

Trading ideology for dialogue: an opportunity to fix international aid for health?

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ABSTRACT: The history of international aid for health is characterized by trends in donor assistance, which fundamentally reflect the political or economic ideology of the donor. Shaping aid in the mould of ideology has greatly affected the sorts of aid that are available to developing countries, often with little regard to their actual health needs. We present a retrospective analysis of trends in aid giving from the 1960s to the present, and argue that despite much evolution in aid policy, at no time have the health needs of poor countries been paramount. Donors' insistence on the dissemination of ideology, which we characterize as "aid proselytism", explains in large part why policies in health aid have not shown satisfactory results, or have been repudiated after a number of years (e.g. user fees for health services, or vertical disease control programs). We recommend that in preference to ideology, a revolutionarily different model is needed, in which recipient countries drive the aid process from the bottom-up, by proposing anti-disease interventions consistent with their health needs and political priorities. These proposals should be given an independent, technical evaluation; and as a general rule, they should be funded if technically sound. Such a model procedurally separates the technical imperatives of good aid schemes from donors' extraneous ideology, and further involves developing countries in the governance of their own health needs. We evaluate the new Global Fund for AIDS, Tuberculosis and Malaria in light of this recommendation.

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"We don't know if it works but we know what's good for you"¹

In 1910 the Nobel Laureate and discoverer of the malaria parasite, Ronald Ross, propounded in his famous "sanitary axioms" that most fundamental observation about disease and development: "Widespread diseases, especially endemic diseases cause much pain, poverty, sorrow, expense and loss of prosperity to the people...and the rule is to grudge spending a hundred pounds for

¹ Foreign aid described by an official from Central Board of Health in Zambia

disease which costs thousands'². Too little has changed in the century since, and though the amount of development aid allocated to the health sector has recently started to increase in recognition of the fact that health is fundamental to human and economic development³, the administration of international aid for health remains deeply controversial. Both the professional and lay press are increasingly reporting that, despite some qualified successes, development aid policies for health have not realized their intended goals, and have often used inadequate—or even deleterious—strategies, with the greatest harm usually to the poorest.^{4 5 6}

In this paper, we track the evolution of policies governing international health aid since the 1960s. We consider the major multilateral actors include the World Bank, WHO and UNICEF, as well as the European Community (EC). We argue that the evolution of aid policy, instead of reflecting needs of the recipient countries, is driven by the changing ideologies of the donor themselves. Listening to views from poor countries, where the practice and delivery of international health aid must take place, is seldom decisive of policy. Thus aid policies emerge from a monologue of donors, rather than a dialogue including recipients; and this is so despite window-dressing to mask this reality. This lack of dialogue, we believe, underscores most of the failures of international health; and it suggests the urgent need for a restructured aid process, in which projects are not merely “guided” or “shaped” by the recipient countries, but actually *designed* by them, with donors providing finance and technical backup alone.

1. Major Trends in Policy

The fact that donors, and chief among them multilateral donors, shape health policies for developing countries is well known. Yet why donors should have such influence is perplexing, given that they are actually quite ungenerous with their funds. From 1972-1990, external assistance accounted for under 3% of health spending in developing countries—hardly so rich a

² Ross R.; *The Prevention of Malaria*. 1910, John Murray, London; pp295-296

³ WHO: Report of Commission on Macroeconomics and Health: Investing in Health for Economic Development, December 2001.

⁴ Kim J.Y.; Millen J.V.; Irvin A.; Gershman J. *Dying For Growth* ; 2000, Common Courage Press

⁵ Garrett L. “Betrayal of Trust: The Collapse of Global Public Health; 200, Hyperion

⁶ Gwatkin D. R. The need for equity-oriented health sector reforms. *Int J. Epidemiol.* 2001; 30:720-723.

contribution that developing countries' policies should be held to ransom for it.⁷ Nevertheless, for this small price of admission, donors often affect profoundly even the other 97% that is spent on the health of the poor.

Table 1 summarises the major health policy movements of multilateral donors based on previous reviews and our own observations.^{8 9 10} The policy evolution can be conveniently divided into four, roughly decadal eras:

In the 1960s, macroeconomic growth was seen as ultimate remedy to the poverty of underdevelopment. Growth strategies emphasized state-led capital investment in large infrastructure projects (dams, roads, ports and the like) of the kind taken for granted in a developed, contemporary market economy. Health projects funded by the World Bank or bilateral donors in this era reflect this emphasis on marshalling infrastructure, and often centred around such large capital projects as providing clean urban water supplies, sanitation, and urban or regional hospitals.¹¹ At the same time, WHO policy emphasized steady progress on large, vertical programs of disease control, such as the malaria and smallpox eradication programmes launched in the previous decade.¹²

In the 1970s, several different pressures worked to create a new emphasis on basic human needs. The old, capital-intensive, infrastructural approaches came under fire for benefiting urbanites disproportionately, while doing less for or even harming the larger rural population. The “discovery” by the press of humanitarian crisis in poor countries (e.g. Somalia, Biafra) revealed official aid responses as woefully aloof, which in turn stimulated Non Governmental Organisations (NGOs) to work in crisis relief.^{13 14} A new public mood, deeply suspicious of transnational commerce, led the World Bank to concur in 1975 that “the private market cannot

⁷ Michaud C., Murray C.J.L. External Assistance to the Health Sector in Developing Countries: A detailed Analysis 1972-90. Bull of WHO, 1994, 72 (4) 639-651 p 645.

⁸ Buse K., Spotlight on International Organisations: The World Bank. Health Policy and Planning 1994; 9: 95-99.

⁹ Buse K.; Gwin C. The World Bank and global cooperation on health: the case of Bangladesh Lancet 1998,351; 665-69

¹⁰ Lee K., Collinson S., Walt G., Gilson L. Who Should Be Doing What in International Health: A Confusion of Mandates in the United Nations? BMJ 1996; 312: 302-307.

¹¹ Justice J.; Policy Plans and People: Foreign Aid and Health Development; 1986 University of California Press. Pp 48-59 citing IDRB Annual Reports, World Bank, Washington and WHO documents: The First Ten Years of the World Health

¹² WHO (1968). The Second ten years of the World Health Organization, 1958-1967 (WHO, Geneva).

¹³ B. Kouchner (1986). Charité Business. Ed Le Pré aux clercs, Paris.

be expected to allocate to health either the amount or the composition of resources that is best from a social perspective”¹⁵. These and other influences spawned an emphasis on human rather than economic development, whose culmination and expression in international health was WHO’s “Health for All” strategy, endorsed by the international community in 1978 at the first UN Summit of Alma-Ata. Thus primary health care, and health services at village level, supplanted the former emphasis on grandiose infrastructure investments, or centrally-planned, vertical health programs.

Alma-Ata might have propelled primary health care into the 1980s, if it was not discarded by the international financial events of that decade. The Mexico debt crisis (1982) was the bellwether of many liquidity crises to affect developing countries, which cut public spending on health. Meanwhile, the donor countries, as creditors, became obsessed with defending the international financial order in which poor countries owed them for unrepaid loans. This ushered in an era in which economic, rather than human, development again gained the upper hand. Development institutions such as the World Bank became first and foremost purveyors of “structural adjustment”—a macroeconomic prescription based on the “Washington Consensus” that economic stability and development were best achieved through disciplined privatisation, deregulation and trade liberalisation. Thus while the World Bank increased its health lending considerably in the 1980s (about six-fold, compared to the decade prior), it was with the *quid pro quo* that health loans were part of this larger economic prescription for developing countries.¹⁶ The primacy of economic over health considerations was so thorough that even institutions without the Bank’s financial mandate, such as WHO and UNICEF, spearheaded policies such as the *Bamako Initiative* (1987), which introduced the astonishing principle that the world’s poorest countries (in Africa) should levy user fees and practice “cost-recovery” for public health services.¹⁷

By the 1990s, the human cost of this economic single-mindedness was both acute and embarrassing. As the World Bank’s chief economist candidly admitted, “concentration on

¹⁴ J.-C. Ruffin (1992). *Le piège humanitaire*, ED Hachette Pluriel, Paris.

¹⁵ Health Sector Policy Paper, 1975, World Bank, Washington; p 29

¹⁶ A complete list of the Bank’s health lending is found at: <http://www4.worldbank.org/sprojects/Results> (accessed September 21, 2001).

¹⁷ United Nations Economic and Social Council. Recommendation to the Executive Board for Programme Cooperation, UN Doc E/ICEF/1988/P/L.40.

macroeconomic models had deleterious effects on social welfare” which could not be overlooked¹⁸. International agencies responded with self-critical reports such as *Adjustment with a Human Face* (UNCEF, 1987) and the *World Development Report: Poverty* (World Bank, 1990), which reported that a decade’s fetishism with structural adjustment had crippled health programs, often doing so regressively, with the poorest suffering the worst consequences.^{19 20} This shortly led to another round of reports laced with recommendations to solve this problem, such as the World Bank’s report *Investing in Health* (1993). Yet all the recommendations still had a familiar, economic flavor: support only the most cost-effective health interventions; impose user fees for health services; privatise health systems, or create public-private partnerships. Other proposals concerned improving donor coordination within countries, and using sector-wide approaches (SWAPs) to plan budgets and programs. In short, aid donors spent the 1990s absorbed in how to run health systems with the greatest economic or managerial efficiency, while doing much less to actually restore the lost health interventions that could save lives.

At the start of a new century, there are again signs of change. Despite the policy emphasis on health systems, a number of programs focussed on a single disease or single intervention (i.e. “vertical programs”) were launched in the late 1990s, including the Global Alliance for Vaccines and Immunization, and the International Trachoma Initiative. The lost emphasis on “Health for All” and egalitarianism may be returning, with the WHO in 2001 declaring that “Poverty and inequity [are] the proper focus of the new century”, and the WHO Commission on Macroeconomics and Health endorsing a village based, “Close-to-Client” health services.^{21 22} Looking ahead, donors have agreed to ambitious new international development targets, and specifically, to halve poverty and halt or reverse the incidence of malaria and AIDS by 2015²³. Health policy therefore remains in flux.

¹⁸ Stiglitz J. Remarks at the North South Institute Seminar. Responding to crisis: policy alternatives for equitable recovery and development. 1998, Ottawa Canada. www.world bank.org p11

¹⁹ G. A. Cornia, R. Jolly, F. Stewart (eds.). *Adjustment with a Human Face* (Clarendon Press, Oxford, 1987).

²⁰ World Bank (1990). *World Development Report 1990: Poverty* (Oxford University Press, New York).

²¹ Feacham R.G.A., Editorial WHO Bulletin 2000 ;78 (1) p2

²² WHO Commission on Macroeconomics and Health (2001). *Investing in Health for Human Development*, Working Group N°5

²³ United Nations. “Road Map” of Millennium Summit Goals Sets Out Blueprint, Timetable for Future Implementation. UN Doc PI/1380 (19 September 2001).

2. Where is the logic?

Quite clearly, health policy has shifted emphasis many times over the years. This is remarkable for two reasons, both of which indict the legitimacy of the aid system that produced these policies.

The first problem is one of causality. While donors' policies and strategies for promoting health have evolved through successive policy eras, there is no corresponding evidence that health needs in developing countries were changing so as to necessitate or justify policy shifts at all. In fact, the health problems facing the poorest were remarkably constant throughout.

The second problem is one of misplaced ideology. While donors' shifting policies and strategies were not related to the constant health needs of aid recipients, they were instead malleable to fit the contemporary political, economic or managerial ideology of the aid donors themselves. That is, health aid over the decades has been "top-down", with the donors shaping the organization, management, priorities and rules of access to health systems. Very seldom has health aid been "bottom-up", with the recipients making these choices.

2.1 Policy and Needs:

In the past decades, world health has undergone an "epidemiological transition", which has shifted the leading causes of morbidity and mortality from communicable to non-communicable diseases²⁴. While this is generally true in the high- or middle-income countries, it does not hold for the world's poorest people (the bottom quintile) concentrated in the low-income countries, where infectious diseases still account for 60% of mortality.^{25 26} Diseases of poverty or the tropics—such as acute respiratory and gastro-intestinal infections, tuberculosis, or malaria—still top the mortality statistics as they did in the 1980s.^{27 28} In Sub-Saharan Africa, infectious causes

²⁴ Murray C.L.J. Lopez A.D.; eds. *The global Burden of disease: a comprehensive assessment of of mortality from diseases, injuries and risks factors in 1990 and projected to 2020*. 1996 Cambridge Harvard University Press.

²⁵ Gwatkin D.R.; Guillot M.; Heuveline P. *The Burden of Disease Among the Global Poor*. *Lancet* 1999: 354, 587-589.

²⁶ Khlal M.; *La santé: anciennes et nouvelles maladies* Institut National d'Etudes du Developpement 1997, Paris: 435-460.

²⁷ *Annual World Health Statistics* WHO, Geneva

of death show meager decline over the decades: from 48.2% in 1970, to 47.2% in 1985, and 41.8% in 2000.²⁹ What little progress has been made is very likely reversible by HIV/AIDS, and its opportunistic infections, in coming years.

Given this dismal record, it cannot be said that forty years of aid giving has been highly successful in improving the health of the poorest, who still suffer a staggering infectious disease burden. That reality has been utterly constant, and yet, the policies favored by aid donors have been through one sea change after another. This suggests a fundamental waywardness in those policies which strikes at their legitimacy. In fact, the overall effect of policy changes from the 1960s and 1970s to the present is largely to *return*, almost cyclically, to objectives that were once in vogue in then later discarded: today's focus on poverty alleviation, close-to-client health care and egalitarianism as goals for health aid is hardly different from the "Health For All" policy of three decades ago.

This unintentional cyclicity pertains not only to how policy is articulated, but to how aid agencies implement it in the design of projects. For example, vertical programs aimed at a single disease (e.g. malaria) or using a single intervention (e.g. smallpox vaccine) lost support in the 1970s as policy favored primary health care. But now vertical programs are winning support again: the Global Alliance for Vaccines and Immunization, or the International Trachoma Initiative, are undeniably vertical, even though not described as such ("vertical" remains a dirty word). Similarly, donors have several times changed policy on who should perform the operational side of health programs. In the 1960s and 1970s, donors backed the public sector, while in the 1980s and 1990s donors' fixation on privatization caused them to shift support to the private sector. More recently, donors are enthusiastic about "public-private partnerships", and the need to involve civil society. None of these policy revisions can be attributed to a change in the health needs of poor countries. All of them can be attributed to the excruciatingly slow

²⁸ Murray C.L.J. Lopez A.D. Global Health Statistics: a compendium of incidence, prevalence and mortality for over 200 conditions 1994 Harvard School of Public Health Harvard University Press

²⁹ Gribble J.N.; Preston S.H. eds The epidemiological transition 1993 National Academic Press, Washington, table p 200.

realization by donors that each sector of society has core skills, all of which are useful to providing health services.³⁰

2.2 Fashions and aid proselytism:

So, if the backdrop of illness in the poorest countries has changed little over the years, what has caused aid policies constantly to shift, or even travel full circle? We believe that donors' political and economic ideology, much more than the actual biomedical imperatives of health, drives health policy.

One clear example of this is the policy of making the poor pay “user fees” to access health services. WHO and UNICEF made this official policy in Africa with the *Bamako Initiative* in 1987, quite at variance with the egalitarianism of “Health for All” that had preceded it. This policy change came about in an era when it was fashionable to view development predominantly in economic instead of human terms, and during the fiscal stringency of structural adjustment, when it was popular to privatize the costs of services, in this case by making users pay.

While this was perhaps attractive as financial policy, as health policy, it proved foolish. The weight of evidence is that user fees have regressively impeded access to health services for the poorest, while collecting very little revenue for those services.^{31 32} Rarely do user fees raise more than 5% of recurrent health costs, or in one flagship *Bamako Initiative* project, just \$0.30 *per capita*—probably about what it costs of collecting and administering the fee itself.^{33 34} Nor do user fees have a clear rationale in making health services available to more people. Where donors claim the *Bamako Initiative* boosted vaccination coverage (to 73% for DTP/polio in Guinea in 1995), this is called into question by poor results in later years (48% in 1996, and 57%

³⁰ J. D. Wolfensohn (President of the World Bank). A Proposal for a Comprehensive Development Framework. Available at <http://www.worldbank.org/cdf/cdf.pdf> (Accessed 21 Sep. 01)

³¹ D. Arhin-Tenkorang (2000). Mobilizing Resources for Health: The Case for User Fees Revisited. WHO Commission on Macroeconomics and Health Working Paper WG3:6. Available at http://www.cmhealth.org/docs/wg3_paper6.pdf (accessed September 24, 2001).

³² Kim J.Y.; Millen J.V.; Irvin A.; Gershman J. Dying for Growth 2000; Common Courage Press. Chapter IV: 142-148

³³ J. K. Wang'ombe (1997). Cost-recovery strategies in sub-Saharan Africa. In G. J. Scheiber, Ed., *Innovations in Health Care Financing*. World Bank Discussion Paper 365.

in 1999).³⁵ Nor is this an isolated case: in French West Africa, where UNICEF, WHO and other donors pushed recipient governments most aggressively to implement the *Bamako Initiative*, vaccination rates *decreased* for the six basic childhood diseases between 1990 and 1999.³⁶ Over a decade into the *Bamako Initiative*, the WHO and the Global Alliance for Vaccines and Immunization (including UNICEF) conceded their error, declaring in 2001 that “user fees discourage people from seeking vaccination.”³⁷

Given that intuition and evidence both argue against charging the poorest for services such as childhood vaccination, what explains donors’ attachment to mistaken policies such as the *Bamako Initiative*? The answer is that donors back policies that mirror their own domestic political or economic ideology, thus turning aid into a sort of “donor proselytism”. This is clearest when, for instance, donors decline to fund programs because of programs because of political beliefs at home (the American refusal to fund population control programs involving abortion is an example), but subtler proselytism dressed up as “guidance” also exists. Consider a recent World Bank book about health finance: after surveying the experience of Japan, Germany, and the United States with user fees, the Bank declares these as “Lessons for Developing Countries”, without seriously weighing the adverse evidence of user fees in poorer economies.³⁸ Donors may be so wedded to their ideology and policies that they even suppress adverse evidence of being mistaken. For example, the Executive Director of UNICEF recently credited the *Bamako Initiative* for “improved and sustained immunization coverage”, despite the fact that WHO statistics show this is certainly false.^{36 39}

Needless to say, aid policy based on ideology over evidence is devastating, for in effect it serves donors’ priorities above recipients’ actual health needs, which are forgotten. The same point is

³⁴ A. Soucat *et al.* (1997). Local cost sharing in Bamako Initiative systems in Benin and Guinea: assuring the financial viability of primary health care. *Int J Health Plan Mgt* 12 Supp 1:S109-135.

³⁵ Knippenberg R *et al.* Sustainability of primary health care including expanded program of immunizations in Bamako Initiative Programs in West Africa: an assessment of 5 years’ field experience in Benin and Guinea. *International Journal of Health Planning and Management*, 1997, 12 (suppl.1):S9–S28.

³⁶ Based on WHO data for Benin, Burkina, Cameroon, Côte d’Ivoire, Gabon, Guinea, Mali, Mauritania, Niger, Senegal, Togo, and an average drop in coverage from 56.2% to 52.9%. Available at <http://www.who.int/vaccines-surveillance/documents/coverage%201974-1999.zip> (accessed September 24, 2001).

³⁷ S. England, M. Kaddar, A. Nigam, and M. Pinto (2001). Practice and policies on user fees for immunization in developing countries.

³⁸ World Bank (1996). *An International Assessment of Health Care Financing: Lessons for Developing Countries*.

³⁹ Statement of UNICEF Executive Director Carol Bellamy. Bamako, Mali, 8 March 1999. Available at <http://www.unicef.org/exspeeches/99esp3.htm> (accessed September 25, 2001).

noted by other critics who point to the distracting effect of donors' economic or geopolitical interests.^{40 41 42 43 44} Our analysis argues that the health sector is not without these problems.

Recently donors have promoted health sector reform, and the use of Sector Wide Approaches (SWAPs), to restore recipients' voice to the aid process. SWAPs are defined by one author as a forum "in which [the recipient] government and donors can use joint planning and management systems" to create "the overall policy, institutional, and financial framework within which health care is provided".⁴⁵ Another author defines them as "a broad framework within which all resources are co-ordinated in a coherent and well-managed way, in partnership, with recipients in the lead".⁴⁶

These definitions suggest that SWAPs achieve an objective, ideology-free goal of efficiency, while making recipients' health needs paramount. But in fact SWAPs have less to do with delivering health interventions *per se*, so much as donors reforming the management of the health sector, and this can cause recipients' needs can lag behind. As one commentator writes:

In the process of setting up a SWAP, a lot of attention and energy can go towards developing plans and setting up systems of accounting and monitoring. Actual service delivery is often the last thing to be initiated, even though this is the most important part of the process.⁴⁷

Thus while SWAPs purport to put recipients "in the lead", analysts find they prioritize donors' quest for efficient aid management over the giving of health aid itself; and this is the experience of the authors (Périn; formerly a European Union aid officer). The literature confirms that SWAPs remain tightly controlled by donors⁴⁸, and that far from being a panacea for aid co-ordination, they achieve inconsistent results.^{49 50 51} Further, the literature contains no persuasive

⁴⁰ Stephanek J. A new book on poor-world development., September 1999 Praeger Publishers

⁴¹ Hellinger S, Hellinger D., O'Regan F. Aid for Just Development 1998, Lynne Rienner Publishers.

⁴² Jepma C. J.; The Tying of Aid. 1991; Development Centre Studies, OECD

⁴³ Hibou B. Les méfaits du cathéchisme économique. Esprit, août-septembre 1998; pp 98-139.

⁴⁴ Sindzingre A. Les Bailleurs de fond en mal de légitimité. Esprit, juin 2000 pp: 116-127

⁴⁵ Cassels A., Janovsky, K. (1998) Better health in developing countries: are sector-wide approaches the way of the future? *Lancet* 352:1777-1779.

⁴⁶ Walt, G., Pavignani, E., Gilson, L., Buse, K. (1999). Managing external resources in the health sector: are there lessons for SWAPs? *Health Policy and Planning* 14:273-284.

⁴⁷ Salm A.P.; Promoting Reproductive and Sexual Health in the area of Sector-Wide Approaches. Editorial *Reproductive Health Matters* 2000 ; 8 (15): p19

⁴⁸ Buse K. Keeping a tight grip on the reins: donors control over aid coordination in Bangladesh. *Health Policy and Planning* 1999 14 (3): 219-228

⁴⁹ Walt G.; Pavignani E.; Gilson J.; Buse K. Managing External resources in the health sector: are there lessons for SWAPs? *Health Policy and Planning* 1999 14 (3) 273-284.

evidence that co-ordination for co-ordination's sake (as distinct from increased donor spending) has benefited the health of the poor, which draws into question whether it is donors or recipients who gain most from SWAPs. On the contrary, the observation that donor-driven health sector reform “seems to have actually harmed public health services and provision...when driven by forces outside the health system”, is plausible.⁵²

3. Global Fund

Donor interests and ideologies can—and do—prevail over recipient country interests this way because, even in SWAPs, there is no assurance of dialogue in which recipients can voice their own health priorities and have them fairly evaluated. We therefore suggest a new model is overdue, in which recipient countries articulate their own health needs and freely propose the interventions they want; and in which aid donors may agree to fund those proposals, if they are technically sound. This model can limit the interference of donor proselytism and extraneous ideology in two important ways: (1) by separating the technical evaluation of projects from political considerations, and; (2) by more symmetrically sharing power with developing countries.

At this writing, a new Global Fund for AIDS, Tuberculosis and Malaria is not yet operational, but is promising major changes along the lines we advocate. We speculate here as to its best points, and its potential weaknesses.

What is revolutionary about the Fund is the institutional separation of technical and political functions of aid-giving, and the sharing of power symmetrically with developing countries. Its Board of Directors comprises 7 votes from among donor countries, 7 from developing countries (though not all are so poor as to be recipients), 1 from non-governmental organizations, and 1

⁵⁰Foster M. New approaches to development co-operation: what can we learn from experience in implementing Sector-Wide Approaches. Centre for Aid and Public Expenditures. Working paper N° 140. Overseas Development Institute October 2000.

⁵¹Peters D.; Chao S.; The sector-Wide Approach in Health: what is it? Where is it leading. *Int J of Health Planning and Management* 1998 13, 177-190.

⁵²Berman P.A.; Bossert T.J.; A Decade of Health Sector Reform in Developing Countries: What Have we Learned? Paper presented at the symposium “Appraising a decade of health sector reform in developing countries” Washington March 15 2000.

from the private, industrial sector; and international bodies (e.g. WHO, the World Bank) hold advisory, non-voting seats. The co-presidency is held jointly by one donor and one developing country. This governance structure, in turn, is separated from a technical structure beneath it, comprising a Technical Review Panel (TRP) of 17 scientific and operational experts in AIDS, TB and Malaria, whose function it is to review aid proposals for scientific and technical merit before a funding decision is made by the Board. Importantly, those proposals are authored by developing countries and travel “up” to the TRP and the Board, reversing the historical plan where projects and programs were created by donors and travelled “down” to the recipient country. Finally, the Fund raises money from developed governments and the private sector, which is pooled in a common account by the World Bank as fiduciary agent, with disbursements controlled by the Board.

Thus the Fund resembles a charitable foundation that grants money to applicants competitively, with an *ex ante* evaluation similar to peer review to help choose among proposals. The authors have proposed this foundation-like model elsewhere, and it is supported widely by scientists, and the editors of the *Lancet*.^{53 54} Within the Fund, it will remain true that donors care about “why” to intervene, in terms of their economic or geopolitical interest; that technical agencies formulate “how” to intervene, having regard to technological and operational constraints; and that recipient countries urge for “which” health problems they want intervention, often depending on domestic politics. These roles are entrenched, and it would be Utopian to try and change them. What the Fund can do is connect them institutionally and regularize their dialogue, while hopefully enlarging the intersection at which agreement and successful aid projects are found.

But will this work, better than before? Maybe. Good institutions are a precondition, but not a guarantee, of good outcomes. It is not yet clear if donors will accept a subordination of their power to the Fund model. Reluctance to capitalize the fund is probably due to donors’ scepticism (it has raised a one-off \$2 billion, and so far not the annual \$7-10 billion called for). Or donor power could simply migrate under the table: the recent experience of Malawi, which was warned by donors not to submit a large proposal to the Fund (\$450 million over 5 years) but instructed to submit a smaller request (\$10 million in the first year) is extremely alarming, and if

⁵³ Attaran A., Sachs J. Defining and Refining International support for combating the AIDS Pandemic. *Lancet* 2001 ; 357: 57-61

repeated will reduce the Fund into a fig-leaf for old ways of doing business. This would be an enormous opportunity lost, and it is vitally important to the health of millions that donors resist tactics like these and remain engaged in good faith. The stakes are so high that in the normally complaisant world of international health, incidents of this sort should be disclosed to the press and publicly aired (perhaps in the *Lancet*). With the benefit of hindsight into past failures, the world—and especially its poorest—can ill afford such a remarkable and unprecedented system as the Fund, to fail.

Table 1: Schematic representation of major health policy trends

Years	WB	UN	EC
1960	Economic growth against poverty Infrastructures (water, sanitation ...)	Vertical disease control Diarrhoea, Malaria, Tuberculosis ...	Economic integration Rome Treaty 1957
1970 1975-78	Poverty alleviation Health policy paper	Vertical disease control Alma-Ata Summit Health Policy	Poverty alleviation Lome Convention* Infrastructures (Hospitals)
1980 1981 1987 1989	Structural adjustment WDR Adjustment and Growth Health Policy Paper. Health Loans WDR Barriers to adjustment Financing in Health / Cost recovery WDR Financial Systems	Primary Health Care & Essential Drugs Adoption of Global Strategy of Health for All Policy for Polio Eradication. Bamako Initiative (WHO UNICEF). 1 st AIDS control programme Adjustment with Human Face UNICEF	Rural development Rural development programmes Structural adjustment in Latin America
1990 1990 1993 1996 1997 1999	Agenda for Reform WDR Poverty WDR Investing on Health WDR Role of State. HPN strategy Good Governance	Health Systems Development Children Vaccine Initiative SWAP papers Review of Health for All Strategy Bridging the gaps for Health For All	Integrated development 1 st health programmes Asia, Latin America Program Aid SWAPs
2000	Poverty Poverty Reduction Sector Program	Disease Control Malaria, AIDS, Tuberculosis	Poverty/disease control Cotonou Convention*

Legend = SA: structural adjustment. ACP: African Caribbean and Pacific countries. LA: Latin America. MED: Mediterranean. WR: World Report. HNP: Health, Nutrition and Population. PRSP: Poverty Reduction Sector Programs. HIPPC: Highly indebted poor countries. PHC: Primary Health Care. TB: tuberculosis. SWAP: Sector-Wide Approach Programme.

Poverty : Global orientation

“WDR”: Publication

* The Lome (1977) and the Cotonou Convention (2000) are agreements between 77 ACP countries and the European Commission containing the objectives and rules of EC aid.

Full lines illustrate the current dynamics of the decision process. Recipient's role remains essentially to prove its capacity to integrate donors' approaches: e.g. funding instruments or technical outcomes that are predetermined by donors in accordance with their political motives. It is only where the recipients' absorptive capacity overlaps with the donors' predetermined financial and technical offerings (central box) that aid projects or programs can succeed, and this may not be the case for the recipients' most pressing health needs.

Broken lines represent a new definition of roles with improved dialogue. Recipient countries start the process with a demonstration of political commitment and their specific health needs, contained within a funding proposal (1a). Technical agencies or others with expertise can help refine the proposal for merit (1b). The improved proposal is then examined by an independent technical panel which evaluates its scientific and medical soundness and operational feasibility; cost is not a criterion at this stage (2). Those proposals which survive technical scrutiny and which are therefore of high quality are then considered by donors, who may or may not approve funding to the full level requested taking account of budgetary constraints (3). As such, scientific, technical and operational considerations are procedurally walled off from and are not subordinated to political and budgetary considerations, although ultimately these may enter into the final funding decision.

Figure 2: Decision-Making in Health Development Aid

