

Perspective Paper

Strengthening Health Systems

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Perspective Paper

Strengthening Health Systems

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RethinkHIV: The Project

2011 marks the 30-year anniversary since the Centers for Disease Control and Prevention introduced the world to the disease that became known as AIDS. Despite 30 years of increasing knowledge about transmission, prevention, and treatment, and current annual spending of \$15 billion, every day around 7,000 people are infected with the HIV virus and two million die each year. The HIV/AIDS epidemic has had its most profound impact in sub-Saharan Africa, which accounts for 70 percent of new worldwide infections and 70 percent of HIV-related deaths, 1.8 million new infections in children each year, and has 14 million AIDS orphans.

Humanitarian organizations warn that the fight against HIV/Aids has slowed, amid a funding shortfall and donor fatigue. Yet HIV is still the biggest killer of women of reproductive age in the world, and of men aged 15-59 in sub-Saharan Africa. Time is ripe for a reassessment of current policy and expenditure.

The Rush Foundation has asked the Copenhagen Consensus Center to commission a group of leading health academics to analyze HIV policy choices and identify the most effective ways to tackle the pandemic across sub-Saharan Africa.

RethinkHIV identifies effective interventions in the fight against HIV/Aids across sub-Saharan Africa. It applies cost-benefit analysis to highlight investments and actions that can make a significant difference.

The Copenhagen Consensus Center has commissioned eighteen research papers by teams of top health economists, epidemiologists, and demographers who examine the cost-effectiveness of a range of responses to HIV/AIDS in sub-Saharan Africa under the following topics:

- Efforts to Prevent Sexual Transmission
- Efforts to Prevent Non-Sexual Transmission
- Treatment and Initiatives to Reduce the Impact of the HIV/AIDS Epidemic
- Research and Development Efforts
- Social Policy Levers
- Initiatives to Strengthen Health Systems

A panel of five eminent economists, including recipients of the Nobel Prize, convenes in the fall of 2011 to carefully consider the research and engage with the authors. The Expert Panel is tasked with answering the question:

If we successfully raised an additional US\$10 billion over the next 5 years to combat HIV/AIDS in sub-Saharan Africa, how could it best be spent?

After deliberating in a closed-door meeting, the Nobel Laureate Expert Panel provides their answer, highlighting investments and actions that could be most effective avenues for additional funding. Their findings and reasoning are released in the fall of 2011, and published in full alongside all of the research in a collated volume in 2012.

RethinkHIV will generate global discussion regarding responses to HIV/AIDS in sub-Saharan Africa. To participate in a dialogue on the research and findings within sub-Saharan Africa, a Civil Society Conference and forums for youth are held following the Expert Panel meeting in late 2011.

The Civil Society Conference is a means of creating a dialogue with African civil society and to agree on a set of bold new actionable priorities with society politicians, civil society organizations, influential thought-leaders, and others within sub-Saharan Africa.

It is hoped that the project will motivate donors to direct more money to the investments and actions that are demonstrated to be most effective to curtail the pandemic in sub-Saharan Africa.

All of the research papers, and many different perspectives on priorities can be found online at the project's website:

www.rethinkhiv.com

You are invited to join the dialogue and provide your own perspective on priorities for action in Africa.

The Copenhagen Consensus Center

The Copenhagen Consensus Center is a Danish state-funded think- tank that commissions and promotes research highlighting the most effective responses to global challenges. The Center is led by author Bjorn Lomborg, named 'one of the 100 Top Global Thinkers' by Foreign Policy in 2010, 'one of the world's 75 most influential people of the 21st century' by Esquire in 2008, and 'one of the 50 people who could save the planet' by the Guardian in 2008. The Copenhagen Consensus Center is implementing the project, which follows the format of past projects such as Copenhagen Consensus 2004, Consulta de San José in 2007, Copenhagen Consensus 2008, and Copenhagen Consensus on Climate in 2009.

www.copenhagenconsensus.com

The Rush Foundation

The Rush Foundation, based in Lausanne, is dedicated to providing fast, effective funding for innovative thinking addressing the HIV/AIDS epidemic in sub-Saharan Africa. The Rush Foundation is the sponsor of the project. The Rush Foundation was launched in 2010 to fund sustainable projects in sub-Saharan Africa focused on alleviating the pandemic through innovative thinking, and to shake up the status quo in HIV thinking by spearheading thought leadership projects and debates that will help reframe HIV policy. Among other initiatives, the Rush Foundation is currently designing a grant programme with ActionAid in Africa aimed at generating new, sustainable HIV initiatives on the ground.

www.rushfoundation.org

The Papers

The body of research for RethinkHIV comprises 18 research papers. The series of papers is divided into Assessment Papers and Perspective Papers. Each Assessment Paper outlines the costs and benefits of at least three of the most promising responses, interventions, or investments to HIV/AIDS in Sub-Saharan Africa within the respective category. Each Perspective Paper reviews the assumptions and analyses made within the Assessment Paper. In this way, a range of informed perspectives are provided on the topic.

Contents

RethinkHIV: The Project	4
The Copenhagen Consensus Center	5
The Rush Foundation	5
The Papers	5
Introduction	8
Methodological Issues	8
Why monetise the value of a life year?	8
Extrapolating to the whole of Africa without taking into account country differences	9
The Proposed Solutions	11
Strengthening health services and improving access to them	11
The use of incentives in driving change	12
Cash on delivery through an 'Abuja Goal Fund'	13
An Alternative Approach: Support the Global Fund	17
References	21

Introduction

This 'perspective' paper reflects on the methodology employed by McGreevey *et al*, comments critically on their proposed solutions and offers an alternative suggestion: support the Global Fund in its efforts to involve communities in the AIDS response.

Methodological Issues

This section considers two methodological concerns about the McGreevey *et al* paper: their monetisation of a human life year; and the way they extrapolate costs and benefits to the entire African continent without taking into account regional differences.

Why monetise the value of a life year?

McGreevey *et al* employ cost-benefit analysis where the value of a disability-adjusted human life year lost (DALY) is assumed to lie between \$1,000 and \$5,000, i.e. lower and upper bounds conforming to average per capita incomes in low and rich countries respectively. Monetising life years in this manner allows one to calculate benefit-cost ratios in the same metric, and it allows for the application of the same discount rate to the numerator and denominator. The problem, however, is that it presents a particular approach to valuing human life – in terms of economic productivity – as if it is a normal, technical issue rather than something which ought to be debated and owned by the societies in which allocation decisions are made. And, by valuing human life in this way, it is but a small step – and one strongly implied by the monetised benefit-cost approach – to target support to the employed, the better educated, the more highly skilled ahead of the less productive, the poor and the unemployed.

Put differently, expressing benefit-cost ratios in such fully monetised terms is a framework which lends itself naturally to rationing resources to those who are most valuable economically – whilst disguising this in a pseudo-technical calculation. Societies may well decide to ration or target their interventions to particular groups. But this should ideally be done through an open and transparent process, where the choices and arguments are clearly articulated and discussed.

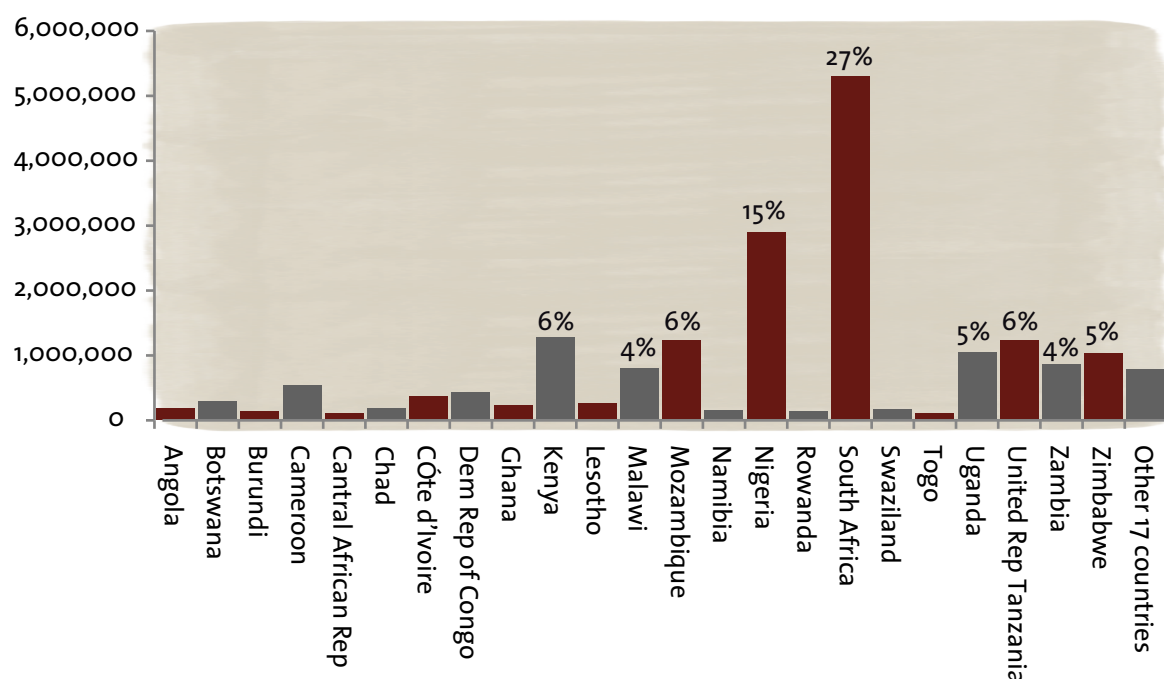
Benefit-cost analysis should thus be presented in as simple, and as clear a way as possible – and in a manner which facilitates discussion about the social choices involved in evaluating one intervention over another. The clearest metric is cost per life saved, or cost per life year saved in the current period. One could also present cost per DALY – but in doing so, policy makers need to be made aware of the assumptions of the value of a human life that are already built into the DALY calculation. Notably, the DALY uses age weights which give a higher value to people in their productive years and substantially less weight to children and the elderly. It also values years of life with a disability less than years of life without disability. Most policy makers probably do not realise this – hence one should at least present them with cost per life years gained (no weighting, no disability adjustment) as well as cost per DALY calculations. They can then see how much the implicit valuations about human life profoundly shape what appear to be purely technical calculations. For benefit-cost calculations over time, future costs can be discounted by an interest rate – ideally linked to a measure of expected inflation. If policy makers choose to apply the same discount rate to future years of life, this should be their choice. They may well choose to value current and future years of life on a different basis to cost estimates.

A simple and clear approach is also useful for analysts as it is all too easy to lose sight of the fact that the DALY already rests on assumptions about the value of human life at different ages and levels of disability. Thus when McGreevey *et al* adopt Jamison's argument for counting the year of life saved for an infant has one half year rather than a full year in order to reflect the 'relative benefits of saving the life of a child vs that of a young or mature adult', this appears not to take into account the fact that the DALY already gives a very low weight to the value of saving an infant year of life. In Box Table 1 (A and B), when McGreevey *et al* value adult DALY's at \$1,000 and infant DALYs at \$500 and then apply different discount rates to infants, adults aged 22 and adults aged 50, it seems that they are effectively heaping additional age-weighting on top of a calculation which *already* employs age-weighting in the calculation of the DALY itself. The result is a calculation which obscures precisely how much weight is being provided to years of life for people in different stages of their lives. As such, it obfuscates rather than facilitates sensible policy discussion about how to allocate health resources in accordance with social norms.

Extrapolating to the whole of Africa without taking into account country differences

The second methodological issue I would like to highlight concerns the way in which Africa-wide estimates of the cost of programmes or interventions are arrived at by multiplying per person costs (either based on pure assumption or on the basis of single country studies) by the relevant number of adults in Africa. For example, in estimating the costs of rolling out a new cohort of rural community health workers across Africa, data from Malawi are simply extrapolated to the entire continent by multiplying purported per person costs in that country by the number of

Figure 1: Number of HIV positive people in countries with 1% or more of the total Sub Saharan African HIV positive population in 2009 (% share indicated for the largest nine)



Source: UNAIDS (<http://www.unaids.org/en/dataanalysis/epidemiology/>)

African adults. Such an exercise is ultimately meaningless not only because the level of economic development (and health systems capacity) varies dramatically across Africa (see Table 1 below), but because the number of HIV positive people is highly concentrated in East and Southern Africa. As shown in Figure 1 below, South Africa has more than a quarter of the total HIV positive African population, and that nine countries account for over three quarters of the total. Costs and benefits are thus likely to vary significantly across Africa. Single Africa-wide ball-park estimates make no sense in this context.

Addressing the HIV epidemic in Africa ought to take cognizance of where most of the HIV positive people are – and the specific socio-economic challenges facing those countries as well as their level of development. Table 1 reports key development indicators for the nine countries highlighted in Figure 1. It shows that gross national income (GNI) per capita ranges from \$330 in Malawi to \$6,100 in South Africa, and health system capacity ranges from a low of 39% of women giving birth in the presence of skilled health care workers in Nigeria, to 91% in South Africa. It also shows that the countries face different HIV disease burdens (with HIV prevalence ranging from 4% in Nigeria to 18% in South Africa). The fact that life expectancy at birth is lower in South Africa than it is in Malawi reflects this high burden of HIV – both in absolute terms and as a share of the total population. The key take-home message is that not only is the distribution of HIV-positive people highly concentrated in Africa, but that the high burden countries face different scales of the epidemic and have very different labour markets and economic and institutional capacities on hand to deal with it. HIV-related and health systems support thus has to be calibrated to country-level requirements.

In short, extrapolating on the basis of the Malawian experience – where the level of economic development (and wage costs) are relatively low, the burden of HIV relatively high (which means it has a relatively high social purchase) – to the whole of Africa is unhelpful, even for calculating ball-park estimates. At the very least, they should include specific country estimates for South Africa and Nigeria – and ideally also for Tanzania, Kenya and Mozambique.

Table 1: Development Indicators for the Nine Countries Highlighted in Figure 1

Country	GNI per capita (2010)	Literacy rate	Poverty head-count ratio	Life expectancy at birth	Births with skilled health staff	HIV prevalence (15-49)	% of young women (men) ever tested for HIV
Kenya	\$780	87%	46%	55	44%	6%	18% (13%)
Malawi	\$330	74%	52.4%	54	54%	11%	5% (4%)
Mozambique	\$440	55%	54.7%	48	55%	12%	13% (6%)
Nigeria	\$1,180	61%	54.7%	48	39%	4%	5% (5%)
South Africa	\$6,100	89%	23%	52	91%	18%	n/a
Uganda	\$490	73%	24.5%	53	42%	7%	n/a
Tanzania	\$530	73%	33.4%	56	43%	6%	15% (11%)
Zambia	\$1,070	71%	59.3%	46	47%	14%	13% (7%)
Zimbabwe	\$460	92%	72%	45	60%	14%	n/a

Source: World Bank Data (<http://data.worldbank.org/>), UNAIDS <http://www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets/>

The Proposed Solutions

McGreevey *et al* propose four solutions. Two entail improving health services and access to them (a test for the cryptococcal antigen and a new cohort of community health workers). The other two solutions are explicitly incentive-based: a \$5 payment to Africans for HIV testing; and results-based donor funding to incentivise African governments to spend more on health. I comment briefly on the first two, and then spend more time exploring the appropriateness of their incentive-based proposals.

Strengthening health services and improving access to them

In ‘Solution 2’ McGreevey *et al* argue for the deployment of a new group of community health workers to the rural population of Africa at a cost of \$640 million per year. They come to this figure on the basis of an unpublished Malawian study which suggests that one community health worker can ‘take care of 565 households per year at a per-person cost of eighty cents per year’.¹ Precisely what ‘taking care of’ involves is unclear, but McGreevey *et al* suggest that there is evidence that the Malawi pilot project assisted in promoting mother to child transmission prevention as well as improved maternal health and access to family planning. They estimate that similar services could be rolled out across Africa (at a cost of 80 cents per adult per year) and that similar benefits (in terms of reducing births, maternal deaths, infant HIV infections) would result – but on an Africa-wide scale.

Promoting family planning, maternal health and mother to child transmission prevention is a good idea – as is doing this through a new cohort of community health workers. But it is unrealistic to assume that the costs and the benefits can be extrapolated across Africa in this way. Malawi is a relatively small, impoverished, low-wage country. Wage rates for community health workers in other countries – especially the high HIV prevalence countries of Southern Africa – are likely to be much higher, and where large distances are involved in servicing rural areas, logistical costs will probably also be substantially higher. Furthermore, the benefits will vary from country to country depending on HIV prevalence and the existing level of fertility. There is no easy ‘one size fits all’ approach to estimating costs and benefits of such interventions across Africa. The benefit cost estimates are best disregarded.

In ‘Solution 3’ McGreevey *et al* propose that money be allocated for testing for the cryptococcal antigen (CRAG) in order to identify those at risk of developing cryptococcal meningitis, and to treat the disease in the early stages when outcomes are much more positive. The case seems compelling, but I am not in a position to comment on the medical costs involved, or on whether the costs and benefits are realistic on an Africa-wide basis. Clearly the benefit cost ratios will be much higher in countries with high HIV prevalence rates (notably Southern Africa) – and it may well be the case that the costs are prohibitively high (relative to the benefits) in the low HIV prevalence countries in the West and North.

¹ The studies that informed this estimate were either missing from the references (McCoy 2011) or unpublished. Also, no data was provided on the wages paid to these workers, whether there was any assessment of the quality of their services, and the cost of administrative over-head.

The use of incentives in driving change

The ‘big idea’ in McGreevey *et al* is the use of incentives to change the behaviour of people and governments. They propose two solutions in this respect: a voucher worth \$5 for every adult in Africa who comes in for an HIV test (Solution 1); and donor funding for health to governments conditional on progress towards the Abuja goal of 15% of domestic budgetary spending on health (Solution 4).

McGreevey *et al* believe that the \$5 voucher will incentivise and facilitate people to take the step of testing for HIV – and that in this regard, it could serve as one of the ‘critical enablers’ identified by Schwartländer *et al* (2011) as being necessary for a successful AIDS response. More specifically, the authors propose that every adult aged 18 to 49 be given a voucher² worth \$5 (US) in exchange for being tested, counselled and if necessary treated. They argue that this avoids stigmatisation because there is no explicit targeting. But this is not the case. In practice, a \$5 voucher will result in a form of self-targeting which targets the poor (richer people will not be incentivised to spend their time in a queue just to obtain a \$5 voucher). This, will, of course, vary from country to country, where one would also expect more people (including the relatively better off) in countries like Malawi and Mozambique, to be incentivised by a \$5 voucher – than would be the case in a middle-income country like South Africa (see Table 1). Where HIV is associated with poverty, then this probably does not matter. However, the empirical evidence suggests that HIV is not only, or even primarily a disease of poverty in Africa and that it is often the case that people at the higher end of the income distribution have higher HIV prevalence rates (e.g. Gillespie *et al*, 2007; Nattrass 2009).

McGreevey *et al* go on to assume that not only will this intervention be successful at reaching all adults, but that this will cut new HIV infections by a quarter of a million (i.e. result in a 20% reduction in the number of expected annual infections in Africa). This impact is totally unrealistic given the lack of supporting evidence for this. Padian *et al* (2010) have shown that the only systematic evidence on HIV prevention impacts comes from biomedical interventions such as male circumcision, mother to child transmission prevention and antiretroviral treatment. The absence of evidence in support of HIV testing as a prevention intervention is not, of course, evidence of the absence of any positive impact. The point is that the positive impact of HIV testing on behaviour change has not yet been demonstrated – and thus the assumed benefits of this intervention are pure conjecture.

There is, however, a bigger problem with this proposal – namely that it will be logistically impossible to implement. How does one stop poor people doing many tests in order to accumulate cash? If the program is to be offered to all adults (aged 18-49) on a single day, it is safe to assume that there will be insufficient health personnel to provide the necessary services (no matter what is assumed about other programs upgrading health services). If it is to be run over a period of time, then how does one prevent corruption and multiple testing? Are ID documents to be marked? If so, what are the legal and social ramifications of that? Given these problems and complexities, the benefit-cost ratios presented by McGreevey *et al* seem totally overblown – as is the claim that the initiative will bring ‘the whole population of Sub-Saharan Africa into participation in the fight against AIDS’.

Finally, there is also a very real danger that monetising the incentive for HIV testing could undermine other efforts to encourage people to know their status as an act of civic duty as well as individual responsibility. An example, at six day-care centres in Haifa, a fine was imposed on parents who were late picking up their children at the end of the day. Parents responded to the fine by doubling

² Why a voucher and not cash? This is never explained or justified.

the amount of time they arrived late. When after 12 weeks the fine was revoked, their enhanced tardiness persisted – the fine seems to have undermined the sense of ethical obligation the parents felt to avoid inconveniencing the teachers and lead them to think of lateness as a commodity that could be purchased. Bowles (2008) argues that this is an example of how preferences adapt to circumstances – and why we should be concerned about ‘incentivising’ individuals to act out of monetary considerations rather than social responsibility. Incentives can reframe the way that people understand appropriate behaviour and those who gain pleasure from acting in a socially responsible way may lose the incentive and the signal to do so when the action becomes rewarded. By contrast, game theoretic experiments which punish people for anti-social behaviour generate feelings of shame, and subsequent changes in behaviour (see summary in Bowles 2008). It may well be that a society-wide ‘know your status’ campaign drawing in community leaders at all levels would not only be cheaper, but much more effective than the \$5 voucher proposal.

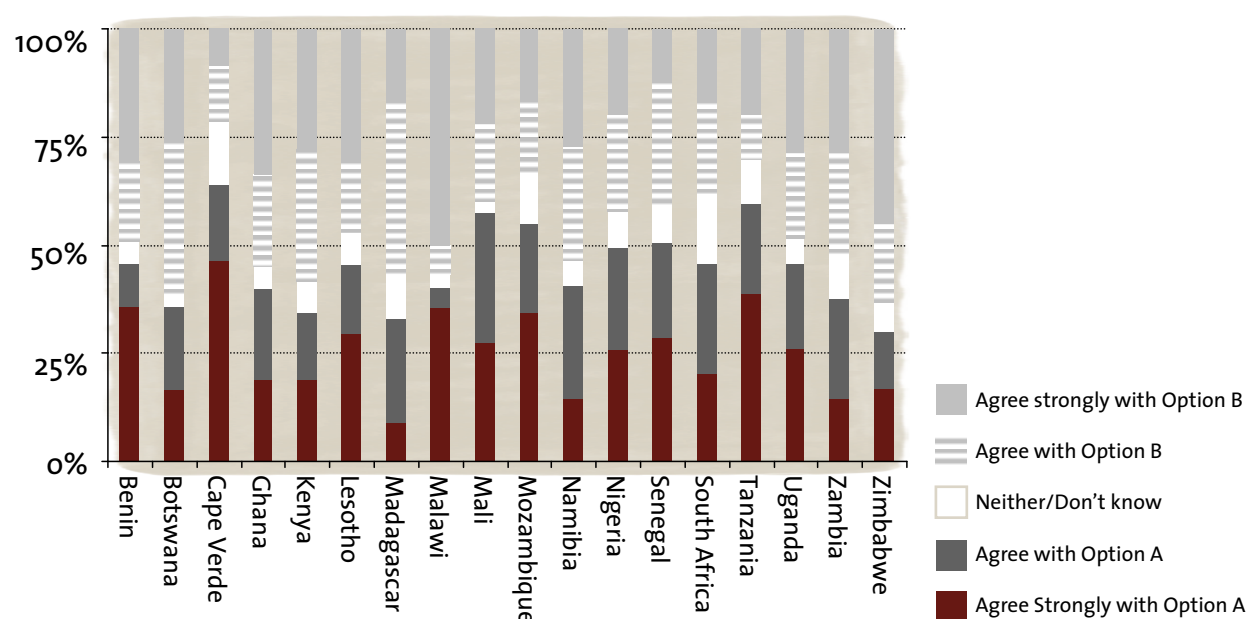
Cash on delivery through an ‘Abuja Goal Fund’

The second incentive-based intervention proposed by McGreevey *et al* is their ‘Solution 4’ to promote results-based donor funding through a new institutional vehicle they call the ‘Abuja Goal Fund’. Their suggestion is that donor funding to African governments be conditional on progress towards the Abuja goal of allocating 15% of public spending on health, and that the Abuja Goal fund be set up with an initial endowment of \$1 billion. Drawing on work by the High Level Taskforce on Health Systems Strengthening, they suggest that encouraging African governments to move towards this goal could have substantial benefits in terms of preventing child and maternal deaths, Tuberculosis and HIV deaths and decreasing the number of births.

The key idea here is that the fund would be used to ‘induce’ African governments to allocate more of their own resources to health and that target shares (and its progress over time) would be the subject of negotiation between the Abuja Goal fund and the country government concerned. They argue that such results-based funding practices are already evident in the Global Fund (which makes future tranche payments contingent on adequate progress) and that World Bank structural adjustment lending (in which loans were made conditional on policy changes) also serve as a relevant precedent. They note that it is difficult to know exactly how an Abuja Goal Fund would contribute to the process, but that ‘incentives matter and governments respond positively to them’.

Precisely how the conditional grants will be monitored and managed is left unspecified. At no point do McGreevey *et al* squarely face the tension between what country governments wish to do and what donors essentially impose on them through ‘incentivised’ lending. They merely state, in a very unconvincing manner, that their proposal is a ‘hands off’ approach. They are also silent on the political-economy of why most African country governments have not already allocated 15% of their budgets to health. In some (probably most) countries it could be that governments are pursuing other objectives and that the citizenry would prefer more resources for health. But it may also be the case that some African country governments are reflecting a more wide-spread view among the citizenry that other spending priorities are more important. If the former, then an Abuja Goal Fund would be a progressive intervention; but if the latter, then it could easily lose legitimacy in the same way that the IMF and the World Bank have through their conditional lending programs. In countries where most people believe that the government is spending enough on AIDS or health relative to other concerns, then – irrespective of the country’s prior commitment to the Abuja goal – there is very real political danger in using a mechanism such as the Abuja Goal Fund to coerce (albeit through incentives) changes in government policy. In such circumstances, we should either

Figure 2. Responses to the Afrobarometer Survey (2005/6) to Question 66.



opt to allocate health resources to other countries, and/or to support civil society organisations to build popular support for, and understanding of, the need to prioritise health.

What do Africans think about health as a priority? The only systematic survey of African public opinion is that by the *Afrobarometer* project. In its 2005/6 round of surveys in 18 countries, respondents were asked what they thought the country's most pressing problems were and whether they thought that more or less should be allocated to fighting AIDS.

More specifically, question 66 asked: Which of these statements is closest to your view?

- A: The government should devote many more resources to combating AIDS, even if this means that less money is spent on things like education.
- B: There are many other problems facing this country beside AIDS; even if people are dying in large numbers, the government needs to keep its focus on solving other problems".

The results, depicted in Figure 2, show that respondents in most countries typically favoured option A (more resources to AIDS even if it means fewer for other priorities like education), but that in Botswana, Ghana, Kenya, Madagascar, Malawi, Namibia, Zambia and Zimbabwe, more than 50% of respondents agreed with option B (keep the government focus on other priorities). Note that these results cannot be interpreted as meaning that respondents wished to see fewer resources going to AIDS or health – it simply shows that in these countries there is a clear majority in support of continuing to focus on other priorities (i.e. not restructuring the government budget towards more spending on health).

Afrobarometer provides some sense of what people considered to be the three most important problems facing their country in 2005/6. Table 2 shows that most people cited poverty and income-related issues, with health/sickness/AIDS typically coming in third (in the total sample, poverty/famine was mentioned 18% of the time, unemployment/income 17% followed by health/sickness/AIDS 12% of the time). In the case of Malawi, which is poor, lacks safe water supplies and is prone to

famine, it is unsurprising that poverty and famine was the overwhelmingly largest concern (30%), followed by water supply (10%) and health/sickness/AIDS (8%). Dionne *et al* report that Malawians are aware of the vast inflows of donor money for AIDS and suspect the government of creaming off some of this money. Given this context, it is hardly surprising that more respondents in Malawi (50%) than in any other African country sampled, said they *strongly* supported option B.³

Table 2 also shows that by 2008, Botswana and Zambia had already achieved the Abuja goal – hence the majority view in favour of keeping government focussed on other priorities is unsurprising. And, in South Africa, where progress towards the Abuja goal has been slow, and the burden of AIDS high, the relatively low support for keeping governments focussed on other priorities is also unsurprising. Nudging countries like South Africa and Nigeria towards higher health spending is thus unlikely to result in a groundswell of popular protest. But the results for Kenya and Malawi suggest that this may not be the case in these countries. Despite relatively low levels of government spending on health, a majority of respondents supported the government’s current prioritisation of other priorities over AIDS spending. ‘Inducing’ these governments to change their spending patterns dramatically (in Kenya’s case almost tripling the share going to health) may well be seen as an unacceptable imposition of Western values over African priorities – and if this is used by politicians to drum up support, it could delegitimize existing health projects.

Note that the questions asked by the *Afrobarometer* are far from perfect, and the data is relatively dated. Even so, it points to the need to take popular opinion seriously. Just because governments in the past agreed to the Abuja target does not necessarily mean that there is popular support for it today.

Returning to the issue of political legitimacy for health care reform, McGreevey *et al*’s casual acknowledgement of World Bank structural adjustment lending as a form of results-based funding seems innocent of the political baggage with which it was and remains accompanied in Africa. When African governments have been forced to adopt unpopular policy changes (for example, cutting food subsidies, increasing user fees for schooling and health) as part of their World Bank and IMF managed structural adjustment, this has often generated spontaneous popular protests and given African politicians a convenient scape-goat. The Abuja Goal Fund runs a similar danger. Precisely because it sets out to induce governments to change, and offers funding only with strings attached – and in a very public way – there is a serious danger that it could backfire – especially if more donor funding for health is channelled through such an ultimately coercive institution.

Another problem with the Abuja Goal Fund idea is that it does not confront the fact that extra spending on health may well be leveraged out of governments, but at the cost of welfare and other pro-poor programs. For instance, if there is a strong government coalition in favour of policies that benefit the elite (perhaps through industrial policies, highly subsidised tertiary education, urban housing etc) then an unintended and unanticipated consequence of incentivising governments to spend more on health could be that they either spend less on pro-poor projects (such as emergency job creation programs) – and/or spend more on hospitals and high-end medical equipment which cost a great deal (thereby helping achieve the Abuja target by virtue of the expense) but which continue to benefit the elite at the cost of broad-based health care. Monitoring by, and

³ Dionne *et al* claim that we can ‘conclude with confidence that rural Malawians, like the critics of AIDS exceptionalism, would prefer fewer resources be allocated to AIDS and more to other critical day-to-day problems’ (*ibid*: 11). Note that the *Afrobarometer* data do not support this view. At most the data suggest that respondents would like to see more resources going to other priorities.

Table 2: Perceived Most Important Problems Facing Governments (Afrobarometer 2005/6)

Country (2005 HIV prevalence rate)	Most important problem (average of three responses)							Agreed with option B Question 66 (do not shift more resources to AIDS)	% of health expenditure in total govt expenditure (2008)
	Poverty/Famine (% below poverty line)*	Unemployment/ income (unemployment rate)*	Health/sickness/AIDS	Water supply	Economic management	Infrastructure	Education		
Benin (1.8%)	8.0% (33%)	11.5% (n/a)	15.3%	10.0%	5.3%	10.4%	10.7%	49.1%	8.8%
Botswana (24.1%)	15.3% (47%)	27.1% (24%)	16.4%	7.8%	1.6%	3.0%	8.9%	61.5%	16.6%
Cape Verde (<1%)	13.9% (30%)	29.1% (21%)	9.9%	6.3%	1.4%	3.8%	6.6%	21.5%	10.1%
Ghana (2.3%)	7.9% (31%)	18.9% (20%)	10.6%	8.3%	5.6%	8.9%	15.3%	54.9%	8.5%
Kenya (6.1%)	14.5% (50%)	14.4% (40%)	11.4%	7.8%	5.9%	6.7%	8.7%	58.5%	5.8%
Lesotho (23.2%)	18.9% (49%)	23.9% (45%)	6.9%	9.8%	0.8%	8.4%	3.5%	47.0%	8.2%
Madagascar (0.5%)	18.3% (50%)	14.2% (n/a)	10.1%	4.0%	6.3%	10.7%	5.6%	56.6%	14.6%
Malawi (14.1%)	30.6% (55%)	5.1% (n/a)	7.5%	9.6%	3.2%	4.4%	6.2%	56.6%	12.1%
Mali (1.7%)	36.4% (30%)	6.4% (15%)	12.0%	9.8%	1.1%	4.8%	6.6%	40.0%	11.1%
Mozambique (16.1%)	14.5% (70%)	17.4% (21%)	17.2%	9.5%	2.1%	4.3%	10.6%	33.6%	12.6%
Namibia (19.6%)	8.2% (50%)	26.4% (35%)	11.9%	5.7%	2.5%	2.2%	11.6%	53.7%	12.1%
Nigeria (3.9%)	23.9% (60%)	18.7% (n/a)	4.9%	3.7%	6.2%	4.5%	7.3%	42.3%	6.4%
Senegal (0.9%)	17.1% (54%)	13.4% (48%)	18.0%	4.7%	3.8%	4.4%	7.9%	41.2%	11.9%
South Africa (18.8%)	10.5% (50%)	23.4% (26%)	13.0%	6.1%	1.9%	5.4%	4.3%	38.0%	10.4%
Tanzania (6.5%)	10.3% (36%)	6.1% (n/a)	16.7%	10.0%	2.8%	12.2%	9.5%	30.4%	18%
Uganda (6.7%)	19.9% (35%)	7.9% (n/a)	15.5%	10.3%	2.7%	5.8%	11.2%	48.5%	10.5%
Zambia* (17.0%)	22.3% (86%)	19.8% (50%)	9.7%	8.2%	2.4%	6.2%	12.8%	52.3%	15.3%
Zimbabwe (20.1%)	28.9% (70%)	15.2% (70%)	7.4%	2.5%	15.2%	0.6%	2.5%	63.4%	n/a

Source: Afrobarometer (2005/6). Available on <http://www.afrobarometer.org/data.html>; WHO Health Statistics 2011: http://www.who.int/whosis/whostat/EN_WHS2011_Full.pdf;

*CIA Factbook (2005): <http://www.umsl.edu/services/govdocs/wofact2005/>. Note the figures for poverty and famine in Mali are for urban areas only.

negotiations with, officials in the Abuja Goal Fund could perhaps prevent such responses – but it will be difficult (government spending is fungible) and expensive in terms of the additional bureaucracy involved.

An Alternative Approach: Support the Global Fund

RethinkHIV wants to know how an additional US\$10 billion can best be spent in Sub-Saharan Africa to respond to HIV/AIDS. Building better and more integrated health systems on the back of the AIDS response is an obvious area to focus on. As McGreevey *et al* correctly point out, we need stronger health systems, better diagnostic tools and greater community involvement – both on the supply side (community health workers) and the demand side (access to health services). They are also correct to highlight the issue of incentives, both on the side of people taking responsibility for their own health care, and on the part of government in shaping the public health policy. But they are, in my view, mistaken to suggest that we need new top down innovative mechanisms, such as the \$5 HIV testing vouchers and new institutions – notably the Abuja Goal Fund. Rather, we should be supporting domestic organisations to promote HIV awareness and responsibility, and we should be supporting *existing* innovative international institutions such as the Global Fund which already engages successfully with stakeholders at all levels, thereby mitigating some of the political-economic problems touched on above.

Incentives need to be taken seriously – and optimally in an explicitly political frame. As the World Development Report for 2004 *‘Making Services Work for Poor People’* found, adopting old-style public administration approaches to health planning without being alert to the ‘underlying patterns of accountability and incentives’ which affect implementation is doomed to failure (World Bank 2004). And as a recent evaluation of World Bank health funding concludes, ‘the most pervasive lesson from the Bank’s experience with health reform is that failure to assess fully the political economy of reform and to prepare a proactive plan to address this issue can considerably diminish prospects for success’ (World Bank Independent Evaluation Group, 2009). Improving health outcomes is as much a political challenge as it is a technical/planning challenge.

Civil society organisations and patient advocate groups are important in terms of mobilising the citizenry to take responsibility for their own health care – and to demand better services from government. The AIDS response has been crucial in this respect. Patients on antiretroviral treatment, precisely because the long-term management of HIV is handled as a chronic illness, have an ongoing incentive to fight for antiretroviral treatment *and* more effective health systems. As Yu *et al* noted in their assessment of the evidence on the relationship between AIDS spending and health systems:

‘AIDS activists increasingly advocate for the right of access to universal primary health care. They have also changed the dynamics between health care providers and clients, thus helping prepare health systems for the delivery of chronic care, which requires much more give-and-take between care providers and their clients than does the delivery of acute care. Indeed it is the activism for AIDS that has created solidarity about health as a concern for humanity, and as part of the evolving paradigm on globalization.’ (Yu *et al* 2008)

International AIDS activists have also played a key role in driving down drug prices, challenging intellectual property and forging international solidarity on AIDS (Smith and Siplon 2006). In sharp contrast to health interventions which either attempt to coerce governments by inducing them to

change their spending priorities (such as the Abuja Goal Fund) or which simply rely on the good will and capacity of governments to deliver health care to a passive and poor citizenry, AIDS patient groups have built organisations and created political spaces for demanding health care from their governments.

This is most obvious in South Africa, where the Treatment Action Campaign (TAC) waged a successful social and political battle in support of evidence-based approaches to HIV prevention and treatment. In the early 2000s, President Mbeki and his Health Minister Manto Tshabalala-Msimang raised questions about the science of HIV and actively blocked the use of antiretrovirals for HIV prevention and treatment in the public sector (see e.g. Nattrass 2007, Geffen 2010). It was only after sustained pressure from the TAC and its allies that Mbeki and Tshabalala-Msimang were forced to change policy. International pressure also helped, but ultimately the battle was won on the domestic political front as the TAC mobilised support from the trade union movement, health care professionals, people living with HIV and sympathetic individuals in national and local government structures. Indeed, the political costs to Mbeki were such that they contributed substantially to his subsequent removal as president.

The TAC was effective on a range of levels, from high profile legal action, to mass marches and to the building of community-based branches in strategic parts of the country. Donor funding was crucial in supporting these activities. The local level activities were vitally important to – and continue to be – as it is through direct action by affected patient groups that the health sector can be held to account.⁴ Indeed, TAC branches have transformed the relationship between citizen and state in ways which make the building of better health systems more likely. As Jonny Steinberg observes (with regard to the rollout of antiretroviral treatment in Lusikisiki (rural Eastern Cape):

“The idea of demanding that a drug be put on a shelf, or that a doctor arrive at his appointed time, is without precedent. The social movement to which AIDS medicine has given birth is utterly novel in this part of the world, the relationship between its members and state institutions previously unheard of” (Steinberg, 2008).

In short, supporting civil society organisations in high prevalence countries (such as the TAC in South Africa and the AIDS Support Organisation (TASO) in Uganda) can be just as important as supporting governments to undertake health care reforms. Furthermore, by strengthening a cadre of domestic activists to hold governments to account, one can avoid the political costs of having international donor organisations being seen to be strong-arming governments to redirect funding away from domestic priorities.

Supporting domestic patient advocate groups can also help promote greater awareness of HIV and the need to adopt preventative measures. Helen Epstein argues compellingly that it was TASO and related grass roots activism in Uganda which brought about behaviour change (Epstein, 2007). A similar case can be made for South Africa. For example, multivariate regression analysis of survey data from Cape Town shows that simply having heard of the TAC significantly increased the likelihood of respondents practicing safe sex (Grebe and Nattrass, 2011). Changing social attitudes from the ground up surely is a better idea than trying to pay people for once-off HIV testing (as in the \$5 voucher proposal) – especially given the risk that people may then continue to demand to

⁴ Information can be found on the TAC website (www.tac.org.za) about the ongoing activities of TAC branches in urban and rural areas. TAC activists collect information about stock outages, organize protests in towns and outside clinics when services fail, and they provide ‘treatment literacy’ education and support to people living with HIV. Local branches are also active in pushing for integrated TB and HIV health services, for national health insurance and for better maternal and child care.

be paid for HIV testing rather than take responsibility for doing it themselves on a regular basis. Supporting grass-roots initiatives which help reframe the way people see the AIDS epidemic – for example, buying into HIV science rather than Mbeki's AIDS denialism, or accepting that HIV testing is both a private and a public responsibility – should be of central importance in the ongoing AIDS response.

The international AIDS response has catalysed new and innovative international institutions such as UNAIDS and the Global Fund – both of which involve NGOs, civil society and patient stakeholder groups in decision-making at all levels – including in the country co-ordinating mechanisms through which Global Fund grants are channelled (Global Fund, 2009, UNAIDS 2011). The Global Fund already allocates about a third of its funding for health systems strengthening and, as McGreevey *et al* acknowledge, it already operates a system of results based financing where grants are paid out in tranches depending on progress. According to an internal assessment, 94% of its African AIDS programs were successful and helped build better health systems (Global Fund, 2009). This stands in sharp contrast with World Bank AIDS projects, 82% of which were assessed as having performed inadequately due to inappropriate design, too many actors and inefficient monitoring (World Bank Independent Evaluation Group, 2009: 38).⁵

There are various reasons why the Global Fund is successful including performance-related disbursements – but it is support from UNAIDS and strong commitment to building capacity and ensuring genuine country ownership which is key. UNAIDS has brokered and funded the creation of technical support facilities in various regions to assist countries in their programs and applications to the Global Fund. Even during the Mbeki presidency, when relations between state and civil society were strained over HIV (putting corresponding pressure on the country co-ordinating mechanism), Global Fund money was nevertheless successfully channelled to South Africa – kick-starting the AIDS response. This includes the important first pilot antiretroviral treatment project in Khayelitsha, an innovative partnership involving local government, Médecins Sans Frontières (MSF) and the TAC.⁶ Tshabalala-Msimang threw obstacles in the path of donor funding (for example, she blocked a Global Fund grant to KwaZulu Natal for over a year by refusing to sign the necessary documents), but eventually folded in the face of domestic political pressure (Nattrass, 2007). The key point here is that international pressure helps, but ultimately this has to be in partnership with strong domestic constituencies if it is to have sustainable positive effects.

Supporting community organisations, of course, has its own major challenges. There is a persistent lack of capacity amongst African NGOs as well as the ever-present problem of misappropriation of funds. However, it is important to acknowledge that institutions like the Global Fund have already developed networks and processes to address this. More recently (in 2009-10), the Global Fund started the development and implementation of the Community Systems Strengthening Framework to help civil society engage more actively with the Global Fund and obtain much needed funding (UNAIDS, 2011: 7). Ultimately the Global Fund is successful also because of the

⁵ It should, however, be noted that many of the under-performing projects were 'emergency operations for HIV/AIDS in Sub-Saharan Africa at the height of the epidemic, with widespread civil instability in the region, food shortages, internal displacement and millions of refugees' – World Bank spokesman quoted in *The Guardian*, 1 May, 2009: <http://www.guardian.co.uk/business/2009/may/01/world-bank-health-aid-poverty>.

⁶ In 2001, Médecins Sans Frontières in collaboration with the Provincial Administration of the Western Cape, launched a pilot antiretroviral program in Khayelitsha, an African township on the outskirts of Cape Town. It was subsequently highlighted by the WHO in its 'Perspectives and Practice in Antiretroviral Treatment' – a series aiming to show that antiretroviral treatment could be provided successfully to people with AIDS 'even in the most resource-constrained settings' (MSF *et al*, 2003: 1). The Khayelitsha project demonstrated early on very good adherence to treatment regimens and excellent clinical outcomes (*ibid*; Coetzee *et al*, 2004). It also showed how international NGOs, local government and civil society could collaborate in innovative pilot projects even in the face of an unsupportive national political context.

innovative way that it and UNAIDS genuinely forge country ownership through supporting both states and civil society. UNAIDS reports that staff in their country offices spend up to 50% of their time supporting countries in the effective use of Global Fund grants and that the technical support facilities helped unblock implementation challenges in 27 countries in 2010 (2011: 16). The Global Fund can thus draw on a range of established technical offices in ways which even the World Bank cannot.

We should be supporting this international global infrastructure to do what it is already doing – not setting up rival institutional mechanisms such as the Abuja Goal Fund. The \$10 billion should be given to the Global Fund specifically to help it build better health systems on the back of the AIDS response – and to ensure that funding for patient advocate groups continues – especially in Southern Africa, where most HIV positive people reside.

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