the MDGs helped to focus global health resources on important issues, and saved many lives, the global community cannot expect real last change if it continues to have agendas driven by goals that insufficiently reflect the priorities and needs of the people those goals are trying to help.

Our research suggests that advancing human rights requires challenging current power structures. The global consensus to renew the development goals is right, but these cannot be successful without first addressing the long-standing social and economic inequalities that exist in the world today. The combination of private interests, weak accountability mechanisms, and lack of transparency hurt the MDGs. The new health SDG is far more comprehensive than the health MDGs, yet fails to provide an integrated agenda for action. Through re-framing the goal in human rights terms and highlighting participation, more effective partnerships can be developed and the goals will be better able to improve lives. Using human rights as a framework, should better expose the social and political context of development, which will make it easier for the SDGs to contribute to social change and create the conditions that make it possible for every person to lead a decent life.

## **7. Universal Health Coverage**

Several Work Packages have contributed to work on clarifying the difference between universal health coverage within a right to health framework, and outside. In addition, we have engaged with key global actors, like the WHO, to explore the implications of these findings. (WHO. 2015, *Anchoring universal health coverage in the right to health: what difference would it make?* [http://apps.who.int/iris/bitstream/10665/199548/1/9789241509770\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/199548/1/9789241509770_eng.pdf)).

Below we summarise the main findings of our 2014 comparative assessment.

### **Comparing the right to health and Universal Health Coverage**

1. Like the right to health, UHC (as described in the authoritative sources) promotes comprehensive healthcare services, as opposed to disease- or issue-specific services.
2. UHC tracks with the principle of progressive realization as enshrined in the Covenant.
3. UHC very explicitly aims to put an end to the discrimination that is caused by direct payments, and thus UHC affirms at least that element of the principle of non-discrimination. On other causes of discrimination, the authoritative sources of UHC are less clear.
4. UHC seems to embrace the principle of cost-effectiveness prioritization as it promotes nationally determined sets of health services, developed within the epidemiological context of each country.
5. With regards to the principles of participatory decision-making and prioritizing vulnerable or marginalized groups, UHC is less straightforward than the right to health care: the principle of national ownership advanced in the 2012 UNGA Resolution does not necessarily imply that the relevant decision-making processes will be participatory or prioritize vulnerable or marginalized groups.
6. While the right to health entails a 'core content' – related to a set of 'core obligations' which apply to all countries, regardless of their wealth – and thus guarantees a minimum level of health care, UHC does not seem to have any kind of 'floor'. If the economic context of a given country leads to a level of healthcare that does not even address standards health threats, UHC seems to tolerate that.
7. Related to the previous point, the authoritative sources of UHC remain rather silent about the principle of shared responsibility. Although the 2010 World Health Report mentions that low income countries will need international assistance to achieve UHC, it does not mention that this assistance is a matter of legal obligation.

*Source: (Ooms G, Latif LA, Waris A, Brolan CE, Hammonds R, Friedman EA, Mulumba M, Forman L. 2014)*

## **8. Accountability**

The 2030 Agenda for Sustainable Development demonstrates that strengthening accountability is a cross-cutting priority, and citizen engagement in holding authorities accountable is central to making its goals reality. This broad recognition of the importance of accountability is even expressed in one of 17 goals that states: *Goal 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.*

Lessons learned from the Millennium Development Goals (MDGs) and insights gained from the consultation processes leading to the SDGs indicate that the participation of civil society and marginalized communities in inclusive monitoring and follow-up processes is critical to increase the viability of the new global framework.

A human-rights approach also calls for more descriptive and representative monitoring data in order to track and review progress in the populations that experience poverty and marginalization. People-led monitoring is necessary to provide a more comprehensive view of progress, by filling gaps where national statistical systems do not reach and also by giving voice to their needs and experiences of structural barriers to essential services. A participatory approach to monitoring and accountability puts people living in poverty in a position to exercise their right of self-determination, and be the drivers of their own development, as enshrined in human rights convention documents. Giving participatory monitoring and accountability a central role in the SDG commitments represents a shift from the MDG conceptualization of people living in poverty as “aid recipients” to active, collaborating stakeholders in the development process. In this sense, the importance of citizen engagement in monitoring and accountability for the realization of the SDG agenda is twofold: as a means of enhancing evidence of effectiveness and ensuring efforts reach the people that are intended to benefit, and through the intrinsic value of empowering the voice and strengthening the influence of marginalized populations in the decisions that affect their lives.

As focus shifts from defining the post-2015 agenda to its implementation, the technological tools available in this digital age offer great potential for innovation in how citizens engage in monitoring and accountability. New technologies have contributed to an explosion in the volume and types of data available for monitoring the progress of the SDGs, and in the context of this “data revolution”, special attention to the place of citizen-generated data is needed. Initiatives to promote citizen-driven accountability during the past decade have increasingly employed technology to enhance the collection of evidence and its visibility. Examples include the use of social media to monitor and share information on government budget expenditures (Nigeria, BudgIT), and use of cell phones to monitor teacher absenteeism and send data to the Ministry of Education (Malawi, CARE).

As a part of Go4health project, CEGSS engaged with rural indigenous communities in Guatemala who are using SMS to report deficiencies in health care services. Through this engagement, it was evident the important role of users of services providing first hand data that may be useful to monitor public services and assessing the performance of both providers

and public policies. The most relevant aspect of this experience is the level of commitment and ownership that rural indigenous communities have towards SMS technology to monitor complaints from users of services and the responsiveness of authorities to solve complaints and other problems reported. This experience is an example of bottom-up citizen-led accountability that could be expanded to monitor the SDGs related goals, including goal 16 (which deals with accountable institutions). This experience was presented during the Go4health workshop at PMAC, Thailand, in January 2016.

Translating experiences (such as the one described above) to broader scale participation in monitoring and accountability for the SDGs will require working with communities to develop relevant, user-friendly monitoring tools, and developing civil society coalitions to coordinate their application. In order to effectively mobilize people who live in poverty and marginalization to utilize monitoring data to demand accountability to their needs and rights, the foundation of a participatory, citizen-building approach cannot be neglected. A major area of work and collaboration for the short term is developing, field testing and implementing context-sensitive approaches to monitor the way national and subnational authorities are implementing their SDG commitments.

## **Conclusions**

As outlined above, Go4Health project partners exceeded the boundaries set by classic research funding, to synthesise results from the four specific objectives and to bridge them into policy recommendations, and thus provide the best scientific evidence available, from different disciplines and research streams, in a coherent, consistent and accessible manner.

The results can be measured by the number of analytical reports and peer-reviewed journal publications. In addition, the impact of these results on the policy process will be discussed in the next section of this report. The success of the network formed during the Go4Health project can also be measured in terms of joint publications, workshops and briefings. The value-added nature of collaborators working across a number of research streams should ensure a growing body of knowledge, a global research network and operational research capacity in the Americas, Africa, the Asia Pacific region, as well as in the EU.

## Annex 1 – List of Go4Health Publications

**\*\*non-peer reviewed**

### 2012

**The post-2015 international health agenda: universal health coverage and healthy environment, both anchored in the right to health.** Go4Health. Contribution to Thematic Consultation December 2012. \*\*

### 2013

**Universal health coverage anchored in the right to health.** Gorik Ooms, Claire E Brolan, Natalie Eggermont, Asbjørn Eide, Walter Flores, Lisa Forman, Eric A Friedman, Thomas Gebauer, Lawrence O Gostin, Peter S Hill, Sameera Hussain, Martin McKee, Moses Mulumba, Faraz Siddiqui, Devi Sridhar, Luc Van Leemput, Attiya Waris, Albrecht Jahn. Bulletin of the World Health Organization, 91(1):2-2A.

**Recent shifts in Global Governance** Implications for the Response to Non-communicable Diseases. Devi Sridhar, Claire E Brolan, Shireen Durrani, Jennifer Edge, Lawrence O Gostin, Peter S Hill, Martin McKee. PLoS Medicine, 10(7): e1001487

**Realizing the right to health for everyone: the health goal for humanity** Go4Health. Interim report \*\*

**Realizando el derecho a la salud para todos: Salud para toda la humanidad.** Go4Health. Interim report (in Spanish) \*\*

**Global health governance after 2015.** Gorik Ooms, Devi Sridhar, Albrecht Jahn. Lancet (correspondence, introducing Go4Health report), 382(9897):1017 *(if you are interested in this article, please get in touch)*

**A global social contract to reduce maternal mortality: the human rights arguments and the case of Uganda.** Gorik Ooms, Moses Mulumba, Rachel Hammonds, Leila A Latif, Attiya Waris, Lisa Forman. Reproductive Health Matters, 21(42): 129–138

**Community consultations on the post-2015 global health agenda: A demand for dignity, respect, participation and accountability.** Go4Health (WP2). Report \*\*

**Health at a crossroads.** Gorik Ooms. Contribution to UNA-UK Report ‘Global Development Goals: Leaving no one behind’

**Financing a post-2015 health agenda.** Temitope Foloranmi, Devi Sridhar. Contribution to UNA-UK Report ‘Global Development Goals: Leaving no one behind’

**Community engagement.** Eric A Friedman, Walter Flores, Claire E Brolan, Peter S Hill, Sameera Hussain, Moses Mulumba, Laila A Latif, Natalie Eggermont, Lawrence O Gostin. Contribution to UNA-UK Report 'Global Development Goals: Leaving no one behind'

**Global Governance for Universal Health Coverage: Could a Framework Convention on Global Health Hold it Together?** Claire E. Brolan, Jonas Hill, Peter S Hill. *Global Health Governance*, VI(2)

**Climate change and the shared responsibility for global health** .Gorik Ooms, Claire Brolan, Albrecht Jahn, and Peter S Hill. *The Lancet Global Health Blog*, 19 Sept 2013.

**Governance and Financing of Global Public Health: The Post-2015 Agenda.** Devi Sridhar, Claire E Brolan, Shireen Durrani, Jennifer Edge, Larry Gostin, Peter S Hill, Albrecht Jahn, Martin McKee. *The Brown Journal of World Affairs*, XX(1) (*if you are interested in this article, please get in touch*)

**Health rights in the post-2015 development agenda: including non-nationals.** Claire E Brolan, Stéphanie Dagron, Lisa Forman, Rachel Hammonds, Laila Abdul Latif, Attiya Waris. *Bulletin of the World Health Organization*, 91(10):719-719A

**What could a strengthened right to health bring to the post-2015 health development agenda?: interrogating the role of the minimum core concept in advancing essential global health needs.** Lisa Forman, Gorik Ooms, Audrey Chapman, Eric Friedman, Attiya Waris, Everaldo Lamprea, Moses Mulumba. *BMC International Health and Human Rights*, 13:48

## 2014

**Is universal health coverage the practical expression of the right to health care?** Gorik Ooms, Laila A Latif, Attiya Waris, Claire E Brolan, Rachel Hammonds, Eric A Friedman, Moses Mulumba, Lisa Forman. *BMC International Health and Human Rights*, 14:3

**The emergence of a global right to health norm – the unresolved case of universal access to quality emergency obstetric care.** Rachel Hammonds, Gorik Ooms. *BMC International Health and Human Rights* 2014, 14:4

**How can health remain central post-2015 in a sustainable development paradigm?** Peter S Hill, Kent Buse, Claire E Brolan, Gorik Ooms. *Globalization and Health*, 10(18)

**Back to the future: what would the post-2015 global development goals look like if we replicated methods used to construct the millennium development goals?** Claire E Brolan, Scott Lee, David Kim, Peter S Hill. *Type: Globalization and Health* 2014, 10(19)

**Right to health and global public health research: from tensions to synergy?** Gorik Ooms, Rachel Hammonds. *Tropical Medicine and International Health*, 19(6): 620–624.

Health, equity and the post-2015 agenda: raising the voices of marginalized communities. Eric Friedman, Dr Peter Hill, Dr Ana Lorena Ruano. *International Journal for Equity in Health* 2014, 13:82 (10 October 2014)

**Facilitating health and wellbeing is “everybody’s role”: youth perspectives from Vanuatu on health and the post-2015 sustainable development goal agenda.** Simon A Sheridan, Claire E Brolan, Lisa Fitzgerald, John Tasserei, Marie-France Maleb, Jean-Jacques Rory, Peter S Hill. *International Journal for Equity in Health* 2014, 13:80 (10 October 2014)

**Achieving equity within universal health coverage: a narrative review of progress and resources for measuring success.** Anna M Rodney, Peter S Hill. *International Journal for Equity in Health* 2014, 13:72 (10 October 2014)

**Global constitutionalism, responsibility to protect, and extra-territorial obligations to realize the right to health: time to overcome the double standard (once again).** Gorik Ooms, Rachel Hammonds. *International Journal for Equity in Health* 2014, 13:68 (10 October 2014)

**Community participation in formulating the post-2015 health and development goal agenda: reflections of a multi-country research collaboration.** Claire E Brolan, Sameera Hussain, Eric A Friedman, Ana Lorena Ruano, Moses Mulumba, Itai Rusike, Claudia Beiersmann, Peter S Hill. *International Journal for Equity in Health* 2014, 13:66 (10 October 2014)

**Making the post-MDG global health goals relevant for highly inequitable societies: findings from a consultation with marginalized populations in Guatemala.** Ana Ruano, Silvia Sánchez, Fernando Jerez, Walter Flores. *International Journal for Equity in Health* 2014, 13:57 (10 October 2014)

**Aboriginal medical services cure more than illness: a qualitative study of how Indigenous services address the health impacts of discrimination in Brisbane communities** Josifini T Baba, Claire E Brolan, Peter S Hill. *International Journal for Equity in Health* 2014, 13:56 (10 October 2014)

**Perceptions and experiences of access to public healthcare by people with disabilities and older people in Uganda.** Moses Mulumba, Juliana Nantaba, Claire E Brolan, Ana Lorena Ruano, Katie Brooker, Rachel Hammonds *International Journal for Equity in Health* 2014, 13:76 (8 October 2014)

**Could international compulsory licensing reconcile tiered pricing of pharmaceuticals with the right to health?** Ooms G, Forman L, Williams OD and Hill PS. *BMC International Health and Human Rights* 14:37 (2014)

**An alternative model of governance?** Meisterhans, N. *Journal for Development and Cooperation (DC)*, 2014/07, Frankfurter Societäts-Medien, S. 296-298

**Representativeness of the UN post-2015 national consultations.** Faraz Rahim Siddiqui, Eric A Friedman, Anas Nader. *The Lancet Global Health*. Volume 2, No. 11, e631–e632 (November 2014)

**The health-related development goal in the post 2015 negotiations: The right to health – buoyed or drowning in sustainable development?** Go4Health Consortium (December 2014) \*\*

## 2015

**Universal Health Coverage's evolving location in the post-2015 development agenda: Key informant perspectives within multilateral and related agencies during the first phase of post-2015 negotiations.** Brolan CE, Hill PS. *Health Policy and Planning* (2015)

**Count down for health to the Post-2015 Sustainable Development Goals.** Brolan C, Hill P. *Medical Journal of Australia* 202(6):289 (2015)

**"Everywhere but not specifically somewhere": A qualitative study on why the right to health is not explicit in the post-2015 negotiations.** Brolan CE, Hill PS, Ooms G. *BMC International Health and Human Rights* 15:22 (2015)

**Rights Language in the Sustainable Development Agenda: Has Right to Health Discourse and Norms Shaped Health Goals?** Forman L, Ooms G, Brolan CE. *International Journal for Health Policy and Management* 4(12): 799-804. (2015)

**The normative authority of the World Health Organization.** Gostin L, Sridhar D and Hougendobler D. *Public Health* (2015)

**From knowing our needs to enacting change: findings from community consultations with indigenous communities in Bangladesh.** Hussain S, Ruano A, Rahman A, Rashid S, Hill P *International Journal for Equity in Health* 2015, 14:126 (9 November 2015)

**The individual, the government and the global community: sharing responsibility for health post-2015 in Vanuatu, a small island developing state.** Ibell C, Sheridan SA, Hill PS, Tasserai J, Maleb M-F and Rory J-J. *International Journal for Equity in Health* 14:102. (2015)

**Will Ebola change the game?** Moon SE, Sridhar D et al. *Lancet*. (2015)

**Structure, Function and Five basic needs of the global health research system.** Rudan I and Sridhar D. *Journal of Global Health*. (2015)

**Universal Health Coverage and the Right to Health: From Legal Principle to Post-2015 Indicators.** Sridhar D, McKee M, Ooms G, Beiersmann C, Friedman E, Gouda H, Hill P, Jahn A. *International Journal of Health Services* 45(3):495-506. (2015)

**Healthy Ideas: Improving Global Health and Development in the 21st Century.** Sridhar D and Rudan I. Edinburgh: *Journal of Global Health Collections*. (2015)

**Improving health aid for a better planet: the planning, monitoring and evaluation tool.** Sridhar D, Car J, Chopra M, Campbell H, Woods N and Rudan I. *Journal of Global Health*. (2015)

**Ebola, the epidemic that should never have happened** van de Pas R., & van Belle S, *Global Affairs*, 1(1), 95-100. (2015).

**Legal and Financial Responsibility in Promoting Health Equity in Kenya.** Waris A, Abdul Latif L, *JKUAT Law Journal Vol. 1, Law Africa*. (2015)

**Financing the progressive realisation of socio economic rights in Kenya.** Waris A, Abdul Latif L. *University of Nairobi Law Journal Vol 8, Issue 1.* (2015)

**Towards Establishing Fiscal Legitimacy through Settled Fiscal Principles in Global Health Financing.** Waris A, Abdul Latif L. *Health Care Analysis, Springer (vol. 23- 4, p 376-390).* (2015)

**Cautionary notes on a Global Tiered Pricing Framework for Medicines.** Williams O, Ooms G, Hill PS. *American Journal of Public Health* (2015)

**“Health for all: Implementing the Right to Health in the Post-2015 Agenda – Critical Interventions from the Global South”** Meisterhans, N. *Social Medicine/Medicina Social. Department of Family and Social Medicine at Montefiore Medical Center/Albert Einstein College of Medicine and the Latin American Social Medicine Association – ALAMES.*

**Commentary:**

**The comeback of Universal Health Coverage in the post-2015 debate?** Hill PS. *GlobalHealth@Geneva newsletter.* Graduate Institute of International and Development Studies: Geneva (2015a) \*\*

**More is less? Health in the Sustainable Development Goals.** Hill PS. *The Conversation.* September 23. (2015c) \*\*

## Potential impact of the Go4Health Project; including the main dissemination activities and exploitation of the results

The Go4Health Description of Work includes the expected impacts of this Project specifying that partners should “ensure that the health-related development objectives for the period after 2015 are based on the best scientific evidence available and address the main shortcomings of the current MDGs. Effective engagement in the global process for setting new development goals is expected, and the consortium should therefore ensure broad geographic and multidisciplinary coverage.”

As promised, the Go4Health Consortium was diverse; comprised of legal scholars, public health scholar and civil society representatives from Asia (BRAC University, Bangladesh), Latin America (CEGSS, Guatemala), North America (Georgetown University, USA and the University of Toronto, Canada), Sub-Saharan Africa (The University of Nairobi, Kenya and CEHURD, Uganda) Australia (The University of Australia) and Europe (the University of Edinburgh, UK, the London School of Hygiene and Tropical Medicine, UK, the University of Heidelberg, Germany and the Institute of Tropical Medicine, Belgium). This diversity facilitated its effective engagement with the global post-2015 process. Below we shall report on the impact of Go4Health on the post-2015 process. In reporting on Go4Health’s impact we shall highlight the main dissemination activities and exploitation of the results that are key to the impact of the Project, and, where relevant, the wider societal implications of the Project

Our original proposal argued that “to become *the* health-related development objectives for the period after 2015, the proposed objectives should not only be based on scientific evidence, but also must be endorsed by all the key stakeholders.” That these health-related development objectives “propose a better balance between horizontal and vertical approaches to healthcare”. Furthermore, we assumed “that to be achievable and sustainable, the health-related development objectives or NHDGs will have to be embedded in an agreement that allocates responsibilities more explicitly and that identifies mechanisms to ensure accountability.”

Summarising, we committed to deliver:

1. A formulation of NHDGs that is based on the best scientific evidence available;
2. A formulation of NHDGs to which all or most key stakeholders are willing to subscribe or adhere
3. A formulation of NHDGs that strikes a balance between horizontal and vertical approaches to healthcare;
4. A formulation of NHDGs that paves the way towards an improved system for global health innovation;
5. A formulation of NHDGs that is embedded in an agreement that allocates national and international responsibilities more clearly;

6. A formulation of NHDGs that is embedded in an agreement that includes accountability mechanisms;
7. A formulation of NHDGs that addresses any other shortcoming that this action uncovers;
8. Direct and effective engagement in the global process for setting new development goals.

Below we address how each of these was achieved:

*1. A formulation of NHDGs that is based on the best scientific evidence available*

The initial Go4Health formulation of NHDGs drew on extensive scientific and community based research, deliberations and ongoing interaction between the different WPs. Go4Health advocated that “Realizing the right to health” become the post-2015 health and development goal, – and include two targets, “universal health coverage anchored in the right to health” and “a healthy social and natural environment”. This goal and two targets guided subsequent Go4Health analysis.

Our September 2013 Report outlined the first Go4Health proposal of NHDGs, embedded in a supportive global social contract (deliverable three): ‘Realizing the right to health for everyone: the health goal for humanity’, available from: <http://www.go4health.eu/publications/>. This Go4Health Report was presented to the public at a satellite session during the 8th European Congress of Tropical Medicine and International Health (ECTMIH) in September 2013 in Copenhagen, Denmark (<http://ectmih2013.org/go-4-health/>).

In Berlin in September 2014 we presented the first draft of the Second Report on the NHDGs at a multi-stakeholder conference, organised by WP2 partner MEDICO which included civil society, diverse academia and EC and German government representatives. On the basis of this expert feedback, and taking into consideration the findings of other expert groups, we finalised the Go4Health proposal on NHDGs and supportive global social contract in December 2014 (milestone two and deliverable 5). This Second Report is entitled ‘The health-related development goal in the post 2015 negotiations: the right to health - buoyed or drowning in sustainable development? (The Second Go4Health Report) Available from <http://www.go4health.eu/publications/>

The final health SDG, “Ensure healthy lives and promote well-being for all at all ages.” includes universal health coverage as a target, one of the Go4Health targets. Thus, the health SDG is a more comprehensive integrated health goal than those found in the MDGs. Although UHC had been a leading, well-supported contender to assume the role of ‘new health development goal’, (from 2012 until mid-2014) it emerged as one of the health SDG targets, not the umbrella goal many had lobbied for.

As Go4Health we have welcomed the inclusion of UHC in the health goal and have analysed how UHC embedded in the right to health would have had a more transformative impact. We

have engaged in dissemination of this analysis at the WHO (in April 2015), the 9<sup>th</sup> ECTMIH in Basel in September 2015, the European International Studies Association Conference in Sicily in September 2015, numerous EC events, including the June 2015 European Development Days and the Global Health Policy Forum in November 2015 and at the January 2016 Prince Mahidol Award Conference in Thailand, Bangkok. As such we have contributed to the academic and policy debate. As our analysis draws on the opinions of the different communities our civil society partners work with, we believe that we had helped to add their voice to the global discussion.

### *2. A formulation of NHDGs to which all the key stakeholders are willing to subscribe or adhere*

Our original proposal noted that “even if they are based on the best available scientific evidence, the NHDGs will have to be widely endorsed”. We argued that our approach would not be purely academic and that we needed to seek and obtain the endorsement of all the key stakeholders. Indeed, such input and ultimate endorsement from key stakeholders – and none more than from communities for whom the NHDGs stand to have the greatest impact.

A large share of the financial resources we expended was used to consult the communities whose health is most seriously compromised. Go4Health consulted urban and rural communities in several countries in Africa (Uganda and Zimbabwe), Asia (Bangladesh and the Philippines), Latin America (Guatemala) and the Pacific (Vanuatu). Their opinions on; what good health is, which efforts should be prioritised to improve their health, and where these efforts should come from were used as the foundation for the Go4Health NHDGs. We remain convinced that the additional benefit of adopting this participatory approach was that it increased the willingness of all other stakeholders to subscribe to the NHDGs. For example, European NGOs accorded our input more value as we were not just speaking as academics.

In seeking to clarify the allocation of national and international responsibilities – meaning the responsibility of the international community as complementary to national responsibility – requires the endorsement of governments requiring international assistance. A more structural dialogue with these governments was a task of WP3. The culmination of this engagement was WP3 participation in the July 2015 Addis Ababa Financing for Development conference.

WP1 took the lead on dialoguing with governments providing assistance (or in a position to provide assistance). Along with MEDICO they ensured that the German government participated in the Go4Health Berlin conference in September 2014.

Finally, the positioning of multilateral actors vis a vis their roles in improving the accountability of governments and other actors was addressed by WP4 work on global health governance.

### *3. A formulation of NHDGs that strikes a balance between horizontal and vertical approaches to healthcare*

As noted above, the health goal proposed by Go4Health strikes a balance between vertical and horizontal approaches. As our proposal was largely based on the needs expressed by the communities whose health is most at stake, this reflected the importance of a health care system that is able to respond to at least the most common health issues, and thus contribute towards more horizontal approaches.

#### *4. A formulation of NHDGs that paves the way towards an improved system for global health innovation*

Our original proposal asked whether or not new internationally agreed NHDGs include a new system for global health innovation, and whether they may pave the way towards an improved system.

The Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property of the WHO contains 8 elements:

1. Prioritising research and development needs;
2. Promoting research and development;
3. Building and improving innovative capacity;
4. Transfer of technology;
5. Application and management of intellectual property to contribute to innovation and promote public health;
6. Improving delivery and access;
7. Promoting sustainable financing mechanisms;
8. Establishing and monitoring reporting systems.

As anticipated Go4Health had an impact on the first, the fifth, the sixth, the seventh and the eighth elements:

- Prioritising research and development needs: numerous Go4Health publications highlighted which health needs are considered as essential by the communities whose health is most seriously compromised. This helped to indicate which health issues most urgently require additional research and development. Also, Dr. Albrecht Jahn of WP1 is a member of the Consultative Expert Working Group on Research and Development which facilitated impact beyond Go4Health;
- Application and management of intellectual property: our research on access to essential medicines highlighted the need for a clearer allocation of national and international responsibilities for health. A WP3 member, Dr Lisa Forman continues this work by participating in the UN Secretary General's Panel on Access to Essential Medicines.
- Improving delivery and access: this is related to the previous impact issue; we believe that our approach will help to strike the right balance between vertical and horizontal approaches to health systems strengthening, and thus improve the delivery of all essential medicines;
- Promoting sustainable financing mechanisms: here again, solutions may be found within a clearer allocation of national and international responsibilities for health;

- Establishing and monitoring reporting systems: the inclusion of governance in our project – as the essential ‘partner’ of goals – enabled us to highlight problems with the current Global Governance of Health architecture and propose solutions. Go4Health researcher, Gorik Ooms (WP5) was able to contribute Go4Health analysis on this issue to a wide audience through his inclusion on the Lancet-Oslo Commission on Global Governance for Health.

*5. A formulation of NHDGs embedded in an agreement that allocates national and international responsibilities more clearly*

As anticipated, this was both one of the most important elements of the required impact of the Project, and perhaps the most difficult to achieve. The agreed NGHGs (the health SDG) is not embedded in an agreement that allocates national and international responsibilities more clearly, which suggests that the goals may be neither achievable, nor sustainable. Without a clearer allocation of responsibilities, accountability will remain weak, and without stronger accountability, the necessary resources will either not be available, or unreliable in the long run. The Go4Health Reports, and subsequent publications, demonstrate how embedding universal health coverage in the right to health could contribute to addressing this issue. Thus far, outside of the environmental realm, where common but shared responsibility underpins global cooperation, there appears to be little political will to move beyond highlighting the primacy of national responsibility for development.

*6. A formulation of NHDGs embedded in an agreement that includes accountability mechanisms*

The Go4Health proposal highlights the importance of accountability mechanisms, echoing the demand of communities we consulted and the primacy of accountability to human rights. We noted that the MDG process triggered two different kinds of accountability mechanisms: international organisations and international regimes. The Global Fund to fight AIDS, Tuberculosis and Malaria is an international organisation, that supported MDG6; the Every Woman Every Child initiative, its Commission on Information and Accountability for Women’s and Children’s Health first and its independent Expert Review Group later constitutes a regime. WP4 analysis explained what is needed to make international regimes and organisations more accountable, and highlighted aspects that should be part of revised global governance for health. At the PMAC in January 2016, WP2 addressed the potential of bottom up accountability for advancing health goals. Our research notes the absence of a global accountability mechanism, and highlights the failure of the international community to tie the SDG project to human rights or to endorse human rights bodies as potential accountability forces. Thus, from a societal impact perspective, Go4Health partners emphasise the importance of bottom up accountability for progress on the SDGs.

*7. A formulation of NHDGs that addresses any other shortcoming (as may arise during the work)*

The main shortcoming not addressed above is the linking of the different elements of the development agenda. The SDGs, the Financing for Development Conference and the Paris Climate meeting of the Conference of the Parties all occurred in 2015. There was very little

overlap between the different players and the consequence is disparate agendas. Go4Health highlighted the potential for climate negotiations to push wealthier countries to finance social goals but this potential has not yet materialised. At a societal level, consensus on the importance of a holistic approach is growing and Go4Health has been but one of many voices.

#### *8. Direct and effective engagement in the global process for setting new development goals*

When Go4Health launched, the global process for setting new development goals had already begun. Go4Health entered into the global process in December 2012 contributing “The post-2015 international health agenda: universal health coverage and healthy environment, both anchored in the right to health” position paper to the United Nations thematic consultation. From the beginning of the Project, Go4Health team members have participated in numerous local, regional, national and global debates including academics, policy makers and civil society. This continuous, informed engagement contributed to the reputation of Go4Health as an authority on the post-2015 process which led to further speaking requests. Below we review some of these.

With respect to civil society engagement, WP2 partners engaged with communities in Uganda, Zimbabwe, Guatemala, Bangladesh and the Philippines to help connect the local and global discussions. The outputs of these discussions helped shape Go4Health priorities and is found in different reports and articles. In addition, WP2 engaged with policy makers when these results were discussed at World Bank Conferences in Washington DC, including on Public Service Delivery for the Poor and post MDGs (March 2014) and Global Practitioners in social accountability (May 2015). WP2 also contributed to civil society meetings on post-MDGs and accountability in Delhi, India (July 2014), Ayres Rock, Australia, (October 2014), London UK (July 2015) and New York (August 2015). WP5 engaged with European civil society (including on numerous occasions Save the Children, Action for Global Health and Amnesty International (London July 2013) and Save the Children) which contributed to Go4Health gaining new insights into the positioning of different stakeholders in the post-2015 process.

WP1, WP3 and WP4 engaged in a diversity of engagement and dissemination activities. WP1 focused on German and European policy makers at the World Health Summit in Berlin (October 2014 and October 2015) and on public health practitioners at the EUPHA conference in Milan (October 2014), and a workshop on the right to health of the Geneva-based Procher Foundation. At the invitation of the German Federal Ministry of Health WP1 also engaged with German and global health policy specialists in March 2015, on global health policy. Building on its network and expertise WP1 also engaged with Tanzanian researchers in August-September 2015. WP3, WP4 and WP 5 engaged with international relations specialists at the International Studies Association conference in New Orleans, USA in January 2015. WP3 and WP 5 also participated in the European International Studies Association meeting in Sicily, Italy in September 2015. WP1 and WP5 interacted with DG DEVCO on regular basis throughout the Go4Health Project, participated in the regular Global Health Policy Forum meetings and participated in an EC panel at the 2015 European Health Forum in Gastein, Austria.

All WPs engaged with a diverse European public health audience at the September 2013 satellite session during the 8th European Congress of Tropical Medicine and International Health (ECTMIH) in September 2013 in Copenhagen, Denmark. All WPs also engaged with a diverse development focused audience at the 2015 European Development Days in Brussels in June 2015. Finally, all WPs interacted with national policy makers, global and national health policy specialists and academics at the PMAC in Bangkok, Thailand in January 2016.

### **Wider societal Impact**

The Go4Health Description of Work notes that “What is expected from us, as expressed on the Research & Innovation pages of the website of the European Commission – to *“engage, whenever appropriate, with actors beyond the research community and with the public in order to foster dialogue and debate on the research agenda, on research results and on related scientific issues with policy makers and civil society”* – is central to our project.” It is worth reiterating that the elements of dialogue and debate are woven into the entire proposal and the subsequent work under the Project was driven by this dynamic. As a consequence, the development of the NHDGs included two stages of dialogue with communities in Africa, Asia and Latin America. Furthermore, we engaged in dialogue with governments of countries providing assistance, with governments of countries requiring assistance, with civil society organisations and with multilateral actors at each step along the way of developing and refining the NHDGs. This helped to ensure that we continually tested and reformulated our ideas and incorporated feedback from all major sets of stakeholders, including communities, civil society groups, global health policy makers and government representatives.

Further, our major dissemination events in Copenhagen, Berlin, Brussels and Bangkok provided space for debating our findings and proposals, with key stakeholders, academics and policy makers. In reflecting on the impact of the Go4Health Project it is clear that this commitment to engagement and dialogue is what distinguishes Go4Health, enabling it to have impact beyond the scientific community and in society at large. Three key features of the Go4Health Project contributed to this potential impact and serve as entry points for understanding the wider societal implications of the project. These features included, first, the geographical diversity of the different partners, second, the mix of civil society and academics partners, and their mutual respect and finally, the medium-term duration of the Project.

### *Geographical diversity*

Go4Health partners were drawn from many regions of the globe including North America, Latin America, Sub-Saharan Africa, South Asia and Oceania. Although the context of the research and results are important, the experience of marginalisation and the opportunity to provide input demonstrated the importance of grass-roots engagement and that some research results are not context specific. Working as a team allowed for the cross fertilisation of learning and results. Thus, the wide geographical remit of the project contributed to Go4Health partners, and the communities they worked with, learning from other parts of the world. For example,

WP2 partners CEGSS (Guatemala) CEHURD (Uganda) and BRAC (Bangladesh) collaborated on numerous publications and multiple dissemination events. The geographical diversity also contributed to the impact of the research as it afforded Go4Health teams more entry points, credibility vis a vis their conclusions and the opportunity to link Go4Health partners with potential collaborators or key informants.

#### *Mix of civil society and academic partners*

Academics often work in an ivory tower. The goals, theories and frameworks proposed by Go4Health academic partners were given a reality check through the assistance of Go4Health civil society partners and their community partners. Academic partners listened to and took account of this feedback and reformulated proposals, as is reflected in the two Go4Health reports which stress the importance of community consultation and participation in informing global goal setting. Working as a diverse team allowed academics to understand better the potential and weaknesses of bottom-up accountability mechanisms to complement the weak global level accountability mechanisms. The cross fertilisation, that is the exchange of information between those who focus more on academics and those who focus more on implementation, contributed to the richness of the analysis. From a scientific perspective this is important as it enhanced the value and impact of the results. From a societal perspective this is important as the opportunity to critically evaluate proposals with the people whose lives they impact offers the potential to improve the proposals.

#### *Duration of the Project*

The post-2015 process was clearly a unique period in history as the final outcome offers the potential to impact global policy for decades. To have the opportunity to engage with the final three years of this process from multiple perspectives was of great value from an academic and a societal perspective. Academic partners had the opportunity to reflect on how developments unfolded, and to adjust to changes in the process rather than providing an incomplete analysis due to time constraints. Civil society partners could commit to a long duration engagement with the communities they consulted. The community research was not simply a 'box ticking' exercise but an ongoing dialogue between the researchers and community members. Thus both the quality of the research and the community engagement with the Project benefited. These two outcomes have a society level impact as they both contribute to improving the global knowledge base and to increasing the engagement of communities that are often marginalised vis a vis global and national processes that impact upon them.