

D I . I The global health landscape

The last few years have been good for 'global health'. Everyone talks about it. Large amounts are spent on it. Many universities have created departments of global health. The prominence of health indicators among the Millennium Development Goals also shows the ascendancy of 'global health' in international affairs. Even Hollywood celebrities fly the 'global health' flag.

The need to 'govern' health at a global level is important for several reasons. For a start, health care itself has become 'globalised'. Health workers are imported and exported from one country to another. Tele-medicine, medical tourism and the number and size of multinational medical enterprises are expanding. The Severe Acute Respiratory Syndrome (SARS) epidemic, multi-drug-resistant tuberculosis and the threat of a lethal global flu pandemic have further focused attention on global health governance and the need for laws, guidelines and standards to optimise disease control across national borders. Finally, many of the underlying determinants of poor health are global in nature. The effects of the globalised economic system on poverty and nutrition, as well as climate change, all point to the need for strong and effective global health leadership.

Meanwhile, a raft of new organisations, institutes, funds, alliances and centres with a 'global health' remit have mushroomed, radically transforming the 'global health landscape', raising questions about the accountability, effectiveness and efficiency of global health governance.

Development assistance for health and global health partnerships

Development assistance for health (DAH) has increased dramatically. According to the World Bank it rose from US\$2.5 billion in 1990 to almost US\$14 billion in 2005 (World Bank 2007). Most of this increase has come

from official donor country aid. But new sources of global health financing, in particular the Gates Foundation, have been significant. Private funding now accounts for about a quarter of all development aid for health (Bloom 2007). In sub-Saharan Africa, external health sector funding accounts for 15 per cent of all health spending on average, and a much higher proportion of public health financing (World Bank 2007).

There are three main sets of sources of DAH (see Figure D1.1). The first is official government aid, mainly from member countries of the Development Assistance Committee (DAC) of the OECD. In 2006, DAC countries collectively disbursed \$10.6 billion for health assistance, of which the United States contributed approximately half. The US proportion of aid increased in 2007. The amount of non-DAC aid for health to low- and middle-income countries is not known because of a lack of available data. For example, China, which has increased its development assistance budget in recent years, provides few data on where and what this money is spent on.

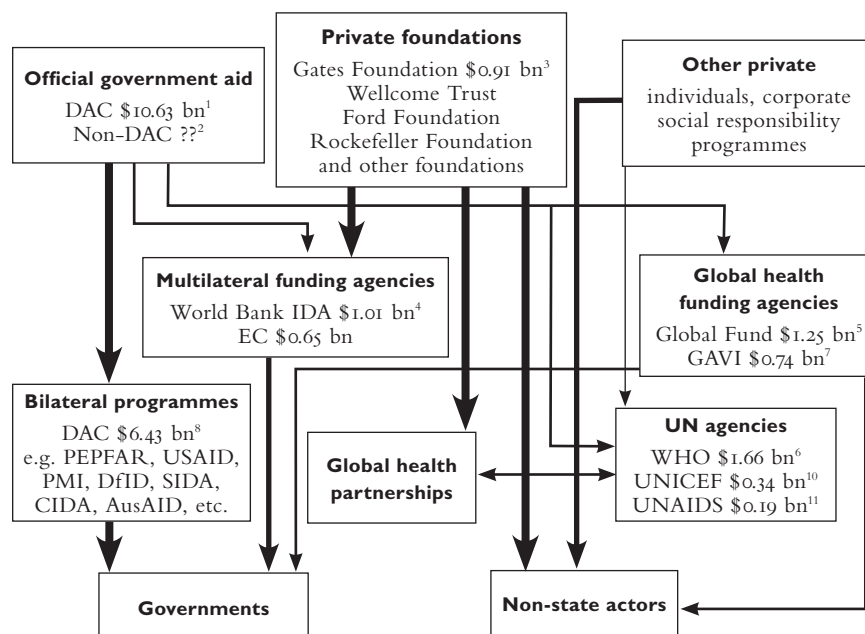
The second set comprises private foundations, and in particular the Gates Foundation. In 2006, the Gates Foundation awarded 195 global health grants totalling US\$2.25 billion. Finally, funding is also provided by individuals, typically through donations to international humanitarian and health-related organisations and charities, as well as by businesses, often through what are called 'corporate social responsibility' programmes.

The recipients of DAH can be broadly grouped into four sets of actors. The first group consists of recipient-country governments. The second consists of a variety of non-state actors involved in providing health services at country level, including non-governmental organisations (NGOs), faith-based organisations and a variety of health research organisations. The third group consists of UN agencies such as the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). And the final group consists of what are called global health partnerships (GHPs), many of which are relatively new.

Some DAH is channelled directly from donor to recipient. For example, donor governments may channel their funding to recipient governments or NGOs directly through bilateral programmes of aid; the Gates Foundation makes many grants directly to NGOs and research organisations. Some DAH, however, is channelled through multilateral agencies or new global health financing agencies such as the Global Fund to Fight AIDS, TB and Malaria (GF) and the GAVI Alliance.

Figure D1.1.1 illustrates a summarised version of the complex and convoluted global health aid architecture. However, each box listed in the contains a much bigger number of separate actors and institutions.

FIGURE DI.1.1 Overview of global funding in health in 2006



Notes

1. Current bilateral and multilateral disbursements (gross) for health and population programmes by DAC countries in 2006. The commitment of US\$1.01 billion to the World Bank has been added to this figure. The total current commitments (gross) for 2006 are \$13.64 billion.
2. A figure for 2006 is not available. However, for comparison, non-DAC countries total ODA (net) for 2005 was \$3.23 billion. Note that health-sector spending will be a small fraction of this figure. The list of non-DAC countries does not include China (see the World Bank Development Indicators 2007 for more details: http://siteresources.worldbank.org/datastatistics/Resources/table6_11.pdf).
3. Grants paid for global health in 2006. The commitments made in 2006 are much larger at \$2.25 billion (www.gatesfoundation.org/GlobalHealth/Grants/default.htm?showYear=2006).
4. Current commitments (gross) for health and population programmes by Development Assistance Committee (DAC) countries via the World Bank in 2006. Data for disbursements in the health sector alone were unavailable.
5. Current disbursements (gross) for health and population programmes by DAC countries via the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2006. The current commitments (gross) for 2006 are \$1.73 billion.
6. Current disbursements (gross) for health and population programmes by DAC countries via the European Commission in 2006. The current commitments (gross) for 2006 are \$0.51 billion.
7. Cash received by the Global Alliance for Vaccines and Immunisation in 2006. Annual disbursements were unavailable.
8. Current bilateral disbursements by DAC countries in 2006. The cash received by GAVI from DAC countries of \$0.74 billion has been deducted for the purposes of the overview – it is included in the OECD figures as ‘bilateral assistance’.
9. Half of the WHO proposed programme budget for 2006 and 2007.
10. Current disbursements (gross) for health and population programmes by DAC countries via UNICEF in 2006.
11. Current disbursements (gross) for health and population programmes by DAC countries via UNAIDS in 2006.

Sources: OECD 2008; Gates 2006; GAVI 2008; WHO 2006.

According to the UK government, global health assistance is now ‘over-complex’, and includes 40 bilateral donors, 26 UN agencies, 20 global and regional funds and 90 global health initiatives (DFID 2007). In addition, international NGOs such as Médecins Sans Frontières, Oxfam, Save the Children, International Planned Parenthood Federation, Care International and CAFOD have become bigger, more numerous and more important to health-care delivery in low-income countries (LICs).

At the global level, the new actors have caused a crisis of identity for many of the more established actors such as the WHO, UNICEF and the World Bank and the bilateral donor agencies. The adoption of narrow results-based performance measures have also led some global health initiatives to pursue their objectives without enough consideration of the impacts of their activities on the wider health system or the wider aid system. The chase for funding, success and public attention undermines efforts to ensure a more organised system of mutual accountability, coordination and cooperation (Buse and Harmer 2007).

The competitive and uncoordinated global environment results in expensive transaction costs for ministries of health having to deal with so many partners and having to manage fragmented health provision and competing for the limited numbers of trained staff. Zambia, for example, has major support from fifteen donor agencies, all of which demand separate reports, meetings and time from government officials. Bilateral donor channels often run outside Zambia’s efforts to coordinate a sector-wide approach to health systems development.

According to the World Bank, ‘never before has so much attention – or money – been devoted to improving the health of the world’s poor’; but it warns that ‘unless deficiencies in the global aid architecture are corrected and major reforms occur at the country level, the international community and countries themselves face a good chance of squandering this opportunity’ (World Bank 2007).

The ninety or so global health initiatives come in different shapes and sizes. Some have been established as global health financing agencies (e.g. the Global Fund and the GAVI Alliance); some have been established to provide coordination around efforts related to a particular disease or health issue (e.g. the Partnership for Maternal, Newborn and Child Health; Stop TB; Roll Back Malaria; the Global Health Workforce Alliance); while many others have been established to improve the availability of medicines, vaccines and other health technologies (e.g. the Medicines for Malaria Venture; the Alliance for Microbicide Development; the International AIDS Vaccine Initiative). Sixteen of these GHPs have been described in brief in Table D.1.1.1 to illustrate the different types of GPP and their complex configurations.

TABLE DI.1.1 **Summary of selected GHPs**

GHP	Major partners	Purpose of partnership	Main funders
Alliance for Microbicide Development	American Foundation for AIDS Research, AIDS Vaccine Advocacy Coalition, Family Health International, Gay Men's Health Crisis, Global Campaign for Microbicides, Global Microbicide Project, International Family Health, International Partnership for Microbicides, National Organizations Responding to AIDS, WHO	Advocate for and support microbicide development	International Partnership for Microbicides, Rockefeller Foundation, Gates Foundation, other foundations, ODA
Aeras Global TB Vaccine Foundation	More than fifty IGOs, universities, biotech and pharmaceuticals companies, vaccine manufacturers, foundations, advocates and governments	Develop new vaccines against TB and ensure availability to all who need them	Gates Foundation, ODA
Global Alliance for the Elimination of Lymphatic Filariasis	More than forty IGOs, universities, biotech and pharmaceuticals companies, vaccine manufacturers, foundations, advocates and governments	Advocate for and fund the development and provision of technologies and services to treat and prevent lymphatic filariasis	Gates Foundation, ODA
Global Alliance for Improved Nutrition	Tetra Pak, World Food Programme, Danone, UNICEF, Cargill, WHO, Helen Keller International, Micronutrient Initiative, National Fortification Alliance, Unilever, World Bank Institute	Reduce malnutrition through food fortification and other strategies to improve nutritional health of at-risk populations	Gates Foundation, ODA
Global Alliance for TB Drug Development	GlaxoSmithKline, Bayer, RTI International, Stop TB partnership	To develop and ensure the availability of affordable and better TB drugs	Gates Foundation, Rockefeller Foundation, bilateral donors, DFID
Global Alliance for Vaccines and Immunisations	UNICEF, WHO, World Bank, civil society organisations, public health institutes, donor and implementing country governments, Gates Foundation	Promote the development of new vaccines and expanded coverage of existing vaccines	International Finance Facility, Gates Foundation, ODA

GHP	Major partners	Purpose of partnership	Main funders
Global Fund to Fight AIDS, Tuberculosis and Malaria	UNAIDS, WHO, World Bank, Stop TB, Roll Back Malaria, bilateral donors, recipient governments, Gates Foundation, CSOs and business sector	Finance HIV/AIDS, TGB and Malaria programmes in low- and middle-income countries	Gates Foundation, ODA
International AIDS Vaccine Initiative	Over twenty partners from different sectors	Develop an HIV/AIDS vaccine	Gates Foundation, New York Community Trust, Rockefeller Foundation, World Bank, corporate donors, other foundations and charities
International Trachoma Initiative	Over thirty partners from different sectors including universities, foundations, governments, advocates and IGOs	Support the treatment and prevention of trachoma worldwide	Gates Foundation, pharmaceuticals corporations, Rockefeller Foundation, ODA
Mectizan Donation Programme	African Programme for Onchocerciasis Control; the Carter Center River Blindness Program; CDC; Helen Keller International, International Eye Foundation; Merck, Pan American Health and Education Foundation, pharmaceuticals corporations, SightSavers International, UNICEF, World Bank, WHO	Provide administrative oversight of the donation of Mectizan by Merck for the treatment of onchocerciasis	Merck, GlaxoSmithKline
Medicines for Malaria Venture	Africa Matters Ltd, Hospital Clinic Universitat de Barcelona, GlaxoWellcome, Program for Appropriate Technology in Health, Medicines for Malaria Venture, European and Developing Countries Clinical Trials Partnership, Oswaldo Cruz Foundation, Gates Foundation, Tsukuba Research Institute, Global Forum for Health Research	Develop new malaria treatments	Gates Foundation, Rockefeller Foundation, ODA, pharmaceuticals corporations, IGOs, US National Institutes of Health, Wellcome Trust

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GHP	Major partners	Purpose of partnership	Main funders
Pediatric Dengue Vaccine Initiative	WHO, UNICEF, UNDP, US Army and Navy, CDC, NIH, Mahidol University in Bangkok, Pedro Kouri Tropical Medicine Institute in Havana, Ministry of Public Health in Thailand, Taiwan CDC, and other ministries of health in Southeast Asia and the Americas, Sanofi Pasteur, GlaxoSmithKline, Hawaii Biotech	Develop dengue vaccines and diagnostics	Gates Foundation, Rockefeller Foundation
Roll Back Malaria	UNICEF, UNDP, WHO, World Bank, ExxonMobil, GSK, Alternate, Novartis, BASF, Gates Foundation, UN Foundation	Enable sustained delivery and use of effective programmes through coordination, evaluation and advocacy on behalf of partners	World Bank, GFATM, BGMF, ODA
Stop TB	WHO is the main partner. Another seven hundred partners including IGOs, universities, biotech and pharmaceuticals companies, vaccine manufacturers, foundations, advocates and governments	Eliminate tuberculosis as a public health problem through coordination in prevention, treatment and advocacy	WHO, ODA
Global Health Workforce Alliance	WHO plus a hundred partners including IGOs, universities, foundations, advocates and governments	Identify and implement solutions to the health workforce crisis.	WHO
Partnership for Maternal, Newborn and Child Health	WHO, World Bank Group, UNICEF, ODA plus over 240 partners including IGOs, universities, foundations, advocates and governments	Provide a forum coordinating action to address the major conditions that affect children's health	WHO

While the new global health initiatives have raised the profile of certain diseases, and helped develop new technologies for many neglected diseases (often through effective brand-building exercises, good public relations and the allocation of resources to advocacy and communications), the recognition that there has been too much poor coordination, duplication and fragmentation has led to a number of initiatives aimed at improving harmonisation and supporting country-led development. These include the 2005 Paris Declaration on Aid Effectiveness; the Three Ones Agreement (to encourage all agencies addressing HIV/AIDS to work through one action framework, one national coordinating authority and one monitoring and evaluation system); and the International Health Partnership (IHP) initiative launched by the UK government in 2007 to improve coordination around country-driven processes of health-sector development.

Since July 2007, eight international organisations have also been meeting to develop a framework for coordination and to define more clearly their respective roles and responsibilities (UNICEF 2007). The group, known as the 'Health 8', comprise the WHO, Global Fund, Global Alliance for Vaccines and Immunisation, United Nations Population Fund, World Bank, UNAIDS, UNICEF and the Gates Foundation. While these initiatives are welcome, the problems of poor coordination by donors and external agencies have been present for many years, and the prospect that these new initiatives will be successful is poor for three reasons.

First, there are simply too many global health actors and initiatives – better coordination and a truly country-driven approach to health improvement will require a radical rationalisation and shrinkage of the global health architecture. Second, consensus on a coherent health systems development agenda is missing. Third, there is inadequate monitoring of the policies and actions of donors and GHPs – they are largely immune from scrutiny or censure.

The lack of a shared understanding or vision for health systems strengthening (HSS) is discussed in greater detail in Chapter B1. The point to stress in this chapter is that health systems have actually been weakened by the way in which global health programmes and policies are organised and orientated. There is some recognition of this to the extent that most global health institutions are now stressing the importance of 'health systems strengthening'. However, behind the rhetoric are a lack of clarity and even contradictions within and between global health institutions about what constitutes 'health systems strengthening'.

It is, for example, unclear where organisations and GHPs stand on the role of public institutions and markets within the health sector. There is no clear or shared view on the circumstances under which for-profit

and not-for-profit providers should be encouraged or discouraged, nor any policy guidance on how countries should respond to the problems associated with health-care commercialisation. Long-term strategies to strengthen the administrative and stewardship capacities of ministries of health remain either absent, under-resourced or undervalued. Without a detailed analysis of how vertically organised selective health programmes will support across-the-board (horizontal) HSS plans, the glib and opaque notion of 'diagonalisation' has been promoted.

Furthermore, the lack of leadership and policy coherence around a HSS agenda among the big global health actors operating out of Geneva, Washington, London and Seattle is only a little better than the prospect of bad leadership and policy. As discussed in the chapter on the World Bank, there is a worry that the same neoliberal thinking that helped to decimate health systems in many countries in the 1980s will prevail into the future.

Finally, what is also glaring is the lack of meaningful debate on two critical policy tensions. The first is between strategies needed to respond immediately and urgently to preventable and treatable adult and child deaths in poor countries and the longer-term strategies required to strengthen health systems. The second is between a predominantly clinical and technicist approach to disease and illness and a more developmental and holistic approach to health improvement.

Accountability and inappropriate partnerships

A major feature of the changing global health landscape has been the promotion of the 'public-private partnership paradigm' since the 1990s, based on the argument that international cooperation in today's globalised world can no longer be based primarily on the multilateralism of nation-states. Partnerships involving business organisations and civil society are required to achieve what governments and the UN cannot manage alone (Martens 2007).

Although this new approach coincided with a period of zero real growth and real budget cuts to the UN, which was forced to seek supplementary funding from the private sector and fulfil its mandate through partnerships with other organisations, the theory was that public-private partnerships occupy a middle ground between markets and states, permitting 'more nuanced and potentially more effective policymaking' (Kaul 2006). Although reference is often made to partnerships with civil society, the main focus of attention has been on partnerships between intergovernmental organisations (IGOs) and business/industry.

Within the health sector Gro Harlem Brundtland strongly encouraged public–private partnerships during her tenure as director-general of the WHO. The Rockefeller and Gates foundations were also instrumental (Widdus 2003). The Rockefeller Foundation, for example, helped establish the Initiative on Public Private Partnerships for Health (IPPH), which promotes international public–private partnerships in the health sector. And many global health partnerships (GHPs) rely almost entirely on the Gates Foundation for funding, or list it as a major donor.

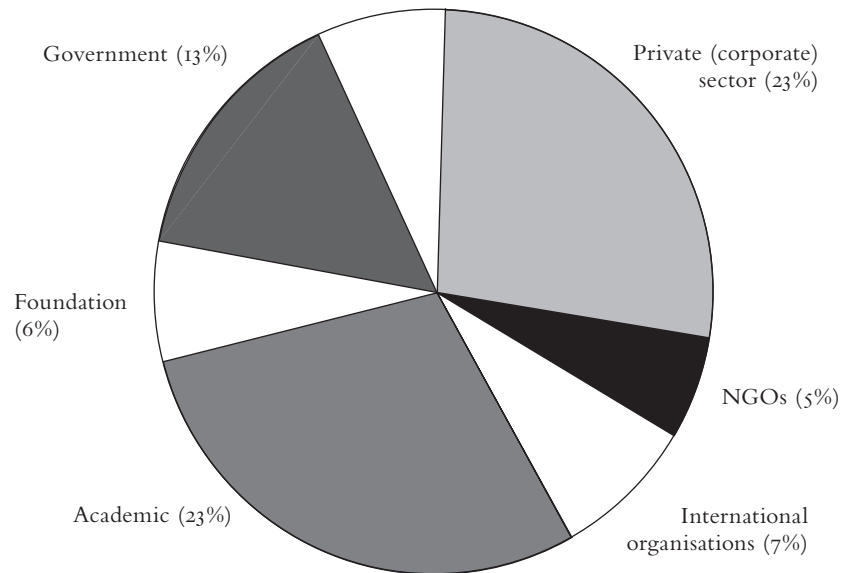
In addition to the issues raised earlier of coordinated and more effective DAH, the new global health landscape raises political issues about the accountability of global health actors and global health governance.

While partnerships are good in principle, there must be an appropriate framework of principles guiding their development and ensuring that the integrity, authority and capacity of public bodies to carry out their public functions are maintained (or developed where necessary). Partnerships must reflect an appropriate spread of power, roles and responsibilities across the public, private and civic sectors.

Presently, the balance of power between public institutions, business and civil society appears skewed in favour of the corporate sector. Globalisation, economic liberalisation and the growth in wealth of multinational corporations require the existence of global public health institutions that are able to ensure appropriate regulation of commercial behaviour to protect health.

One concern is that the public–private paradigm has diminished global public responsibility and allowed businesses to wield undue influence (Buse 2004). Civil society organisations (CSOs) have pointed out fundamental conflicts between commercial goals and public health goals, and a lack of stringent guidelines to govern public interaction with the commercial sector. According to Wemos, ‘industry partnerships and industry sponsorship without strong, enforceable, accountable and transparent guidelines for these relationships will undermine and destroy the WHO’s role and responsibility’ (Wemos 2005).

The imbalance of power is exemplified by an analysis conducted by Buse and Harmer of the composition of the boards of twenty-three selected GHPs (see Figure D1.1.2). Out of a total of 298 board seats, the private (corporate) sector occupied 23 per cent; academic and NGO representatives occupied 23 per cent and 5 per cent respectively; and international and government representatives occupied 20 per cent. The WHO was found to be significantly under-represented at the board level of the most important partnerships (Buse and Harmer 2007). Overall, low- and middle-income countries account for 17 per cent of all seats.

FIGURE DI.1.2 **GHP board analysis**

Source: Buse and Harmer 2007.

A notable imbalance not represented in the figure above is the huge influence wielded by the Gates Foundation. It is on the board of all the major GHPs as well as being a major funder. But, unlike the WHO, it is free of any form of democratic or political accountability.

These findings raise a number of questions. Why is the private (corporate) sector so well represented, especially when its financial contribution is so modest? Why are publicly mandated institutions, such as the WHO, under-represented? On this evidence, the WHO is clearly underpowered to hold its private partners to account where it matters most – at the decision-making level. Why is NGO representation limited? And while global public–private initiatives (GPPIs) give the impression of equal rights for stakeholders and broad representation, in practice it is the wealthy actors from the North that dominate, whether they are governments, corporations or private foundations (Martens 2007).

In theory, GHPs concerned with health in LICs should be accountable to the governments and people of low-income countries. In practice, the under-representation of Southern stakeholders in governance arrangements, coupled with the Northern location of most GHP secretariats, is reminiscent of imperial approaches to public health. While the broken health systems of

many poor countries lie in a state of disrepair, a vast global health industry operating a loosely connected portfolio of initiatives and programmes exists to help the poor. But the poor themselves and the public institutions of the South are mostly invisible as real partners.

In addition, many governments lack the skills or inclination to provide effective stewardship over their countries' health systems. Universities, NGOs and the local media may also be underdeveloped and unable to perform an effective watchdog role over both the government and the international aid industry.

If one steps back to take a panoramic view of the global health landscape, one might even conclude that, while purporting to do good for the world's poor, the global health apparatus not only helps to excuse a global political economy that perpetuates poverty and widens disparities, but also benefits the corporate and rich world through 'bluewashing' (the lending of credibility by the UN) and the opportunity for companies to establish new markets in medical products with minimal commercial risk, while improving access to public and academic expertise and to governments. Bull and McNeill's (2007) investigation into GHPs concluded that 'there are some examples of behaviour by the big pharmaceutical companies which appear to be altruistic, but also many cases in which the companies have enjoyed the benefits of an expanded market without contributing to bringing the prices down.'

Final comments

Many of the radical changes to the global health aid architecture remain inadequately described and evaluated. More work is needed to understand the changes taking place and to enable a more informed and critical discussion. While this chapter deals specifically with 'health', it also reflects on global governance more generally, and on the role of the United Nations, the corporate sector and others in managing the challenges of social and economic development worldwide. The chapter draws out three suggestions for action by civil society.

The first concerns the need for effective and accountable global health leadership. It is possibly a good thing that the 'Health 8' has been formed – hopefully it will lead to a clearer delineation of roles and functions and better coordination. But it is unclear who is ultimately responsible for bringing order to the chaotic environment and how the key actors will be effectively held to account.

Better leadership should also produce a more rational system of development assistance for health. The current system is too fragmented, competitive and top-down. It does not place a premium on country-based plans and

strategies. The principle of the International Health Partnerships is sound and must be supported, but this will require strategies to develop the capacity of ministries of health to provide effective stewardship and improved systems for holding both external agencies and governments to account.

There are also particular implications for the WHO, the World Bank and the Gates Foundation. In theory, the WHO has the mandate and legitimacy to provide the much-needed global health leadership. In practice, its funding arrangements and its reluctance to assume more leadership prevent it from doing this. The challenge facing civil society and the WHO in ensuring more effective public and accountable leadership in global health is discussed in Chapter D1.2. The World Bank, no longer the dominant player on the field, has an important role to play as a bank. But its democratic deficiencies, neoliberal instincts and record of poor and biased research do not make it an appropriate institution for global health leadership. The Gates Foundation is arguably the dominant player currently. But it lacks transparency and accountability, and, as described in Chapter D1.3, it has become an over-dominant influence.

There is no simple solution to the challenge of knitting together the approaches, ideologies and agendas of the different actors. But civil society organisations need to generate more debate and discussion about global health leadership and accountability.

The second issue, related to the first, is the need for a coherent health systems development agenda. This must include the strengthening of public health systems and their absorptive capacities. There is a special need to examine and challenge the ongoing promotion of market-based solutions to health systems failures. Independent and critical assessments of the major global health initiatives and their impact on health systems within low-income countries are badly needed. Health systems policies that are consistent with the principles and logic of the 1978 Alma Ata Declaration need to replace the top-down, disease-based and neoliberal policies that are currently prevalent.

Low-income countries already struggle with a narrow policy space due to globalisation and dependence on external donors. Their policy space is shrinking even further as aspects of health that are characterised as 'global public goods' come to be increasingly 'managed' from the outside by global institutions. The lack of coordination among global health actors currently undermines efforts to ensure effective national health stewardship. However, externally supported health programmes have the potential to support the double aim of improving access to health care *and* contributing to the social, political and systems-wide changes that are required to sustain health improvements.

The third issue concerns the public–private paradigm. There are good reasons for thinking that the present distribution of risk and benefit across the public and private sectors are skewed in favour of the private sector, and that the current partnership models are inefficient. The UN should conduct a comprehensive review of the entire public–private paradigm. Specifically, the WHO needs to monitor and set up transparent regulatory mechanisms of GHPs.

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DI.2 **The World Health Organization and the Commission on the Social Determinants of Health**

This chapter is written in the belief that it is worth aspiring to an accountable and effective multilateral global health agency, driven by a desire to promote health with the understanding that the distribution of health and health care is a core marker of social justice.

For many, the World Health Organization (WHO) is emblematic of an organisation designed to enable international cooperation in pursuit of a common public good. Its constitution, written in a different era, needs to be updated to reflect current realities, but it remains a good reminder of the aspirations that have been invested in it. Among the principles governing the WHO's constitution are:

- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.
- The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states.
- Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.
- The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

The actual state of global health indicates a reality that is more brutal, cynical and unforgiving than the WHO's constitution suggests. But for many, the hopes and ideals reflected in the constitution are worth fighting for.

As an intergovernmental organisation, the WHO is also important because it has the mandate and opportunity to establish or influence laws,

regulations and guidelines that set the foundations for international and national health policy. It is the closest thing we have to a ministry of health at the global level. Given the degree and extent of globalisation, this calls for greater public interest in and scrutiny of the WHO. Support for the WHO also reflects support for the United Nations (UN) system. For all its often-reported structural and operational failings, the UN (including the WHO) does much good and is ultimately irreplaceable and vital to human security.

Since publication of the first *GHW*, there have been significant changes at the WHO, including the election of a new director-general following the sudden death of Director-General Dr Lee Jong-wook in May 2006. Regrettably, many of the challenges facing the WHO that were identified in the first *Global Health Watch* remain, and in some cases have become more acute. The WHO is still pushed and pulled by the tidal forces of international politics; it remains underfunded, and over-reliant on so-called 'public-private partnerships'; it faces a crowded global health arena; and internally, low morale among staff and the sclerotic nature of WHO bureaucracy are still problematic.

This chapter is not a comprehensive review of the WHO over the past three years. Rather it describes a selection of issues to illustrate the challenges facing the WHO. These include:

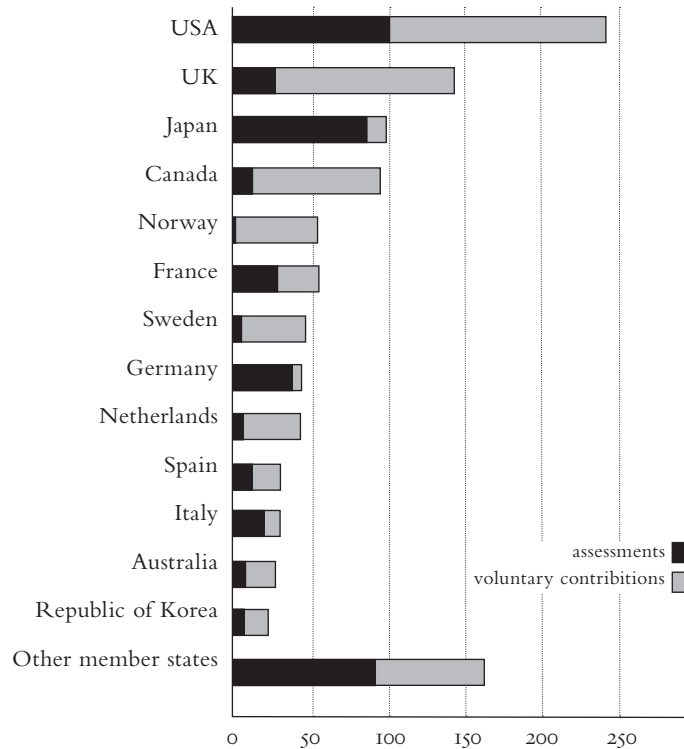
- the WHO's funding and budget for 2008/09;
- the highly contentious boundary between trade and health policy;
- international developments in global preparedness for a potential avian flu pandemic;
- progress made by the Commission on the Social Determinants of Health.

Underfunded, donor-driven and compromised?

Most of the WHO's funding comes from its member states. 'Assessed contributions' provided by member states (usually through ministries of health) form the basis for the WHO's regular budget funds (RBFs). The relative contribution of each state is calculated using a UN funding formula based on a country's population and size of economy. This results in a small number of countries providing most of the WHO's core budget. For example, the United States' assessed contribution is currently 22 per cent (it used to be 25 per cent but this was reduced following US requests). In contrast, Tuvalu contributes 0.001 per cent (WHO 2007a).

In addition to the assessed contributions, the WHO receives extra-budgetary funds (EBFs), in the form of grants or gifts. These are contributed

FIGURE DI.2.I Assessed and voluntary contributions from WHO member states in 2006



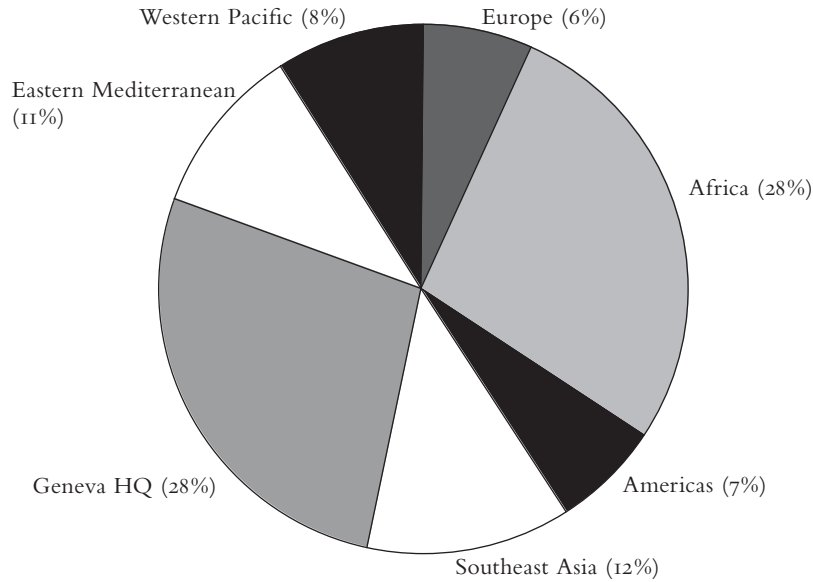
Source: WHO 2007c.

by member states (usually from their ODA budgets), other parts of the United Nations, foundations, non-governmental organisations (NGOs), charities and private companies.

The relative contribution of RBFs and EBFs has changed over time. In 1970, EBFs accounted for 20 per cent of total WHO expenditure, with over half these funds coming from other UN organisations (Lee 2008). EBFs exceeded RBFs for the first time in the 1990/91 biennium. Today, EBFs account for about three-quarters of the WHO's expenditure, most of which is sourced from member states (WHO 2007b). Unlike the RBFs, most of the voluntary contributions made to the WHO are tied to specific projects determined by the donors, although some donors provide EBFs that are not tied to specific projects.

The US was the largest contributor in terms of both assessed and voluntary contributions in 2006, followed by the UK, Japan, Canada, Norway,

FIGURE DI.2.2 Allocation of 2008/09 budget by region



Source: WHO 2007d.

France, Sweden, Germany and the Netherlands. The Gates Foundation provided voluntary contributions of \$99.4 million in 2006, which made it the third equal (with Japan) largest contributor of funding to the WHO (see Figure DI.2.1) (WHO 2007c).

The much greater reliance on EBFs reflects the preference of donors towards having greater control over the use of their money. In addition, it reflects a period of financial austerity imposed upon the UN as a whole. First, major donors introduced a policy of zero real growth in 1980 to the RBFs of all UN organisations. In part, this was a reaction to the perceived ‘politicisation’ of UN organisations, in particular UNESCO and the International Labour Organisation (ILO), but also to the WHO’s campaigns against irrational prescribing of medicines and breastmilk substitutes (Lee 2008). Then in 1993, a policy of zero nominal growth was introduced, reducing the WHO’s RBFs in real terms.

The WHO (and other UN organisations) have also had to contend with late or non-payment by member states. Non-payment by the United States has been particularly problematic. By 2001, the US had become the largest debtor to the UN, owing it US\$2 billion. Arrears to the WHO rose from around US\$20 million in 1996 to US\$35 million in 1999 (Lee 2008).

TABLE DI.2.1 **Budget for WHO strategic objectives, 2008/09**

Strategic aim	Budget		RBF	EBF
	(US\$ m)	(%)	(%)	(%)
1. Communicable diseases	894.043	21.1	9.5	90.5
2. HIV/AIDS, malaria and tuberculosis	706.932	16.7	6.9	93.1
3. Non-communicable disease, mental health, injuries and violence	158.104	3.7	28.6	71.4
4. Maternal and child health, sexual and reproductive health and healthy ageing	359.833	8.5	15.5	84.5
5. Emergencies, disasters and conflicts	218.413	5.2	8.1	91.9
6. Risk factors to health: alcohol, tobacco, other drugs, unhealthy diet, physical inactivity and unsafe sex	162.057	3.8	24.1	75.9
7. Social and economic determinants of health	65.905	1.6	21.9	78.1
8. Environmental health	130.456	3.1	25.1	74.9
9. Nutrition, food safety and food security	126.934	3.0	18.2	81.8
10. Health services	514.054	12.2	27.2	72.8
11. Medical products and technologies	134.033	3.2	23.3	76.7
12. Global health leadership	214.344	5.1	65.1	34.9
13. Organizational improvement of WHO	542.372	12.8	52.8	47.2
Total working budget	4,227.480	100.0	22.7	77.3

Source: WHO 2007e.

The problems associated with a heavy reliance on EBFs are fairly apparent. They include unhealthy competition among departments within the WHO and with NGOs and other organisations chasing donor funding, as well as limitations on the WHO's ability to plan, budget and implement its strategic aims coherently. Even projects authorised by World Health Assembly (WHA) resolutions are reliant on a chase for funding.

In theory, budget allocations are determined by the WHA and WHO Regional Committee meetings. In practice, they are set by the WHO Secretariat under the influence of donors and powerful member states. It is difficult to determine what conditions donors place on their funds and what impact this has on budget-setting by the secretariat.

The WHO's budget for the 2008/09 biennium, made up of both RBFs and EBFs, is US\$4.2 billion (WHO 2007d). This is an increase of 15 per

cent on its previous biennium. The Geneva headquarters is allocated \$1.18 billion (27.8 per cent), with the rest shared across the six regions. The Africa region receives the biggest proportion of regional funding – \$1.19 billion (see Figure D1.2.2) (WHO 2007d). Although the Western Pacific is the second largest region by population, its relatively small budget is related to the WHO's lack of presence in China.

The budget for 2008/09 is also subdivided into thirteen strategic objectives (see Table D1.2.1). What is striking about the budget is the reliance on EBFs and the high allocations to communicable diseases relative to food and nutrition; non-communicable disease; social and economic determinants of health; and environmental health.

Putting health first

With its dependence on EBFs, the WHO is particularly vulnerable to donor influence. Margaret Chan, director-general of the WHO, said that she will 'speak the truth to power', and certainly the WHO has resisted pressure from powerful interests in the past (quoted in Schuchman 2007). It did so, to some extent, when it helped establish the Framework Convention on Tobacco Control and the International Code on the marketing of breastmilk substitutes. On both occasions, civil society organisations and member state representatives also played a vital role in protecting the WHO from being bullied.

But on other occasions it has buckled under pressure. When the WHO recommended the lower consumption of free sugars and sugar-sweetened drinks, the sugar industry lashed out with a barrage of threatening letters, and appeals to the US government to intervene (which it did) (Simon 2005). By the time the WHO finalised its Global Strategy on Diet, Physical Activity and Health, it had been heavily watered down (Cannon 2004). As one WHO official noted: 'During discussions on the Global Strategy on diet, US representatives never made a mystery of the fact that they would not let WHO go beyond a sanitary, education-focused strategy' (quoted in Benkimoun 2006). Ongoing challenges to the public health responsibility and independence of the WHO are often played out in the arena of trade, as illustrated by the following recent stories.

Our man in Bangkok

Few people will have heard of William Aldis, but for a short period he was the WHO's top health adviser in Thailand. In January 2006, he published an article in the *Bangkok Post*, criticising a bilateral trade agreement that was being negotiated between the US and Thailand. Aldis was concerned

that the treaty would have negative consequences for Thailand's generic drug industry and on the cost of second and third-line HIV drugs (Aldis 2006). The US was furious. Its ambassador to the UN visited the then head of the WHO, Dr Lee, and followed this up with a letter. According to a staff member who read the letter, Lee was reminded of the need for the WHO to remain 'neutral and objective' over matters of trade (quoted in Williams 2006).

Aldis quickly found himself transferred to the WHO's New Delhi office. Although the WHO strongly denied that the decision was due to pressure from Washington, *The Lancet* was in no doubt about the real significance of Aldis's transfer: 'This action was a clear signal of US influence on WHO' (Benkimoun 2006).

The anecdote involving Aldis is part of a longer-running story of pressure from the US to prevent the WHO from taking a proactive, health-protecting stance with regard to trade negotiations and trade policy, even though the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the General Agreement on Trade in Services (GATS) have extensive and profound implications for health care across the world.

The WHO does have a unit dealing with trade and health. But it is small and underfunded. In 2006, the WHA passed Resolution 59.26 on international trade and health.¹ Although welcome at one level, the resolution was weak, vague and half-hearted.

Tripping up over TRIPS

Controversy followed the WHO back to Thailand in February 2007 when Margaret Chan visited the National Health Security Office in Bangkok. Much to the dismay of many, Chan praised the pharmaceuticals industry, promoted drug donation as a solution to the problem of poor access to medicines and suggested that the Thai government's recent issuing of three compulsory licences to import and/or produce locally generic copies of patented drugs for HIV/AIDS and heart disease was counterproductive. Chan is alleged to have said: 'I'd like to underline that we have to find a right balance for compulsory licensing. We can't be naive about this. There is no perfect solution for accessing drugs in both quality and quantity' (quoted in Third World Network 2007).

NGOs and Thai health officials were appalled. The president of AIDS Access Foundation summed up the general feeling: 'It's disappointing. The [WHO] should have supported drug access and promoted the study of quality and inexpensive drugs for the sake of the global population rather than supporting pharmaceutical giants' (Treerutkuarkul 2007). A worldwide petition followed. Chan later wrote to the Thai minister of public health

stating her deep regret that her comments had been ‘misrepresented’ in the Thai press, and for any embarrassment that this may have caused.

Censorship and the even more slippery slope of self-censorship

Conflicts between public health and commerce are nothing new. But it is important that such conflicts are played out in the open, particularly when they involve the WHO. In 2006, acting head of WHO Anders Nordstrom should have informed senior WHO staff of US opposition to a report co-written by a member of WHO staff and jointly published with the South Centre. He didn't. The report was shelved, and senior staff only found out about US complaints from a leaked memo. The publication, *The Use of Flexibilities in TRIPS by Developing Countries: Can They Promote Access to Medicines?*, had been critical of US interpretation of the WTO's TRIPS agreement. The perception was that the top brass at the WHO had bowed to US pressure (IPW 2006).

The US subsequently demanded a full review of the WHO's publication policy. At the January 2008 Executive Board meeting, it was proposed that all publications by the WHO should be subject to review and clearance by a Guidelines Review Committee and that sensitive publications should be cleared by the director-general herself. When several developing-country delegations raised concerns that the proposals were too ‘centralised’ and could result in external censorship, Margaret Chan gave the following reassurance: ‘in no situation during my tenure will I compromise editorial independence don't worry I can stand the political pressure – it is our duty to guard publications based on science and that are peer reviewed’ (Tayob 2008).

Partnerships or the privatisation of international health policy?

During the leadership of Director-General Brundtland, partnerships with the private sector became a prominent feature of the WHO. According to David Nabarro, Brundtland's senior adviser,

We certainly needed private financing. For the past decades, governments' financial contributions have dwindled. The main sources of funding are the private sector and the financial markets. And since the American economy is the world's richest, we must make the WHO attractive to the United States and the financial markets. (quoted in Motchane 2002)

The argument goes that if a financially dependent public institution such as the WHO enters into a partnership with a wealthy partner such as a major multinational, the latter will set the agenda and the former will become its stooge. The WHO is particularly sensitive to this charge. If the

WHO is perceived to have been hijacked by the private corporate sector, it will lose its authority as an impartial norm-setter on global health issues.

Has the WHO compromised itself through its partnership with the private sector? It is hard to say. But there are certainly reasons for concern. In June 2006, the WHO became embroiled in controversy again when its director of mental health and substance abuse, Benedetto Saraceno, suggested to the head of the European Parkinson's Disease Association (EPDA) that EPDA accept a donation of \$100,000 from GlaxoSmithKline on WHO's behalf (Day 2007). In an email, Saraceno wrote:

WHO cannot receive funds from the pharmaceuticals industry. Our legal office will reject the donation. WHO can only receive funds from government agencies, NGOs, foundations and scientific institutions or professional organisations. Therefore, I suggest that this money should be given to EPDA, and eventually EPDA can send the funds to WHO which will give an invoice (and acknowledge contribution) to EPDA, but not to GSK. (quoted in Day 2007)

Although Saraceno explained that his email had been 'clumsily worded', the incident demonstrates a likely side effect of the WHO's funding arrangements and the need to clarify the WHO's protocol for engaging in relationships with the private sector. There has not been a comprehensive review of WHO-private sector relations since the publication of the WHO's *Guidelines on Interaction with Commercial Enterprises to Achieve Health Outcomes* seven years ago. A report (Richter 2004) on the WHO and the private sector, which called for a public review and debate on the benefits, risks and costs of public-private interactions in health when compared to alternatives, fell on deaf ears. Half a decade on, civil society should renew pressure on the WHO to take a fresh look at WHO-corporate relationships.

The avian flu vaccine controversy

The prospect of a global flu pandemic is the subject of intense discussion and fear. World attention was further focused when the Indonesian Health Ministry announced in early 2007 that it would no longer provide avian flu viral material to the WHO's 'Global Influenza Surveillance Network' (GISN) for the purposes of assisting with surveillance and vaccine development.

The GISN is made up of the WHO, four Collaborating Centres (WHO CCs) based in Australia, Japan, the United Kingdom and the United States, and about nine WHO H₅ Reference Laboratories.² GISN's work and outputs rely on viruses being submitted every year by various country-based National Influenza Centres (NICs).

The Indonesian government discovered that avian flu viral material that it had voluntarily submitted to the GISN ended up in the hands of

pharmaceuticals companies for vaccine development, without its permission. This was contrary to WHO guidelines, which state that any further distribution of viruses beyond the WHO reference laboratories must require the permission of the originating country (WHO 2005, 2006).

When the WHO was taken to task about the breach of its own guidelines, the guidelines were removed from the WHO website. The WHO then proposed a new document³ describing best practices for sharing influenza viruses and viral sequence data. This latest offering contradicted the Convention of Biological Diversity (CBD) principle, which holds that countries have national sovereignty over their biological resources and should derive a fair share of the benefits arising from the use of them.

There has been a dramatic increase in the number of patent applications covering the influenza virus (or parts of it), as well as for actual vaccines, treatments and diagnostics, in recent years (Hammond 2007). The discovery that patents had been sought on modified versions of other viral material (and its use in vaccines) shared through GISN without the consent of the supplying countries reinforced the perception that the GISN is part of a system that begins with the free sharing of viral material, which goes through the WHO, then through public laboratories, and finally ends up with private pharmaceuticals companies having a monopoly over the end product.

The system results in a clear set of winners and losers. Commercial vaccine developers have already obtained many millions of dollars' worth of contracts from developed countries to supply vaccines, in addition to grants and subsidies for their R&D activities. Populations in developed countries have a better chance of being protected from a flu pandemic, although the taxpayer is probably paying an extremely high premium to keep the commercial companies well in profit.

Developing countries, particularly those most likely to be badly affected, face potentially astronomical bills for the purchase of vaccines and other medical supplies. As drug companies can produce only a limited amount of vaccines in a given year, many developed countries have made advance purchase orders for vaccines, limiting even further the prospects of countries like Indonesia benefiting from vaccine development (Fedson 2003).

These and related issues were raised by Indonesia, together with the support of more than twenty other developing countries, at the 2007 WHA, culminating in a resolution that sets out a series of proposals to achieve both 'the timely sharing of viruses and specimens' and the promotion of 'transparent, fair and equitable sharing of the benefits arising from the generation of information, diagnostics, medicines, vaccines and other technologies' (WHA 2007f). The resolution also recognises the sovereign right

of states over their biological resources and the right to fair and equitable sharing of benefits arising from the use of the viruses.

At the intergovernmental meeting convened in November 2007, tensions resurfaced. Indonesia reiterated the need for developing countries to have trust in a multilateral system that did not undermine their sovereign rights over biological resources (based on the CBD), nor disadvantage the health of people living in poor countries. Developed countries in turn argued that the stance taken by Indonesia was jeopardising global health security and violated the WHO's International Health Regulations (IHR), which was designed to ensure international compliance with a set of public health standards and practices aimed at preventing and mitigating global health risks. Presently, the IHR does not expressly require the sharing of biological samples (Fidler 2007). It has been suggested that even though Indonesia is not in contravention of the letter of the law, its stance is in violation of the spirit of the IHR. However, the primary sticking point is the lack of a mechanism to ensure equitable access to vaccines and technologies in preparation and in the event of a global flu pandemic.

This incident succinctly illustrates the fundamental conflict between a patent-based system of commercial vaccine production and the WHO's mission to promote and protect health worldwide. Having failed to manage properly the practices of actors within the GHSN, the WHO now has the opportunity to demonstrate its value and worth both as a technical agency and as a moral arbiter on international health policymaking.

The Commission on the Social Determinants of Health

When the WHO's Commission on Macroeconomics and Health (CMH) reported in 2001, many public health activists criticised the way that health care had been portrayed in a purely instrumental way as a requirement for economic development. The notion of health as a human right and the economic and political determinants of poor health and under-resourced health systems were largely ignored.

Thus when the WHO launched the Commission on the Social Determinants of Health (the Commission) in May 2005, many people hoped this would mark the beginning of a new programme of work that would engage with the fundamental economic, political and social determinants of health, complementing the WHO's existing focus on diseases and health services.

Michael Marmot, a British epidemiologist known for studying health inequalities, chairs the Commission. There are eighteen other commissioners, including the Nobel prizewinning economist Amartya Sen. Nine Commissioners come from rich countries, but twelve live in them. Four come

from Africa, two from Asia, and one from Latin America. As a group, the commissioners represent a broad spectrum of views, ranging from a former senior US administration official with impeccable Republican credentials, to individuals with progressive credentials such as Pascoal Mocumbi (former prime minister of Mozambique), Giovanni Berlinguer (Italian member of the European Parliament), Monique Begin (former Canadian minister of health) and Fran Baum (People's Health Movement).

The Commission consists of five workstreams (Irwin et al. 2006):

1. Nine *knowledge networks* (KNs) to inform policy proposals and action on the following topics: early childhood development; globalisation; health systems; urban settings; women and gender equity; social exclusion; employment conditions; priority public health conditions; measurement and evidence.
2. *Country-based workstreams*, involving more than ten countries at the time of writing.
3. Engagement with *civil society*, involving the inclusion of civil society representatives on the Commission and formal consultations with civil society groups.
4. Engagement with *key global actors and initiatives*.
5. *Institutional change* at WHO to advance the work of the Commission after it ends. This has mainly involved the creation of a separate KN and engagement with the regional WHO offices, of which only the Pan American Health Organization (PAHO) seems to be taking the Commission's work seriously. As for institutional change in Geneva, several hurdles appear in the way of overcoming the disproportionate influence of clinically oriented disease-based programmes that do not readily view health through a broader social and political lens.

The conceptual framework for the Commission's work is based on an understanding that ill-health and unequal health outcomes are produced through a chain of causation that starts from the underlying social stratification of societies and that interventions can be aimed at: decreasing stratification by, for example, redistributing wealth; decreasing exposure to factors that threaten health; reducing the vulnerability of people to health-damaging conditions; strengthening the community and individual level factors which promote resilience; and providing accessible, equitable and effective health care.

Representatives of civil society have attended all but one Commission meeting and made presentations to the commissioners. They have participated in the KNs and fed into the thinking of the Commission. Civil society groups have been contracted to conduct consultations in each

region of the world although there have been questions about the extent to which this engagement is real or token, and about the lack of administrative support and funding to support this work.

At this stage it is only possible to provide an interim and partial assessment of the Commission's work. In July 2007, the Commission released an Interim Statement. Among other things, it explicitly promoted health as a human right and with intrinsic value. It stressed the importance of fairness and equity, gender, and the value of social movements in achieving change. And it provided strong support for the principles of the Comprehensive Primary Health Care (PHC) Approach, calling for 'a global movement for change to improve global health and reduce health inequity'.

Compared to many recent WHO reports, the Interim Statement is much more strongly committed to equity. It doesn't explicitly criticise neoliberalism, but provides a strong voice for action to reduce inequities and goes beyond poverty reduction to consider issues of trade imbalance and net outflows from poor to rich countries. However, it was disappointing that the Interim Statement failed to draw lessons that have contemporary significance from historical analyses of population health improvement in Europe that identify, for example, the role of wealth accumulation through colonial exploitation and the agricultural and industrial revolutions, and later social reforms enacted by the state following bitter struggles by the urban poor. The final report of the CSDH, launched in August 2008 (CSDH 2008), will be important as it sets out an agenda for action on the social determinants of health and establishes the pursuit of health equity as a crucial matter of social justice.

Prospects for the future

The Commission has an opportunity to make a significant and lasting impact on the future performance of the WHO, as well as upon the broader health policy landscape. But to do this, it must resist the pressures to produce a weak, consensus report that is acceptable to all players. It must stay true to its intellectual idealism and challenge the climate of cynicism about what multilateral institutions can achieve.

Thus far, the Commission appears not powerful enough to have much influence on the major players in global health, especially given the neoliberal perspectives of some actors, and the widespread support for vertical, top-down, disease-based programmes by other actors. Pressure from civil society will be required to ensure that the progressive aspects of the Interim Statement are retained in the final report.

A crucial determinant of the Commission's impact will be whether its central messages are adopted, supported and championed by the WHO.

Dr Chan will be pivotal. She must give full support to the Commission's report through her personal endorsement and the commitment of resources to enable implementation of the recommendations. At the time of writing, the WHO seems to be adopting a wait-and-see approach. Global Health Watch must monitor the extent to which the WHO takes up the strong social justice message of the report and whether it puts bold action on the social determinants of health equity at the centre of its operations.

However, there was considerable anger at the failure of Dr Chan to support and budget for ongoing work at the 2007 World Health Assembly. Thailand's senior health official Dr Suwit Wibulpolprasert insisted that a reference to social determinants be reinserted into the WHO's budget document to indicate that the Organization will take the goals of the CSDH seriously.⁴ The Commission will now report to the World Health Assembly in May 2009.

Conclusions

This chapter has placed the WHO under the spotlight. It is intended to make uncomfortable reading.

The WHO's funding situation is unacceptable. Instead of being funded as a democratic UN agency, it is in danger of becoming an instrument to serve donor interests and yield 'quick gains' even if this may not serve the WHO's overall strategic goals. The imbalance between EBFs and RBFs must be corrected. Civil society organisations, thus far, have failed to take this up as an issue. But in the meantime, the WHO should exert stronger independence, resist the influence of donors, and demand greater support for its own strategic plan and programmes.

While the need for 'better funding' is obvious, does the WHO need 'more funding'? By common consensus, it does. The increase in the WHO's 2008/09 budget is therefore cause for optimism. But the WHO needs to do more to improve its administrative and management performance, and a good place to start would be for its regional offices – particularly in Africa – to demonstrate their value more than they currently do.

The WHO also needs to reappraise its purpose, roles, responsibilities, budget allocations and workplan, especially in light of the changing global health landscape. The emergence over the last twenty years of other actors, notably the World Bank, the Gates Foundation, GAVI and the Global Fund, as well as the public–private partnerships paradigm, has left the WHO often following an agenda, rather than setting it.

The WHO must 'speak the truth to power', as its director-general promises it will. But that means standing up to powerful industries and

being more prepared to speak out against its most powerful member state. Critically, the WHO must define a stronger role for itself in the trade arena, particularly in the face of worldwide economic liberalisation and growing corporate power. Too often, social aims and objectives are treated as secondary concerns when it comes to the way the global political economy is shaped and governed. Often, the needs and priorities of the poor are neglected in favour of those of the rich. The application of basic public health principles at the global level provides some form of protection against these trends. But the WHO needs to assert itself as the guardian of international public health. But in doing so, it must not be forced into a limited role of monitoring and controlling communicable diseases within a narrowly defined health security agenda.

Some will say that as a multilateral organisation, governed by its member states, the WHO will always be held hostage to international politics. This is true. But it is equally true that significant improvements in global health and a concurrent reduction in the gross disparities in health and access to care will only be achieved through political negotiation and international diplomacy. This should place the WHO at the centre of the stage, not as a peripheral player.

Change is possible. But for this to happen, civil society organisations must also come together around a coordinated plan to strengthen the ability of the WHO to fulfil its mandate and to act as an organisation of the people as well as of governments.

Notes

1. See www.who.int/gb/ebwha/pdf_files/WHA59-REC1/e/Resolutions-en.pdf.
2. See www.who.int/csr/disease/influenza/surveillance/en/and www.who.int/csr/disease/avian_influenza/guidelines/referencelabs/en/.
3. A60/INF.DOC./1 dated 22 March 2007.
4. See www.twinside.org.sg/title2/avian.flu/news.stories/afns.008.htm.

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DI.3 The Gates Foundation

We expect the rich to be generous with their wealth, and criticize them when they are not; but when they make benefactions, we question their motives, deplore the methods by which they obtained their abundance, and wonder whether their gifts will do more harm than good. (Bremner 1988)

So wrote Robert Bremner in *American Philanthropy*. Clearly a full and informed understanding of philanthropy requires not just an assessment of what it does and who it benefits, but also where the money has come from and how it is managed and used.

The Gates Foundation is a major player in the health sector, spending billions of dollars on health across the world. Most published literature and media coverage have focused on the positive impact of the Gates Foundation. The purpose of this chapter is to stimulate a more critical discussion about this important global health actor and about philanthropy in general. It is based on information from peer-reviewed publications, magazines and newspapers, websites, and some unpublished information. It also draws on interviews with twenty-one global health experts from around the world in academia, non-governmental organisations, the World Health Organization (WHO) and government, all of whom requested anonymity or indicated a preference to speak off the record. Several who recounted specific incidents or experiences asked that these not be described so as to protect their identity. Some journalists who specialise in global health were interviewed on the record. The Gates Foundation also contributed by replying to a set of written questions drafted by the GHW. Finally, an analysis of all global health grants issued by the Foundation was conducted.

Background

The Bill and Melinda Gates Foundation was formed in January 2000 following the merger of the Gates Learning Foundation and the William H. Gates Foundation. By 2005, it had become the biggest charity in the world with an endowment of \$29 billion. To put this in perspective, the second and third biggest international benefactors – the UK's Wellcome Trust and the Ford Foundation – have endowments of about \$19 billion and \$11 billion respectively (Foundation Centre 2008). The donation of \$31 billion from US investor Warren Buffett in June 2006 made the Gates Foundation even bigger (Economist 2006a). Its annual spend will increase to over \$3 billion in 2008.

On the Foundation's website, a set of fifteen guiding principles reflect the Gates family's views on philanthropy and the impact they want the Foundation to have:

- This is a family foundation driven by the interests and passions of the Gates family.
- Philanthropy plays an important but limited role.
- Science and technology have great potential to improve lives around the world.
- We are funders and shapers – we rely on others to act and implement.
- Our focus is clear – and limited – and prioritizes some of the most neglected issues.
- We identify a specific point of intervention and apply our efforts against a theory of change.
- We take risks, make big bets, and move with urgency. We are in it for the long haul.
- We advocate – vigorously but responsibly – in our areas of focus.
- We must be humble and mindful of our actions and words. We seek and heed the counsel of outside voices.
- We treat our grantees as valued partners, and we treat the ultimate beneficiaries of our work with respect.
- Delivering results with the resources we have been given is of utmost importance – and we seek and share information about these results.
- We demand ethical behaviour of ourselves.
- We treat each other as valued colleagues.
- Meeting our mission – to increase opportunity and equity for those most in need – requires great stewardship of the money we have available.
- We leave room for growth and change.

Operationally, the Foundation is organised into three programmes: Global Health, Global Development and the US Program. The Global Health Program, which is the focus of this chapter, commands the biggest slice of the Foundation's spending.

Philanthropy: more than business, less than charity?

Chambers Dictionary defines philanthropy as ‘a charitable regard for one’s fellow human beings, especially in the form of benevolence to those in need, usually characterized by contributing money, time, etc. to various causes’ (Chambers 2008). The origin of the word is Greek: *philia*, love; and *anthropos*, man.

The tradition of philanthropy has strong American roots from a hundred years ago when multimillionaire industrialists created foundations through which to channel their wealth. The first was the Russell Sage Foundation set up in 1907, followed by Rockefeller in 1910 and Carnegie in 1911 (Smith 1999). By the early 1960s, foundations were growing at a rate of 1,200 per year. Today, US foundations have assets of \$500 billion and spend around \$33.6 billion annually (Gundersen 2006). The Gates Foundation is, by far, the biggest of the big American foundations.¹

The growth of private philanthropy mirrors the growth of private wealth in the US and other parts of the world, especially Europe. The global wealth boom and the collapse of the Soviet state have also created billionaires in countries like Russia, India, Mexico and Turkey, some of whom have initiated philanthropic initiatives in their own countries. As of 2007, there were 946 billionaires (nearly half of whom were US residents) with a combined net worth of about \$3.5 trillion (Forbes 2007). The number is growing. *Forbes* magazine calculated a 23 per cent increase in the number of billionaires between 2006 and 2007.

But an equally astounding fact is that over 2.5 billion people live on less than \$2 a day – more than ever before (Chen and Revallion 2007). Andre Damon (2007) describes this paradox as ‘a by-product of the staggering growth of social inequality, the vast accumulation of personal wealth by a financial oligarchy at the expense of the rest of humanity’. This line of thinking implies that the origins of philanthropic wealth matters. To most people it matters if philanthropic spending is based on wealth that has been accumulated unethically, especially if it has involved either the direct or indirect exploitation or oppression of people.

Bill Gates made his money from technological innovation, business acumen and a favourable patents regime which enabled him to control large segments of a lucrative market. For some, Microsoft is one of the great success stories of modern-day business and Bill Gates’s subsequent philanthropy an exemplar of generosity and humanity.

But there is a need to look at philanthropy more critically. The lack of examination of how wealth is created can perpetuate the myth that scarcity, rather than inequality, is at the root of much persisting social and

TABLE DI.3.I **Forbes top twenty billionaires in 2008**

Name	Citizenship	Net worth (\$ bn)	Residence
1 Warren Buffett	US	62	US
2 Carlos Slim Helu and family	Mexico	60	Mexico
3 William Gates III	US	58	US
4 Lakshmi Mittal	India	45	UK
5 Mukesh Ambani	India	43	India
6 Anil Ambani	India	42	India
7 Ingvar Kamprad and family	Sweden	31	Switzerland
8 K.P. Singh	India	30	India
9 Oleg Deripaska	Russia	28	Russia
10 Karl Albrecht	Germany	27	Germany
11 Li Ka-shing	Hong Kong	27	Hong Kong
12 Sheldon Adelson	US	26	US
13 Bernard Arnault	France	26	France
14 Lawrence Ellison	US	25	US
15 Roman Abramovich	Russia	24	Russia
16 Theo Albrecht	Germany	23	Germany
17 Liliane Bettencourt	France	23	France
18 Alexei Mordashov	Russia	21	Russia
19 Prince Alwaleed Bin Talal Alsaud	Saudi Arabia	21	Saudi Arabia
20 Mikhail Fridman	Russia	21	Russia

Source: Forbes 2007.

economic problems and nurtures a culture of *noblesse oblige* for the wealthy and privileged to help the less fortunate. Neither does it help address the implications of conceding such power to the wealthy.

Furthermore, in many countries, philanthropy is a way for the rich to avoid paying tax. In the US, it is estimated that 45 per cent of the \$500 billion that foundations hold actually 'belongs to the American public' in

the sense that this is money forgone by the state through tax exemptions (Dowie 2002). Similarly, corporate social responsibility programmes can distract public attention away from the lowering of corporate tax rates across the world and the avoidance of tax by the rich.

It should also be noted that philanthropy is not always philanthropic. As *The Economist* suggests: 'The urge to give can have many different guises', including at times nothing more than 'a vain hope of immortality, secured by your name on a university chair or hospital wing' (Economist 2006b).

Many foundations also give to 'causes' that benefit the wealthy through, for example, the funding of museums, the arts and other cultural interests, or of hospitals, universities and research (for example, cancer research). Funds are also spent on plush offices, generous salaries to foundation employees and large stipends to trustees. Unsurprisingly, US foundations are seen by some as an extension of America's banks, brokerage houses, law firms, businesses and elitist universities.

None of this is to suggest that philanthropy doesn't have a good side. Some great things have been achieved through private acts of charity and good. But it is vital in today's world of immense wealth and enduring poverty to question the mainstream portrayal of philanthropy as being entirely benign.

In 1916, the US Commission on Industrial Relations warned that foundations were a danger because they concentrated wealth and power in the service of an ideology which supported the interests of their capitalist benefactors (Howe 1980). In the US, some benefactors play an important role in supporting think-tanks that advocate cuts in public services for the poor while advancing the agenda of 'corporate welfare' and privatisation (Covington 1997). There have also been examples of philanthropy being used covertly to support and further US political, economic and corporate interests abroad (Smith 1999; Karl and Karl 1999; Colby and Dennett 1995).

Even foundations with an explicit social and liberal agenda often support actions and programmes that are conservative in nature and fail to serve the long-term interests of the poor. In some instances, foundations have acted to steer labour or social movements towards more conservative positions by, for example, paying the leaders of social movements to attend 'leadership training programmes' or enticing them into well-paid jobs within professionalised non-governmental organisations (Allen 2007; Hawk 2007).

By premissing social change and development upon charity and the benevolence of the wealthy, the energy required to mobilise political action to tackle the root, structural injustices within society is dampened (Ahn 2007). Instead of campaigning for land reform and land rights, for example, NGOs and charities are harnessed to ameliorate the living conditions of

slum dwellers whose land has been appropriated. Philanthropy can be a potent instrument for 'managing' the poor rather than empowering them. Few grants go to civil rights and social movements. Even fewer are given to programmes calling for a redistribution of wealth and land.

Robert Arnove (1980) charged that foundations can have

a corrosive influence on a democratic society; they represent relatively unregulated and unaccountable concentrations of power and wealth which buy talent, promote causes, and in effect, establish an agenda of what merits society's attention. They serve as 'cooling-out' agencies, delaying and preventing more radical, structural change. They help maintain an economic and political order, international in scope, which benefits the ruling-class interests of philanthropists.

The need for professionalised NGOs to compete for funding also promotes division and competition within civil society, while increasing the power of patronage of private funders.

So far as the Gates Foundation is concerned, most people believe that humanitarianism lies at the core of its work in global health. It is fundamentally a charitable organisation. But whether its work is based on a true commitment to equity and social justice is open to question.

Its motivations were called into question following two articles published in January 2007 in the *LA Times* on the investments of the Gates Foundation (Piller et al. 2007). The articles described how investments worth at least \$8.7 billion (excluding US and foreign government securities) were in companies whose activities were contrary to the Foundation's charitable goals.

Initially the Foundation reacted by saying that it was rethinking its investment policy (Heim 2007). However, it subsequently announced that there would be no changes to the Foundation's investment policy because it would have little impact on the problems identified by the *LA Times* (Gates Foundation 2008). The Foundation told GHW that it 'can do the most good for the most people through its grant-making, rather than through the investment of its endowment'. On its website,² the Foundation also notes that Bill and Melinda Gates have chosen not to 'rank' companies because 'there are dozens of factors that could be considered, almost all of which are outside the Foundation's areas of expertise'. The two exceptions to this rule are that the Foundation will not invest in tobacco, or in companies that represent a conflict of interest for Bill or Melinda.

Many people find the 'passive investor' stance of the Gates Foundation disappointing. Many other foundations (e.g. the Wellcome Trust), charities and individuals practise ethical and socially responsible investment and some even pursue a policy of active shareholder involvement. Why not the Gates Foundation?

TABLE DI.3.2 Twenty largest individual grants awarded by the Gates Foundation, 1999–2007

Grantee	Year	Total (\$ m)	Length (months)	Purpose
GAVI Alliance	1999	750	60	Purchase new vaccines
GAVI Alliance	2005	750	120	General operating support
Global Fund	2006	500	43	Support the Global Fund in its efforts to address HIV/AIDS, tuberculosis and malaria in low- and middle-income countries
Medicines for Malaria Venture	2005	137	60	Further develop and accelerate antimalarial discovery and development
PATH	2005	108	72	Clinical development of the RTSS malaria vaccine
University of Washington	2007	105	120	Create the Health Metrics Institute at the University of Washington
Global Alliance for TB Drug Development	2006	104	60	Decrease tuberculosis mortality by developing new anti-TB treatments
International AIDS Vaccine Initiative (IAVI)	2001	100	60	Accelerate the global effort to create and distribute AIDS vaccine via vaccine design studies, clinical infrastructure and non-human primate studies
Global Fund	2002	100	120	General operating support
PATH	2004	100	48	Support the continuation and expansion of the work of the Malaria Vaccine Initiative from 2004 through 2007
Aeras Global TB Vaccine Foundation	2004	82	60	Develop and license improved TB vaccine for use in high burden countries
PATH	2006	75	60	Support a portfolio of pneumococcal vaccine projects
PATH	2001	70	120	Support the elimination of epidemic meningitis in sub-Saharan Africa
University of Washington Foundation	2007	61	72	Conduct a placebo-controlled proof-of-concept Phase III trial of the safety and efficacy of TDF and FTC/TDF in reducing HIV acquisition among HIV-negative partners within heterosexual HIV-discordant couples

Grantee	Year	Total (\$ m)	Length (months)	Purpose
International Partnership for Microbicides	2003	60	60	Strengthen capacity in microbicide development
Save the Children Federation	2005	60	72	Test and evaluate newborn health care tools and technologies
University of Washington Foundation	2003	60	48	Facilitate multi-site study in Africa to assess the efficacy of acyclovir treatment on the transmission of HIV
Columbia University	2004	57	60	Reduce maternal deaths in developing countries by improving access to life-saving treatment for serious obstetric complications
Americans for UNFPA	2000	57	60	Reduce HIV/AIDS, STIs and unintended pregnancies by designing and implementing comprehensive, sustainable adolescent reproductive health programmes in Botswana, Ghana, Tanzania and Uganda
International Vaccine Institute	2002	55	72	Fund effective and affordable dengue vaccines for children in dengue-endemic areas

Source: Data from Gates Foundation website.

Overview of the Gates Foundation's global health grants

According to the Foundation's website, the majority of funding is provided for research in the areas of malaria, HIV/AIDS, immunisation, reproductive and maternal health, and other infectious diseases. The breakdown of funds (as published on the website) provided between late 1998 and March 2007 are as follows:

HIV, TB, and reproductive health	\$1,854,811,111
Infectious diseases	\$1,869,151,983
Global health strategies	\$2,874,141,716
Global health technologies	\$466,671,428
Research, advocacy and policy	\$766,612,229

248 **Holding to account**

Based on data collated from its website, we calculated that the Foundation had awarded 977 grants for global health from January 1999 to December 2007. The cumulative total of these grants was US\$ 8.1 billion. Individual grant amounts vary considerably in size, ranging from \$3,500 to \$750 million. The twenty largest grants are shown in Table D1.3.2.

Grants are awarded for varying lengths of time, with some lasting for periods of less than a year, whilst others cover periods of up to eleven years. When grants are examined in terms of amounts per month, there is slight variation in the top ten grantees (see Table D1.3.3).

TABLE D1.3.3 **Top ten grantees in terms of amount/month**

Grantee	Year	\$/month	Purpose
GAVI Alliance	1999	12,500,000	Purchase new vaccines
Global Fund	2006	11,627,907	Support the Global Fund in its efforts to address HIV/AIDS, tuberculosis and malaria in low- and middle-income countries
GAVI Alliance	2005	6,250,000	General operating support
World Health Organization (WHO)	2006	3,314,493	Support the Global Polio Eradication Initiative in accelerating polio eradication in Nigeria and preventing international spread of wild poliovirus across west and central Africa
Medicines for Malaria Venture	2005	2,283,333	Further develop and accelerate antimalarial discovery and development projects
PATH	2004	2,083,333	Support the continuation and expansion of the work of the Malaria Vaccine Initiative 2004–07
WHO	2005	2,083,333	Support the initiative to eradicate the polio virus
Elizabeth Glaser Pediatrics AIDS Foundation	2007	1,944,201	Accelerate the development of a global paediatric HIV/AIDS vaccine through basic research and Phase I clinical trials
Global Alliance for TB Drug Development	2006	1,740,064	Decrease tuberculosis mortality by developing new anti-TB treatments
International AIDS Vaccine Initiative (IAVI)	2001	1,666,667	Accelerate the global effort to create and distribute AIDS vaccine via vaccine design studies, clinical infrastructure and non-human primate studies

Source: Data from Gates Foundation website.

TABLE D1.3.4 **Top ten favoured grantees based on cumulative total of grants, 1999–2007**

Grantee	Cumulative amount awarded
World Bank Group	134,486,883
Institute for One World Health	144,825,148
University of Washington	151,973,070
IAVI	153,780,244
Johns Hopkins University	192,320,238
Medicines for Malaria Venture	202,000,000
World Health Organization	336,877,670
Global Fund	651,047,850
PATH	824,092,352
GAVI	1,512,838,000

Source: Data from Gates Foundation website.

A number of grantees are strongly supported by the Gates Foundation. Table D1.3.4 lists the top ten grantees in terms of the cumulative amount received from the Gates Foundation.

Accountability, influence and domination

The Gates Foundation is governed by the Gates family. There is no board of trustees; nor any formal parliamentary or legislative scrutiny. There is no answerability to the governments of low-income countries, nor to the WHO. Little more than the court of public opinion exists to hold it accountable.

The experts interviewed by the GHW cited the lack of accountability and transparency as a major concern. According to one, ‘They dominate the global health agenda and there is a lack of accountability because they do not have to implement all the checks and balances of other organisations or the bilaterals.’ Another described how the Foundation operates like an agency of a government, but without the accountability.

In addition to the fundamental lack of democratic or public accountability, there was little in the way of accountability to global public health institutions or to other actors in the health field. The fact that the Gates Foundation is a funder *and* board member of the various new Global Health

Initiatives (e.g. the Global Fund; GAVI, Stop TB Partnership; and Roll Back Malaria) means that other global health actors are accountable to the Gates Foundation, but not the other way round.

When these concerns were put to the Foundation, their reply focused on programmatic transparency accountability: 'We take accountability very seriously, and one of our top priorities is to effectively monitor the impact of our grant-making. We require grantees to report on their progress against agreed-upon milestones, and we often support third-party evaluations of our grants.' They continue, 'We are working to improve and expand the information we make available to the public, which already includes a detailed overview of grant-making priorities, information on all grants to date, annual reports, third-party evaluations, and case studies of what we're learning.' They also explain that by funding groups such as the Health Metrics Network and the Institute for Health Metrics and Evaluation, the effectiveness of investments in global health, including their own, would become easier to measure.

The Gates Foundation website states: 'Once we've made a grant, we expect the grantee to measure the results. We require our grantees to carefully track and report on their work in the field. ... We seek to share evaluations in various forums, including by circulating them to our partners and posting them on our site.'

In reality, there is surprisingly little written about the pattern and effectiveness of grant-making by the Gates Foundation. Limited information is available on the Foundation's website. A Global Health Programme Fact Sheet and a Global Health Grantee Progress document provide minimal information about specific diseases and conditions, and identify some of the grantees who receive recurring funding for ongoing work. Annual reports with more detailed financial information are also available. But none of these documents provides comprehensive information, or any data or analysis about the outcome of completed grants and projects.

Several interviewees also felt that the way grant proposals are solicited, reviewed and funded is opaque. Many grants appear to be made on the basis of personal contacts and informal networking. While the Foundation has advisory committees consisting of external experts, there has been no critical evaluation of how they are constituted, to what extent they are free from the patronage of the Foundation, nor whether they represent an appropriate mix of views and expertise.

The absence of robust systems of accountability becomes particularly pertinent in light of the Foundation's extensive influence. As mentioned above, it has power over most of the major global health partnerships, as well as over the WHO, of which it is the third-equal biggest single funder.

Many global health research institutions and international health opinion-formers are recipients of Gates money. Through this system of patronage, the Foundation has become the dominant actor in setting the frames of reference for international health policy. It also funds media-related projects to encourage reporting on global health events.

According to one of our interviewees, a senior health policy officer from a large international NGO, the sphere of influence even encompasses bilateral donors:

You can't cough, scratch your head or sneeze in health without coming to the Gates Foundation. And the people at WHO seem to have gone crazy. It's 'yes sir', 'yes sir', to Gates on everything. I have been shocked at the way the bilateral donors have not questioned the involvement and influence of the Gates in the health sector.

The Foundation also funds and supports NGOs to lobby US and European governments to increase aid and support for global health initiatives, creating yet another lever of power and channel of influence with respect to governments. Recently, it announced a Ministerial Leadership Initiative aimed at funding technical assistance to developing-country ministries of health.

The extensive financial influence of the Foundation across such a wide spectrum of global health stakeholders would not necessarily be a problem if the Foundation was a passive funder. But it is not. It is an active funder. Very active and very involved, according to many people.

Not only is the Foundation a dominant actor within the global health landscape; it is said to be 'domineering' and 'controlling'. According to one interviewee, 'they monopolise agendas. And it is a vicious circle. The more they spend, the more people look to them for money and the more they dominate.' Interviewees also drew attention to similarities between Microsoft's tactics in the IT sector and the Foundation 'seeking to dominate' the health sector. In the words of one interviewee: 'They work on the premiss of divide and conquer. They negotiate separately with all of them.' Another interviewee warned of their 'stealth-like monopolisation of communications and advocacy'.

According to another interviewee, the Foundation has generated not just a technical approach, but also one that is elitist. Another interviewee described the Foundation as 'a bull in a china shop and not always aware of what has gone before – they have more to learn about learning'.

In February 2008, a senior official from a public agency broke cover. Arata Kochi, the head of the WHO's malaria programme, released a memorandum that he had written to his boss in 2007. According to the *New York Times*, which broke the story, Kochi complained that the growing

dominance of malaria research by the Gates Foundation was running the risk of stifling diversity of views among scientists and of wiping out the WHO's policymaking function (McNeil 2008).

While recognising the importance of the Foundation's money, Kochi argued that many of the world's leading malaria scientists are now 'locked up in a "cartel" with their own research funding being linked to those of others within the group'. According to Kochi, the Foundation's decision-making is 'a closed internal process, and as far as can be seen, accountable to none other than itself'. Others have also been critical of the 'group think' mentality among scientists and researchers that has been induced by the Foundation.

The concerns raised by Kochi's letter were felt by many others in October 2007 when, apparently without consultation with the WHO or any other international bodies or so-called partners, at a conference in Seattle, the Foundation launched a new campaign to eradicate malaria. Apart from the lack of consultation, what was astonishing about the announcement was that it took everyone, including the WHO and the Roll Back Malaria Initiative, completely by surprise. For many people, this was another example of the Foundation setting the global health agenda and making the international health community follow.

The Gates Foundation in the health sector

Venture philanthropy

Partnership with industry is an explicit and prominent part of the Gates Foundation's global health strategy. Many of its senior employees also come from the corporate world. Chief Executive Patty Stonesifer is former senior vice president at Microsoft. The head of the Global Health Programme, Tadataka Yamada, came from GlaxoSmithKline.

The Gates Foundation also appears to be favourably disposed to actors like the McKinsey consulting group, which are consequently carving out a more prominent role for themselves in international health and development. According to one interviewee, private-sector players like the Foundation instinctively turn to their own kind to produce research on health.

Unsurprisingly, the Foundation's approach to global health is business-oriented and industrial in its approach. Such an approach is in keeping with what has been called 'venture philanthropy', the charitable equivalent of venture capitalism whereby 'social investors' search for innovative charitable projects to fund (Economist 2006c). As with venture capitalists, there is a demand for a high 'return', but in the form of attributable and measurable social or health outcomes (Economist 2006d).

The Foundation's corporate background and its demand for demonstrable returns on its investment appear to have resulted in a bias towards bio-medical and technological solutions. In the words of one interviewee: 'The Gates Foundation is only interested in magic bullets – they came straight out and said this to me.' One analysis of the Foundation's research grants linked to child mortality in developing countries found a disproportionate allocation of funding towards the development of new technologies rather than to overcoming the barriers to the delivery and utilisation of existing technologies (Leroy et al. 2007). Another example of the Foundation's technological orientation is its 'Grand Challenges in Global Health' – an initiative designed to stimulate scientific researchers to develop new technological solutions for major health problems.

In a critique of the 'Grand Challenges', Birn (2005) argued that 'it is easy to be seduced by technical solutions and far harder to fathom the political and power structure changes needed to redistribute economic and social resources within and between societies and foster equitable distribution of integrated health-care services.' According to her, 'The longer we isolate public health's technical aspects from its political and social aspects, the longer technical inventions will squeeze out one side of the mortality balloon, only to find it inflated elsewhere.'

Health systems

Criticisms of the Foundation's technological and clinical focus would be tempered if more attention were paid to strengthening health systems, capacitating ministries of health to provide more effective stewardship and management, and tackling the market failures that are so prevalent in the mainly commercialised health systems of low-income countries.

However, going on past performance the Gates Foundation has not been interested in health systems strengthening and has rather competed with existing health services. One interviewee explains that the business model approach to health improvement is seen as distinct from 'development', which is the remit of official development assistance. Another said: 'the Gates Foundation did not want to hear about systems strengthening, they said that was for governments.'

Because results are more easily delivered through vertical and selective programmes, and more so through NGOs that can bypass national bureaucracies and integrated planning systems, the Foundation has been a significant reason for the proliferation of global public-private initiatives (GPPIs) and single-issue, disease-based vertical programmes, which has fragmented health systems and diverted resources away from the public sector.

Neither has there been great interest in health systems research. In the words of one interviewee: 'They are not yet ready to accept that health systems etc. are researchable questions. They do not see the importance of research in this area.' Another recounted: 'The issues we presented to the Gates Foundation were around health-system strengthening, demand and access. We had no magic bullets, but a lot of priorities around operational research – i.e. not technological research. The Gates Foundation said that we were not thinking big enough.'

However, there are signs that the Foundation is turning its attention to health systems strengthening. According to one interviewee, a senior health policy adviser at the Foundation confirmed that 'health systems' was a new area of work they want to expand into. Another sign is that the Foundation is a signatory of the International Health Partnership, which is designed to improve aid effectiveness in the health sector and help strengthen health systems through a country-driven process.

But what would the Foundation's interest in health systems mean in practice? How will it marry 'venture philanthropy' with health systems strengthening? Where does the Foundation stand on the issue of the balance between markets and plans, and between the public and the private? Will it allow itself to be subjected to more bottom-up priority-setting? Will it shift away from short-term results towards long-term development?

When GHW asked the Gates Foundation if it would ever consider helping to fund the recurrent salary costs of public-sector health workers, it avoided answering the question directly: 'This is an important issue and we are strongly committed to ensuring that trained health workers are in place in developing countries. We are exploring ways the Foundation can contribute to efforts to address this issue.' And when asked if it would put funds into budget support or a country-wide SWAp (sector-wide approach), the reply was similarly evasive: 'We're open to many approaches to improving global health. For example, the Malaria Control and Evaluation Partnership in Africa (MACEPA), a Foundation grantee that supports Zambia's national malaria control program, is integrated into that country's sector-wide approach to health care.'

However, it appears that the corporate, market-oriented instincts of the Foundation will be extended to the health sector. Various remarks made in private and public by Gates Foundation employees indicate a wish to expand the role of the private sector in delivering health care in low-income countries (for example, see Cerell 2007). Recently, the Foundation funded and worked with the International Finance Corporation (an arm of the World Bank) to explore ways to invest more in the private health sector in Africa (IFC 2007).

Too close to Pharma?

The ties between the Foundation and the pharmaceuticals industry, as well as its emphasis on medical technology, have led some health activists to question if the Foundation is converting global health problems into business opportunities. Others worry about the Foundation's position with regard to intellectual property (IP) rights and the effect this has on the price of essential medicines.

Microsoft played an important role in pushing through the TRIPS agreement, and, together with other corporations, it is still lobbying to strengthen IP rights even further. At the 2007 G8 meeting in Germany, for example, a joint letter from various corporations, including Microsoft, helped push through an agreement that higher levels of IP protection should be demanded in emerging economies, especially regarding the issuing of compulsory licences for the manufacture of medicines. Many NGOs were dismayed. Oxfam suggested this would 'worsen the health crisis in developing countries'; MSF said the decision would 'have a major negative impact on access to essential medicines in all developing countries and fails to promote health innovation where it is most needed' (MSF 2007).

When GHW questioned the Gates Foundation on the issue of IP, it replied that it was working to overcome market barriers to vital drugs and vaccines in the developing world, but in a manner that was consistent with international trade agreements and local laws. This is similar to the position of Big Pharma, which is either to leave alone or to strengthen IP rights, while encouraging a greater reliance on corporate social responsibility and public-private 'partnerships' to overcome market failures.

But it is not clear where the Gates Foundation stands on the TRIPS flexibilities designed to enable poor countries to avoid the barriers created by patents and monopolies. For example, when Tadataka Yamada was reported in *The Economist* as saying that compulsory licensing could prove 'lethal' for the pharmaceuticals industry, one would be forgiven for wondering if he was speaking as a former employee of GlaxoSmithKline (Economist 2007e). However, in September 2007, he appeared to endorse the use of compulsory licences and even criticised his former employers by saying: 'Pharma was an industry in which it was almost too easy to be successful. It was a license to print money. In a way, that is how it lost its way' (Bowe 2007).

When asked about the patents on medicines, vaccines or diagnostic tools that the Gates Foundation itself has helped to develop, the Foundation said: 'We work with our grantees to put in place Global Access Plans designed to ensure that any tool developed with Foundation funding be made accessible

at a reasonable cost in developing countries. We're employing a variety of approaches to help achieve that access, including innovative IP and licensing agreements.' However, whether Gates philanthropy will improve access to knowledge and technology, or buttress the trend towards the increasing privatisation of knowledge and technology, remains to be seen.

Final word

If 'global health' ten years ago was a moribund patient, the Gates Foundation today could be described as a transfusion of fresh blood that has helped revive the patient. The Gates Foundation has raised the profile of global health. It has helped prime the pipelines for new vaccines and medicines for neglected diseases. It is offering the prospect of the development of heat-stable vaccines for common childhood infections.

Bill Gates could have spent his money on art museums or vanity projects. He could have spent his money on cancer research, or on the development of space technology. He chose instead to tackle the diseases of the poor. He chose to go to Africa with much of his money.

The Foundation has also resisted the evangelical excesses of the Bush administration by, for example, supporting comprehensive sexual and reproductive health programmes. It has cajoled the pharmaceuticals corporate sector to become more responsible global actors. It has encouraged civic activism around the right to life-saving treatment. It has supported NGOs to pressure donor governments to live up to their aid commitments.

The Foundation has done much, and it will be doing even more as its level of spending sets to increase. But there are problems with what is happening. The Foundation is too dominant. It is unaccountable. It is not transparent. It is dangerously powerful and influential.

There are problems with the way global health problems are being framed. Technocratic solutions are important, but when divorced from the political economy of health they are dangerous. Public-private partnerships are potentially important, but unless the mandate, effectiveness and resource base of public institutions are strengthened, and unless there is much stronger regulation of the private sector (especially the giant multinationals), they can be harmful. Charity and philanthropy are good, but, unless combined with a fairer distribution of power and wealth, they can hinder what is just and right.

Similarly, the development of new technologies and commodities is positive but less so if the Foundation is not more supportive of the implementation by low- and middle-income countries of legitimate TRIPS flexibilities, such as compulsory licences.

The ability of individuals to amass so much private wealth should not be celebrated as a mark of brilliant business acumen, but seen as a failure of society to manage the economy fairly. Nothing is as disappointing as the Gates Foundation's insistence on continuing to act as a 'passive investor'. The reasons for *not* adopting an ethical investment strategy are unconvincing and reveal a double standard.

It is natural for he who pays the piper to call the tune. But other actors in the global landscape appear unable or unwilling to provide an adequate counterbalance to the influence of the Foundation. There is a profound degree of self-censorship. People appear scared to contradict the Foundation, even on technical, public health issues. This is not healthy. Joel Fleishman, author of *The Foundation*, argues that rather than accountability being a voluntary trait, foundations should be obliged to be accountable to the public (Fleishman 2007).

The Gates Foundation needs to consider its relationships with other actors. While it should preserve its catalytic, innovative and bold approach to global health, it needs to learn to know when it should follow and not lead. At the global level, the mandate and responsibility of organisations like the WHO must be strengthened, not weakened and undermined. And at the country level, while many low-income-country governments suffer from a real lack of capacity, the institution of government must be respected and strengthened.

There are concerns about the Foundation's rose-tinted perspective of the market and the simplistic translation of management practices from the commercial sector into the social and public sector of population health. For this reason, it could be argued that the Foundation should stay out of the business of strengthening health systems. It has neither the expertise nor the mandate to participate in this field of public policy. On the other hand, because the Foundation has a massive impact on health systems through its financing of GPPIs and its contribution to the dominance of a top-down, vertical approach to health-care delivery across the world, it should be involved. But it would then need to adopt a clearer, more evidence-based and responsible role towards national health systems.

One way forward suggested by several GHW interviewees was for the Foundation to support more people with experience of working in under-resourced health-care settings or with the understanding that health improvement is as much about facilitating appropriate social, institutional and political *processes* as it is about applying technocratic solutions.

Another way forward was for civil society to demand a comprehensive and independent evaluation of all its grantees and grants. In the absence of rigorous public debate and challenge from international health agencies

and public health experts, it may be necessary for civil society to take the lead in making demands for improved performance and more accountability from the Gates Foundation.

Notes

1. See www.foundationcenter.org.
2. See www.gatesfoundation.org/AboutUs/Announcements/Announce-070109.htm.

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DI.4 The Global Fund to Fight AIDS, Tuberculosis and Malaria

One of the most prominent new actors within the global health landscape is the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), a private foundation based in Switzerland. As of June 2007, GF-supported programmes are said to have extended antiretroviral treatment (ART) to 1.1 million people; provided TB treatment to 2.8 million people; and distributed 30 million insecticide-treated bednets (ITNs).

However, there is a need for a more critical assessment. It is one thing to claim improvements in coverage or the distribution of medical outputs, it is another to demonstrate their impact and cost-effectiveness. Given its focus on three diseases, it is also necessary for the GF to avoid collateral damage to other essential health services.

Generally speaking, the GF's work in funding and catalysing responses to HIV/AIDS, TB and malaria has been successful. Many people have benefited. However, it is not possible to say whether these benefits are sustainable, or have been cost-effective and equitably distributed, without better data and more detailed country-by-country analysis.

History, functions and modus operandi

The beginnings

The GF first took shape at the G8 summit in July 2000 when a commitment was made to address the harms caused by HIV/AIDS, TB and malaria (G8 Communiqué 2000). At a 2001 Organisation of African Unity (OAU) Summit, Kofi Annan called for a 'war chest' of \$10 billion per year to fight HIV/AIDS and other infectious diseases (Annan 2001). The UN Special Session on HIV/AIDS subsequently established a working group to delineate



IMAGE DI.4.1
**HIV activists in
 South Africa**

the functions and structure of the GF. The GF approved the first round of grants in April 2002 – three months after the first meeting of its board.

Throughout this period, treatment activists in civil society played a critical role in creating the political momentum required to create the GF, whilst helping to drive down the cost of medicines and winning the argument that ART was feasible in even the poorest countries. Their use of moral persuasion, legal tactics and calculated acts of civil disobedience were critical aspects of their challenge to both governments and pharmaceuticals companies. By shaping the structure and policies of the GF, civil society organisations (CSOs) thus demonstrated their ability to influence global health governance (GF 2007a).

Functions

From the beginning, the GF was set up as a financial instrument, not an implementing agency. Its aim and purpose were to leverage additional financial resources for health. It would operate transparently, demonstrate accountability and employ a simple and rapid grant-making process. It would support country-led plans and priorities, and there was a particular emphasis on developing civil society, private-sector and government partnerships, and supporting communities and people living with the diseases. It would adopt a performance-based approach to disbursing grants.

Organisational structure

The GF is headed by an executive director and has approximately 240 staff located in Geneva. As it is a non-implementing agency, there are no staff based in recipient countries.

It is governed by a 24-member Board of Directors, of whom 20 are voting members. The voting members consist of: 7 representatives from developing countries (one from each of the six WHO regions and an additional representative from Africa); 8 from donor countries; 3 from civil society; 1 from 'the private sector'; and a Gates Foundation representative. The four non-voting members are representatives of UNAIDS (the Joint United Nations Programme on HIV/AIDS), the World Health Organization (WHO), the World Bank, along with a Swiss citizen to comply with the legal status of the GF. The three civil society seats are designated for: one 'developed country non-governmental organisation (NGO) representative'; one 'developing country NGO representative'; and one person who represents 'communities affected by the diseases'.

Grant-making

The GF responds to proposals received from countries. These are reviewed by a Technical Review Panel (TRP), consisting of various appointed experts. Grants are awarded through specified 'rounds' of funding. Since its inception, there have been seven rounds of grant-making. As of December 2007, the GF had approved a total of US\$10 billion to 524 grants in 136 countries, with US\$4.8 billion having actually been disbursed to recipients in 132 countries (GF 2008a). Proposals take the form of five-year plans – grants are initially approved for two years (Phase 1) and then renewed for up to three additional years (Phase 2). Because the earlier grants have come to the end of their five-year lifespan, there has been much discussion about what should happen next.

As part of its 2007–2010 strategy, the GF has announced the introduction of a Rolling Continuation Channel (RCC). This will allow the continued funding of high-performing grants for up to a further six years. It is said that this will help improve performance in the last years of life of a grant; facilitate the expansion of successful programmes; reduce the risk of gaps in funding; and remove the costs associated with countries having to submit a new proposal.

Allocation of funds

Between 2002 and 2007, 55 per cent of grant funds were disbursed to sub-Saharan Africa countries. When stratified by income, 64 per cent, 28 per cent and 8 per cent of disbursements went to low-, lower-middle- and upper-middle-income countries respectively (Grubb 2007). During this period, 57 per cent, 15 per cent and 27 per cent of grant funds were allocated to HIV/AIDS, TB and malaria programmes respectively. The Fund estimates that it provides two-thirds of all global donor funding for malaria,

TABLE DI.4.1 **Allocation of funding across the spectrum of health interventions (%)**

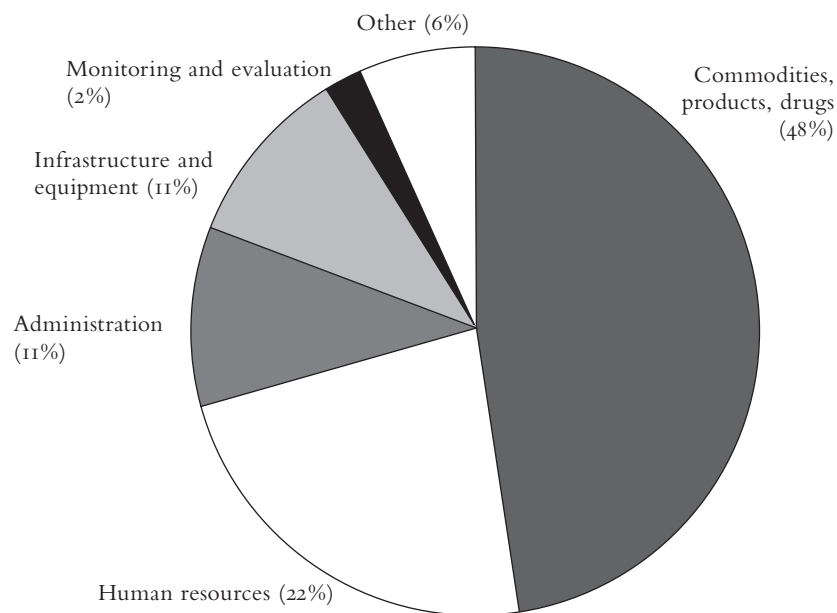
	Treatment	Prevention	Care and support	Other
HIV/AIDS (\$315 million)	32	30	14	24
Tuberculosis (\$223 million)	25	15	6	54
Malaria (\$202 million)	40	35	—	25

Source: Global Fund 2007d.

45 per cent of all global donor funding for TB, and about 20 per cent of funding for HIV/AIDS (CGD 2006). Relatively more funding has been allocated to treatment than to prevention (see Table DI.4.1).

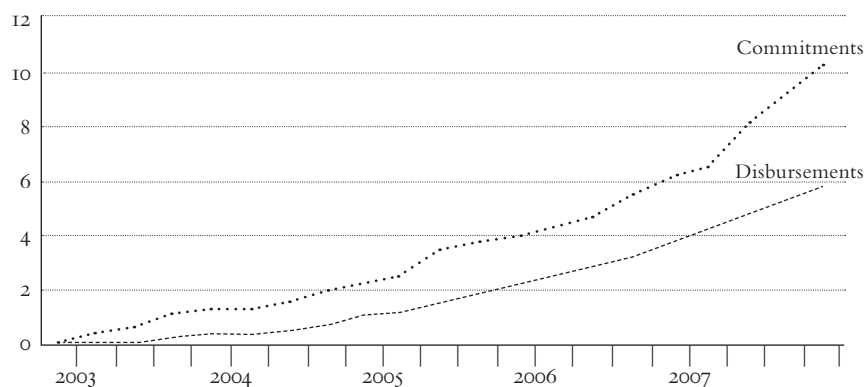
The lion’s share of funding is spent on commodities, products and medicines (Figure DI.4.1). The second largest item of expenditure is ‘human resources’, mostly in the form of training interventions.

FIGURE DI.4.1 **Resources by budget item after Round 6**



Source: Global Fund 2008b.

FIGURE DI.4.2 The rising financial commitments of the Global Fund
(actual and projected commitments and disbursements, cumulative totals,
US\$ billion)¹



Source: Global Fund 2008c.

Funding the Fund

As expected, the annual expenditure and projected commitments of the GF have steadily and rapidly increased (see Figure DI.4.2). In March 2007, the GF presented a three-year funding projection for 2008–10 which amounted to US\$5 billion for existing commitments, and an additional US\$7.2 billion per annum for new grants. In view of these demands, ‘funding the Fund’ has become a critical issue.

About 96 per cent of the GF’s contributions come from donor countries. The biggest contributor is the United States, followed by France, Italy, the European Commission (EC) and the United Kingdom.

Private-sector funding is relatively small, although it increased in 2006, mainly because of a pledge of \$500 million by the Gates Foundation. Another source of private financing has been the (RED)TM Initiative,

TABLE DI.4.2 Funding disbursements of the Global Fund
(as of 1 October 2007)

	Treatment (%)	Prevention (%)	Care and support (%)	Other (%)
HIV/AIDS (\$315 million)	32	30	14	24
Tuberculosis (\$223 million)	25	15	6	54
Malaria (\$202 million)	40	35	—	25

Source: Global Fund 2008d.

BOX DI.4.1 Trends from the 2007 replenishment meeting

- The four countries that pledged (or are projected to pledge) the most for 2008–10 were the US (\$2,172 million), France (\$1,274 million), Germany (\$849 million) and the UK (\$729 million).
- The three countries that pledged the largest percentage of their gross national income (GNI) were Norway (0.087 per cent), Ireland (0.076 per cent) and Sweden (0.075 per cent).
- The three developed countries that pledged the smallest percentage of their GNI were Japan, Finland and Switzerland.
- The three countries whose pledges grew the most since the previous three years were Russia (increased 8.7 times), Saudi Arabia (3.6 times) and Spain (3.4 times).
- The Gates Foundation pledged \$300 million, an increase of 50 per cent from the 2005–07 period.

Source: GFO 2007a.

through which participating companies contribute a percentage of their sales to the Fund. As of March 2008, the Initiative has contributed \$61 million. So far, the GF has discouraged private-sector contributions in the form of earmarked donations or non-financial contributions (GF 2008d).

'Replenishment meetings' take place every two years to discuss the funding of the GF. At the meeting in September 2007 (see Box DI.4.1), the GF was pledged *at least* \$6.3 billion for the period 2008–10 by twenty-six governments and the Gates Foundation (GFO 2007a). With projections that other donors will give a further \$3.4 billion, the Fund has secured a total of \$9.7 billion. This is enough for it to continue operations at its current level for at least another three years, but less than the \$12–18 billion that it predicted it would need for 2008–10.

How the GF works within countries

A general requirement of the GF is the establishment of a Country Coordinating Mechanism (CCM) consisting of representatives from government; multilateral or bilateral agencies (e.g. UNAIDS, WHO); NGOs; academic institutions; private businesses; and people living with the diseases. The CCM is expected to oversee the submission of proposals to the GF as well as grant implementation.

In most countries, the CCM is chaired by a representative of government. In order to ensure adequate multi-stakeholder involvement, the GF has a set of criteria for CCM composition which are supposedly used

to determine eligibility of grant proposals (GF 2005). These include the requirement for non-governmental CCM members to be selected through clear and transparent processes, and the inclusion of people living with and/or affected by the diseases. In addition, GF priorities for the future are said to include strengthening ‘community systems’, increasing the representation of vulnerable groups, and providing more support for CCM administration (GF 2007b).

The actual awards of grants are made to a named principal recipient (PR). Government agencies are the PR for about two-thirds of all grants. Nonprofit development organisations and multilateral organisations also act as PRs. In some countries a dual- or multiple-track model is used – where a grant is split across more than one recipient. As part of a set of strategic innovations for the next four years, the GF intends to promote the routine use of ‘dual-track financing’ (GF 2007b).

Government institutions are the main implementing agencies in about 59 per cent of grants, while NGOs represent 30 per cent of implementing agencies. Government agencies make up a higher proportion of implementing agencies in sub-Saharan Africa than in Asia.

Because there is no GF presence in recipient countries, Local Fund Agents (LFAs) are hired to monitor grant implementation, and to rate performance. LFAs may also be used to review budgets and work plans prior to the signing of a new grant agreement. There is normally one LFA per country. Most LFAs come from two of the big private consultancy firms (see Box DI.4.2).

Grant recipient and LFA reports are then used by the relevant GF portfolio manager to score the progress and achievements of the projects. Grant disbursement and renewal ratings are posted onto the GF website to encourage CCMs and other stakeholders to track progress. Countries deemed to be performing poorly can have further disbursements of funding withheld, or the grant cancelled or handed over to another principal recipient.

BOX DI.4.2 List of LFAs and number of countries served

- PricewaterhouseCoopers (69)
- KPMG (28)
- Emerging Markets Group (8)
- Swiss Tropical Institute (8)
- UNOPS (7)
- Crown Agents (1)
- World Bank (1)

Discussion

A model of good global health governance?

A frequent comment about the GF is that civil society and developing-country representatives are prominent in its governance structures. With a board of twenty-four that includes five representatives from low-income countries and three from civil society, this may be true relative to other global institutions. However, numerically, the board is still dominated by donor representatives. And while there are only two representatives of the private sector, one of them is currently chair of the board and the other is the Gates Foundation. In addition, the Gates Foundation funds the McKinsey firm to perform a range of secretariat functions on behalf of the GF.

However, the GF appears to live up to its reputation for transparency. Financial information is readily available, as are details about the approval of proposals and the disbursement of funding. An electronic library houses both internal and external evaluations of the Fund. Transparency has also been enhanced by the regular publication of the *Global Fund Observer* (GFO), a newsletter produced by an independent NGO called Aidspan. It reports on the financing of the Fund; monitors progress and comments on the approval, disbursement and implementation of grants; provides guidance for stakeholders within applicant countries; reports and comments on board meetings. Altogether it provides a useful information service and performs an important 'watchdog' role (GFO 2008).

The GFO reflects the extensive engagement of CSOs with the GF, which arises in part from the existence of a large, well-resourced and well-organised network of disease-based NGOs that feel a degree of ownership over the GF. Not only do they effectively engage with the GF, they have established mechanisms for influencing the policies of other stakeholders, in particular donors, vis-à-vis the GF.

Indeed a form of interdependency exists. Many CSOs which were formed to address HIV/AIDS, TB and malaria view the GF as an important ally. At the same time, the GF understands the importance of CSOs to its own survival and growth. There is a dedicated Civil Society Team within the GF's External Relations Unit, as well as various forums through which CSOs are encouraged to influence GF policies and practices (for example, the biannual Partnership Forum). The GF has even helped create and support a number of 'Friends of the GF' organisations designed to advocate on its behalf.

The GF and its constellation of associated actors thus present a number of features which have broader relevance. For example, there is much about

the GF's provision of information that can and should be replicated by other global health initiatives, and the GFO is an exemplary model of civil society monitoring that should be applied to other institutions.

When it comes to CS engagement, the model may be less transferable. The degree of transparency and 'democratic space' that exists in relation to the GF may have been tolerated because the GF embodies a relatively shared set of aims across a wide range of stakeholders. Northern governments, including the US; developing-country governments; the medical profession; health activists; pharmaceuticals companies; venture philanthropists; and the 'celebrity' spokespersons of the West's conscience – all share an interest in seeing action taken against 'the big three' diseases. It is hard to see how synergy across such diverse constituencies could be replicated in organisations like the WTO or the World Bank, for example. Nonetheless, the GF may provide a useful benchmark for comparison.

National governance

As global institutions become more numerous and prominent, important questions arise about their effect on governance at the national level. National governance is especially pertinent to the GF because an effective and equitable response to HIV/AIDS, TB and malaria ultimately requires the protection of human rights, social development, peace and effective health-sector stewardship, which in turn requires governments to work and democracy to flourish.

Together with its civil society partners, the GF can claim some credit for having enhanced participatory approaches to health policymaking in many countries. A key instrument has been the CCM. While its primary purpose is to help plan and oversee the implementation of GF grants, it is also intended to enhance public accountability and enable the entry of vulnerable and marginalised groups into health policymaking spaces. Some CCMs have been criticised for being tokenistic and lacking representation of rural groups, for example, but in several countries they have become arenas within which relationships between government, civil society and NGOs are being contested and redefined.

The GF has also influenced governance processes by acting on allegations of corruption and financial mismanagement. In 2005, it suspended grants to Uganda following reports of mismanagement and irregularities in procurement and subcontracting (Bass 2005). In 2006 it suspended two grants to Chad and phased out its grants to Myanmar for similar reasons.

It appears therefore that the potential for 'public health' to catalyse positive change within countries is being demonstrated by the GF. However, it should be noted that in some countries CCMs have sometimes been viewed

as an inappropriate, unnecessary and inefficient imposition from outside and a reminder of the need for the GF and health activists to be better informed about the historical, political and social context of governance within countries and to reject the temptation of a one-size-fits-all approach to 'good governance'.

Health-sector governance

The GF impacts on health-sector governance by boosting health budgets and by placing considerable expectations on countries to deliver on various HIV/AIDS, TB and malaria targets. Its influence on health budgets is shown in Table DI.4.3, which lists the five countries where GF grants made up the biggest proportion of total health expenditure between 2003 and 2005. In Burundi, GF grants amounted to more than the entire public budget for health, including direct funding of public services by other donors. GF grants were also a significant proportion of total health expenditure in Burundi (32 per cent), Liberia (17 per cent) and the DRC (15 per cent) respectively.

Concerns have been raised about the ability of countries to absorb such large injections of funding. Initially there was an assumption that capacity within countries would either be sufficient or that technical assistance (TA) would be provided by other agencies to help ensure effective use of GF grants. This did not turn out to be the case. According to one analysis, 'the international community dramatically underestimated TA requirements' and had not anticipated constraints in human resources, basic management and health systems infrastructure (CGD 2006). In addition, the expectation that other agencies would support capacity development caused irritation

TABLE DI.4.3 **The contribution of the GF to national expenditure on health, May 2003²**

	GF disbursements (US\$ million)	GF disbursements as % of total health expenditure	GF disbursements as % of public health expenditure
Burundi	21.8	31.8	118.2
Liberia	14.2	17.6	28.0
Dem. Rep. Congo	48.3	15.3	31.1
Rwanda	53.1	12.6	22.4
Gambia	10.4	12.4	46.0

Sources: Global Fund 2008c; WHO 2007b.

and led to other agencies complaining that supporting GF programmes was an ‘unfunded mandate’.

Such experiences raise the issue of donor and agency coordination. As discussed in Chapter D1.1, there is now greater explicit recognition of the need for external agencies to cooperate and harmonise their activities. One manifestation of this recognition is the 2004 Three Ones Agreement, which was designed to encourage all agencies to work together on HIV/AIDS through one action framework, one national coordinating authority, and one monitoring and evaluation system.³ However, thus far, even the modest goals of this agreement, dealing with only one disease area, have not been met.

While the lack of coordination among donors and global health initiatives isn’t the fault of the GF alone, it should take on the challenge of ensuring maximum harmonisation with the US government’s Presidents Emergency Plan for AIDS Relief (PEPFAR) and the World Bank’s Multi-Country AIDS Programme (MAP). One promising development has been the decision by the GF to invite National Strategy Applications from recipient countries, the purpose of which is to help eliminate parallel planning efforts and improve harmonisation among donors and other relevant health programmes (GF 2007b).

Strengthening health systems

The intense global focus on three diseases has led to concerns about other health priorities being undermined. The expansion of NGO-run projects has further fragmented already disorganised health systems. There is now recognition that general health systems weaknesses are constraining the scale-up of dedicated HIV/AIDS, TB and malaria programmes. So what is the GF doing to prevent the displacement of resources from other essential health services and to avoid undermining the longer-term agenda of health systems development?

At one point the GF had a stand-alone grant application process for ‘health systems strengthening’ (HSS). However, this was stopped due to views (mainly among external stakeholders) that the GF did not have the mandate or ‘comparative advantage’ to fund HSS.

Presently, the GF encourages applicants to budget for HSS activities within disease-specific grant proposals, but states that these activities must be ‘essential to reducing the impact and spread of the disease(s)’ (GF 2007c). The board has also decided that grants can be used to strengthen public, private or community health systems, but only if it helps to combat the three diseases (GFO 2007b). Examples of HSS actions given by the GF consist of activities that one would expect in any disease-based plan (e.g. training health workers, purchasing and maintaining diagnostic equipment).

On paper, therefore, the GF does not support the argument that because of the extraordinary money and public attention that have been captured by the 'big three' diseases, the GF should help strengthen the health system *as a whole* and for the benefit of other health needs.

However, the GF maintains a view that its grants naturally strengthen health systems by pointing, for example, to the huge investments in training health workers. In fact only a quarter of GF expenditure has been on 'human resource' line items, most of which has been training-related, with more than 80 per cent focused on clinical training targeted at the three diseases. By contrast, little has been directed at human resource (HR) recruitment or remuneration, or strengthening systems-wide HR management and administrative capacity. There has also been little analysis of the impact of GF spending on the 'internal brain drain' within countries.

The GF has also had the opportunity to support and strengthen procurement, logistics and supply systems within countries. But in many low-income countries, separate stand-alone systems for HIV/AIDS, TB and malaria supplies remain in place. While this makes sense from the perspective of disease-specific targets, it is also costly and inefficient and can ultimately delay the development of effective and efficient integrated systems.

On a positive note, a WHO report identified seven countries where GF grants were strengthening health systems (WHO 2007a). Most notable was a Round 5 Grant to Malawi, which was used to support a six-year, sector-wide HR programme. Other examples listed were Afghanistan's Round 2 proposal, which included interventions to build managerial and administrative capacity in the Ministry of Public Health; Rwanda's Round 5 grant, which helped expand community-based health insurance schemes, electrify health centres and support generic management training; Kenya's Round 6 proposal, which included plans to renovate a third of all public dispensaries, recruit 155 staff, strengthen district-level planning and management, and train laboratory technicians to provide an essential laboratory package; Ethiopia's Round 1 proposal for TB, which focused on improving drug supply management across the health system.

However, the effect of these grants on strengthening health systems cannot be assumed. For example, although the GF contributed to Malawi's sector-wide HR Programme, it is not known to what extent this has expanded HR capacity as a whole, or mainly expanded capacity for HIV/AIDS, TB and malaria services. The question of whether the privileged funding of these services has strengthened or weakened health systems overall has provoked fierce debates within the international health community. The answer, however, is likely to vary from country to country.



IMAGE DI.4.2
**Sign on tree
in rural village**

Conclusion

This chapter has provided a broad-brush sketch of the Global Fund, placing it in the context of global health governance more generally, and of weak and fragmented health systems in low-income countries. Any recommendations about the GF have to take into account the many other actors within the global health environment, as well as the particular priorities and health systems requirements at the country level.

The GF has recently completed a strategic planning exercise which has resulted in a number of future plans (GF 2007b). First, the GF intends to grow over the next few years in terms of both the number of grants and its annual expenditure. It is projected that by 2010 the GF will be spending US\$8–10 billion per year, triple the level in 2006. Resource mobilisation efforts will become ever more important. At present it is unclear where this requirement for additional funding will come from.

But as the GF embarks upon Round 8, one is struck by the lack of debate about the optimum and appropriate size of the GF. Just how big should it become? Can it get too big? What should its size be relative to that of other agencies? What will be the opportunity costs associated with the tripling of expenditure from 2006 to 2010? Can it have too many grants spread across too many countries? There are currently 517 grants spread across 136 countries – why so many countries? Would it be prudent to focus attention on a smaller number of ‘struggling’ countries or on high-burden countries? Should its remit be extended to include a broader set of diseases? Should it become a global fund for health systems in general?

Another issue for the GF (together with other initiatives) is its impact on health systems, particularly in relation to five interconnected issues:

- ensuring appropriate, coordinated, country-led and sector-wide health planning and management;
- fixing the current Balkanisation of health systems by bringing order to the disjointed and vertical projects and programmes;
- harnessing the large and unregulated commercial sector to serve the public good;
- reducing the inequity between urban and rural populations, between rich and poor, and between privileged and unprivileged diseases and illnesses;
- guarding against an inappropriate overconcentration on medical technologies and products at the expense of health promotion and tackling the social determinants of ill health.

The GF can and should play a more responsible HSS role in many more countries, especially where it accounts for a significant proportion of public health expenditure. In these countries, the GF should explicitly encourage HSS activities that will improve services for HIV/AIDS, TB and malaria, but only in a way that simultaneously strengthens the whole health system.

Even the Fund's Technical Review Panel (TRP) noted that of the \$2,762 million approved for Round 7 grants, only 13.1 per cent was targeted towards HSS actions, and that there was an opportunity to do more in this area (GFO 2007c). It also felt that many of the proposed HSS actions were focused on the immediate obstacles to health-care delivery, and not enough on planning, financing and other more upstream actions. The TRP therefore recommended that the GF provide intensive technical support on HSS for Round 8 and add health systems indicators to the monitoring and evaluation framework (GFO 2007c).

The GF must avoid creating perverse incentives through its target-driven approach. Coverage targets must not be set in a way that overemphasises numbers 'treated' or 'reached' at the expense of measures of quality, equity or sustainability. The short and quick route to expanding coverage is not always the best route to take in the long term. While it is best to 'raise all boats' rather than to pull back on services for HIV/AIDS, TB and malaria, there must be stronger guarantees that other priority health services are not being harmed.

The GF can help by encouraging better monitoring and research. The difficulties of having to make choices between the three diseases and the health system as a whole, or between short-term/emergency demands and long-term development needs, will be eased with better data. The GF can

also insist on proposals being demonstrably aligned to sector-wide plans or health systems policy. In the long run, the GF should also consider what proportion of its grants should be pooled into sector-wide budgets and set itself some targets accordingly.

In late 2008, a Five Year Evaluation of the Fund is due to be published. In spite of the evaluation being one of the biggest ever commissioned, there are two limitations. First, it is largely reliant on retrospective study methods. Second, it does not address the specific question of the GF's impact on the wider health system.

Interestingly, national debates on the relative priorities of treatment versus prevention have subsided. Although there is consensus that both treatment and prevention are important, and furthermore are interlinked, it is not clear whether the optimum balance between different treatment and prevention strategies has been achieved within countries. The GF's expenditure pattern appears to reflect an emphasis on treatment over prevention. Although there are methodological difficulties in generating the data to determine if this is true or not, it is important to keep asking the question, if only to ensure that careful thought and consideration continue to go into the process of priority-setting.

When all Round 1 to 6 grants are taken into account, 48 per cent of the GF's budget is allocated to drugs, commodities and other products. Most of the 22 per cent of expenditure on human resources is used to train existing health workers to use these drugs, commodities and products. A further 11 per cent is allocated to infrastructure and equipment. Such facts, particularly in light of the heavy involvement of the private sector, must raise further questions about the broader orientation of the GF response to HIV/AIDS, TB and malaria. Is it overly biomedical? Does it reflect the lessons learnt about achieving 'good health at low cost' from countries and settings such as Sri Lanka, Costa Rica and Kerala?

It would not be appropriate to make a list of concrete recommendations to the GF given the need to bring greater coherence and order to the broader global health landscape. However, this chapter aims to provide a good description of a new actor on the global scene and raise some useful questions, in the hope that the relevant actors will seek out the correct answers.

Notes

1. This figure makes a number of assumptions about grant approvals, renewal and disbursement rates and other variables. But it shows the general trend of an increasingly steep rise in both commitments and disbursements.
2. Total health expenditure refers to all spending on health, including by private individuals. Public Health Expenditure refers to spending by public bodies only,

such as the Ministry of Health. However, some funding may have originated from external donors. For example, Burundi spent \$18 million through the Ministry of Health between 2003 and 2005, \$14 million of which was sourced from the GF (the GF spent \$7 million elsewhere in the health economy through private organisations in this time).

3. www.who.int/3by5/newsitem9/en/.

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DI.5 The World Bank

The World Bank is emerging from a period of intense controversy in the wake of the presidency of Paul Wolfowitz, who stepped down as a consequence of a favouritism scandal in June 2007. Under the new leadership of Robert Zoellick, the institution is once more being backed by donors, and it has launched a high-profile new health strategy.

This chapter looks at the way the Bank's funding, structure and internal incentives shape its behaviour. It describes the history of the Bank's involvement in the field of health and raises serious questions about the central planks of its new strategy for the sector.

Overview of the Bank

History and structure

The World Bank Group comprises five parts, all set up at different times and with different roles:

- The *International Bank for Reconstruction and Development* (IBRD) is the oldest arm, established at the founding of the Bank in 1944. It was set up to finance the reconstruction and development of the war-ravaged European economies, but it gradually moved into financing large infrastructure projects in newly independent developing countries from the 1950s onwards. The IBRD lends money to governments at market interest rates. Its financial resources come from its initial endowment from its shareholders, from money raised on the financial markets and from interest payments made on its loans.
- The second major arm is the *International Development Association* (IDA), which was established in 1960 to provide grants and soft loans (i.e. with

low interest rates and long repayment periods) to developing countries. The IDA's budget is replenished by donor countries every three years.

These two core components of the World Bank Group are supplemented by three affiliates:

- The *International Finance Corporation* (IFC), which was established in 1956 to allow lending directly to the private sector. The IFC has its own staff, budget and building and is somewhat smaller than the rest of the Bank. Its aim is to facilitate private-sector investment and development in low- and middle-income countries.
- The *International Centre for Settlement of Investment Disputes* (ICSID), which was set up in 1966 to arbitrate on international investment disputes.
- The *Multilateral Investment Guarantee Agency* (MIGA), which was established in 1985 to provide financial guarantees to foreign investors wishing to invest in developing countries.

Governance

On its website, the Bank describes itself as a co-operative. There is some truth in this statement, in so far that it has 185 country members who are shareholders in the Bank. However, this comforting formulation of the Bank's identity belies the reality of an institution that mirrors global inequality. For a start, the Bank's shareholders do not have equal power. Votes are weighted according to a country's financial contributions.

The Bank's five most powerful shareholders – the United States, Japan, Germany, United Kingdom and France – control 37.24 per cent of votes in the IBRD, and 39.78 per cent of votes in the IDA (Weaver 2007). The Bank's primary clients, low- and middle-income countries (LMICs), have little say. Even larger developing countries such as Brazil, Russia, India and China struggle to influence Bank decisions. The recent call made by African finance ministers meeting in Maputo for improvements in Africa's decision-making position at both the World Bank and the International Monetary Fund (IMF) shows that this is a key issue, but their demands appear to have been left unanswered (Agencia de Informacao de Mocambique 2007).

The most powerful donor state is the US, which controls 16.4 per cent of the votes on the IBRD's board (Weaver 2007) and 14.7 per cent on the IDA board. With an 85 per cent 'super-majority' required to change the Bank's constitution, the dominance of the US is considerable. Furthermore, the Bank president is, by tradition, an American chosen by the US president in consultation with the US Treasury. Many of its staff are American or have been educated in American institutions and its working language is

English (Weaver 2007). All these factors give weight to the accusation that the Bank operates in the interest of its major shareholder.

Because the IDA is dependent on aid financing from donor countries, the three-yearly rounds of IDA replenishments are often accompanied by government lobbying, in particular by the US. For example, in 2002 the US used the IDA replenishment meetings to lobby for an 'increased role for the private sector in health care, education and water' (Weaver 2007).

However, it is important to note that the Bank has a degree of independence. Much of the Bank's resources are raised independently of governments on the capital markets. The president, senior managers and its staff are also important in setting the Bank's agenda.

When the US appointed Paul Wolfowitz, a key neoconservative in the Bush administration and an architect of the war on Iraq, as president of the Bank in 2005, there was widespread protest both in diplomatic circles and by World Bank staff themselves. His appointment was felt to exemplify US government contempt for multilateral institutions. Once in post, he brought in a team of lieutenants who 'set about administering the Bank in a brutal and highly ideological way'. They showed 'undisguised contempt for senior managers' (Wade 2007), causing widespread dissatisfaction among staff. When he was finally caught up in a favouritism scandal, the lack of support from staff contributed to him eventually losing his job.

Since then, Robert Zoellick, a former US deputy secretary of state and lead trade representative, has become the Bank's latest president. NGO reactions were unfavourable. Zoellick has close ties to the private sector, coming immediately from a stint at US investment bank Goldman Sachs and previously serving on the advisory board of US energy giant Enron.

What is the Bank?

The structure of the World Bank, with its five arms, reflects its complex nature and multiple personalities. For its first few decades, the Bank mainly invested in large infrastructure projects which could generate high rates of return. It was believed that this kind of investment would drive economic growth and development. Finance for 'human capital' was seen as wasteful, or at least money which would not generate much visible return. It was only towards the end of the 1960s that investment in people's skills began to be understood as necessary for economic growth. Subsequently, the Bank's education programmes began to grow.

The idea of development also soon came to be seen as being more than about just generating wealth – fighting poverty mattered too. It was Bank president Robert McNamara who, in the 1970s, took the Bank into the

fields of poverty eradication, agriculture, social projects, as well as urban development and public administration (Vetterlein 2007). Over time, the Bank extended its activities to the health sector.

With the establishment and growth of the IDA, the Bank began to transform into a donor agency, offering grants or soft loans. In doing so, it transformed further, by developing in-house research and policy analysis capacity as an adjunct to its lending and grant-making activities. This aspect of the Bank's work was given explicit attention during the presidency of James Wolfensohn when he sought to identify the Bank as a 'knowledge bank' for the world.

The Bank is therefore an institution with many forms of power. It has the power to raise capital for development projects. It has the power to act as a donor. It has the power to generate knowledge and frame policy development. It is therefore important that this influence is used benevolently.

But many people believe that it has not been used benevolently or wisely. For some, the Bank has been a key player in driving forward the set of neoliberal policies known as the 'Washington Consensus' which has facilitated a form of capitalism that has increased disparities, deepened poverty and enriched multinationals.

Others are critical of an internal intellectual climate rooted in and dominated by an economic rationality that leads to unnecessarily narrow policy advice (Rao and Woodcock 2007). Weaver also notes how this climate pushes staff to adopt a blueprint approach rather than a country-by-country approach. While the Bank's rhetoric consists of 'putting countries in the driver's seat', reality may be closer to what some have styled the taxi-cab approach in which 'the country is in the driver's seat, but no-one is going anywhere until the Bank climbs in, gives the destination and pays the fare' (Pincus and Winters 2002, cited in Weaver and Park 2007).

A recent high-profile peer review of the World Bank's research output also noted the use of research 'to proselytize on behalf of Bank policy, often without taking a balanced view of the evidence, and without expressing appropriate scepticism. Internal research that was favourable to Bank positions was given great prominence, and unfavourable research ignored' (Banerjee et al. 2006). This dominance of particular, 'accepted' points of view is reinforced by a low tolerance of public dissent or criticism by staff. As Wade puts it: 'the Bank's legitimacy depends upon the authority of its views; like the Vatican, and for similar reasons, it cannot afford to admit fallibility' (Wade 1996, cited in Weaver 2007).

The Bank has come under tremendous criticism from many directions for a string of failures, especially related to its structural adjustment programmes (SAPs). The scandal and damage caused by Wolfowitz, coupled with the

fact that lending to middle-income countries from the IBRD is small and declining as a percentage of total flows to these nations, suggested at one point that the Bank's influence was diminishing. However, from another perspective the Bank is in good health: the IDA was recently pledged a record \$41.6 billion for the period 2008 to 2011, 30 per cent more than in the prior three years. IFC investments have also been rising and totalled \$8 billion in 2007.

The World Bank in health

History

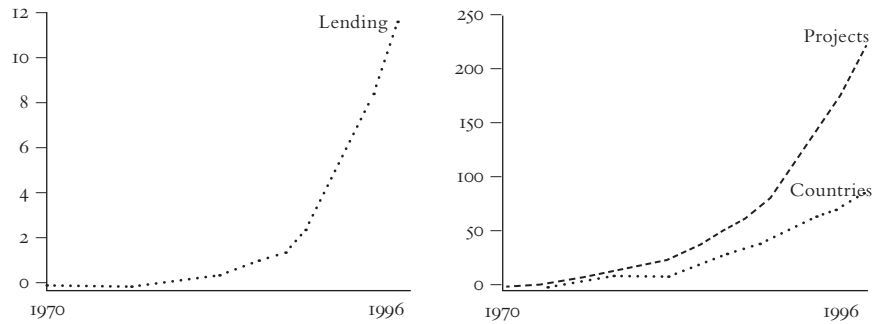
The Bank's first significant venture into the health sector was the Onchocerciasis Control Programme (regarded as one of its most successful initiatives). This was followed in 1975 by the formulation of a health policy paper which focused on basic care, the urban bias in health services and community workers. A key message that signalled a different perspective from the prevailing health policy discourse at the time was the Bank's interest in discouraging unnecessary health care and 'charging for services at their real cost' (Brunet-Jailly 1999).

But the Bank did not really invest in the health sector until a second health policy paper in 1980 set out guidelines for health-sector lending. Money would be funnelled towards 'basic health infrastructures, the training of community health workers and para-professional staff, the strengthening of logistics and the supply of essential drugs, maternal and child health care, improved family planning and disease control' (Brunet-Jailly 1999).

When the health systems of low-income countries were hit by the worldwide recession and debt crises of the late 1970s and 1980s, and at a time when its own SAPs were forcing cuts in public expenditure on health, Bank lending in the health sector grew enormously (Figure D1.5.1). This was partly the Bank following the general rise in international attention towards human development. In addition, it was reacting to the negative effects of structural adjustment. Health lending was a way of shoring up public budgets in the midst of economic crisis and adjustment (Brunet-Jailly 1999).

The World Bank soon became the world's leading external financier of health in low-income countries. With the World Health Organization (WHO) in decline, it also became prominent in developing international health policy and strategy. The 1993 *World Development Report, Investing in Health*, called for more funding for health, but linked this to a cost-effectiveness agenda and a call on governments to prioritise a 'basic package' of services. It argued that by focusing on a basic package of services,

FIGURE D1.5.1 **Cumulative growth in HNP lending and projects**
(1996 US\$ billion)



Source: World Bank 1997.

governments could ensure that more public resources were spent on the poor and priority population health measures such as immunisation programmes. Other services could be purchased by patients through insurance and out-of-pocket payments. The report argued that public-sector provision could be deeply inefficient and rarely reached the poor. Governments were encouraged to boost the role of the private sector.

These ideas fitted the broader neoliberal orientation of the Bank. In contrast to the integrated, participatory and comprehensive vision of the primary health care (PHC) approach, the Bank's reforms limited the role of the public sector and encouraged the privatisation and segmentation of the health system. The multi-sectoral and public health emphasis of the PHC approach was replaced with an emphasis on technologies that were amenable to the cost-effectiveness analyses of the Bank's economists.

The expanding Bank portfolio and the criticism it was attracting led the Bank to publish a formal Health, Nutrition and Population (HNP) Strategy in 1997. Now the Bank argued against private financing of health care and promoted the need for risk-pooling, but continued to encourage the growth of the private sector's role in health-care provision.

At the turn of the century, calls began to be made on the Bank to step up its funding to combat the HIV crisis and other priority diseases. The Bank responded with the high-profile Multi-Country AIDS Programme. However, the programme has conflicted with its systems approach to health-sector policy, and been plagued by monitoring, evaluation and ownership weaknesses common in other parts of its work (See Box D.1.5.1).

BOX D1.5.1 The Multi-Country AIDS Programme

While adult HIV prevalence rates soared in the 1980s and 1990s, it took the World Bank's management until 1997 to acknowledge the severity of the crisis and 2000 before it began a robust funding effort to tackle it. In 1999, the Bank declared that the HIV crisis was Africa's main development challenge and committed itself to what it termed 'business unusual' by launching its Multi-Country AIDS Programme (MAP). It described MAP as 'unprecedented in design and flexibility' with emphasis on 'speed, scaling-up existing programmes, building capacity, "learning by doing", and continuous project rework'. It committed nearly US\$1 billion to twenty-four countries to what was generally acknowledged as a bold and innovative approach to the pandemic (World Bank 2000).

Evaluations undertaken by the Bank's Operations Evaluation Department (OED) have shown that the Bank made substantial progress in persuading governments to increase political commitment to tackle HIV, improve the efficiency of national AIDS programmes, create and strengthen national AIDS institutions and build NGO capacity (World Bank 2005). However, these same evaluations also showed that a cluster of institutional weaknesses that severely reduced the relevance and effectiveness of the Bank's first generation of HIV interventions (1986–97) and efforts to tackle other priority diseases (World Bank 1999) continued into the new millennium and persist today.

These weaknesses seemed to have their roots in the fact that the Bank was an institution whose 'core business processes and incentives remained focused on lending money rather than achieving impact' (World Bank 1999). The interim review of MAP (World Bank 2001) found that although it was anticipated that the Bank would allocate 5–10 per cent of programme funds for monitoring and evaluation (M&E), it 'contributed almost no financial resources to provide M&E technical and implementation support to task teams and clients' (World Bank 2001).

In places like sub-Saharan Africa where there is 'a dearth of information at the country level and local levels on the epidemic' (World Bank 2005), the Bank resorted to blueprint models of programming, not tailored to local needs. OED found that the Bank needs to 'improve the local evidence base for decision-making and should create incentives to ensure that the design and management of country-level aids assistance is guided by relevant and timely locally produced evidence and rigorous analytical work' (World Bank 2005). A formulaic approach obviously undermines ownership, relevance and effectiveness.

Since 2000, the Bank's dominance in health has arguably shrunk. Its lending to the health sector has fallen by nearly one-third. Middle-income countries are borrowing less from the Bank to fund their health-sector investments. The number of staff working in the HNP sector has also fallen by 15 per cent from 243 to 206. And the arrival of new actors such as the Global Fund, GAVI and the Gates Foundation have crowded out some of the Bank's policy and programmatic space.

The shrinking health portfolio has not been matched by any increase in effectiveness. In fact, the implementation quality of HNP projects is now the lowest out of all nineteen sectors in the Bank (World Bank 2007). Monitoring and evaluation data on impact are 'scarcely available', despite the recognition of this problem in the 1997 strategy (World Bank 2007).

The Bank has become more sensitive to the charge that its policies have been harmful to the poor. The pro-poor rhetoric has strengthened and it has rowed back on its advocacy of user charges. But policy contradictions remain, particularly on the central issue of commercialisation. Influence from the US, as well as internal ideological predispositions, have meant that the financing and providing role of the private sector remains high on the agenda.

The new World Bank health strategy

The Bank's latest health-sector strategy was developed in 2007, and sets out to steer the Bank into five key areas (World Bank 2007).

I *Renew Bank focus on results*

The lack of a 'results focus' was noted in the 1997 Health Sector Strategy and criticised in the 1999 OED evaluation of the Bank's activities. Donors have been putting pressure on the Bank to focus on results within IDA. Little appears to have improved.

As the new Strategy notes, monitoring and attributing blame or praise for outcomes are difficult in the health sector. All donors face dilemmas in how to report their impact. More demands for measurement of results, if pushed too far, can have adverse affects such as focusing only on what is visible, popular and measurable, while neglecting interventions that may be unfashionable or hard to measure such as strengthening public administration, improving management systems or enhancing health worker performance. Creating the social, economic and political changes needed for health reform is also a slow process not amenable to donor demands for swift change.

284 **Holding to account**

A results strategy can also damage the goal of putting countries in the driving seat. Too often, results are set by the donors, measured by the donors, and their success evaluated by the donors (Eyben 2006). Not only does this weaken government capacity and undermine autonomy and sovereignty in policymaking; it also does nothing to enhance the fragile links of accountability between governments and their people.

Whilst there is a clear need for a massive improvement in monitoring and evaluation, this should not be linked to blueprint approaches to aid disbursement and more conditions on client countries. Instead, the Bank should focus resources (as the Strategy suggests) on building up country-led health surveillance systems, to enable informed debate about health priorities and policies at the country level, which Bank funding should then respond to.

2 Strengthen well-organised and sustainable health systems

A strong feature of the Bank's Strategy is its claim to have a comparative advantage in health system strengthening (even though the Strategy noted that the Bank itself requires 'significant strengthening' in this area). The intention of the Bank is to establish itself as the lead global technical agency for health systems policy. This intention is exemplified by its earlier role in influencing the decision to close down the Global Fund's health system strengthening 'window', and in a comment in the 2007 Strategy which suggested that the WHO's comparative advantage was not in health systems but in technical aspects of disease control and health facility management.

When it comes to health systems policy in the 2007 Strategy, the attitude taken towards commercialisation and the public sector remains largely unchanged from previous positions. A notable bias remains, with the public sector frequently described as being inefficient and anti-poor, while the potential of the private sector to deliver health care to the poor is highlighted.

The Strategy notes that private providers 'deliver most ambulatory health services in most low-income countries' (World Bank 2007). This is true. However, the Strategy fails to say anything about the importance of the public sector in the provision of in-patient services. Hospital care is nothing like as commercialised as primary level care, with most in-patient services in low-income countries taking place in the public sector. In many countries, public-sector hospitals arguably place a floor under the lack of quality and high costs that patients, especially the poorest ones, face in market-driven systems (Mackintosh and Koivusalo 2005). The health-sector strategy could have addressed this reality and proposed more support to public hospitals in poor countries.

The Bank also shows how better-off groups in society tend to capture more of the benefits of public spending on health than poorer ones. While true, this again shows only part of the picture. Public spending may be unequally distributed, but it is generally not as unequally distributed as market incomes. In fact public spending on health frequently narrows these inequalities. Chu et al. (2004) show that in sub-Saharan Africa 'all thirty available studies find government health spending to be progressive' in that the poor benefit more relative to their private income or expenditure than the better-off. But building on these redistributive effects – maintained in desperately poor circumstances – is not, it appears, a priority for the Bank.

User fees are downplayed much more than in the Bank's past, but there is still an emphasis on strengthening demand-side interventions through financial incentives, to be mediated by insurance schemes of various sorts. There is little in the Strategy about strengthening public-sector management and service provision, encouraging non-financial incentives for health workers, or building effective public accountability and community empowerment mechanisms. In overall terms, the Strategy suggests a continued inclination towards pro-private, market-oriented policies and segmented health systems, with a public sector charged mainly with the responsibility for financing a basic package for the poor.

3 Ensure synergy between health system strengthening and priority disease interventions

Buried in the appendices of the HNP Strategy are two shocking figures: whilst aid devoted to HIV/AIDS more than doubled between 2000 and 2004, the share devoted to primary care dropped by almost half; at the same time only about 20 per cent of all health aid goes to support the government programme (as general budget or sector-specific support), whilst about half of health aid is off-budget (World Bank 2007).

The Bank acknowledges the problems caused by vertical disease programmes but maintains that health system strengthening can be achieved whilst concentrating new resources on priority diseases (World Bank 2007). But, as discussed in other chapters, the claims that this will be done lack the credibility that would come from a concrete description of how it will happen.

4 Strengthen inter-sectoral action

The Bank is an immense creature with many different parts. The potential for the Bank to join up different sectors to promote health is highlighted in the 2007 Strategy. However, the Bank itself admits that intersectorality is difficult to realise 'due to both Bank and client constraints' (World Bank

2007). Hall (2007) explains that one reason for this is that there are few incentives for cross-departmental collaboration within the Bank. In fact, 'a department's kudos is judged by the size of its own managed portfolio rather than by its participation in cross-sector collaboration.' This leads to competition over project ownership and under-recognition of cross-sectoral activities. This tendency is reinforced by the fact that staff promotion is based on project portfolio size and financial turnover, which creates further inter-departmental competition. The Strategy is silent on how these constraints will be overcome.

5 *Increase selectivity and improve engagement with global partners on division of labour*

The HNP Strategy sensibly proposes a better division of labour to prevent duplication of effort and reduce the number of institutions to engage with. It suggests that the Bank should work with others that share its comparative advantages in 'health system finance, intersectorality, governance and demand-side interventions' (World Bank 2007), and also collaborate to develop policy and knowledge; it will increasingly concentrate its advocacy strength on health systems rather than global partnerships.

But the strategy paper goes further to implicitly marginalise the role of agencies such as the WHO and United Nations Children's Fund (UNICEF), which are already involved in health system policy at the global level. There is no systematic comparison of strengths and weaknesses between these agencies and the Bank, so there is some uncertainty as to why the Bank feels it has a comparative advantage.

Private-sector development, the IFC and health

As mentioned earlier, the IFC has grown in size recently. The health sector is not currently a prominent part of the IFC. Of its US\$8.2 billion budget for 2007/08, health and education together accounted for 2 per cent (US\$164 million) (Warner 2008). The recent independent evaluation of IFC projects noted that the health and education sector on average performed the worst of all the IFC's investments (World Bank IEG 2007). There are also no clear criteria for determining when and whether it is appropriate to support private-sector growth in the health sector. Nevertheless following an upbeat study of the Bank's potential role in private-sector development undertaken by McKinsey's and financed by the Bill and Melinda Gates Foundation, the IFC announced that it would coordinate some \$1 billion in equity investments and loans to finance private-sector health provision in sub-Saharan Africa.

Conclusion

The World Bank remains an institution that promises much but that still delivers poorly. It remains unduly influenced by the rich countries of the world, and by the same economic orthodoxy that has largely failed the planet over the past few decades. Civil society organisations should call for:

- An independent panel to review the Bank's role in health and the comparative advantages of the Bank and the other leading global health institutions. This should include an assessment of the depth of these different organisations' accountability to developing countries. It is unclear how far an organisation with the skewed accountability of the World Bank should be involved in setting global health priorities and policy guidelines.
- Country-level debate about the Bank's vision of greater private-sector involvement in the health sector.
- More country-level analysis of the health impact of the World Bank's projects and policies.

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D2 Government aid

No one really knows if the entire 'aid industry' is a good or bad thing. Most people working in the aid industry probably feel strongly that aid is good, or at least that it can do much good. Certainly they are able to point to the translation of aid money into lives saved, clinics built and medicines dispensed. Others argue that aid deflects attention from the structural economic and political inequalities between rich and poor countries that perpetuate poverty. It has also been suggested that aid is used to further the foreign policy and economic objectives of donor countries and that it creates dependency and enables corruption.

In this subsection of *Global Health Watch 2*, we discuss the foreign assistance programme of the world's biggest donor: the United States. This is followed by a chapter that discusses aspects of the aid programmes of two smaller donor countries: Canada and Australia. It then ends with a chapter describing the linkage between 'security' and 'health' which has been strongly promoted by the powerful donor countries, in particular the US.

Have the rich countries delivered on their commitments?

Commitments to reach the UN target of 0.7 per cent have generally been poor. Major donor countries have provided a mere 0.26 per cent of their gross national income (GNI) to official development assistance (ODA) in 2004. Indeed since the Millennium Summit in 2000, based on Reality of Aid (ROA)¹ calculations, deducting new aid resources due to aid to Afghanistan and Iraq, debt cancellation, and support for refugees in donor countries, only 25 per cent (or \$6.9 billion) of the \$27 billion in new aid

resources from 2000 to 2004 were available for poverty reduction or Millennium Development Goals (MDG) programmes.

Even the Development Assistance Committee (DAC) secretariat of the Organization for Economic Cooperation and Development (OECD) registered caution about the will of donors to meet their own targets. They noted that the recent ‘aid boom’ in 2005–06 was primarily due to debt relief for Iraq and Nigeria, and emergency aid to countries hit by the Indian Ocean tsunami in December 2004.

Aid effectiveness

According to ROA, aid ‘is hobbled not only by the severe shortfalls in committed aid outlined above but also by the myriad problems in aid relationships that stray from the principles of equality and mutuality in development cooperation’. It lists three aspects of aid effectiveness:

- The political economic relationships surrounding aid partnerships. This refers to issues of selectivity of aid partners and the use of aid to leverage political, economic, military and other concessions from the recipient country; the economic underpinnings of aid relationships such as debt, export credit agencies and tied aid; and policy conditionalities.
- Administrative issues regarding lack of harmonisation of donors, alignment to country priorities and systems, management for development results and accountability mechanisms.
- Issues of aid delivery and implementation.

Does aid go to countries that most need it?

According to ROA, ‘instead of allocating their aid based on where it is most needed, rich countries often favour recipients that are of direct political or economic interest to them.’ As a result, ‘the most impoverished people of the planet actually receive less aid than people living in middle-income countries.’

What about tied aid?

Tied aid mandates developing countries to buy products only from donor countries as a condition for development assistance. According to ROA 2006, the US, Germany, Japan and France insist that a major proportion of their aid is used to buy products originating only in their countries.

What about conditionalities?

Many have argued that conditionalities imposed by the World Bank and the International Monetary Fund (IMF) on developing countries have harmed

development in some of the poorest countries. ROA suggests that there is a growing body of evidence that conditionality has failed:

- aggregate World Bank and IMF economic policy conditions rose on average from 48 to 67 per loan between 2002 and 2005;
- the World Bank and IMF continue to put conditions on privatisation and liberalisation despite the acknowledged frequent failures of these policies in the past;
- IMF macroeconomic conditions impair much needed spending on social and economic development.

Note

1. ROA is a North–South international non-governmental initiative focusing on analysis and lobbying of the international aid regime. It produces a two-yearly report on aid effectiveness for poverty reduction.

D2.I US foreign assistance and health

The unparalleled military, economic and cultural power of the United States gives it the capacity to impact hugely on global health, both negatively and positively. Many people feel that the balance sheet is negative despite the large amounts of aid the US has given to the developing world. They cite, among other things, US influence over the design of a global political economy that has widened inequalities and obstructed poverty alleviation; multiple examples of US foreign policy undermining democracy and fuelling conflict; the use of military force and other means to secure control of strategic natural resources; the hindering of efforts to tackle climate change; and opposition to the International Criminal Court.

This view of the US is at odds with its image of itself and the role it projects onto the global landscape – that of the leader of the free and democratic world; benevolent and principled; and the largest contributor of official development assistance. This chapter provides a contribution to this discussion by looking at various aspects of US foreign assistance, as well as US policy in certain priority global health challenges. A longer and more detailed version of this chapter is available from the GHW website.

An introduction to US foreign assistance

The organisation of foreign assistance

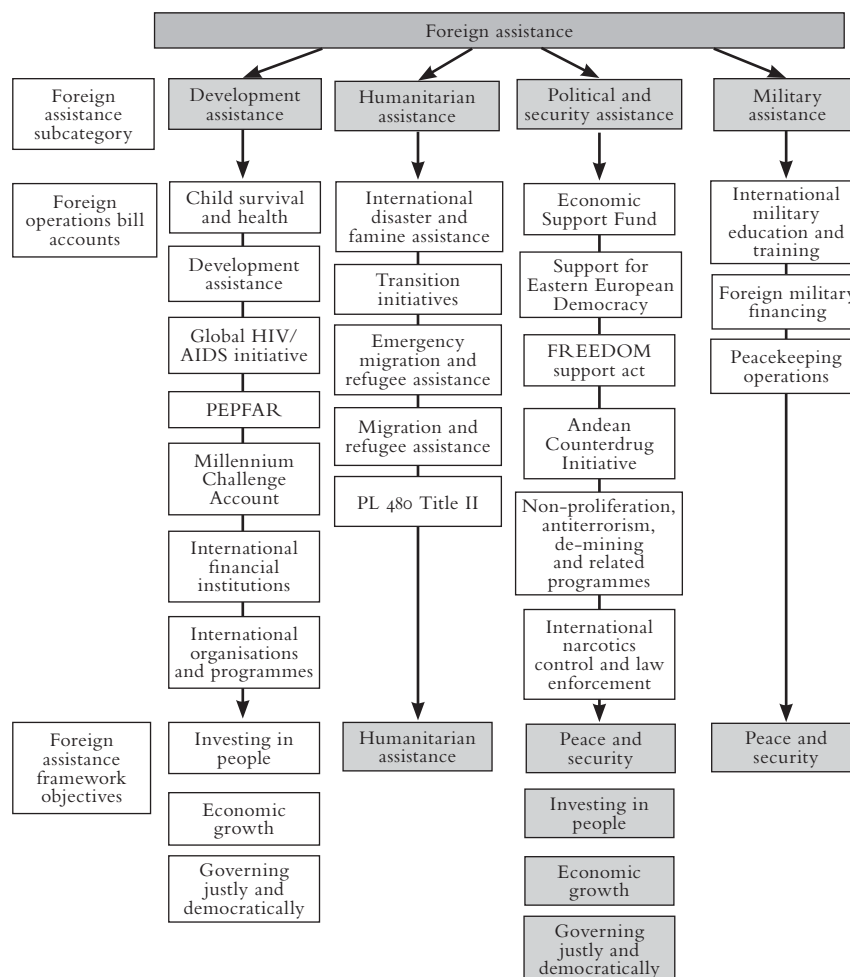
A number of definitions are used to describe and measure aid. The term *official development assistance* (ODA) refers to the definition used by the Organization for Economic Cooperation and Development's (OECD) Development Assistance Committee (DAC), which counts only non-military grants and low-interest loans to low- and middle-income countries. The

term *foreign assistance* refers to the full range of programmes funded by the US Foreign Operations Bill (also known as the Foreign Assistance Bill), including military assistance and aid to high-income countries. As a result of these differing definitions, the figures for the US's contribution to development often appear contradictory.

Foreign assistance appropriated by the Foreign Operations Bill is commonly divided into four subcategories. These are:

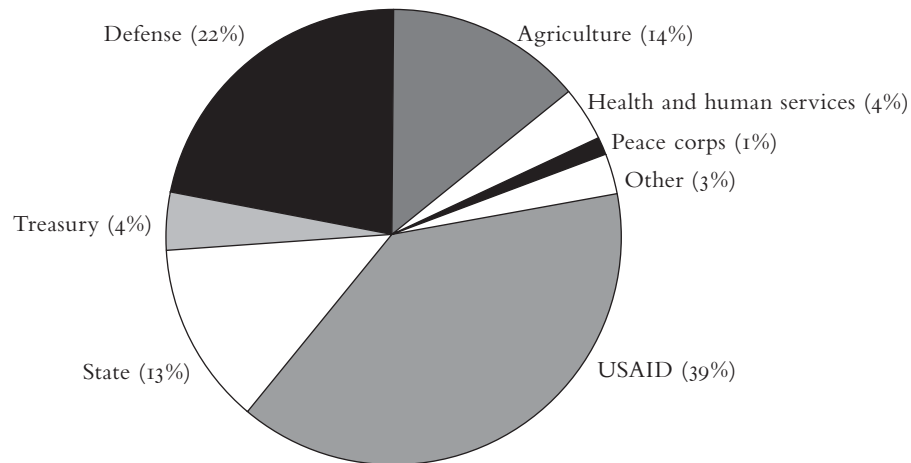
- *Development assistance*, which includes support for health, education and other development programmes. Until recently, Child Survival and Health used to be the primary health account of US foreign assistance, but there are new initiatives now for HIV/AIDS through the President's Emergency Plan for AIDS Relief (PEPFAR) and malaria. Development assistance funds are also split between bilateral assistance to countries and multilateral assistance that is channelled through organisations like the World Bank and the World Health Organization (WHO). The Treasury manages the bulk of multilateral aid, whilst most of the bilateral assistance is administered by USAID, the State Department, PEPFAR, the Millennium Challenge Corporation (MCC), and other smaller agencies such as the Peace Corps.
- *Humanitarian assistance*, which consists of responses to humanitarian emergencies, is mainly administered through USAID's Office of Foreign Disaster Assistance (OFDA) and Office of Transition Initiatives. A proportion is also administered by the State Department's Bureau of Population, Refugees and Migration.
- *Political and security assistance*, which is designed explicitly to support the economic, political or security interests of the United States and its allies, and includes finance to help countries economically, as well as programmes to address terrorism, narcotics and weapons proliferation. The most prominent instrument for administering these programmes is the State Department's Economic Support Fund.
- *Military assistance*, which refers to the provision of equipment, training and other defence-related services by grant, credit or cash sales. Most of this is administered by the Department of Defense (DoD).

Foreign Assistance funding is allocated to a number of accounts that are administered through a convoluted system involving multiple agencies (see Figure D2.1.1). At the last count, 26 different agencies were conducting aid programmes, although the majority of US foreign assistance is managed by USAID, the Department of Defense (DoD), the Department of State and the Department of Agriculture (which administers the US food aid budget). See Figure D2.1.2.

FIGURE D2.1.1 **The structure of US foreign assistance****The key agencies**

Historically, USAID has been the main agency for implementing US programmes in health, education, humanitarian relief, economic development, family planning and agriculture. It currently operates in about ninety countries, but its share of foreign aid is declining: from 50.2 per cent of total ODA in 2002 to 39 per cent in 2005 (OECD 2006a). One cause of this decline has been the increase in foreign assistance disbursements to the DoD, up from 5.6 per cent of the ODA budget in 2002 to 21.7 per cent in 2005 (OECD 2006a).

FIGURE D2.I.2 Management of US ODA by agency, 2005



Source: OECD 2006b.

The arrival of the DoD in the development arena has been one of the most conspicuous policy events of recent years, representing vividly the extent to which the US government is blurring the boundaries between defence, diplomacy and development. The DoD now accounts for nearly 22 per cent of United States' ODA but also works in the provision of non-ODA assistance, including training and equipping of foreign military forces in fragile states.

A large proportion of DoD funding and activities is accounted for by massive reconstruction efforts in Afghanistan and Iraq and humanitarian relief after the Indian Ocean tsunami (OECD 2006b). However, it has also expanded its remit to include activities that might be better suited to USAID or other civilian actors. This includes being a contractor to PEPFAR in Nigeria, work in HIV/AIDS vaccine research, and the building of schools and hospitals in Tanzania and Kenya. These activities and the announcement of a US military command for Africa, AFRICOM, 'raise concerns that US foreign and development policies may become subordinated to a narrow, short-term security agenda at the expense of broader, longer-term diplomatic goals and institution-building efforts in the developing world' (Patrick and Brown 2007).

The role of the State Department, the US equivalent of a Ministry of Foreign Affairs, in development and humanitarian relief is also a cause for controversy. The State Department is traditionally and increasingly accorded a higher status than USAID. Under the Bush administration, it has acquired

a lead role in HIV/AIDS interventions through the location of PEPFAR within the State Department, consolidated its longer-term management over funds for the UN system and has seen its Economic Support Fund budget expand. The Economic Support Fund is used to promote the economic and political interests of the US by providing assistance to allies and countries in transition to democracy, supporting the Middle East peace negotiations, and financing economic stabilisation programmes (US Department of State and USAID 2005). However, the State Department has limited development expertise and has often relied on USAID to implement the development aspects of its politically negotiated assistance programmes.

Another reason for the decline in USAID's share of the budget has been the introduction of new agencies in the delivery of aid, such as the MCC and various presidential initiatives, including PEPFAR. The MCC, established in January 2004, has been described as the 'most important foreign aid initiative in more than 40 years' (Radelet 2003). This is because of its large budget (originally promised to stand at \$5 billion a year by 2006, although it is currently falling far short of this) and its unique approach to foreign assistance, namely that it only awards assistance to countries that have met minimum standards in relation to three aspects of development: ruling justly, investing in people and encouraging economic freedom.

The indicators that have been established to assess country eligibility include measures of civil liberties, political rights, control of corruption and rule of law; indicators of health and education coverage; and various indicators of trade, commercial regulation and fiscal policy. Although it is the closest the US comes to giving budget support to developing-country governments, there are concerns that the criteria and standards used by the MCC to determine eligibility are designed to push through a set of reforms that will maximise US corporate and foreign policy benefits. In addition, the MCC's lack of consultation with other donors, overemphasis on measurable results and short-term horizons (the MCC limits countries to one five-year Compact) are likely to be prejudicial towards aid harmonisation and sustainable development.

The other big new agency is PEPFAR. First announced by Bush in his 2003 State of the Union address, the five-year \$15 billion prevention, care and treatment initiative for AIDS relief started in early 2004. Its management is independent from USAID, with lines of reporting that go to the secretary of state, but in-country implementation is often carried out in conjunction with USAID. PEPFAR's budget is now considerably larger than the Child Survival and Health account of USAID. In the fiscal year (FY) 2007, the PEPFAR budget was US\$3.14 billion while the Child Survival and Health budget was US\$1.59 billion (US Department of State 2007).

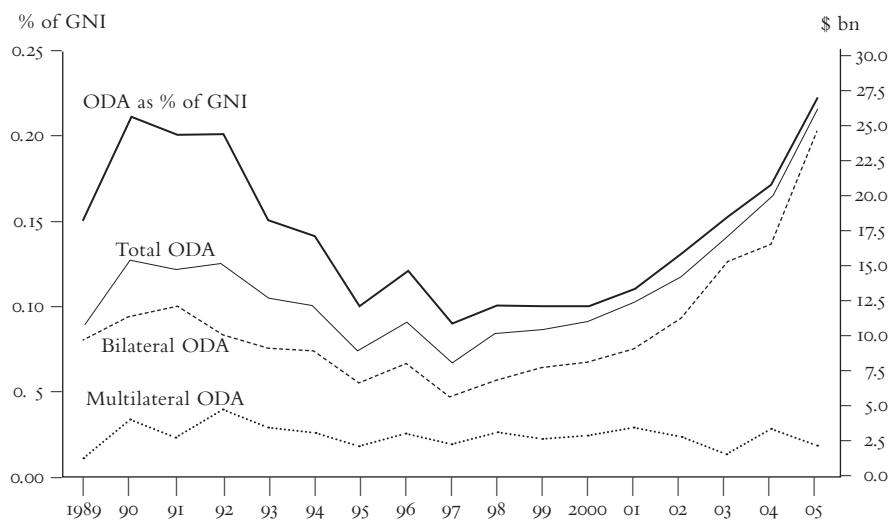
Finally, reforms to the architecture of US foreign assistance also appear to involve USAID being increasingly drawn into the orbit of the Department of State (Patrick 2006). It is believed that this will ensure that USAID's traditional focus on development will come under the greater influence of the Department of State's focus on foreign policy. The head of USAID (who is appointed by the president) now also acts as director of foreign assistance (DFA), an office that carries some responsibility for the coordination of State Department foreign aid programmes. The post is at the level of deputy secretary of state and marks another sign of the growing strategic importance of foreign aid.

Expenditure

The United States aid programme is the largest in the world. In 2005, it contributed almost twice as much ODA as Japan, the next largest donor. Contrary to expectation, the Bush administration increased spending on foreign assistance. Much of this can be attributed to expenditure in Iraq and Afghanistan, and debt relief (particularly to the Democratic Republic of Congo and Nigeria). Aid to sub-Saharan Africa (SSA), particularly for HIV/AIDS, also accounts for some of the increase.

The exact amount of foreign assistance spent on health is difficult to calculate because of the convoluted system of accounts and agencies. However, the Child Survival and Health and Global HIV/AIDS accounts

FIGURE D2.I.3 US net ODA disbursement
(at constant 2004 US\$ billion and as share of GNI, 1989–2005)



Source: OECD 2006b.

take up the bulk of health funding. Overall, US spending on health has increased from about US\$1.6 billion in 2001 to just over US\$4 billion in 2006, giving the US's foreign aid health programme a considerably larger budget than that of the WHO. Compared with other DAC members, the US also allocated a higher percentage of its total ODA to health – 18 per cent compared with a DAC member average of 13 per cent in 2002–04 (OECD 2005).

However, whilst it donates large amounts in absolute terms, the US has one of the lowest rates of aid as a percentage of gross national income (GNI), a mere 0.22 per cent in 2005. Although this is its highest level since 1986, it is well below the DAC average of 0.47 per cent of GNI, and the US has failed to set a timetable for reaching the 0.7 per cent target of the UN.

Who gets US foreign assistance?

It has long been the case that aid recipients are often selected on the basis of their strategic value to the US. However, several of these countries are also in need of assistance. For example, Sudan and Ethiopia are important for geopolitical reasons but are also desperately poor. It is also noteworthy

TABLE D2.I.1 **Top ten recipients of US foreign assistance**
(as % of total ODA 1984–2005)

	2005		1994		1984
Iraq	25.1	Israel	10.9	Israel	14.1
Afghanistan	3.8	Egypt	7.1	Egypt	13.0
Egypt	2.7	El Salvador	4.1	El Salvador	2.5
Sudan	2.1	Somalia	3.6	Bangladesh	2.3
Ethiopia	2.0	Haiti	2.7	Turkey	2.2
Jordan	1.3	Philippines	1.8	Costa Rica	2.1
Colombia	1.3	Colombia	1.4	India	1.9
Palestine	0.8	Jordan	1.3	Northern Marianas	1.7
Uganda	0.8	Jamaica	1.3	Philippines	1.6
Pakistan	0.8	Bolivia	1.2	Sudan	1.6
% of total	40.7		35.4		43.0

Source: OECD 2006a.

FIGURE D2.I.4 Recipients of US foreign assistance by region



Source: US Department of State 2007.

that Israel and Egypt are receiving less ODA than previously. Furthermore, only three of the 1994 top ten appear in the 2005 top ten, and only four of the 1984 top ten appear in the 1994 top ten.

In 2005, the United States directed 29 per cent of its ODA to low-income countries and 70 per cent to middle-income countries, in contrast to the DAC member average of 53 per cent and 47 per cent respectively (OECD 2006a). When the Foreign Operations budget request for FY 2008 (which includes 'military assistance' and aid to high-income countries) is analysed, more than 15 per cent of the funds are earmarked for high-income countries such as the United Arab Emirates, Qatar, Singapore and Israel.

Under the new Foreign Operations FY 2008 budget request, Africa experiences the biggest increase in funding – up 54 per cent on FY 2006. Over 75 per cent of the resources for Africa will be focused on development programmes, mainly to do with HIV/AIDS. The largest recipients in Africa are Sudan, South Africa, Kenya, Nigeria and Ethiopia, followed by Liberia, the Democratic Republic of the Congo and Somalia. These eight

countries claim over 56 per cent of the budget for Africa, but account for 65 per cent of the population in the region. In overall terms, the largest recipients of ‘development-focused aid’ will be Iraq, Afghanistan, South Africa, Kenya and Nigeria.

A large proportion of each regional budget is concentrated in a small number of countries. In the East Asia and Pacific region, Indonesia, Vietnam and the Philippines claim 79 per cent of the total budget but only account for 21 per cent of the population of the countries to which US aid is given in the region. In the Near East, Israel, Egypt, Iraq and Jordan account for 93 per cent of the region’s budget and again account for a disproportionately low percentage of the total population of US aid-recipient countries in the region, in this case 40 per cent. Only in South and Central Asia, where Afghanistan, Bangladesh, India and Pakistan receive 93 per cent of the budget, does this reflect the share of the population. Across the total proposed FY 2008 budget, the top ten recipients receive 63 per cent of the total resources, leaving a mere 37 per cent for the remaining 143 recipient countries of US foreign assistance (Bazzi et al. 2007).

Many agendas, many drivers

Self-interest and aid

The US is open about the way it combines self-interest with aid, stating on its website that ‘US foreign assistance has always had the twofold purpose of furthering America’s foreign policy interests ... while improving the lives of the citizens of the developing world.’ These two aims do not have to be in conflict with each other, but often are. The election of George W. Bush and the ascendancy of a reactionary, neoconservative administration, combined with the events of 9/11, have resulted in self-interest and the security of the US becoming paramount within its foreign assistance programmes. The 2002 National Security Strategy also formally added ‘development assistance’ to the two traditional bastions of foreign policy: ‘defence’ and ‘diplomacy’.

Not only is aid being increasingly used to achieve geopolitical objectives, but underdevelopment and ill-health are being framed as security threats. For example, during Bush’s first election campaign, no new initiative to deal with the HIV/AIDS crisis was announced and the efforts of Clinton were actually disparaged. After 9/11, AIDS became an issue of relevance and the groundwork for establishing PEPFAR was laid by identifying the need to secure public health as part of the Global War on Terror. The increased coupling of ‘aid’ and ‘global health’, driven largely by the US, is discussed in greater detail in Chapter D2.3.

TABLE D2.1.2 **The foreign assistance framework**

Five objectives of foreign assistance framework	Categorisation of countries
1. Advancing peace and security	1. Rebuilding
2. Promoting just and democratic governance	2. Developing
3. Encouraging investments in people	3. Transforming
4. Promoting economic growth	4. Sustaining partnership
5. Providing humanitarian assistance	5. Restrictive

A new US Foreign Assistance Framework crystallises the aim of building and sustaining ‘democratic, well-governed states’ into five new objectives and five different categories of countries (see Table D2.1.2). Funding for objectives 2, 3 and 4 are described collectively as ‘development-focused aid’.

Two other observations about the new framework are worth noting. One is the conspicuous lack of focus on poverty reduction. Unlike other donors, the US has no international poverty reduction policy. In fact the framework contains only one mention of poverty reduction and even this had been absent in earlier versions. Second, the categorisation of countries is perplexing – what, for example, makes Tanzania a ‘transforming state’ but its more developed neighbour Kenya a ‘developing state’?



From the American people?

According to the USAID logo, American foreign assistance is a gift ‘from the American people’. The administration believes that this logo has a positive impact on the minds of people overseas and helps fulfil public diplomacy goals. But do the American people see US foreign assistance as their gift to the developing world?

In reality, US public support for foreign assistance is weak and always has been, in part due to the low levels of knowledge and understanding about the root causes of poverty, global inequity, as well as the positive and negative dimensions of the aid industry. Findings from poll after poll reveal

that most people have an incorrect and overinflated perception about the generosity of the United States, thereby leading to opposition to requests for increased aid budgets. Attitudes to aid are also complicated by the common perception that much US aid is wasted by recipient countries and fails to reach the poor. Unsurprisingly, in one poll, 64 per cent of Americans support helping poor countries as a measure to combat international terrorism, whilst aid for poverty reduction is less popular (Chicago Council on Foreign Relations 2004).

Congress

In the US system of government, Congress exerts considerable influence over foreign assistance. It can review and block proposed policy; attach earmarks and directives to accounts; and request oversight investigations and policy reviews. The influence of Congress opens up foreign assistance plans to the influence of myriad special interest groups. The scope and specificity of these influences have increased so much over the years that the Foreign Assistance Act has been likened to a 'Christmas tree' of different whims and special interests (Raymond 1992).

The ability of Congress to specify precisely how much money USAID and other agencies can spend on any programme area in the upcoming year means that USAID missions and other programmes abroad find it very difficult to adjust and adapt their activities according to changing circumstances and local conditions.

NGOs: abroad and at home

The delivery of aid through non-governmental organisations (NGOs), of which private voluntary organisations (PVOs) are a component, is a prominent feature of the US approach to international development.¹ During the 1990s, USAID's overseas presence shrunk as part of efforts to streamline government. This had the consequence of further changing the character of USAID from being an implementing agency to being a contracting agency.

By 1996, 34 per cent of USAID's assistance was channelled through PVOs and NGOs (OECD 2006b). Today the figure is almost certainly much higher, with USAID reporting channelling \$2.4 billion through PVOs in FY 2007 (USAID 2007). Globally this trend is reflected by the percentage of ODA being channelled through NGOs increasing from 0.18 per cent in 1980 to 6 per cent in 2002, according to the OECD (2005).

Currently, USAID works with more than 200 national PVOs and around 30 international PVOs as primary grantees or contractors (USAID 2007). However, the relationship is tightly controlled and includes having

to comply with complicated grant agreements and contracts, including 'branding and marking' guidelines. For example, during the 2004 tsunami aftermath, some NGOs were reprimanded by USAID for not sufficiently publicising its contribution. PEPFAR also has requirements regarding the branding of its HIV/AIDS programmes, even if this might accentuate the stigmatisation of the recipients of support.

Within the US, a striking feature about the PVO community is its greater reliance on government funding compared with European NGOs' relationship with their national governments. This reliance is reflected in a more muted and uncritical interaction between PVOs and the US government. Although a few PVOs play a courageous role in questioning the US's role in holding decision-makers to account, many pursue a more 'pragmatic' line of self-censorship and avoid the role of campaigning for a more just and fair US impact on global development and health.

Stafano Prato, of the Society for International Development, notes that donors are increasingly engaging NGOs as implementing agents of government agendas. As a result of a growing financial dependency, NGOs are being co-opted into governmental policies and limiting their capacity to be more active and freely expressive in important political spaces (Prato 2006).

In contrast to Europe, there is reduced effort on the part of civil society organisations to inform the public about the purposes or achievements of aid or to act as a watchdog of their government's policies. Worryingly, the constant invocation of patriotism, 'Anti-Terrorist Financing Guidelines', the prosecution of several Muslim charities, and restrictions placed on the freedom of speech of PVOs operating in Iraq represent concerted attempts by the administration to further close down the space for civil society debate and dissent. In a newspaper article, a UK parliamentarian described this as part of the new American imperium: 'you not only invade countries, but also charities' (quoted in Maguire 2003).

Making a profit from poverty

The aid industry is good business for many American companies. The reconstruction effort in Iraq is a prime example of the murky way in which foreign assistance budgets have been channelled into the bank accounts of corporations with close connections to the Bush administration. US food aid is another example of business interests trumping development (see Box D.2.1.1). Specifically, business has been a persuasive lobby for the 'tying' of aid to the purchase of US goods and services. According to a former USAID administrator, 'foreign assistance is far from charity. It is an investment in American jobs, American business' (quoted in Bate 2006).

BOX D2.1.1 US food aid

The US accounted for 59 per cent of international food aid between 1995 and 2003 (Congressional Research Service 2005). In FY 2006 it delivered food aid to over fifty countries (US Government Accountability Office 2007). However, complaints are made about US food aid:

- A large proportion is channelled bilaterally rather than through the coordinated and multilateral system of the World Food Program (WFP).
- US law specifies that 75 per cent of all food aid transported must be handled by shipping companies carrying the US flag, which has the effect of inflating costs.
- Very little of the US contributions to the WFP is as cash, which would give the WFP more opportunity to purchase food from sources that are closer to where the need is.
- The dumping of US food aid distorts local markets, undermines local agriculture, contributes to long-term food insecurity and increases delivery costs.
- Food spoilage is common due to poor management.

At the root of these problems is the use of food aid to subsidise US agribusiness (e.g. Cargill, Louis Dreyfus, ADM/Farmland, and Kalama Export Company) and open up markets for their expansion. Unfortunately, the 2007 Farm Bill, which proposed that a quarter of emergency food aid should consist of crops purchased from other countries, was blocked by the agriculture and shipping business sectors and charities dependent on selling US food aid for their income.

Source: Oxfam 2005.

According to the OECD, only 3 per cent of total US bilateral ODA to least developed countries was untied (OECD 2006a), despite the negative impact of tied aid (OECD 2001). The OECD (2001) estimates that by excluding non-US firms from contracts, tied aid raises the costs of goods and services by between 15 and 30 per cent (OECD 2001). Untying American aid could have added an extra \$4.37 billion to the aid effort in 2005, a sum of money that could have been used to provide health care for nearly 135 million people a year in developing countries. Tied aid also results in projects that are capital-intensive or that require US-based technological expertise rather than in projects that are based on local priorities and needs assessments.

Onward Christian soldiers

America is a nation that has experienced a steady erosion of the boundary between the seats of public office and the pulpits of Christian churches. The influence of evangelical Christian groups has not left foreign assistance programmes untouched. Kent Hill, a well-known conservative evangelical with no formal qualifications in medicine or health, is USAID's head of Global Health. In 2001, President Bush launched the Faith-Based Initiative as an embodiment of his philosophy of 'compassionate conservatism'. This entailed advocating the role of Christian organisations in delivering health, education and welfare services in the US and overseas. Whilst this was another embodiment of Bush's hostility towards public institutions, it was also a reward to the Christian groups for their part in his election victory.

According to the *Boston Globe*, between FY 2001 and FY 2005 more than \$1.7 billion was allocated to 159 faith-based organisations (FBOs) (Stockman et al. 2006). FBOs accounted for 10.5 per cent of all USAID dollars to NGOs in 2001 and 19.9 per cent in 2005. This growth in FBO grantees has not only increased the undue influence of religious doctrine on sexual and reproductive health programmes, but has also incorporated inexperienced and unqualified agents into the health sector, some of whom seem more interested in the use of government money for proselytisation.

Forget the UN

US foreign assistance is also characterised by a long history of mistrust and hostility towards the UN and multilateralism. This has manifested itself in a decline in the share of America's ODA to multilateral organisations from almost 26 per cent in 2002 to 8 per cent in 2005 (OECD 2006b).

The Bush administration's relationship with the United Nations Population Fund (UNFPA) is emblematic of its lack of enthusiasm for multilateral organisations and the imposition of national values on to the international stage. In July 2002, US funding to UNFPA was cut off because its presence in China was said to imply tacit support for China's family-planning policies, which include coercive abortion and involuntary sterilisation. Four separate investigative teams, including one sent by the US Department of State, concluded that UNFPA was in fact working to end coercive population control. However, the US continues to withhold funding.

According to Ilona Kickbusch, unilateralism has not only changed US policy but has also influenced the way health advocates frame the global health agenda: 'The subtle but definite shift in orientation and language is very evident, and indeed many international documents read as if they have been written for members of Congress rather than for the broader global

health community. This is clearly an expression of American hegemony' (Kickbusch 2002).

The United States in global health

Notwithstanding the self-serving agendas of US foreign aid, the US is the largest international donor of global health assistance and its spending on health has increased since 2000. Health care reaching millions of people is sustained by US aid. But it is questionable whether this funding is used in a way that maximises benefit, efficiency and equity.

The primary agents of US global health

The two primary agents of US foreign assistance for health are USAID and PEPFAR. Within USAID, its Bureau for Global Health plays the biggest role with an annual budget of around \$1.6 billion and presence in USAID Missions in approximately sixty countries. A substantial amount of funding for health in disaster and emergency situations (\$79 million in FY 2006) is also provided through USAID's Office of Foreign Disaster Assistance (OFDA).

USAID also has inter-agency arrangements with the National Institutes of Health (NIH), the US Department of Health and Human Services (DHHS) and the Centers for Diseases Control (CDC). These agencies possess specialist skills in epidemiology, disease surveillance and biomedical research and have seen large increases in funding since 2002. In 2005, USAID was also handed responsibility for administering the President's Malaria Initiative (PMI).

The five-year PMI was launched in 2005 to reduce malaria deaths by 50 per cent in fifteen focus countries with a budget of \$300 million in FY 2008, which will grow to \$500 million in 2010. In recipient countries the PMI is led by USAID in collaboration with the US Department of Health and Human Services and CDC. It implements activities in four areas: indoor spraying of homes with insecticides, provision of insecticide-treated mosquito nets, provision of anti-malarial drugs, and treatment to prevent malaria in pregnant women.

Whilst the PMI's profile has been low compared with that of PEPFAR, it has won praise for its measured approach and desire to learn from past mistakes. However, critics counter that the same initiatives could have been incorporated into existing institutions such as the Global Fund and the Roll Back Malaria Campaign, and that the insistence upon setting up a parallel programme has reduced the overall potential impact. There have also been criticisms of specific aspects of PMI's programme, such as the

overly complicated voucher systems used to distribute insecticidal nets and the use of DDT pesticide in indoor spraying.

PEPFAR was set up as a separate administration to USAID. It received a five-year \$15 billion budget for HIV/AIDS prevention, care and treatment in 2004. As of March 2007, PEPFAR reports having supported antiretroviral treatment for approximately 1.1 million in its fifteen focus countries. Figures from 2006 show that up to 2 million orphans and vulnerable children and another 2.4 million people living with AIDS were provided care services from PEPFAR.

However, PEPFAR has garnered much criticism for its undue and ineffective emphasis on abstinence programming; restrictive policies surrounding the distribution of condoms and the purchase and use of generic medicines; ineffectual procurement and distribution mechanisms; lack of investment in health systems strengthening; excessive focus on targets, which have turned health projects into a 'numbers game'; burdensome application and reporting requirements; and lack of harmonisation with other actors working in the sector.

Finally, PEPFAR is severely limited by a requirement for it to spend not less than 55 per cent of its funds on treatment activities, of which at least 75 per cent should be spent on the purchase and distribution of antiretroviral pharmaceuticals. Only 20 per cent of budgets can be spent on prevention, of which one-third must be used to promote abstinence; 15 per cent is earmarked for palliative care of individuals with HIV/AIDS; and only 10 per cent for assistance to orphans and vulnerable children. Such an arbitrary and top-down allocation of funds, with a clear bias towards treatment and pharmaceuticals purchasing, fails to meet even the most basic requirements of needs and evidence-based public health planning.

Harmonisation and country support

Although the US endorsed the Paris Declaration on Aid Effectiveness in 2005, it has made limited progress towards its goals, particularly in the areas of aid harmonisation and predictability. In many countries, there is even poor coordination between the various US agencies operating in-country, let alone with other donors.

One of the major deficiencies of US assistance for health stems from its annual appropriation cycles, which constrain the potential for long-term planning. A strong emphasis on measurable results and the potential for financial penalisation if results are not achieved can also have negative effects on sustainability and the setting of appropriate targets. For example, at a 2007 PMI conference in Tanzania, it was made clear to implementing partners that it would be difficult to convince Congress to authorise the

following year's budget if they could not present strong results for this year, even though it was recognised that many of the required interventions would take longer than a year to show effect.

The US also provides little support for general budget support (GBS) and sector-wide approaches (SWAs) because of its preference for earmarking resources, attributing results to US funding and operating through NGOs. Often the result is a portfolio of project-based activities that run in parallel to on-budget activities supported by recipient governments and other donors through a more harmonised approach.

The absence of support for government processes also limits the United States' ability to support crucial aspects of health systems development, such as the recurring costs of personnel. Although US-funded health programmes employ many local people in their projects, there is a need to distinguish short-term workforce expenditure from longer-term investment in human capacity development that can only be done effectively through harmonised and predictable aid modalities.

Health priorities

Given its strong unilateralism, the US has a particular responsibility for ensuring that its health spending matches the needs and requirements of the people in recipient countries. However, there has been limited evaluation of the appropriateness of US development assistance for health.

The rapid increase in the funding of PEPFAR and PMI has also encroached upon the budgets of more traditional conduits of health assistance and concentrated aid in a smaller number of 'focus' countries. It also appears to have contributed to a decline in spending on maternal and child health, which is 22 per cent less than it was ten years ago (Daulaire 2007).

Others have also questioned the appropriateness of the way HIV/AIDS and malaria have dominated the United States' development assistance for health (Mathers et al. 2006; Global Health Council 2006; MacKellar 2005). Shiffman (2006) argues that research into different diseases is also prioritised according to the potential profit for pharmaceuticals companies.

Health systems

The United States' record on health systems strengthening (HSS) is poor. During the 1980s and 1990s, USAID supported many of the neoliberal reforms that contributed to the dysfunctionality of many health systems (Ruderman 1990). Non-participation in SWAs, the disproportionate funding of NGOs, short-term financing and support for vertical disease-based initiatives continue ultimately to hinder comprehensive and coherent health systems development.

USAID does have some HSS projects, including a \$125 million five-year flagship programme called Health Systems 20/20 and the Quality Assurance/Workforce Development (QA/WD) Project. The Agency is also promoting community-based health financing in a number of countries. However, a closer analysis reveals several shortcomings. For example, 'Health Systems 20/20', which only works in eleven countries, includes a focus on HIV/AIDS in three countries and consists of a portfolio of work that is piecemeal and lacking in any substantial commitment to HSS.

Finally, USAID's leaning towards market-based health systems and privatisation remains evident. For example, a recently published manual for conducting a comprehensive 'health systems assessment' emphasises the benefits of expanding private-sector delivery without any mention of the potential disadvantages. When regulation is discussed, it is in relation to creating an environment that promotes private-sector development, rather than in relation to regulation that will curtail harmful private-sector practices.

Intellectual property and generic production

Under the current international intellectual property rights regime, the supply of affordable medicines is hindered by pharmaceuticals oligopolies. It was hoped that the 2001 'Doha Declaration on the TRIPS Agreement and Public Health' would allow poor countries easier access to generic medicines. These safeguards centre upon the use of compulsory licensing agreements; parallel importing; and permitting manufacturers to conduct regulatory tests before a patent has expired to speed the entry of generic drugs into the market.

However, the US in particular has put pressure on developing countries not to utilise the safeguards provided in the Doha Declaration. Furthermore, the US has enforced even stronger standards of intellectual property protection through bilateral and regional trade agreements. The Peruvian Ministry of Health has calculated that under the terms of its free-trade agreement with the US, Peru will incur additional medicine expenses of \$199.3 million within ten years (Oxfam 2006).

When Bush acknowledged in his 2003 State of the Union Address that lower-cost antiretrovirals could 'do so much for so many', it was hoped that the US stance towards generic drugs would be softened, at least for PEPFAR programmes. Instead, a burdensome and inefficient system limits access to medicines (Health Gap 2005). This includes:

- the establishment of a parallel approval system for generic AIDS drugs that duplicates the WHO pre-qualification programme and undermines national policies and protocols;

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- the approval of only a small number of generic AIDS drugs for procurement;
- a reliance on single-source suppliers that has led to shortages and stock-outs of essential medicines.

The US also imposes strict procurement rules and regulations on non-PEPFAR grants and contracts with USAID. Prior approval must be obtained for the procurement of pharmaceuticals and must be restricted to the list of US-approved products. Waivers to these regulations can be awarded but many PVOs avoid providing pharmaceuticals as part of their USAID-funded programmes because of the complicated rules and regulations associated with their procurement.

Human resources for health

The global health crisis is fuelled by a well-documented shortage of health workers in many countries. Much of this crisis stems historically from the structural adjustment programmes implemented by the World Bank and the IMF, and supported by USAID. Caps on salary levels, ceilings on the number of public-sector health workers, and limits to investment in higher education and training were all advocated (Ruderman 1990).

Today, the US does little to support the development of a public workforce of health providers in poor countries. Instead, the US actively encourages the recruitment of foreign-trained health personnel and international medical graduates. In 2002, more than 23 per cent of doctors practising in the US had come from abroad, the majority from low- or lower-middle-income countries (Hagopian et al. 2004), while the share of nurses from low-income countries grew from 11 per cent in 1990 to 20.7 per cent in 2000 (Polsky et al. 2007).

US-based training programmes for foreign health workers have been presented as a form of human capacity development for low-income countries. However, the benefits of this form of aid are undermined by the fact that few of the trainees return to their home countries (Mick et al. 1999). A more effective approach is USAID's American Schools and Hospitals Abroad (ASHA) programme, which provides grants to private, non-profit universities and secondary schools, libraries and medical centres abroad.

Finally, the HR crisis in poor countries is aggravated by the strong US support for stand-alone disease-based initiatives and preferred use of NGOs, which has resulted in an internal brain drain of public workers into the private sector. In Tanzania, for example, a focus country for PEPFAR and PMI, competition for skilled health workers is intense and has resulted in the movement of doctors from clinical practice into NGO programme

management. A local health programme manager working for an NGO on a PEPFAR or PMI-funded project gets paid around \$30,000 a year, compared to around \$8,000 a year as a general practice doctor.

Sexual and reproductive health policies

Sexual and reproductive health policies are among the most controversial issues in US foreign assistance. Since 1973, the US approach to abortion, contraception and sexual health promotion has become increasingly conservative and ideological.

One of the most polarising policies is the 'Global Gag Rule', which restricts foreign NGOs that receive US family-planning assistance from advocating for or providing abortion-related services, even with their own resources and even if abortion is permitted by local laws. Organisations that provide information about abortion services forfeit all family-planning assistance from USAID and the Department of State.

In an amendment to the original 1984 policy, Bush's 2001 legislation does not prohibit the use of population funds for post-abortion care. It also permits referrals for abortions or abortion services that are performed with the NGO's own funds in order to save the life (but not the health) of the mother and if the mother was made pregnant by rape or incest. Nonetheless, there is evidence that the Rule leads to an overall loss of life. The International Planned Parenthood Federation (2006) estimates that of 19 million women who had an unsafe abortion in 2006, approximately 70,000 died as a result.

The Global Gag Rule also impacts on comprehensive reproductive health services by either forcing clinics to stop providing access to abortion or to cut back on their services when they forfeit US funding. For fear of falling foul of the Rule, many organisations have been discouraged from activities that are actually permissible, such as providing post-abortion family planning or conducting research on the consequences of illegal abortion. It can thus deny women access to contraception, counselling, referrals and accurate health information, causing more unwanted pregnancies and more unsafe abortions.

The common misconception that US agencies are prohibited from purchasing, distributing or promoting condoms and other contraceptives is not true. The US government is the largest distributor of condoms in the world and provides more than a third of total donor support for contraceptive commodities (UNFPA 2005).

However, the mark of social conservatives can be seen through the increasing credence given to views that condoms are ineffective and encourage immoral behaviour. USAID has diluted its advice on the effectiveness of

condoms in preventing HIV transmission, and the CDC has edited its fact sheets to remove instruction on how to use condoms and how to compare the effectiveness of different kinds of condom. The Bush administration has also tried to restrict sex education in schools on the false understanding that it would promote underage sex.

PEPFAR's relationship with condoms also illustrates the influence of the Christian right lobby. Where PEPFAR supports condom promotion, there are restrictions aimed at limiting condom provision to high-risk populations, ignoring the interaction between high-risk populations and the general public.²

The 'Anti-Prostitution Pledge' prohibits PEPFAR funds from being spent on activities that 'promote or advocate the legalisation or practice of prostitution and sex trafficking'; and from being used by any group or organisation that does not explicitly oppose prostitution and sex trafficking. However, because the pledge does not clearly define what it means to 'oppose' prostitution, many organisations have avoided all health activity related to commercial sex in order to avoid any difficulty.

Many experts argue that the best way to reduce the negative health impacts of the sex industry is to decriminalise sex work and enable better access for clinical and public health services. The moralising approach of the current administration, however, does the opposite by reducing access for health workers and stigmatising the very individuals who need to be reached with health care.

Despite implicit opposition to the Anti-Prostitution Pledge, most NGOs have adopted the 'pragmatic' approach of altering their programmes to protect their funding. However, three courageous US-based organisations (DKT International, the Alliance for Open Society, and Pathfinder International) have filed two separate lawsuits against USAID arguing that the Pledge violates rights to free speech and is unconstitutional.³

Conclusion and recommendations

The US tendency to favour unilateralism, short-term gain and commercial interests, and to assuage the immediate demands of the country's security complex, make elusive the longer-term approaches necessary for lasting change for the world's poorest and most vulnerable. In the words of the former head of the Division of Global Health at Yale University School of Medicine, these approaches

indicate the close interplay between the global-health debate and the wider political and economic context within which the United States defines its role. American unilateralism weakens international organisations and mechanisms,

and its hegemonic power defines strategies proposed in the global forum. The global-health challenge is increasingly defined in economic and managerial terms rather than as a commitment to equity, justice, democracy, and rule of law. (Kickbusch 2002)

In response to this assessment of United States aid, the following recommendations are made to health advocates:

- *Lobby for greater US aid effectiveness* The United States should fully adopt and adhere to the standards set out in the Paris Declaration on Aid Effectiveness. This would contribute to making American aid more transparent, predictable and effective. It incorporates re-engaging with the multilateral system and promoting better coordination with other donors; untying aid and disentangling the nation's foreign assistance from the bottom lines of powerful US business interests; providing more long-term and predictable aid; and streamlining the bureaucratic architecture responsible for the appropriation and management of foreign aid.
- *Reclaim poverty reduction as the primary goal of aid* It is vital that the US targets its development and humanitarian assistance where the need is greatest, rather than according to the US's own national security concerns. The US should reorient its aid agenda to have a more explicit poverty focus and emphasis on the attainment of the Millennium Development Goals.
- *Insist that the large vertical disease-based health initiatives do not eclipse other US technical assistance and funding to the health sector* The tendency towards vertical programming and the lack of support given to the overall development and sustenance of health systems, human resources and training are detrimental to the efficacy and long-term impact of initiatives such as PEPFAR and the PMI.
- *Question whether the agents and agencies of US aid are suitable and effective* The move towards securitising and politicising aid and the concomitant marginalisation of USAID vis-à-vis new initiatives and actors in development such as the MCC, PEPFAR and the Department of Defense must be closely monitored. USAID is not an agency without flaws but it, and other development-focused agencies, should be strengthened rather than abandoned. The movement towards a much greater role for the Department of Defense in US humanitarian and development work is undesirable.
- *Assess the appropriateness of domestic agendas for international policies* Policies that are motivated by parochial or localised concerns should not be allowed to translate into international policies affecting the lives of

millions of people around the world. Inappropriate religious and moral agendas should not be pursued. The United States' own health-care-worker demands should not outweigh those of developing countries; and US business interests should not dictate the terms of aid at the expense of the right of all people to health.

- *Encourage greater levels of knowledge and engagement about development among the American public* Currently, the voices of single-issue or ideologically charged interest groups are disproportionately heard whilst the majority of the American public remains uninformed and disengaged from the foreign aid and development debate. Greater efforts are required to make foreign assistance an accessible issue for the broader US public, ensuring that the tyranny of the minority ceases to define US aid policy.

These are ambitious aims for a more humane and poverty-focused agenda for American foreign assistance. NGOs and international bodies are beginning to engage more vocally with these debates. In today's politicised and securitised environment it is inevitable that they will come up against considerable opposition from the vested interests who profit, either in soft or hard financial and power terms, from the current structures of US foreign assistance. But it is important that these issues are understood, discussed and debated. It is only with knowledge that civil society and global health advocates around the world will be able to stand up and demand from the United States and other donors the reforms and policies that will make the right to health and the right to the conditions necessary for health a reality for all people.

Notes

1. USAID defines a PVO as a tax-exempt, non-profit organisation working in, or intending to become engaged in, international development activities. These organisations receive some of their annual revenue from the private sector (demonstrating their private nature) as well as contributions from the public (demonstrating their voluntary nature). Non-governmental organisations include any entity that is independent of national or local government. These include for-profit firms, academic institutions, foundations and PVOs. The US uses the term 'NGO' for local and partner-country NGOs only.
2. For details of the activities permissible under PEPFAR funding, see *PEPFAR Guidelines for Implementing the ABC Approach, 2006* at: www.pepfar.gov/guidance/c19545.htm
3. See the Brennan Center for Justice at New York University for details of *Alliance for Open Society vs. USAID* and the legal case that applies to both cases. www.brennan-center.org/stack_detail.asp?key=102&subkey=8348 www.soros.org/initiatives/health/focus/sharp/articles_publications/publications/pledge_20070612/antipledge_20070612.pdf.

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D 2 . 2 Canadian and Australian health aid

Official development assistance (ODA) is becoming an increasing feature of the public health landscape in low- and middle-income countries (LMICs). However, questions about the appropriateness and efficacy of such aid has been raised with some commentators suggesting that ODA reflects the strategic interests of the donor country rather than the developmental needs of countries that receive the aid. This chapter reviews some of the structures, policies and programmes of Canadian and Australian ODA. It reflects on the recent trends that have emerged from these countries' giving patterns, analyses the impact that the respective ODA has had in recipient countries, and then provides a snapshot of the Cuban approach to development assistance in juxtaposition to the Canadian and Australian systems. A more detailed version of this chapter can be found on the GHW website.

Canadian aid

Canada is a high-income country whose role in the world is often portrayed as that of a middle power. In 1976, Canada joined with the world's most powerful economies to form the Group of Seven (now the G8 with the addition of Russia), positioning itself to play a leadership role in promoting development. This built on the favourable international image Canada had established in the 1950s by championing peacekeeping, diplomacy and multilateral cooperation. In spite of this legacy and despite Canada being among the wealthiest countries in the world, the country's actual delivery of ODA tells a story that undermines its benevolent reputation.

Overview of players and policies

Canada's lead agency for development assistance is the Canadian International Development Agency (CIDA). Among its stated objectives are to 'support sustainable development in developing countries in order to reduce poverty and contribute to a more secure, equitable, and prosperous world; to support democratic development and economic liberalization ... and to support international efforts to reduce threats to international and Canadian security' (CIDA 2006). Its humanitarian goals are thus intermixed with Canadian commercial, political and security objectives, with conflicting results for health programming. For example, Canada continues to export asbestos, a known carcinogen banned domestically, to LMICs in order to support Canadian commercial interests.

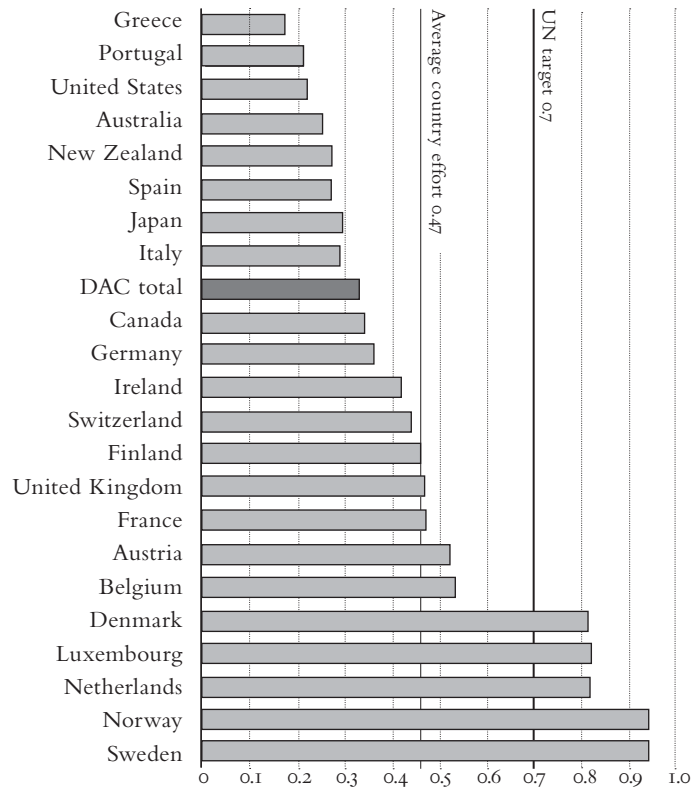
Health has always been part of CIDA's mandate, although a specific 'Strategy for Health' was only published in 1996. CIDA has also recently expressed commitments to increase support for HIV/AIDS and health systems strengthening. Its focus on HIV/AIDS, in particular, may be seen as a response to public pressure. In addition to its own bilateral and targeted programmes, CIDA channels funds through multilateral efforts, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Nevertheless, Stephen Lewis, the former UN special envoy for HIV/AIDS in Africa and a respected Canadian, has observed that the government 'seems to have all the time in the world for conflict and very little time for the human condition' (quoted in Collier 2007). When the government published its International Policy Statement (IPS) in 2005, it stopped short of any dramatic reorientation towards the needs of vulnerable population groups, an issue that had been raised during the extensive consultation period prior to the release of the IPS. Health is limited to the development sector of the document and is not mentioned in relation to diplomacy, defence or commerce. The 2006 election of Conservative prime minister Stephen Harper appears to have further reduced the chances of a more substantive focus on health in Canadian foreign policy, with anti-terrorism and the promotion of Canadian business interests being primary preoccupations for the government.

Official expression of Canadian health aid priorities tends to focus on globally defined objectives such as the Millennium Development Goals (MDGs). However, CIDA's 2002 strategic statement also stresses a comprehensive approach to development cooperation based on a set of principles, including local ownership of strategic initiatives, improved donor coordination, and greater coherence between aid and non-aid policies.

While this statement represents an important step away from the critical weaknesses of traditional vertical, narrowly focused, non-sustainable

FIGURE D2.2.1 Net ODA as a percentage of GNI, 2005



Source: Adapted from *OECD Factbook 2007* (OECD 2007).

donor projects, CIDA is still criticised for its high degree of dependency on IMF and World Bank conditionalities, and the limited participation of civil society actors representing the poor and marginalised (Tomlinson and Foster 2004).

One positive dimension of Canada’s international development effort in the health sector is its support of research for and with partners in LMICs. The drivers for this effort are the International Development Research Centre (IDRC) and the Global Health Research Initiative (GHRI).

IDRC was established in 1970 to ‘initiate, encourage, support, and conduct research into the problems of the developing regions of the world and into the means for applying and adapting scientific, technical, and other knowledge to the economic and social advancement of those regions’.¹ It provides assistance almost exclusively to researchers and institutions based

in LMICs. While health has not been a primary focus, several initiatives have explicitly targeted health-related issues, including: the ‘Ecosystem Approaches to Human Health’ initiative; the ‘Governance, Equity and Health’ programme; the ‘Research for International Tobacco Control’ initiative; and the ‘Tanzania Essential Health Interventions Project’ (TEHIP).

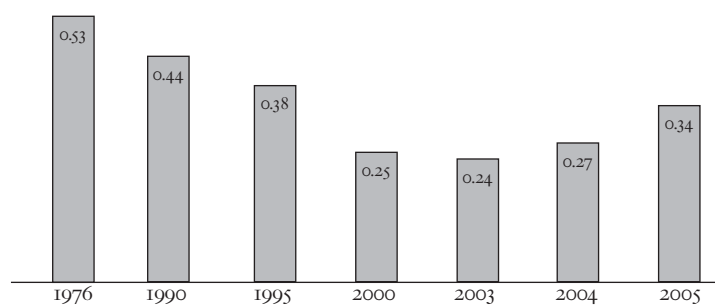
Canada’s GHRI was launched in 2001 to promote coordination among four key funding agencies: CIDA, IDRC, the Canadian Institutes of Health Research, and Health Canada (the Canadian Federal Ministry of Health). From 2002 to 2005, the GHRI invested about CAN\$8 million in new funding for global health research, supporting the work of more than seventy collaborative teams of researchers from Canada and several LMICs (Neufeld and Spiegel 2006). In addition, a new CAN\$10 million fund, the Teasdale–Corti programme, was launched in 2006 to provide longer-term funding (IDRC 2007a).

Trends in Canadian ODA disbursements

Although it was a Canadian prime minister who headed the 1969 UN Commission that recommended that all developed countries contribute 0.7 per cent of their gross national products to ODA, there has never been a government policy to ensure implementation of this objective.

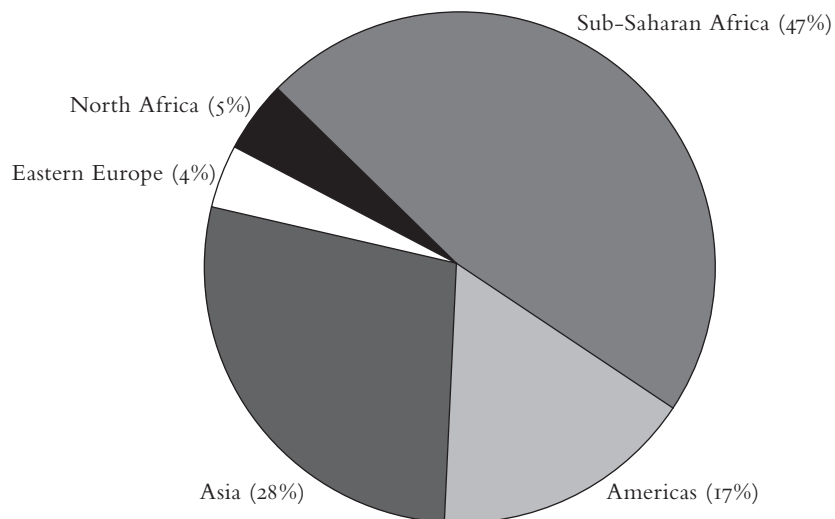
While Canadian ODA grew steadily in the first few years of CIDA’s and IDRC’s existence, the overall funding trend has been one of declining commitments, which has been reversed only very recently (Figure D2.2.2). The high point of 0.53 per cent of GNI in 1976 was reduced to less than half this level by 2000.

FIGURE D2.2.2 Net Canadian ODA as a percentage of GNI, 1976–2005



Source: OECD ODA Statistics 2004–05 (OECD 2006).

FIGURE D2.2.3 **Proportion of CIDA expenditure by region, FY 2005–06** (total expenditure CAN\$2.782 billion)



Source: CIDA 2007.

TABLE D2.2.1 **Top ten recipients of gross ODA, 2004–05**

Rank	Country	Amount (US\$ million)
1	Iraq	229
2	Afghanistan	73
3	Ethiopia	62
4	Haiti	60
5	Indonesia	56
6	Ghana	50
7	Bangladesh	50
8	Mozambique	42
9	Mali	40
10	Cameroon	39

Source: OECD ODA Statistics 2004–05 (OECD 2006).

TABLE D2.2.2 **Untied aid as a percentage of total ODA, 1990/91–2004**

Country	1990–91	2004
Norway	61	100
Ireland	–	100
Switzerland	78	97
Japan	89	94
Netherlands	56	87
Sweden	87	87
Australia	33	77
Canada	47	57

Source: Human Development Report 2006 (OECD 2006).

The IPS did, however, pledge to double ODA by 2010, and to give particular attention to the needs of Africa (see Figure D2.2.3). The Conservative government elected in 2006 reasserted this pledge and in 2007 the Canadian parliament passed an all-party Better Aid Bill. Nevertheless, the implications of this for ODA remains to be seen – policy statements in 2007 have notably indicated a move away from the targeting of increased aid to Africa (Riley 2007).

In recent years, there has also been a heightened commitment to military involvement in Afghanistan, and the portion of ODA associated with security-related issues has grown substantially, with Iraq and Afghanistan now being the largest recipient countries (Table D2.2.1).

Furthermore, in spite of being a signatory of the *Paris Declaration on Aid Effectiveness*, a very significant percentage of Canada's ODA is still tied (i.e. restricted to the procurement of goods and/or services from mainly Canada, or some other specific countries).

Health-sector aid

Strengths and weaknesses of the Canadian approach to health-related ODA are illustrated in the example of the Tanzania Essential Health Interventions Project (TEHIP), funded by IDRC in the 1990s. TEHIP was praised for its degree of local community involvement, systematic application of health information to guide interventions and, ultimately, its impact on improving health outcomes (IDRC 2007b). Despite the widely acclaimed success of TEHIP, there have been delays in the 'roll-out' of this project. Indeed,

under the auspices of CIDA's African Health Systems Initiative (AHSI), the expansion of TEHIP is barely in progress.

AHSI aims to improve access to basic health care by providing assistance to train, equip and deploy existing and new African health-care workers. As with the majority of CIDA's health-sector work, these aims are undermined by tacit acceptance of delivery models and privatisation policies drawn from international financial institutions. The extent of private-sector involvement in CIDA health-care reform projects is unclear, but CIDA does have a general mandate to target private-sector development in its work (CIDA 2003), a possible source of tension in the case of health-related ODA.

AHSI is also a useful starting point to stress another contradiction. While it sets out to strengthen health-care systems and support human resources in health, several Canadian provinces are simultaneously recruiting physicians and nurses from the very same countries and regions, compromising efforts to build health systems, and contributing to large financial losses incurred by the source countries. Some of the authors of this chapter have witnessed, in various forums, an inexcusable lack of communication between Canadian ODA officials and provincial health officials on this issue.

Another dimension along which Canadian ODA can be assessed is its humanitarian disaster relief interventions. In the mid-1990s, Canada established the Disaster Assistance Response Team (DART), a military organisation designed to deploy rapidly anywhere in the world to help in crises ranging from natural disasters to complex humanitarian emergencies. This programme has produced mixed results.

Following the October 2005 earthquake in Pakistan that killed 73,000 people and displaced an additional 3 million, Canada's official response came through DART at a cost of over CAN\$15 million. Conceived to provide immediate support *for up to forty days*, until more permanent aid takes over, DART became fully operational in Pakistan fourteen days after the earthquake. While the Department of National Defense viewed the operation as 'an unconditional success', DART's own members (Agrell 2005), as well as independent observers (Valler 2005), questioned the actual value of the operation. It was especially criticised for the excessive emphasis given to technological solutions, contrasting greatly with the approach of Cuba (discussed in Box D2.2.1 later in the chapter). This type of criticism has been expressed at least as early as Canada's 1985 relief operation following the earthquake in Mexico City (Montoya 1987). It also followed DART's deployment for the 2004 Asia-Pacific tsunami disaster (CBC 2005). As in the case of Pakistan, it was suggested that a more effective response would have included the rapid deployment of human resources able to venture out and reach victims in the shortest possible time.

Australian aid

Most of Australia's aid (about 90 per cent) is absorbed by the Asia–Pacific region (AusAID 2005). Table D2.2.3 shows the top ten recipients of Australia's bilateral aid budget for 2007–08 by partner country or region. Africa receives limited aid from Australia; and more of the 2007–08 budget is allocated to Afghanistan than to the whole of Africa (see Table D2.2.3). Note that this excludes aid allocated to regional efforts and multilateral organisations.

When it comes to generosity, Australia's record is poor. It has not reached the UN's target of allocating 0.7 per cent of GNI to aid. The general trend has been a decline from a high of 0.5 per cent in 1974–75, which has only been partially reversed in recent years (see Figure D2.2.4). Although the 2007–08 Australian federal aid budget represents a AU\$209 million increase over the previous year's budget, aid still only accounts for 0.3 per cent of GNI. However, the newly elected federal Labor government has pledged to raise Australia's official aid to 0.5 per cent of GNI by 2015–16, with a vague commitment to work towards the UN goal of 0.7 per cent (Rudd 2007).

Most of Australia's aid budget is managed by AusAID, an agency within the Department of Foreign Affairs and Trade. However, a notable feature

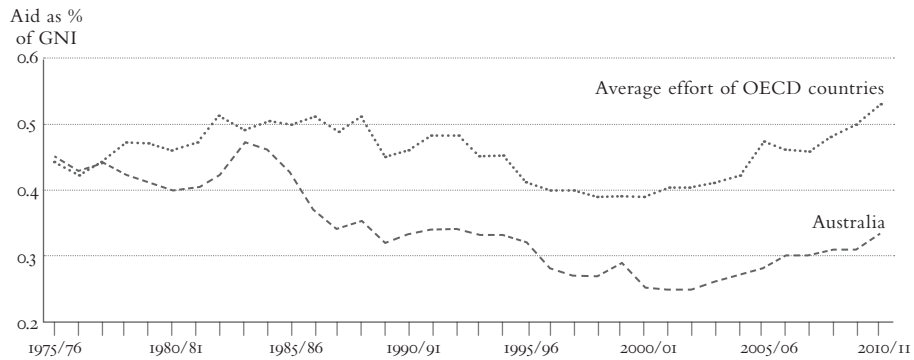
TABLE D2.2.3 Top ten recipients of the 2007–08 Australian aid budget

Country/region	Budget estimate (AU\$ million)	% of total budget
Indonesia	458.8	14.5
Papua New Guinea	355.9	11.3
Solomon Islands	223.9	7.1
Philippines	100.6	3.2
Afghanistan	99.6	3.2
Africa	94.4	3.0
Vietnam	90.8	2.9
Timor-Leste	72.8	2.3
Cambodia	54.0	1.7
Bangladesh	47.6	1.5

Source: Australian Government 2007.

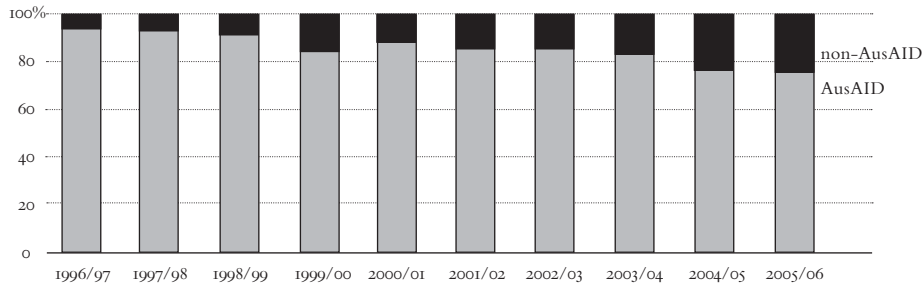
of Australia's aid is that as much as a quarter of it is delivered by 'other government departments' including the Australian Centre for International Agricultural Research, the Treasury and the Australian Federal Police (Duxfield, Flint and Wheen 2007) – a trend that increased under the Howard government (see Figure D2.2.5).

FIGURE D2.2.4 Australian aid levels compared with the average effort of OECD countries



Source: AusAID 2005. Note: The 'average effort' of OECD countries is the unweighted average of their ODA/GNI ratios.

FIGURE D2.2.5 Proportion of Australian aid administered by AusAID and other agencies



Source: AusAID 2005.

Overview of players and policies

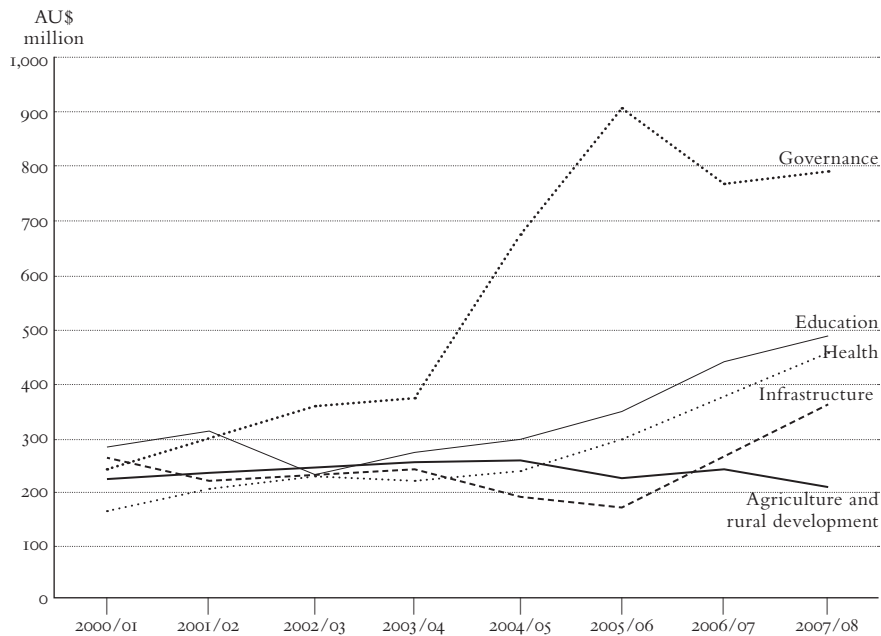
As with other donors, Australia is explicit about the use of aid to further its own strategic interests. Development assistance is expected to be 'in line with Australia's national interest' (AusAID 2007). By helping to reduce poverty and promote development, 'the aid program is an integral part of Australia's foreign policy and security agenda' (Australian Government 2006).

The priorities and approaches laid down during the Howard government's term of office from 1996 to 2007 have been criticised for accentuating the use of aid to serve Australian security, foreign policy and economic interests, particularly following the terrorist attacks on the US in 2001 and the Bali bombings in 2002. In addition, the government introduced a 'whole of government' approach whereby all public service departments were encouraged to align their work with Australia's overall foreign policy and security objectives (Pettitt 2006). The approach of the new Rudd government appears promising for improving the effectiveness of Australia's aid programme. Labor has pledged to consider separating AusAID from the Department of Foreign Affairs and Trade 'to ensure its independence in policymaking', along with 'establishing a Legislative Charter on Australian Development Assistance to guarantee that aid is spent on poverty reduction and not political agendas'. These actions would be greatly enhanced by the creation of a Global Development Institute to conduct research into 'creative responses to aid delivery', which Labor says it will also consider. NGOs therefore need to keep pressuring the government to deliver on these commendable pledges.

One of the ways in which aid has been used to promote Australia's foreign policy interests is through the funding of 'good governance' programmes. Figure D2.2.6 reveals that much of the increase in the Australian aid budget in recent years has comprised funding for 'governance' and 'security' issues, while allocations to health, education and agriculture have remained static (with health generally comprising around 12 per cent of the aid budget). Under Howard, spending on 'governance programs' grew to become the largest sector of the aid budget for 2007–08 (Australian Government 2007).

The emphasis on law, security and governance is illustrated by Australia's aid to the Solomon Islands – the poorest country in the Pacific. In 2003, following political tension and conflict, Australia agreed to work with the Pacific Islands Forum to field the Regional Assistance Mission to Solomon Islands (RAMSI), the aims of which are to stabilise and strengthen the state, particularly through the reform of the core institutions of government

FIGURE D2.2.6 Australian aid budget, 2000–2007



Source: AusAID 2007.

(Baser 2007). Australia's four-year contribution to RAMSI includes the provision of 235 Australian Federal Police and 130 technical advisers. Of the \$95.4 million of aid budgeted for the Solomon Islands in 2007–08, over 70 per cent will be directed through RAMSI.

Justification for channelling so much aid through RAMSI was based on the long-standing view within the Australian Department of Defence that the island nations to the north and east (referred to as the 'arc of instability') pose a security threat to Australia (Ayson 2007; Hameiri and Carroll 2007; Pettitt 2006). By 2005 the view that neighbouring countries had the potential to become breeding grounds and refuges for transnational criminal groups and terrorists had become so entrenched within AusAID that an OECD Development Assistance Committee (DAC) review concluded that Australia's development programme was at risk of being 'dominated by an Australian-driven law and order agenda rather than a broader development agenda with strengthening local ownership' (OECD 2005). The increased concern with regional and national security has been criticised and questioned by other commentators (e.g. Davis 2006).

It is also difficult to see how the allocation of AU\$160 million for detaining asylum-seekers in offshore detention centres and sending others home

(Nicholson 2007), as well as the allocation of AU\$2.5 million for improving the customs and quarantine standards of Pacific Island nations (Commonwealth of Australia 2005), would have assisted in reducing poverty.

Furthermore, Cirillo (2006) asserts that problems of 'governance' are only described as such when they are perceived to impede the Australian interest. It has been argued that Australia's intervention in the Solomon Islands is related to economic interests in the Gold Ridge mine, the islands' oil palm plantations and the business activities of Australian companies (Action in Solidarity with Asia and the Pacific 2003). Anderson (2006) goes so far as saying that Australia uses its military and security aid in Asia and the Pacific to protect foreign investments by containing the social disruption caused by Australian logging, mining and gas industries.

In light of worsening development indicators in Asia–Pacific, the decision to assign so much of the aid budget to 'governance', counterterrorism and migration management has been extensively critiqued (Hameiri and Carroll 2007; Pettitt 2006). Others have also called for a higher proportion of aid to be allocated to health, education and other basic needs (Duxfield and Wheen 2007; Zwi et al. 2005; Zwi and Grove 2006). Even a government-commissioned review of the aid programme in 1996 warned that 'the pursuit of short-term commercial or diplomatic advantage through the aid program can seriously compromise its effectiveness and should play no part in determining project and program priorities' (Simons Committee 1997)

Kilby (2007) asserts that AusAID's preference for dealing with absolute poverty rather than inequality may have actually exacerbated poverty among some groups, and increased the rural–urban divide. He sees part of the problem as a product of poverty analyses which 'provide an overview of where the poor are, but not much about who the poor are or why they are poor'. Without a deeper analysis of the drivers of poverty in each country, merely alluding to poverty reduction does not guarantee poverty-reduction outcomes.

Hopefully, with a commitment by the new Rudd government to use the MDGs as the basis for the aid programme's strategy (which the former government was unwilling to do), and Labor's emphasis on human rights and respect for indigenous rights and culture, Australia's aid programme will become more effective in bringing about long-term health and development gains in the Asia–Pacific region – where two-thirds of the world's poor live.

Health-sector aid

The characteristics of global development assistance for health described in Chapter D1.1 apply as much to the Asia–Pacific region as elsewhere: vertical

disease-based programmes and a tendency to fund lots of small and often short-term projects through Australian NGOs and contracting agencies. The extensive use of technical cooperation provided by firms based in Australia (AusAID 1997) has come at the expense of high transaction costs and the failure to develop capacity in recipient countries.

Another area of controversy is AusAID's policy prohibiting the use of funds for 'activities that involve abortion training or services, or research trials or activities, which directly involve abortion drugs'. The United Nations Association of Australia stated that Australia's aid programme 'denies funds for activities that educate about safe abortion and denies assistance until a woman seeks post abortion care, assuming she survives the unsafe procedure' and that the guidelines 'have the effect of driving women down the path to unsafe abortion with the associated shame, disability, and often, death' (United Nations Association of Australia 2007). According to Christina Richards, former CEO of the Australian Reproductive Health Alliance, AusAID restrictions are 'more restrictive than domestic policies, and seek to influence practice and values in recipient countries in ways that contravene international human rights' (Richards 2007).

Despite the Howard government formally untying all aid in 2006, Australia's development assistance has been termed 'boomerang aid' because one-third of official aid never leaves Australia and up to 90 per cent of contracts are won by Australian-based companies (Duxfield and When 2007).

In fact AU\$88.5 million of official aid budgeted for 2007–08 has been earmarked for government departments other than AusAID without being earmarked for any particular region or country. Some of this funding will reach the shores of Australia's developing-country partners, but much will not. For example, a significant portion of Australian aid is effectively used to support Australia's tertiary education sector – one of Australia's largest export industries – through the provision of scholarships for students from the Asia–Pacific region to study at Australian universities. This is arguably designed to subsidise Australian universities, which have suffered from public funding cuts (Anderson 2006).

Conclusion

This chapter shows that ODA is often informed by self-interest and in general has failed to provide catalytic support for health systems development. There is a strong need for ODA to support health systems rather than discrete health services and vertical programmes. Civil society organisations have a role to play in ensuring that their governments move away from a

BOX D2.2.1 Cuba's approach to foreign aid for health

In August 2005, following the disaster of Hurricane Katrina in the US, Cuba offered to send a medical brigade of 1,586 health professionals along with 36 tons of supplies to the affected region. The brigade was assembled and ready for deployment within days of the hurricane. While Washington refused the offer, the brigade eventually applied its services a few months later, following the devastating Pakistan earthquake. By the time Canada's foreign affairs team arrived in Pakistan, Cuba already had 300 health professionals in the affected region. By the time the first Canadian doctors landed in Pakistan, the Cuban brigade had 600 health professionals on the ground, had constructed several field hospitals, and was already journeying to outlying regions, on foot, to treat victims in their home communities.

Altogether, 1,481 Cuban physicians and 900 Cuban paramedics served in Pakistan (Gorry 2005). The brigade managed to treat 103,000 patients over a three-month period (Granma International 2006). Upon leaving Pakistan, Cuba offered 1,000 medical scholarships for young Pakistanis to receive free medical training so that they could carry on the work the Cuban brigade had begun.

Cuban medical internationalism is a long-standing cornerstone of its foreign policy, dating back to assistance given to Chile after an earthquake levelled Santiago in 1960. Cuba has provided medical assistance to over 100 countries worldwide, including ideologically hostile nations, such as Nicaragua, following the 1973 earthquake that struck during the reign of the Somoza dictatorship.

For a poor country that has struggled with interminable economic shortcomings, Cuba has provided widespread health-care services to some of the poorest regions in the world. In response to Hurricane Mitch in 1998, Cuba sent medical brigades to Honduras, El Salvador, Guatemala and Nicaragua, countries that still receive Cuban assistance. As of 2007, Cuba had 31,000 health-care professionals working in 71 countries (CubaCoopera 2007).

Unlike many ODA interventions in times of disaster, Cuba, more often than not, remains on site well after other countries have pulled out. In East Timor, Cuban physicians remained for a year following earthquakes and landslides that left the country in peril (Gorry 2006). Cuba's approach involves strong investment in human resources – more so than material resources – to achieve long-term stability rather than short-term relief. Since 1999, Cuba has trained over 11,000 medical students from twenty-nine different countries, including the US (Huish and Kirk 2007). Aid is not a short-term endeavour but is seen as long-standing cooperation, knowing that achieving impact in communities takes as much time as it takes effort.

'donor interest' model of ODA to a 'recipient need' model, and must call for comprehensive and detailed evaluations of their countries' ODA and for the pledge of countries committing 0.7 per cent of its gross national income to aid to be realised.

The case study in Box D2.2.1 provides an alternate model of international aid and offers some salutary lessons for countries wanting to examine their own aid programmes.

Note

1. For more information, see www.idrc.ca.

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D 2.3 Security and health

A recent development in global health has been the way in which health issues are being framed in terms of security. This section describes the origins of this development and raises questions that civil society should be grappling with.¹

One of the drivers for this development is the awareness of the potential for fast-moving epidemics to deliver shocks to the global economy. The threat of a lethal influenza pandemic has further accentuated the process of framing disease as a security issue. In 2005 the World Health Assembly (WHA) adopted a revised version of the International Health Regulations, which establishes a set of obligations and standards for countries to respond to 'public health emergencies of international concern'. In 2007 the World Health Organization (WHO) devoted its annual *World Health Report* to 'Global Public Health Security in the 21st Century'.

Bioterrorism has been another focus of attention, especially following anthrax attacks in the US, which led to increased international collaboration via the Global Health Security Initiative (GHSI).² However, while there are some synergies between preparedness for bioterrorist events and other health risks, the overall nature of the bioterrorism preparedness agenda and the disproportionate allocation of scarce resources, particularly within the US, have been questioned (Tucker 2004).

Since the Cold War, and especially after the 9/11 terrorist attacks on the United States, issues such as poverty, climate change and HIV/AIDS have also become framed as security threats by virtue of their negative impact on economic and political stability, both within countries and across borders. A range of US government agencies, including the Departments of State and Defense and the Central Intelligence Agency (CIA), began working

on HIV–security links during the mid-1990s. A resulting US Strategy on HIV/AIDS argued that the pandemic needed to be seen not only in terms of human health or international development, but also as a threat to ‘international security’ and to the security of the US (USDS 1995).

It noted that ‘as the HIV/AIDS pandemic erodes economic and security bases of affected countries, it may be a ‘war-starter’ or ‘war-outcome-determinant’. It also described how ‘HIV directly impacts military readiness and manpower, causing loss of trained soldiers and military leaders’, and how ‘worldwide peacekeeping operations will become increasingly controversial as militaries with high infection rates find it difficult to supply healthy contingents.’

This view subsequently gained ground within Washington. In 2000, the US National Intelligence Council (NIC) issued a report on the threat of global infections to the US (NIC 2000). In the same year, the Clinton administration declared that HIV/AIDS represented a threat to US national security interests. This led to a US-backed UN Security Council resolution identifying HIV/AIDS as a threat to international peace and security (UNSC 2000).

The National Intelligence Council returned to the subject in 2002, issuing a report on five countries (Nigeria, Ethiopia, Russia, China and India) strategically important to the United States that identified links between disease, political instability and the threat to socioeconomic development and military effectiveness (NIC 2002). By 2005 the Global Business Coalition on HIV/AIDS was making links between AIDS, economic decline and potential terrorist threats, including speculating on how a steady stream of orphans might be exploited and used for terrorist activities (Neilson 2005).

At one level, the linkage of health to security can be viewed positively in the sense that it can highlight the concept of *human security*, which can help move the focus in security thinking away from state security and more towards people and their basic rights and needs.

At another level, there are risks associated with extending the scope of security into the health and development spheres. Importantly, the framing of health in terms of security has emerged from global power centres. As the foreign policy and intelligence agencies of the most powerful states are drawn into the domain of health within low- and middle-income countries, health policies and programmes may be co-opted into serving economic and political projects, especially in the post 9/11 landscape in which counter-terrorism has emerged as an overriding policy priority, and which has made the space for health and human rights harder to maintain.

While the interest of security actors in selected aspects of public health has increased markedly, parts of the public health and medical communities have also adopted the language of security, seeing opportunities to advance broader public health goals. By accentuating the destabilising effects of HIV/AIDS and poverty, civil society groups have helped gain much-needed attention and resources for the long neglected health concerns of poorer countries.

Yet the linking of health with security is not necessarily a win–win situation. Crucially, those seeking to use security arguments to boost health up the political agenda may not be able to control where the logic of security takes them. While the linking of health and security may generate more attention and resources for health, the use of health as an instrument of foreign policy, or as a bridge for securing better control over strategic resources in other countries, is also evident. For example, the 2002 NIC report on HIV/AIDS stated in relation to Nigeria that HIV/AIDS could contribute to the deterioration of state capacity in a country important to US energy security and US counterterrorism strategies (CSIS 2005).

This forms part of the context for the massive increases in US aid for Nigeria. Indeed, through 2007 PEPFAR allocated some US\$578 million for Nigeria, far outstripping other donors. As part of this, PEPFAR is creating a total HIV surveillance system for the Nigerian military; conducting prevention initiatives; creating more reliable supply chains; and organising treatment for military personnel and dependants who are living with HIV.³

To an extent this might be welcomed. HIV/AIDS is a multidimensional problem affecting all sectors of society, including the military. The HIV/AIDS–security link has also drawn attention to the spread of HIV via military and security forces in conflict or peacekeeping situations. But questions might be asked as to whether targeting such sectors in HIV/AIDS relief risks privileging certain parts of society because of their relevance to US strategic goals (Elbe 2005).

There is now concern that political and economic elites will be able to insulate themselves from the worst effects of HIV/AIDS while exploiting scaled-up AIDS relief to entrench their positions (de Waal 2006). While saving lives in the short term, HIV/AIDS relief could perpetuate a closed political loop that is detrimental to wider human security and fails to address the deeper-rooted social determinants of health. It is also noteworthy that the hypothesis that high-prevalence HIV/AIDS epidemics would destabilise national and regional security has not been substantiated, raising the question of whether HIV/AIDS has been used opportunistically by the security apparatus (Whiteside et al. 2006; Barnett and Prins 2006).

The trade-offs associated with the linking of security to health is illustrated also with the prevention and control of acute infectious disease outbreaks. Some authors argue that global health security has helped to normalise the intrusive and extensive use of external surveillance and the suspension of sovereignty across a range of policy areas (Hooker 2006). Whilst protecting the health security of populations is a good thing, it is necessary to ask who is being secured, from what, how, and at whose cost?

The surveillance of public health threats requires a major upgrading of data capture and information systems. While efforts have been made by the WHO and other agencies to ensure that data are managed and used for politically neutral and scientific purposes, some researchers have identified links between public health surveillance networks and intelligence communities, calling its supposed neutrality into question (Weir and Mykhalovskiy 2006). It also places demands on poorer countries to develop surveillance and response strategies that can help protect the global community. However, it is unclear whether such demands are affordable or appropriate to their health priorities (Lee and Fidler 2007). The focus on cross-border infectious disease control may mask structural problems in global public health, leading to solutions which benefit the rich more than the poor.

The linking of health and security therefore creates a complex political space that requires discussion and research, particularly in relation to three issues (Lee and McInnes 2004).

First is the process of determining what is and isn't a security issue. The same powerful actors who determine what constitutes a security issue also tend to be responsible for shaping international responses to those threats. Placing health issues in national security strategies or on the agenda of bodies like the UN Security Council, or defining the WHO's role in terms of global security, creates a space where particular ideas of security and associated interests that are promoted must be questioned and reframed if necessary.

Second is the danger that efforts to address health problems deemed important through a security lens, rather than more objective measures of need, will distort health priorities. How is the conceptualisation of health as a poverty, justice or human rights issue to be reconciled, for example, with strategic objectives linked to 'fragile states', 'failed states' or 'rogue states'? What are the consequences of health being used as an instrument of foreign policy?

Third, a concern with security may reinforce problematic aspects of health policy. For example, the desire to enhance security may lead donors

to prioritise bilateral funding mechanisms at the expense of multilateral channels. A ‘control and containment’ focus on infectious disease outbreaks may detract from more effective and sustainable approaches to health promotion. Vertical, disease-control policies and programmes, with their emphasis on disease prevention, may flourish at the expense of comprehensive primary health-care programmes and emphasise an authoritarianism within the health sector that runs against principles of decentralisation and community empowerment, or could lead to certain communities being demonised as ‘security threats’ (Elbe 2006).

Final comments

The recently created links between health and security will help raise the profile of certain health issues, but they may also reframe them to the advantage of the more powerful. The key question is whether this shift represents a welcome advance in ideas of security, or the co-option of health by vested interests, raising the risk that security will simply lead to new forms of selectivity and inequality in the landscape of global health and the global political economy. Public health advocates need to examine and debate the issue in four ways:

- Monitor the links being made between health and security in a wide range of settings.
- Contribute to the evidence base on how health–security links are affecting global health initiatives in practice. More detailed case studies from a wider range of places are required.
- Encourage critical debate and discussion about different conceptions of security, whilst constantly advancing perspectives grounded in human rights and ethics.
- Support networks of enquiry and discussion for groups from different disciplines and regions to develop more comprehensive understandings of links between health and security, whilst building the capacity to react to unwanted developments in the field.

Notes

1. A longer version of this chapter is available at www.ghwatch.org.
2. The members of the GHSI are Canada, France, Germany, Italy, Japan, Mexico, the UK, the US and the EU. See www.ghsi.ca/english/index.asp.
3. Information on PEPFAR in Nigeria via www.pepfar.gov/.

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D 3 . I **Protecting breastfeeding**

Today nearly all governments and health-care institutions recognise breastfeeding as a health priority. Yet global breastfeeding rates remain well below acceptable levels – according to the United Nations Children’s Fund (UNICEF), ‘more than half the world’s children are not as yet being optimally breastfed’, and many children suffer from malnutrition and chronic morbidity as a consequence of sub-optimal breastfeeding. Improved breastfeeding practices could save some 1.5 million children’s lives per year (WHO 2001; UNICEF 2008). One of the causes of the problem is the persistent marketing of infant formula products by commercial companies. According to UNICEF (1997): ‘Marketing practices that undermine breastfeeding are potentially hazardous wherever they are pursued: in the developing world, WHO estimates that some 1.5 million children die each year because they are not adequately breastfed. These facts are not in dispute.’

Formula companies give the impression that promoting breast-milk substitutes is like any other type of advertising. However, artificial feeding products are not like other consumer or even food products. The object of artificial feeding is the replacement of a fundamental reproductive activity that destroys the natural sequence of birthing to feeding. Artificial feeding is inferior to breastfeeding, costly and, in many parts of the world, tragically harmful.

While no one would suggest a complete ban on infant feeding formula, it is imperative that women are not misled by spurious or misleading information about artificial feeding, and that health-care systems do not deliberately or inadvertently support inappropriate artificial feeding or diminish the importance of natural feeding.

The evolution of the problem

The establishment of bottle-feeding cultures is embedded in the history of the development and promotion of industrial 'replacement' products. Since the late nineteenth century, Nestlé, the world's largest producer of infant formulas, has undermined women's confidence in their ability to breastfeed and, through clever social marketing, created a benign acceptance of its products.

Initially, a lack of knowledge about the sub-optimal nutritional value of artificial milk and the important protective immunological properties of breastmilk helped create a more accepting environment for artificial feeding, especially among mothers who had to work outside the home. Marketing included the association of artificial feeding with being a good (even angelic) mother, and persuaded communities that formula milk is nutritionally better, as well as more fashionable and modern than breastmilk. Special promotions and the liberal provision of free samples drew women into the practice of artificial feeding in many parts of Asia, Africa and Latin America. By the 1970s it was estimated that only 20 per cent of Kenyan babies and 6 per cent of Malaysian babies were predominantly breastfed (WABA 2006).

Health-care workers have also been complicit. The industry has successfully established subtle and overt advertising through the health system by providing health workers with free 'gifts' that carry the logos of companies and products, publishing 'health education' materials and sponsoring health conferences. All this helps companies and their products to be identified with those who promote and protect health.

Once seduced into using artificial milk, mothers can become trapped by their decision. In poor economic situations, they can soon find themselves diluting formula milk or turning to cheap replacements to calm a hungry baby. The desperation of mothers of young babies dependent upon formula foods in New Orleans after the Hurricane Katrina disaster demonstrates that similar problems can occur in developed countries as well. Responses to humanitarian emergencies and natural disasters still often result in inappropriate donations of formula foods from governments, the public and milk companies; there have also been allegations of 'dumping' formula that is close to expiry.

The developing world, where the majority of the world's babies are born, is seen as a lucrative market for infant-food industries. The threat of undermining normal infant and young child feeding has expanded to include commercial food products to address nutrition needs of the 6- to 24-month age group. Follow-on milks were developed by companies as a

strategy to get around the restrictions of the International Code of Marketing Breastmilk Substitutes. The aggressive promotion of these milks, which are supposedly for older babies, is very confusing and health professionals all over the world have long noted how these milks inevitably end up being used as breastmilk substitutes for very young babies.

In an attempt to circumvent the strong condemnation they receive from the global health community, many companies have formed 'partnerships' with UN agencies ostensibly to combat malnutrition. No doubt these industries see good business sense in linking their brands with the humanitarian image of UN agencies in order to benefit from the billions in aid funds pouring into these agencies from donor governments. Global Alliance for Improved Nutrition (GAIN) global health partnership opens its website with the message, 'Improving nutrition can also seriously benefit your business by creating growth in new and existing markets.'

The health effects of the problem

Breastmilk is vital for mother and child health, regardless of socioeconomic setting. Although the health and development consequences of less than optimal breastfeeding are significantly worse for mothers and infants in low-income countries, research on the risks of formula feeding finds an increased risk of gastric and respiratory infectious diseases, higher levels of non-communicable diseases such as diabetes, and lower IQ capacity and visual acuity (Malcove et al. 2005; Weyerman et al. 2006; Cesar et al. 1999). Studies have demonstrated mortality rates up to 25 per cent higher for artificially fed compared to breastfed children (Victora et al. 1989; WHO 1981).

Over the past few years, milk companies have also exploited the dangers and concerns associated with HIV transmission through breastmilk (Iloff et al. 2005). Evidence, however, shows that exclusive breastfeeding for the first months of life reduces both mortality and the risk of transmission (Guise et al. 2005).

During early 2006, Botswana was battered by a diarrhoeal outbreak serious enough to require outside intervention from the Center for Disease Control (CDC) and UNICEF. Most of those affected were infants under eighteen months old. Abnormally heavy rains in the first months of 2006 resulted in flooding and dirty puddles of standing water, which combined with poor sanitation to spread the disease, killing 470 children between January and April. According to UNICEF, infant formula played a significant role in the outbreak and the CDC reports that formula-fed babies were disproportionately affected by the disease – one village, for example, lost 30 per cent of formula-fed babies. According to a report by the National

AIDS Map organisation, not having been breastfed was the most significant risk factor associated with children being hospitalised during the period of the outbreak.

The International Code of Marketing Breastmilk Substitute

When it became recognised that artificial feeding was both harmful and being promoted in ways that were unethical, a civil society campaign led by the International Baby Food Action Network (IBFAN) successfully enabled the World Health Organization (WHO) and UNICEF to establish the International Code of Marketing of Breastmilk Substitutes (the International

BOX D3.I.I Summary of the International Code

1. No advertising or promotion of breastmilk substitutes to the public.
2. No free samples or gifts to mothers.
3. No promotion of products covered by the Code through any part of the health-care system.
4. No company-paid nurses or company representatives posing as nurses to advise mothers.
5. No gifts of personal samples to health workers.
6. No words or images, such as nutrition and health claims, idealising artificial feeding or discouraging breastfeeding, including pictures of infants on product labels.
7. Only scientific and factual information may be given to health workers regarding the product.
8. Information explaining the benefits of breastfeeding and the costs and hazards associated with artificial feeding must be included in any information on the product, including the labels.
9. No promotion of unsuitable products, such as sweetened condensed milk.
10. Warnings to parents and health workers that powdered infant formula may contain pathogenic microorganisms and must be prepared and used appropriately, and that this information is conveyed through an explicit warning on packaging.
11. Governments must provide objective information on infant and young child feeding, avoiding conflicts of interest in funding infant feeding programmes.
12. No financial support for professionals working in infant and young child health that creates conflicts of interest.

Source: IBFAN 2007.

Code) (IBFAN 2007). This was adopted by the World Health Assembly (WHA) in 1981 as a *minimum* requirement for all member states, which are required to implement it in its entirety in their national guidelines and legislation on the marketing of infant feeding formulas, bottles and artificial nipples (see Box 3.1.1).

Subsequently a number of additional resolutions have been adopted. These resolutions have equal status to the International Code and close many of the loopholes exploited by the baby food industry. Some of the resolutions include stopping the practice of free or low-priced breastmilk substitutes being given to health facilities (1992); ensuring that complementary foods are not marketed for or used in ways that undermine exclusive

BOX D3.1.2 The International Baby Food Action Network

IBFAN is a global network with a presence in over 100 countries. It has been successfully working since 1979 to protect health and reduce infant and young child deaths and malnutrition. Some of its priority activities include:

- Supporting national implementation of the Global Strategy for Infant and Young Child Feeding, adopted at the World Health Assembly (WHA) by a resolution in 2002.
- Monitoring compliance to the International Code of Marketing of Breastmilk Substitutes as well as subsequent relevant WHA resolutions at the country level.
- Raising awareness of and support for the human right to the highest attainable standard of nutrition and health for women and children.
- Protecting all parents' and carers' rights to sound, objective and evidence-based information.
- Informing the public of the risks of artificial feeding and commercial feeding products.
- Working to improve the quality and safety of products and protecting optimal, safe infant feeding practices through the Codex Alimentarius product standard-setting process.
- Promoting maternity protection legislation for mothers returning to work.
- Promoting sustainable complementary feeding and household food security recommending the widest possible use of indigenous nutrient-rich foods.
- Supporting and providing health worker training for the implementation of the UNICEF/WHO Baby Friendly Hospital Initiative.

and sustained breastfeeding (1996); recognising exclusive breastfeeding for six months as a global public health recommendation and declaring that there should be no infant-food industry involvement in infant nutrition programme implementation (2002).

IBFAN monitors the implementation of the Code, and their 2006 report notes that to date some 32 countries have incorporated the full Code into law; 44 countries have partially incorporated the Code into law; 21 have established the Code as voluntary guidelines (IBFAN 2006). The US and Canada have taken no action at all.

Case studies

I *Commercial pressure: the case of the Nestlé boycott*



Nestlé is the largest baby food manufacturer in the world. For decades, as industry leader, it has led the way in aggressively marketing its products. Saleswomen were dressed in nurses' uniforms and sent into the maternity wards of hospitals throughout many parts of the world. Mothers faced a constant barrage of formula advertisements on billboards, television and radio. Aggressive marketing by Nestlé and its competitors undermined breastfeeding, contributing to a dramatic drop in rates in many countries.

In 1977, a public interest group based in Minneapolis, INFACT USA, launched a campaign to boycott the company's products. Campaigners urged the public not to buy Nestlé brands until it changed its marketing policies. By 1981, the boycott was international and the momentum it gathered contributed to the creation of the International Code. Nestlé's public image was at an all-time low. By 1984, with the boycott in effect in ten countries, Nestlé promised to halt its aggressive promotion and adhere to the International Code and the boycott was suspended. However, the IBFAN groups continued to monitor and the hollowness of Nestlé's promises soon became apparent – while some of the most obvious violations, such as sales staff dressed as nurses and babies' pictures on formula labels, had been stopped, the company had no intention of abiding by all the provisions of the International Code, particularly now the boycott had been suspended. The boycott was reinstated in 1989.

While the boycott has compelled Nestlé to change some policies, such as the age of introduction of complementary foods, and stops specific cases of malpractice if these gain sufficient exposure, Nestlé continues systematically to violate the International Code. It remains the target of the world's largest international consumer boycott, which, in this second round, has been launched by groups in twenty countries. An independent survey by GMI

found in 2005 that Nestlé is one of the four most boycotted companies on the planet (GMI Poll 2005).

Official statements from Nestlé claim that the company abides by the International Code, but only in 'developing nations'. This itself is a violation of the International Code, because, as the name suggests, it is a *global* standard and companies are called on to ensure their practices comply in every country, not just those of Nestlé's choosing.

Nestlé has also fought hard to prevent countries enshrining the International Code in legislation. For instance in 1995, the company filed a Writ Petition with the government of India that challenged the validity of proposed laws implementing the International Code. Nestlé claimed that a law implementing the International Code would restrict its marketing rights and would be unconstitutional. Nestlé battled hard in the courts to stop the Code's legislation in India, but fortunately failed to do so, and India has since passed exemplary laws, which enshrine the Code in national legislation.

2 *Commercial pressure: the case of the Philippines*

Despite the incorporation of almost all of the provisions of the International Code into domestic law in 1981, formula advertising has run rampant in the Philippines over the past two and a half decades. Advertisements on Filipino television claim that formula makes babies smarter and happier and company representatives are sent into the country's poorest slums to promote formula directly to mothers. As a result of these aggressive marketing tactics, the Philippines has some of the lowest recorded breastfeeding rates in the world. Only 16 per cent of Filipino children are breastfed exclusively at four to five months of age, and each year it's estimated that 16,000 infants die from inappropriate feeding practices (Jones et al. 2003). The Department of Health estimates that at least \$500 million is spent annually on imported formula milk and over \$100 million is spent promoting these products (Nielsen 2006) – more than half the total annual Department of Health budget – and where 40 per cent of the population live on less than \$2 a day. To combat this national health disaster, in May 2006 the Department of Health (DOH) drafted the Revised Implementing Rules and Regulations (RIRR), which updated the 1981 law and sought to ban formula advertising altogether.

Almost immediately the formula industry fought back, using the powerful US-based Chamber of Commerce, claiming that the RIRR would illegally restrict their right to do business. In 2006, the Pharmaceutical and Health Care Association of the Philippines (PHAP), representing three US formula companies (Abbott Ross, Mead Johnson and Wyeth), Gerber (now

owned by Swiss Novartis) and other international pharmaceuticals giants, took the Filipino government to court. In July 2006, the Supreme Court declined PHAP's application for a temporary restraining order to stop the RIRR from coming into effect.

Three weeks later, in a leaked letter dated 11 August 2006, the president of the US Chamber of Commerce, Mr Thomas Donohue, warned President Arroyo of 'the risk to the reputation of the Philippines as a stable and viable destination for investment' if she did not re-examine her decision to place marketing restrictions on pharmaceuticals and formula companies and restrict the promotion of infant foods. Within a month, on 15 August, four days after the letter from the American Chamber of Commerce was received, the Supreme Court overturned its own decision by granting a temporary restraining order in favour of PHAP.

However, following an international support campaign coordinated by IBFAN and the Save Babies Coalition, in October 2007 the Supreme Court lifted the restraining order and upheld the following provisions and principles:

- The scope of the laws should cover products for older children, not just infants up twelve months.
- The right of the Department of Health to issue regulations governing formula advertising.
- The need for formula labels to carry a statement affirming there is no substitute for breastmilk, and for powdered formula labels to carry a warning indicating the product may contain pathogenic microorganisms.
- Company information targeting mothers may not to be distributed through the health-care system.
- The necessity for the independence of infant feeding research from baby milk companies.
- Companies cannot be involved in formulating health policy.
- A prohibition on donations (of covered products) and the requirement of a permit from the DOH for donations of non-covered products from companies.

The Court also ruled that the marketing of formula must be

objective and should not equate or make the product appear to be as good or equal to ... or undermine breastmilk or breastfeeding. The 'total effect' should not directly or indirectly suggest that buying their product would produce better individuals, or result in greater love, intelligence, ability, harmony or in any manner bring better health to the baby or other such exaggerated and unsubstantiated claim. (Supreme Court of the Philippines 2007)

While the Court decided not to uphold the outright ban on advertising called for by the health advocates, the committee overseeing the advertising is empowered to curtail the vast majority of it, and the enormous publicity generated by the case has hopefully helped to promote breastfeeding among Filipino mothers.

The campaign now moves to the next stage to close a loophole in the primary legislation to ban advertising completely.

3 *India's legislation on infant-milk substitutes*

The history of the battle against bottle feeding in India dates back to the 1970s when multinational companies promoted infant foods through advertisements and aggressive marketing.

In 1981, Indian prime minister Indira Gandhi made a stirring speech at the WHA in support of the International Code. Many member states agreed to invigorate a suitable national legal framework for implementation of the Code. In 1983, the Indian government launched the 'Indian National Code for Protection and Promotion of Breastfeeding'. Meanwhile several individuals and organisations like Voluntary Health Association of India (VHAI) led national advocacy initiatives with parliamentarians to enact legislation for the protection of breastfeeding.

However, due to the lobbying of baby-food companies, it took eleven years for comprehensive legislation on infant-milk substitutes to be formulated. The Infant-milk substitutes, Feeding Bottles and Infant Foods (IMS) Act came into force in August 1993. With this, India became the tenth country to pass such legislation.

However, having passed this law, India found that it was not fully equipped to implement it and curb the unlawful marketing of the milk companies. In addition there were some ambiguities in the law about the difference in the terms 'infant-milk substitutes' and 'infant food'. There were also some gaps relating to the exemption of doctors and medical researchers from the prohibition of 'financial inducements' to health workers.

The Breastfeeding Promotion Network of India (BPNI) and Association for Consumer Action on Safety and Health (ACASH) have been instrumental in exposing the unlawful practices of baby-food manufacturing companies and in pointing out loopholes that existed in the national legislation. In 1994 and 1995 the Government of India issued a notification in the *Gazette of India* to authorise BPNI and ACASH and two other national semi-government organisations to monitor the compliance with the IMS Act and empowered them to initiate legal action. For nearly eight years, effective implementation of the IMS Act has been poor, with infant-food advertisements appearing on soap wrappers, tins of talcum powder and

other unrelated products. 'I love you Cerelac' posters were widely displayed in the streets and markets; mandatory warnings were not being printed; feeding bottles were given as 'free gifts'; and government-led media also aired commercials of 'Cerelac' and nearly all television channels broadcast commercials for baby foods. The hold of the baby-food manufacturers on the health system grew. Free samples of baby food were given to doctors for 'testing'. Nestlé offered international fellowships to paediatricians and sponsored meetings and seminars. Likewise, Heinz announced sponsorship for research in nutrition.

In 1994, ACASH took Nestlé to court for advertising the use of formula *during* the 'fourth' month when the IMS Act stated that infant foods could only be introduced *after* the fourth month. In 1995, the court took cognisance of offence and admitted the case against Nestlé to face trial, saying that there is sufficient matter on record to proceed with criminal proceedings for violating the IMS Act. Nestlé has been trying since then to find some means to challenge the basic allegation. However, no higher court has so far granted an injunction.

Nestlé has since challenged the validity of the IMS Act in a petition filed in the High Court. Final decisions on this case are still awaited. Apart from Nestlé, two other companies were also taken to court for violating the IMS Act. Johnson & Johnson was the first, which faced two cases for selling feeding bottles on discount, and for the advertising of feeding bottles and promotion of a 'colic-free nipple' (teat). The company has since voluntarily agreed to withdraw completely from the feeding bottle market in India and stopped its manufacturing in late 1996, finally withdrawing completely in March 1997.

Wockhardt, an Indian manufacturer of pharmaceuticals and infant formula, was also taken to court by ACASH due to violations of the labelling requirements similar to those committed by Nestlé. Wockhardt apologised through an affidavit in the Magistrate's Court, undertook to follow the rules, and volunteered to stop using the name of its formula for other paediatric products, such as vitamin drops, which were being used for surrogate advertising of formula.

Acting on BPNI's advice, the Information and Broadcasting Ministry amended the Cable Television Networks Regulation Amendment Act 2000 and its Rules that banned direct or indirect promotion of infant-milk substitutes, feeding bottles and infant foods. Overnight, advertisements on baby food and infant-milk substitutes disappeared from Indian television channels. The action taken by this ministry was a significant victory for breastfeeding advocates and a lesson that other countries could draw on.

Based on their earlier experience, the continued violations by baby-food manufacturers, and the new World Health Assembly (WHA) resolutions, in 1994, BPNI and ACASH approached the government to amend the IMS Act in order to improve the regulation of the marketing of baby foods. The Ministry of Human Resource Development constituted a national task force consisting of experts from various ministries and departments of government as well as voluntary agencies to look into this and suggest amendments. Many meetings of this task force took place.

Workshops to sensitise the media and political leaders were organised. Finally, in 1998, the task force recommended amendments to the 1992 law. However, multinationals succeeded in ensuring that the process was stalled. With the continued efforts of the civil society groups, in March 2002 the bill was taken back to the lower house of parliament before finally being passed in both houses of parliament in May 2003 – some fourteen months after the process began.

The new law now prohibits the following:

- Promotion of all kinds of foods for babies under the age of 2 years.
- Promotion of infant-milk substitutes, infant foods or feeding bottles in any manner including advertising, distribution of samples, donations, using educational material and offering any kind of benefits to any person.
- All forms of advertising including electronic transmission by audio or visual transmission for infant-milk substitutes, infant foods or feeding bottles.
- Promotion of infant-milk substitutes, infant foods or feeding bottles by a pharmacy, drug store or chemist shop.
- Use of pictures of infants or mothers on the labels of infant-milk substitutes or infant foods.
- Funding of ‘health workers’ or an association’ of health workers for seminars, meetings, conferences, educational courses, contests, fellowships, research work or sponsorship.

Despite legislative provisions, Nestlé and other companies have not been thwarted. Under the guise of its Nestlé Nutrition Services, Nestlé continues to sponsor doctors’ meetings, and many new strategies are being used to push the company’s products.

In 2005, the IMS Act as amended in 2003 was under threat. A campaign to save the Act involving both governmental and civil society organisations, with support from the media, was successful.

The Indian experience demonstrates how the sustained advocacy and action by civil society groups can influence public opinion and decision-

makers. Forging links and working with people's representatives in political parties in order to focus their attention on issues that affect their constituencies is also crucial. Campaigns and activist initiatives are doomed to fail if the political will to address a situation does not exist.

India has yet to see the impact of the IMS Act on child malnutrition. However, merely a change in legislation is insufficient. Efforts must now focus on increasing breastfeeding rates in the country.

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D 3.2 Tobacco control: moving governments from inaction to action

The ability of the tobacco industry to stay healthy while its customers get sick is one of the more amazing feats of the last century. In the fifty years since it was first established that cigarette smoking causes lung cancer, worldwide tobacco use has increased. Addiction, corporate power, government indifference and poorly informed consumers are among the factors responsible for the spread of the tobacco epidemic.

Every effort to regulate the industry has been met with an equal or greater effort to evade regulation. The industry has delayed, diluted or derailed tobacco control efforts in country after country. Rival companies have coordinated their efforts in opposing legislation, so that the same tactics, arguments and hired consultants have appeared in places as far flung as Canada, Hong Kong, South Africa and Sri Lanka (Saloojee and Dagli 2002).

The global strategy of the tobacco industry has elicited a global public health response. In May 2003, the World Health Assembly (WHA) adopted its first ever treaty – the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC). The Convention reflects agreement among WHO member states on a set of international minimum standards for the regulation of tobacco use and the tobacco trade. Its basic aim is to stimulate governments worldwide to adopt effective national tobacco control policies. Another aim is to promote collective action in dealing with cross-border issues like the illicit trade in tobacco, Internet sales and advertising.

The WHO sees the Convention as a major weapon in its counterattack against a problem that, if left unchecked, will kill 450 million people in the next fifty years. With 70 per cent of future deaths likely to occur in lower-income countries, the treaty is particularly important for these nations.

TABLE D3.2.1 **An outline of tobacco industry tactics**

Tactic	Goal
Intelligence gathering	Monitor opponents and social trends to anticipate future challenges.
Public relations	To mould public opinion using the media to promote pro-industry positions.
Political funding	Use campaign contributions to win votes and legislative favours from politicians.
Lobbying	Cut deals and influence political process.
Consultancy programme	To produce 'independent' experts critical of tobacco control measures.
Smokers' rights groups	Create impression of spontaneous, grassroots public support.
Creating alliances	Mobilise farmers, retailers and advertising agencies to influence legislation.
Intimidation	Use legal and economic power to harrass and frighten opponents.
Philanthropy	Buy friends and social respectability – from arts, sports and cultural groups.
Litigation	Challenge laws.
Bribery	Corrupt political systems; allow industry to bypass laws.
Smuggling	Undermine tobacco excise tax policies and increase profits.
International treaties	Use trade agreements to force entry into closed markets.

The WHO FCTC has become one of the most widely embraced treaties in the history of the United Nations. By January 2008, 152 parties had ratified the Convention, representing more than 80 per cent of the world's population. This chapter looks at the background to the treaty and its potential role in halting and reversing the tobacco epidemic.

Non-mandatory WHA resolutions

The WHO has long tried to get states to control tobacco. Since 1970, the WHA has adopted twenty resolutions on tobacco and repeatedly called upon member states to take action, but outcomes have been far from optimal. By 2000, about ninety-five countries had legislation regulating tobacco but most states had weak laws. Bans on sales to minors, vague health warnings on tobacco packs, or restrictions on smoking in health

facilities are measures commonly adopted. For the most part, such laws are inconsequential, neither seriously threatening the market for, nor affecting the profitability of, tobacco. On the other hand, a handful of countries with comprehensive policies did succeed in reducing tobacco consumption rapidly and significantly.

It is against this background that the WHO changed tack in 1996 by electing to use its treaty-making powers to regulate tobacco. International conventions to reduce marine pollution or to protect the ozone layer had helped states overcome powerful, organised industry resistance to regulation. Such successful environmental pacts served as precedents for the FCTC (Taylor and Roemer 1996).

The negotiations

Formal negotiations on the FCTC commenced in October 2000. The talks were arduous and highly political. An effective treaty could have quickly and readily emerged, if the talks were simply guided by the scientific evidence. Instead, it was clear early on that WHO member states had conflicting interests and obtaining agreement would be difficult. Countries that were host to the major tobacco transnationals argued for optional rather than mandatory obligations, which would significantly weaken the treaty (Assunta and Chapman 2006). As the treaty was to be finalised by consensus, the challenge for health advocates was to find the highest common denominator – to devise a treaty with meaningful policy measures that would also win wide support.

African, Southeast Asian, Caribbean and Pacific Island countries emerged as the champions of a robust treaty that incorporated international best practice. It is these countries that will bear the future brunt of the epidemic and thus it is appropriate that the FCTC reflect their needs.

Some of the keenest debates were on issues like a tobacco advertising ban and on trade. The United States, Germany and Japan opposed a total ban on tobacco advertising and promotion, arguing that it would not be permitted by their respective constitutions. Early drafts of the treaty only prohibited advertising aimed at youth. The majority of countries rejected this proposal as unworkable and ineffective.

This issue was resolved in the final hours of the negotiations, when a compromise championed by the NGO community was accepted. Tobacco advertising and promotion were banned but with a narrow exemption for countries with constitutional constraints. These states were required to take the strongest measures available, short of a total ban.

The final treaty contains significant recommendations on demand,

supply and harm-reduction strategies. Among its many measures, the treaty requires countries to increase tobacco taxes; establish clean indoor air controls; impose restrictions on tobacco advertising, sponsorship and promotion; establish new packaging and labelling rules for tobacco products; and strengthen legislation to clamp down on tobacco smuggling (WHO 2003). Mechanisms for scientific and technical cooperation, the exchange of information and reporting were also included.

Making the FCTC work

Experience with other treaties demonstrates that the dynamics of negotiation, peer pressure, creating a commonality of purpose, global standard setting and establishing institutional mechanisms all contribute to effective implementation of treaties.

The FCTC negotiations raised the profile of tobacco control among governments to a level never seen before. States that had previously ignored the issue were exposed to the scientific evidence on the health and economics of tobacco control, other countries' experiences and counter-arguments to the industry's positions on core issues. They actively debated options and agreed the content of the treaty. This generated new understandings, greater political commitment and shifts in behaviour.

The negotiations also galvanised non-governmental organisations (NGOs). Truly global NGO coalitions – the Framework Convention Alliance and the Network for Accountability of Tobacco Transnationals – emerged incorporating health, consumer, environmental and legal groups from North and South. The NGOs provided technical support, supplied detailed analyses of the draft texts and advocated key policy positions. They also played a watchdog role, by naming and shaming, or praising delegations.

To ensure that the momentum is maintained, an intergovernmental body, the Conference of the Parties (COP), is responsible for overseeing the Convention. The COP will take decisions in technical, procedural and financial matters relating to the implementation of the treaty, such as the funding and financial support and monitoring and reporting on implementation progress, and the possible elaboration of protocols, among others.

The impact of the FCTC

In international law, states are the most important actors. It is they who have to translate a treaty into national laws and develop enforcement mechanisms. International treaties provide blueprints for action, but it is

not until lawmakers get busy putting decisions into practice at home that lives will be saved.

Public monitoring of compliance with the treaty can provide a powerful incentive for countries to act. As President Mbeki of South Africa noted: 'No head of state will go to the UN and say he or she is for global warming or against the landmine treaty. However, upon returning home from New York or Geneva, under the everyday pressures of government they are likely to forget their treaty commitments.' President Mbeki suggested that it was the task of NGOs to hold governments accountable for their international obligations, so as to make a treaty a reality on the ground.

Already, several states have used the Convention as an umbrella either to introduce new legislation or to revise current laws to bring them into line with the treaty. In 2004, Ireland made history as the first country to implement a total smoking ban in indoor workplaces, including restaurants and pubs. The policy has been remarkably successful, and started a global rush to introduce comprehensive bans on indoor smoking by, among others: England, Estonia, France, Iran, Italy, Montenegro, the Netherlands, New Zealand, Norway, Scotland, Spain, Sweden and Venezuela.

In 2000, Canada became the first country to require picture-based health warnings on tobacco packaging. Countries that have since developed picture-based warnings include: Australia, Belgium, Brazil, Chile, Canada, Hong Kong, India, Jordan, New Zealand, Romania, Singapore, Switzerland, Thailand, the United Kingdom, Uruguay and Venezuela.

Other examples of legislative action in various countries include:

- In 2004, Bhutan banned the sale of tobacco products throughout the Himalayan kingdom. The predominantly Buddhist nation is the first country in the world to impose such a ban.
- Brazil has introduced anti-smuggling measures, including a mechanism for 'tracking and tracing' tobacco products.
- In Cuba, smoking was banned on public transport, in shops and other closed spaces from 7 February 2005. Cuban leader Fidel Castro kicked the habit in 1986 for health reasons.
- France raised the price of cigarettes by 20 per cent in October 2003, provoking a tobacconists' strike.
- India has banned direct and indirect advertising of tobacco products and the sale of cigarettes to children. The law originally included a ban on smoking in Bollywood films.
- In Kenya, a new Tobacco Act was passed in 2007. Among its provisions are a tax increase on tobacco and a ban on smoking in churches, schools, bars, restaurants and sports stadiums.

- South Africa is set to become the first country in the world to have a national ban on smoking in cars when children are present. The country is also set to join New York State and Canada in introducing self-extinguishing cigarettes to reduce the fire risks from tobacco smoking.
- In July 2003, Tanzania banned the selling of tobacco to under 18s and advertising on radio and television and in newspapers. Public transport, schools and hospitals were declared smoke-free zones.

A major challenge in implementing the Convention is that nations will interpret the treaty in different ways. The treaty establishes a set of minimum standards, while encouraging countries to go beyond these. Further, some treaty articles are mandatory and others are discretionary. There is therefore a danger that not all countries will adopt comprehensive tobacco control laws based on best practice, but that a diversity of laws will emerge providing uneven protection for the citizens of different countries and creating potential loopholes that the industry can exploit.

Recognising this problem, the COP will provide guidelines to support countries in drafting more stringent laws. The second meeting of the COP, held in Bangkok in July 2007, adopted guidelines for development of smoke-free legislation. The guidelines recommend the complete elimination of smoking in all indoor public places and workplaces within five years. In addition agreement was also reached to:

- begin work on a protocol to address tobacco smuggling;
- develop guidelines for eliminating tobacco advertising and sponsorship or, where this is not constitutionally permissible, regulating advertising;
- develop guidelines for cigarette warning labels;
- begin work towards guidelines on monitoring the tobacco industry, public education, and helping tobacco users quit;
- to continue initial work on tobacco product testing standards and economically viable alternatives to tobacco growing.

To help countries comply with their legal obligations the Convention includes mechanisms to share information, technology, training, technical advice and assistance. Many lower-income countries had hoped for a global fund to support them in implementing the FCTC, but after intense negotiations the donor countries resisted this idea and instead opted for a bilateral approach to funding. This is less than satisfactory from a developing-country perspective. The European Union (EU), for instance, will fund tobacco control as part of development aid. However, few lower-income countries consider tobacco to be a developmental problem, and not a single country has asked the EU to support its tobacco control programmes as

part of its development agenda. Unless donors specifically earmark funds for tobacco control activities, the latter will remain a poor cousin of other developmental aid programmes.

Conclusion

Tobacco control involves both politics and science, and until recently science has taken a back seat to politics. The FCTC promotes evidence-based measures to control tobacco. Massive challenges still lie ahead in delivering on the promise of the FCTC, but it is safe to assume that business will not get any easier for the tobacco industry.

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