EPISODE 33. DIALOGUES: A CONVERSATION WITH OLUSOJI ADEYI

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Olusoji Adeyi [00:00:02] The power dynamics are evident in today's global health. Contemporary strains of the narrative of what is good for the natives persist in some policy circles and through deleterious variants of technical assistance. They run through the assertions by some leaders and institutions of the Global North on what the Global South needs to fight COVID-19, regardless of, and sometimes directly contrary to, what leaders and institutions of the Global South say they need. They determine much of the dysfunctions in developmental systems for health. Global health thus came into being with major congenital defects that remain uncorrected. The defects persist partly because their definitive diagnoses are unsettling. They endure because their definitive treatments require major changes in the dominant narratives, structures and functions that legitimize the status quo.

Garry Aslanyan [00:01:10] Welcome to Dialogues. I'm Garry Aslanyan. This is a special series of the Global Health Matters podcast. In this series, I'll be blowing open some of the echo chambers that exist in global health. To help me in this quest, I have invited thoughtful and inquisitive individuals from different walks of life. Each of them has explored and written about global health issues from different disciplinary perspectives. I hope this dialogue series will give you, the listeners, an opportunity and space to step out of your daily routine and contemplate global health issues through a different lens. So let's get started.

Garry Aslanyan [00:01:53] In this episode of our dialogue series, I am joined by Olusoji Adeyi. Olusoji, or Soji as he's better known, is a seasoned Nigerian global health practitioner who has held many prominent leadership positions. Based on his experience gained in different initiatives, countries and organizations, he has put his pen to paper to capture his observations, reflections and lessons for the next generation. In his book, Global health in practice: Investing amidst pandemics, denial of evidence and neo-dependency, Soji brings together real life case studies on issues such as development aid, access to medicines and community involvement. Soji is the President of Resilient Health Systems and a senior associate at Johns Hopkins Bloomberg School of Public Health. He currently lives in Washington, DC in the United States. Hi Soji. How are you today?

Olusoji Adeyi [00:02:58] I'm doing very well, thank you Garry. How are you?

Garry Aslanyan [00:03:00] Good. Thank you. I'm looking forward to our dialogue today. So Soji, before we recorded, you told me that your journey in health starts with a very early experience of your father extracting a guinea worm from a local community member's leg, where you lived in Nigeria. How did this experience shape and inspire your career?

Olusoji Adeyi [00:03:26] Garry, thanks for having me on this programme. I grew up in a small city in Nigeria. That's Oyo. Oyo is the land of Shango, the God of Thunder, and my father, who was a nurse, I witnessed him extract guinea worm from a patient's leg. In those days, I think I was probably seven or so. At the time, the impression it left on me was just one of horror and the pain and the fella, it looked so bad. In hindsight, and now this is looking back several decades later, I think that experience and some related experiences informed and shaped my own gravitation towards medicine, towards public health and, crucially, an abiding curiosity about how to improve the lot of the poor and how in pursuing health services and systems and finance. It's especially important to always ask the question, well, how does this affect those who currently do not have access to basic health services? How does it make their lives better? That's a part of the trajectory.

Garry Aslanyan [00:04:46] You mentioned that the book that you wrote is one that you wish you had read when you were about 25 years old. I have to say, some of the things that we'll talk about today, I had also similar reaction of saying, I wish I knew that before. So the question to you is what motivated you to write it and how do you hope it will serve younger generations of those entering global health and what would that really give them as a guiding principle?

Olusoji Adeyi [00:05:18] After finishing medical school and a brief stint as a medical practitioner in Nigeria, I did a Master of Community Health at the Liverpool School of Tropical Medicine in England. I was 25 then, and that was an extraordinary experience. The education there and the professor, the chair of my department, that was the late Ken Newell, who wrote Health by the people. When I left that programme, I felt equipped with the fundamentals needed to serve as a serious professional in global health. I was also acutely aware of what I did not know. However, in hindsight, I wish I had access to a book by my bedside that distilled the fundamental premise of global health, as it is now called. The geopolitics of it. The interface between power, money, knowledge and institutional behaviours. I was aware of a number of questions at that time, but there are some things one learns over the decades and one learns from experience. So I thought the contribution that I could make to put the current generation of 25 year olds in a better position than I was, was to reflect and share with them as best I could what I had learned over the past several decades. And like Toni Morrison said, if there is a book you wish to read and you cannot find it, then it's your duty to write it. Hence the book, Global health in practice.

Garry Aslanyan [00:07:29] Soji, you mentioned you are Nigerian and started your career working there, yet you have also lived and worked for international institutions and lived abroad for a significant period of your life. In your book, how do you hold the tension between perspectives gained in the South, or what the called the South, as well as in the North, or your other experiences outside?

Olusoji Adeyi [00:07:57] I think I'm fortunate to be able to combine those perspectives. The one informs the other. Because I was born and grew up in a developing country, and I've lived in some other developing countries, I have very direct knowledge and lived experiences of how things affect real people on a day-to-day basis. And because I've also lived in the Global North, principally Europe and the United States, for decades now, I have very direct insight into the socio-political dynamics and realities of those societies as well. And those realities affect the way they approach, or they have chosen to approach, global health. Therefore, that combination improves my own capacity to dive into, analyse and understand how and why global health is what it is. But more importantly, to put forth potential solutions to the shortcomings of global health.

Garry Aslanyan [00:09:34] You described new dependency in the South as a pathology, and perhaps an even greater threat than the legacy of colonialism. Could you share a bit more insight into that view?

Olusoji Adeyi [00:09:50] Let me begin by quoting from Shakespeare's Julius Caesar, Act One, Scene Three. "The fault, dear Brutus, is not in our stars, but in ourselves, that we are underlings". What does that have to do with global health? When you asked me about what I call the pathology of new dependency, let's dive into its principal signs and symptoms. Perhaps the most fundamental one is the default setting that when a problem arises, those who were caught or trapped in or have made a choice of new dependency, look outside for solutions instead of looking inside. Some months ago, I was in a discussion with some very, very senior officials in a low- and middle-income country. It was a very serious conversation, and these were very knowledgeable people. But when we moved from analysing the situation to what to do and how to do it, the first proposition from a high ranking official there was, "Well, why don't we put this to a particularly large foundation working in global health?", because they understood the head of that foundation might be able to help out. So the first reaction was not, well,

how do we get this to the attention of the Ministry of Finance in that particular country, or to the Parliamentary Committee on Health, or similar. No, it was to look outside, some benefactor. That's a very telling sign. In terms of the political dynamics, it's a lack of a "compact" between the government and its citizens regarding health. It's almost as if the government does not have to report to its citizens in terms of what it has done or what it is doing on health. And related to that is the failure in many of the low- and lower-middle income countries to take responsibility for financing basic health services. In some of the low-income and low- and middle-income countries, for example, the majority or a vast proportion of key services in their countries are financed by foreign aid. The Global Fund, Gavi or USAID or some others or its expectations of a grant or credit from a development bank. That leads to a shift in the low cost of accountability, which now lies not in the capital cities of those countries themselves, but in northern capitals, and this leads to what I call a pattern of relying on the kindness of strangers. Following them leads to an internalized behaviour, a lack of agency and a refusal to take initiative. It is this whole complexity that I refer to as new dependency.

Garry Aslanyan [00:13:31] And do you think that if governments had a better "contract" with their own people when it came to health, there would be less dependency?

Olusoji Adeyi [00:13:39] Yes. However, that would mean taking responsibility. That will come with accountability, and it is a lot easier to be able to blame outsiders than to take responsibility. So the two go together. So let me share with you a specific example. What I'm about to share with you, I've experienced not in one country, not in two countries, but in a number of countries. So it's a variant of the following. So if I ask some senior officials working in health and health financing, look, your economy can actually sustain more domestic financing for your own basic health services. Why is your Ministry of Finance and your Senate or House of Representatives or Parliament not stepping up to do this, and your Ministry of Health? And these are very knowledgeable people. So the response would be some variant of the following. Look, we're not stupid, we know that all we have to do is nothing, and those Europeans and North Americans who love us more than we love ourselves, who will do more fundraising, they will do more replenishment on CNN or BBC or France 24 television, with billionaires and ex-soccer stars and movie stars and musicians, and they will raise money and the cycle will continue. And the result is that there is a degree of substitution of external financing for domestic resources. And that substitution is in two parts; it's part quantitative, which is straightforward, you put in some money and the country will put its own money elsewhere. It's also qualitative in that big decisions then end up being made primarily outside those countries themselves.

Garry Aslanyan [00:15:33] Okay. So you have a lot of those good insights into all of these issues in the book and you share the history of overseas investments in health and how it originated, and write about how aid is still used as a lever to exert power over nations at times. Maybe you can give an example for our audience what you mean by that.

Olusoji Adeyi [00:16:01] Yes. I think the one that really concentrated minds because it was on such a large scale and it was done in the public domain, is what the world saw at the peak of the COVID-19 pandemic. A few people meeting in Davos sketched on a napkin what was going to become essentially global policy on how to get COVID-19 vaccines and other technologies to low- and middle-income countries, it was called ACT-A for accelerated access to COVID technologies. And within that was COVAX, which was run out of Gavi. COVAX focused on vaccines. In some, when leaders of African countries, the regional entity, the African Union, wanted to buy vaccines at the peak of the pandemic, the high-income countries hoarded those vaccines and the African countries were relegated into a situation where they had to wait for donations. Now, if you go to buy a car or a computer or a pair of shoes, you are empowered as the buyer. But if you are waiting for somebody to donate a car or a pair of shoes or a computer to you, you are disempowered, and you are at the mercy of the donor. And of course, COVID

did not live up to the hype. If you had accountable leadership, they would acknowledge that failure and find ways to do better. But the leadership of Gavi did the exact opposite by claiming they had established a blueprint for how to get vaccines to poor people in an emergency, which was just the exact opposite of what had happened. Now, why is this important? It's an example of how the tremendous imbalance of power leads to policies, decisions and practices that are contrary to the interests of the would be beneficiaries in low- and middle-income countries, and how, in fact, the narrative can be cemented that things worked when in fact they did not. This is just a glaring example of a widespread phenomenon.

Garry Aslanyan [00:18:29] Right. Right. And a very recent one.

Olusoji Adeyi [00:18:33] And a very recent one.

Garry Aslanyan [00:18:34] Let's listen to an extract from your book, Soji, on investments in global health.

Olusoji Adeyi [00:18:42] The asymmetry of financial and institutional power between the Global North and the Global South all too often causes global health enterprises to proceed with a default setting in which the Global North makes the rules, plays the game and referees the game. This is inherently bad, regardless of any party's good intentions. Progress requires both self-awareness and humility on the part of the Global North and more self-funded assertiveness by the Global South to flip the script. The explicit basis for engagement should be the interest of countries whose policies and programmes are under discussion. The need is high for explicit agreements on policy and programme objectives and counterfactuals.

Garry Aslanyan [00:19:40] Thanks for that, Soji. In the context of having so many people in the South relying on health care, and that was strategized and investments were made in northern countries, what kind of actions and strategies do you think are required for countries and communities to have more agency in their health?

Olusoji Adeyi [00:20:04] The need is for a bunch of actions, and they are rooted in overhauling the existing power dynamics in global health. So let's be a little more specific. The first one is clarity of purpose. Now that may sound extremely obvious and simple, but in fact quite often I have noticed that lack of clarity of purpose is a fundamental problem in global health. A second one is using the needs, the realities and the interests of "the recipient countries of the Global South" as the starting point for any deliberation. Third is an emphasis on learning. All too often, it's almost as if principal actors in global health resist learning, because such learning might threaten the status quo, and when it threatens the status quo, that means it threatens the current imbalance. And so it's shut down or suffocated. So what to do? It's essential to overhaul the legacy foreign aid paradigm. That legacy paradigm is that the Global North makes the determination, the rich countries and the institutions, but they dominate, make the determination as to what needs to be done, what can be accessed by whom and on what conditions it can be accessed. In practical terms, it's important to end foreign aid for basic health services and basic health commodities and goods. Now, this is not a call for an abrupt cessation today, but it ought to be done, say by the year 2030, that's a six to seven year period, so that there's a finite date in sight and there is a transition out of it, with exceptions only for say countries at war, because then we're talking about humanitarian purposes, or countries that have suffered sudden and devastating natural disasters. Those would be sensible exceptions there. Then there is a crucial need to end the practice of technical assistance as we currently know it, so that the aid that is given via technical assistance is no longer tied to the source of financing for that technical assistance. It's one of the biggest sources of distortion in global health and it creates a lot of rent seek in global health. For those countries that insist on funding technical assistance, they could set up a challenge fund, and the recipient countries themselves will be responsible for drawing up the terms of reference for the consultants they want, for evaluating the

proposals that they receive and then they will publish the results and the criteria on a website that is available to all. But just because Sweden or Canada or the US or any other country is financing technical assistance does not mean the individuals or companies that provide that technical assistance must come from those countries. Finally, it's important to develop, improve and support mission critical institutions in those low- and lower-middle income countries, because that is what abides. That is what is there for the medium- to long-term. And as we saw during the recent COVID-19 pandemic, that is what stands between those countries and absolute disasters when trouble strikes.

Garry Aslanyan [00:24:02] Soji, you mentioned that it seems like there is resistance to learning. Is it resistance to learning or is it really hierarchical use of knowledge or silos in global health? What do you think of those challenges?

Olusoji Adeyi [00:24:19] Change is not comfortable, and change is resisted by entities and interest groups that benefit from the status quo. So let me give a specific example. I am a United States taxpayer and citizen, so I am going to take an example that is close to home here. I am speaking with you from Washington, DC. One of the examples of bad practice in global health is the business model of USAID. USAID basically channels its money through a bunch of contractors based in or around Washington, D.C., or mostly along the East Coast of the United States. Then they go into developing countries to develop programmes. Now, you can dress it up any way you want, but that is the fundamental premise. Successive heads of USAID have, in the public domain, complained about how inappropriate this is. Why? Because, fundamentally, although they would not put it as directly as I'm about to put it, USAID it would appear, is set up not to help in developing countries, but to help in developing those contractors. Okay? So, here is how it plays out in practice. Some years ago, there was an experiment, a large-scale multi-country programme called the Affordable Medicines Facility for Malaria, aimed at bringing down the prices of malaria medicines and making it easier for people in malaria affected countries to rapidly gain access to those medicines to treat malaria. It involves subsidizing the medicines at the factory gate, then getting out of the way so that private sector and public sector buyers from the countries could get them directly from the manufacturers and then push them through the existing supply chains within the countries, both private and public. It worked. It was very successful. The independent evaluation, which cost in the region of at least US$ 10 million, was published in The Lancet in November of 2012, and this experiment was hosted by the Global Fund in Geneva. I should say, full disclosure, that I was the founding director of that initiative. So the independent evaluation was very positive, but there was a problem. What was the problem? If that programme were continued and expanded, it would put out of business the preferred business model of USAID. It was a threat to that model and it was a threat to the tens of millions of dollar contracts that USAID was dishing out to a few contractors.

Garry Aslanyan [00:27:39] Right, right. I remember.

Olusoji Adeyi [00:27:41] So USAID and the US President's Malaria Initiative, called US PMI, relentlessly attacked and undermined this programme, the AMFM, before the independent evaluation of the US PMI, which is in the public domain, said they were doing that, that they were reported to be undermining it. So USAID and US PMI, through the US delegation to the Global Fund Board, bullied the Global Fund Board into ending that programme. And they did it in a way that will almost make you laugh if it weren't so tragic. The Board said it was going to integrate the AMFM, their programme, into its traditional business model. Now wait a minute. That was the same traditional business model that was not working before the AMFM was designed. So you are going to integrate a sparkling success into a mediocre, if not failing, model. That's what I call refusal to learn. There are many other instances, but that's a poster child for refusal to learn.

Garry Aslanyan [00:28:58] Thanks for that. Soji, as part of our season now and hopefully next season as well, we hope to dive into the geopolitics of global health. You wrote about that in your book around COVID. What do you see going forward, new geopolitical threats, and how can they apply in global health and what can we learn from the COVID experience?

Olusoji Adeyi [00:29:22] I wish I could say that the effects of geopolitics on global health will decline, but it will not. It is not new, but it's going to continue and, in fact, it will become amplified for several reasons. One, the very foundations of global health are rooted in this geopolitics, and I detail this in the book, Global health in practice. Those roots came from an interest in preserving investments and reducing the threats to investments in the colonial era and the early constellation of schools of tropical medicine, as they were called at that time, mostly in Europe, not exclusively, essentially served as the health wing of colonial expedition. Those then fuse with the post-World War two architecture of development financing for health, and when you have a merger of the intellectual technical enterprises with money, you get tremendous power imbalance. Now, to be clear, that network of schools has done a lot of positives in health, in medicine, across the world. They have trained thousands of leaders. So we really must acknowledge that. It is also true that diffusion, the combination of that network of technical knowledge with money, has, in a geopolitical sense, undermined development in the Global South. So what can be done for the future? I think we come back to the importance of a shared agreement to learn. How will this work out in practice? It means the low- and middle-income countries themselves, despite their own fiscal constraints, investing more in their own national, subregional and regional institutions, expanding their own institutional capacity for learning, for practice and for knowledge sharing. That's one. A second one is for external financiers to place more emphasis on supporting such institutions. Now this is boring. It's not glitzy work to say you are supporting so many institutes of public health or public policy or laboratory development, etc. It's not as glitzy as a minister from North America or Europe flying into Nepal or Malawi or Nicaragua to be photographed with cute brown babies and then appear on the cover of Newsweek or Time magazine. So entities like national institutes of public health and national centres for disease control, regional centres for disease control, investing in regional, subregional and often country-based manufacturing of medical products and technologies in low- and lower-middle income countries themselves, so that they are not overly dependent on what comes from outside. That's what it's going to take to realize the shift from the current situation to one that is better. I'm an incurable optimist in this, despite the difficulties that I've outlined. I sincerely believe that a better future is possible.

Garry Aslanyan [00:33:28] A final question to you, Soji. Amid so many challenges in the global health system, do you think it's possible to achieve this ideal of shared humanity, one in which we all are in this together equally?

Olusoji Adeyi [00:33:42] Yes. I believe it is possible to achieve that idea of a shared humanity, or at least it is possible to make considerable progress in that direction. Individual self interests are understandable, but our collective needs as humanity are paramount. So as we face these longstanding and seemingly intractable challenges in health, we also need to take a look at the convergence of those challenges with the very big threat emerging from climate change, for example, the very big threat, and environmental pollution. All of those sticking together point at one overriding need, the importance of addressing challenges to common good. The collective good of humanity. Now, I'm not naive. I know that individual interests play out on a daily basis. Of course, that is understandable. I know that national interests play out on a daily basis, and that leads to conflicts, whether they are on the diplomatic front or any other front of conflict. That is understandable. Having said all those, making large scale lasting progress, improving equity in access to basic services and ensuring fairness across the board are ideals to which we must continue to aspire and afront along with we must continue making progress. I'm very optimistic about the future, despite the challenges. I'm very optimistic. A better future is possible.

Garry Aslanyan [00:35:41] Thank you, Soji, for joining me today and sharing your insights and book that you've written. Best of luck with your future endeavours.

Olusoji Adeyi [00:35:50] Thank you very much, Garry, for having me on this programme. It's been a pleasure.

Garry Aslanyan [00:35:56] In an increasingly polarized world, it is not often that one finds someone with Soji's capacity to bridge many different spheres of global health, and most notably, hold the tension between what are often considered opposing perspectives. His ability to critically reflect with hindsight, humility and hope, provides a sobering take on the state of global health, and yet also constructive guidance on how to move forward into the future. In his book, Soji defines global health to mean the sum of learning, influencing, practicing and applying knowledge and know-how to improve health outcomes and health systems globally. While talking to Soji, I often caught myself thinking how we should approach global health that way more often. May we all never stop learning by listening more before doing, and by placing our collective humanity ahead of our own individual interests.

Garry Aslanyan [00:37:02] Let's hear from one of our listeners, Sheila Mburu, from Chatham House in the UK.

Sheila Mburu [00:37:10] I really enjoyed the first Global Health Matters dialogues with Daisy Hernández, and I particularly liked her focus on the importance of being able to tell the human story in global health. That personal story also illustrated the challenges that minority communities often have, and so through sharing, it gave a really personal and a human lens to Chagas disease, whilst at the same time articulating the broader public health challenges and inequities in the U.S. health system. And I think we need to become better storytellers in public health. We have an opportunity to employ the skills of people like Daisy, who can build those communication skills in public health and bridge that communication gap between health experts and the general public. Because really, telling human stories is how we're going to connect the science and the research with the lives of those impacted by public health issues and also ensure effectiveness of interventions.

Garry Aslanyan [00:38:04] Thank you, Sheila, for your reflection on our Dialogues series and for highlighting the value storytelling can bring to public health. To learn more about our Dialogue series and the content of this episode, visit the episode web page where you will find additional readings, show notes and translations. Don't forget to get in touch with us via social media, email, or by sharing a voice message with your reflections on this episode.

Elisabetta Dessi [00:38:37] Global Health Matters is produced by TDR, a research programme based at the World Health Organization. Garry Aslanyan is the host and executive producer. Lindi van Niekerk and Obadiah George are content and technical producers. Priya Joy is the curator of the Dialogues series. The podcast editing, communications, dissemination, web and social media designs are made possible through the work of Maki Kitamura, Chris Coze, Elisabetta Dessi, Izabela Suder-Dayao and Chembe Collaborative. The goal of Global Health Matters is to produce a forum for sharing perspectives on key issues affecting global health. Send us your comments and suggestions by email or voice message to TDRpod@who.int, and be sure to download and subscribe wherever you get your podcasts. Thank you for listening.