



Report on Wilton Park Conference WP751

SCALING UP HEALTH INVESTMENTS IN DEVELOPING COUNTRIES: LESSONS ABOUT WHAT WORKS

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**In cooperation with:
The Global Fund to Fight AIDS, TB, and Malaria
The Bill and Melinda Gates Foundation
The Institute for Global Health, UCSF**

Introduction

1. The past several years have witnessed dramatic increases in the level of resources available in international health. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), established in 2001, has received pledges of over \$5 billion from donors through 2008, and has commitments totalling \$3 billion in 128 countries. The Bill and Melinda Gates Foundation spent approximately \$1.4 billion in global health initiatives in 2002 alone. The US President's Emergency Plan for AIDS Relief (PEPFAR), announced in January 2003, pledges to spend \$15 billion over the next five years in 15 countries. Additional resources have also become available through the World Bank (especially, its Multi-Country AIDS Program, or, MAP, and IDA credits), regional development banks, the European Community, and bilateral development agencies.

2. Whether or not, and how, developing countries can make effective use of these large sums of new money flowing into their economies and health care sectors has been a source of major contention and debate among experts in development finance and international health policy. Although not enough time has passed for a formal evaluation, the organizers felt that an early and informal assessment of countries' progress with scaling up programs could serve a useful purpose. What kind of challenges have arisen (expected or unexpected), how have countries addressed these, and what lessons can be gleaned from early experiences in scaling up and implementing new programs that might be useful for others? Specifically, participants were asked to reflect on the following issues:

- What has been the impact of the new and innovative financing mechanisms to fight HIV/AIDS and other diseases at the country level?
- What lessons can be gleaned from countries' experiences with recent and rapid scaling up of health investments?
- Which countries have made significant strides forward? Which have met with major challenges?

- How have the most successful countries dealt with known and/or anticipated “bottlenecks” affecting, for example, spending and disbursement practices, program management, drug procurement and supply, and recruitment and training of staff?
- What additional steps are needed to ensure that countries can overcome bottlenecks and effectively address absorptive capacity constraints?

3. A group of high-ranking government officials, representatives from the bilateral and international agencies, civil society, private industry, and non-governmental organizations from the North and South gathered to discuss these issues at the Wilton Park conference on “Scaling Up Health Investments in Developing Countries: Lessons about What Work,” June 16-18, 2004. The following report attempts to capture the tone of the discussion and debate that took place at the conference, and highlights areas of general consensus and agreement that emerged over the course of the three days.

General Observations

4. Although the conference was not intended to serve as a forum to compare the various structures and procedures of the international funding agencies, the developing country participants and others repeatedly commented on their experiences in working with them. For example, many of the structures and processes set in place by the Global Fund from its inception were developed with a view towards distinguishing it from existing bilateral and multilateral aid mechanisms, and, on the whole, developing country participants expressed strongly positive views on the Global Fund’s performance relative to other agencies. In marked contrast, a number of developing country participants expressed strong dissatisfaction with their experiences thus far with PEPFAR.

5. Developing country representatives attending the conference expressed a high level of satisfaction with the Global Fund’s emphasis on country-driven processes. Many felt that such an emphasis has helped to encourage “ownership” of and commitment to projects, the alignment of priorities with local needs, and investments in capacity and skills of recipient countries. Although everyone agreed to its importance, in principle, the concept of “ownership” proved difficult to describe. The operative question was ownership ... by whom? Some public health officials expressed concern that private sector involvement, whether not-for-profit or other, undermined government ownership. But others argued that ownership should be understood more broadly, and should include the participation of civil society. Many participants felt that civic groups such as people living with HIV/AIDS (PLWA) had played key roles in advocacy and planning in their countries, and that this had been facilitated by the Global Fund’s insistence that these groups be represented within the Country Coordinating Mechanisms (CCMs).

6. Developing country participants also expressed appreciation for the flexibilities afforded by Global Fund financing. The Fund’s policies allow a great deal of latitude in countries’ decisions about how to spend their money. Recurrent costs, for example, are rarely permitted under the guidelines of most aid agencies (although many are currently reviewing their policies to accommodate the severe capacity constraints confronting developing countries). The Global Fund also invites, and encourages, countries to include budget lines for information systems, evaluation research, and operations research in their proposals. It was clear from discussion that developing countries are not always aware of the full extent of these flexibilities, and some participants argued that the Global Fund should more actively advertise and market these flexibilities, and encourage other aid agencies to adopt similar policies.

7. Finally, developing country participants tended to view positively the Global Fund’s insistence on openness and transparency in its transactions. Information about

the Fund's activities is accessible on its web site and, as a matter of principle, the Global Fund encourages public debate and the timely deliberation of policy issues. Developing country participants were especially enthusiastic about the Global Fund's commitment to publishing the results of countries' negotiations around drug pricing and supply. However, they also expressed frustration with the limited opportunities they had for learning from each other's experiences in this and related areas.

8. In contrast to these largely positive views on Global Fund performance, some participants, especially developing country participants, expressed strong dissatisfaction with PEPFAR¹. Some participants accused PEPFAR of heavy-handedness in its dealings with developing countries. Others complaints were more specific – focusing on the Bush administration's preference for costly, brand name antiretroviral drugs and treatment programs run by non-governmental, faith-based organizations.

9. Although PEPFAR was welcomed as an additional source of project financing, it adds an additional layer of complexity to the process of scaling up at country level. For the countries that have a health sector and AIDS strategy already in place, not to mention policies and procedures to support newly launched programs and initiatives, PEPFAR's requirements were viewed by participants as duplicative and unhelpful. Despite these negative commentaries, one country did report that it had been able to successfully negotiate terms with PEPFAR representatives during a recent official visit to the country.

10. Beyond these specific comments related to the Global Fund and PEPFAR, some conference participants expressed dismay over a number of disturbing trends in global financing for health. Some complained that global financing continues to be narrowly-focused on disease-specific interventions. A number of participants stressed the importance of health sector strengthening, and several donor representatives called for stepped up budgetary support and/or financing cross-cutting areas (including capacity building, health information systems, and drug, diagnostics and infrastructure). One participant pointed out that new analysis indicates that much of the cost-effectiveness work has over-estimated the impact of disease-specific interventions vis-à-vis systems strengthening.

11. Many participants also raised questions about the sustainability of health projects at their current (or higher) levels of financing. Without a significant increase in contributions, the Global Fund will almost certainly face a financial shortfall in 2005, and its ability to approve any new proposals will be seriously compromised. For developing countries on the verge or already in the process of scaling up, this scenario raised a number of troubling issues. What will happen to the thousands, or tens of thousands, of patients receiving antiretroviral therapy if the external funding dries up? How can (and should) countries be persuaded to switch from cheap anti-malarial drugs to the more expensive, but also more effective alternative, if there is no assurance of long-term funding for such a change in policy? By moving quickly to scale up services, many countries have taken a gamble on the long-term availability of external assistance.

12. It was noted that the lack of donor coordination and harmonization of policies continued to impose a high burden on developing countries. The Global Fund received criticism, although perhaps less than other donors. It was argued that better coordination contributes to more effective outcomes in health care spending. However, the lack of coordination may create needless inefficiencies, weaken government capacity, and

¹ PEPFAR representatives were unable to attend, and therefore the newly launched agency was not represented in these discussions.

undermine the public sector's ability to respond to local health care priorities. Most participants agreed that the creation of the SWAPS (Sector-wide Approaches) has played an important role in improving donor coordination, but expressed concern that the fascination for "new" global initiatives threatened to reverse this progress.

13. Finally, participants highlighted their deep concern and frustration with the problem of "brain drain" from developing countries, primarily to the North. The case of Malawi was offered to illustrate the problem: not only is the country experiencing a major exodus of registered nurses from the public sector to the private, but it is also losing nurses to South Africa, and to the UK's National Health Service. Many countries shared similar stories. Most if not all of the emigrating health professionals have been trained at the public's expense. Participants agreed some way must be found to redress what some described as the grossly unethical result – an effective subsidy to the North by developing country governments.

Common Constraints on Scaling Up, and Selected Country-Level Responses

14. In addition to these general observations, discussion at the conference focused more specifically on how countries are dealing with common constraints on scaling up. As additional resources have become available for health care, internationally, some observers have expressed concern that developing countries would be unable to absorb and make efficient use of these resources. For example, countries may have difficulty setting up financial and management systems that would allow projects to access money from the Principal Recipient, in the case of Global Fund money, for example, or a central account. They may have difficulty obtaining reliable and consistent technical information on 'best practices' or programmatic options for scaling up specific health interventions. Finally, countries may lack sufficient staff or trained personnel to provide the necessary health care services. It was a widely shared view among participants that challenges related to constraints on human capacity are among the most serious and intractable that countries presently face.

15. Participants were not blind to the challenges that countries face. However, it was clear from the discussion that some countries have lessons to share about learning to manage and work within the confines of existing constraints. Thus, the focus of discussion was on the types of strategies that countries have pursued to address common constraints, and the lessons could be gleaned from their experiences. Some of their examples are presented here.

16. Several countries were asked to share their experiences with "moving" money quickly to scale up activities at the local or district levels. Delays were attributed in some cases to problems with procurement, and tensions between government agencies (e.g. National AIDS Councils and National AIDS Programs), as well as between government and non-governmental organizations. However, among the countries that reported strong progress, a key factor was the involvement of non-governmental organizations in service provision. This observation was reinforced by a recent review of recipients of Global Fund money which found that NGOs were actively engaged in service provision of all high performing countries. Participants were divided on the implications this had for the public sector. Some felt that the emphasis on NGOs would weaken the public sector. Others felt that NGO involvement in service provision need not detract from government's role as "steward" of the health care sector.

17. *Ghana* has shown encouraging progress by shortening the time frame required to transfer funds to sub-recipients of the Global Fund award. It has done so by developing a clear implementation and disbursement plan, using the existing financial system of the Ministry of Health to create a special account for Global Fund dollars, and streamlining

the process for approving proposals and disbursing funds. The latter has been facilitated by the appointing four signatories to permit the release of funds (two signatures are required), developing simple contract forms and short proposals, and holding orientation and bi-annual meetings for sub-recipients. An ongoing concern is how to ensure accountability while at the same time encouraging the rapid processing and movement of funds.

18. *Madagascar* has adopted an alternative approach that relies principally on NGO support to facilitate the rapid scale up of programs and activities. Political instability in 2001 prevented Madagascar from forming a Country Coordinating Mechanism, but the Global Fund accepted and approved a US\$1.5 million malaria proposal from Population Services International (PSI) to scale up the social marketing of insecticide treated bed nets. Subsequently, the government created its own CCM, and PSI began to focus more directly on implementation. Currently, PSI is the primary distributor and promoter of long-lasting bed nets in the country.

19. *Swaziland* offered a compelling example of partnering with the private sector to strengthen public sector capacity. The National Emergency Response Committee on HIV and AIDS (NERCHA) was established as an inter-sectoral public-private body responsible for coordinating and assisting with the implementation of all activities dealing with the HIV/AIDS epidemic. Although NERCHA is not an implementing body, one of its important contributions has been defining and developing systems and procedures (administrative and operational) needed to support a coordinated response to the epidemic.

20. Related discussion focused on strategies to harness the energies of the private sector to facilitate the process of scaling up. Some participants objected to efforts to build capacity outside of the public health care system. Others responded that strengthening the capacity of the private sector – which tends to provide services to segments of the population that can afford to make out-of-pocket payments – would permit the public sector to focus more exclusively on the very poor. Unable to resolve the debate directly, participants reviewed several concrete examples of private sector involvement in scaling up health care, and discussed potential implications for other developing countries.

21. In *Pakistan*, the Greenstar Social Marketing and Franchising initiative has provided family planning and other basic health care services and products for nearly twenty years. Greenstar's model was to expand access and improve the quality of health care for low and middle-income clients by existing private sector clinics and practitioners, such as doctors, paramedics, and chemists. By participating in the Greenstar network of service providers, clinics receive basic training and access to low cost, high quality contraceptive products. Participants at the conference discussed whether the franchising model could be successfully applied to other health care services, such as tuberculosis and HIV/AIDS treatment. Some felt that it would be especially relevant in countries in Africa, where private sector out-of-pocket payments are large, and private sector quality is highly variable. Thus, the franchising model could be a relatively low-cost way of scaling up without encroaching on the public sector's clientele, but at the same time improving the quality of private sector providers.

22. Most participants agreed that more progress could be made in the fight against AIDS if private, for-profit firms had a better grasp of the financial and economic consequences of the epidemic. This was certainly the case for TATA Steel in *India* which has adopted an unusually proactive approach to HIV/AIDS prevention and treatment for its employees and the surrounding community in which they work. Jam

Shadpur is an industrial town with a large workforce and migrant labor population. The town is located next to a national highway linking mobile sex workers to workers and migrants. TATA Steel launched its HIV/AIDS program in 1992, but has since expanded its program to include surrounding urban, suburban, and rural areas. Activities range from awareness raising, training, condom distribution, voluntary counselling and testing, care and support, and the strengthening of blood banks. The *Philippines* also offered a number of interesting examples of private sector participation in tuberculosis treatment and control.

23. Participants forcefully argued that HIV prevention activities must be part of a comprehensive AIDS strategy, but acknowledged that the track record for success has been relatively unimpressive. However, some important directions were emphasized by LoveLife, an NGO working in *South Africa*. Also, experiences from *Chile* indicate the need to prioritise prevention activities among high-risk populations, such as migrant labourers, MSM, and sex workers. A national network offers face-to-face and telephone counselling by local health and non-governmental organizations. Condom distribution has been promoted through social marketing in partnership between the public sector and civil society groups.

24. Another topic of great importance to developing country participants involved comparing notes on their experiences with drug supply and procurement. The “high volume, low price” segment of the market for antiretrovirals has evolved rapidly over the past several years, and many countries have been able to take advantage of falling prices. Many countries had successfully worked with international procurement agencies, and/or had adopted a multi-country approach to price negotiations. For example, *Jamaica* was able to lower its costs of providing ARV treatment fell from \$1380 to \$702 per patient per year by accessing the price reductions achieved by the Clinton Foundation in its negotiations in 2003. These prices have been extended to recipients of Global Fund and World Bank grants. *Honduras* began to centralize its drug procurement activities in 1998. In 2001, the Ministry of Health reached an agreement with the main pharmaceutical companies to purchase ARV for first line therapy at \$1380 per patient per year. The price was dropped in 2003 when Central American Health Ministers banded together to negotiate, securing an agreement at \$1054 per patient per year. However, the use of Global Fund resources lowered the price to \$702 per patient per year. In 2004, the price will drop still further – to \$205 per patient per year – for new patients receiving first line therapy and using the generic combination stavudine-lamivudine-nevirapine.

25. Unlike other countries, Swaziland did not rely on the assistance of international procurement agencies. Nevertheless, the country recently completed the selection process for preferred suppliers, securing costs saving of up to 50% from a combination of brand-name pharmaceutical companies and generic producers. Finally, *Bangladesh* described its own experience of working with the TB Global Drug Facility (GDF) to secure high quality drugs at low prices. The preferred method of procurement was, in this case, direct contracting through a low-cost supplier.

26. Several participants expressed frustration that PEPFAR would not permit its support to be used for the purchase of generic drugs, and instead was encouraging countries to purchase higher cost brand name antiretroviral drugs. By contrast, Global Fund policies offered greater flexibility in drug procurement, encouraging countries to acquire drugs at the lowest price possible, while maintaining quality standards. As a general principle, the Global Fund has adopted a “hands off” approach, declining to get involved in direct negotiations in drug procurement. It has pledged to publish the prices secured by its recipients through the competitive bidding process, as a way to ensure

transparency and to promote a healthy, competitive market environment. Nonetheless, some participants encouraged the Global Fund to take a more active role in assisting countries with drug procurement.

27. The final plenary session of the conference dealt with countries' experiences with scaling up antiretroviral treatment. Most countries participating in the conference reported unexpected delays in scaling up and meeting targets, although the reasons often differed. In *Botswana*, progress has been slow due to the unexpected burden of caring for the very sick in the initial patient cohorts. Despite enormous support from the African Comprehensive HIV/AIDS Partnership, a collaboration between the Government of Botswana, the Bill and Melinda Gates Foundation, and the Merck Company Foundation, the antiretroviral program lacks the necessary infrastructure and human resource capacity to keep up with the tremendous demand for therapy. Approximately 300,000 people are HIV-infected in the country, and at least 35% of these are in the 15-49 year age group. However, a large percentage of the population, perhaps as much as 90%, is unfamiliar with their HIV status. There are 15 treatment sites currently operating, and the goal is to have 32 sites in operation by December 2005.

28. In *Rwanda*, an estimated 10-13% of the urban population is HIV-infected and in rural areas the estimates range between 2-7%. Large-scale programs were launched only within the past one to two years. The death rate for the initial cohort of patients was nearly 25%. Today there are 20 facilities providing antiretroviral therapy, and this figure is expected to more than double by the end of 2004. Like other countries, Rwanda is facing enormous workforce constraints, difficulties owing to the lack of donor coordination, and has experienced major delays in drug procurement. The recent decentralization of the health care system has placed additional stress on an already over-burdened system. In developing its program for antiretroviral therapy, Rwanda has looked beyond its borders for lessons from other countries in more advanced stages of scaling up, including Uganda and Botswana.

29. *Nigeria's* response to the epidemic began in earnest following the election of the current President in 1999. Some of the delay has been attributed to the need to confirm population prevalence rates at the sub-national level. Rates of seroprevalence are as high as 12% in some states, and as low as 2.5% in others. The post-1999 period has been characterized by high levels of political commitment, the establishment of multi-sectoral platforms, and the strong participation of civil society groups, including a faith-based forum consisting of Muslims and Christians. Antiretroviral treatment is currently on offer in 25 centres across the country. The centres are tertiary institutions that are expected to serve as training nodes in the next phase of scaling up. Each of the centres offers a range of diagnostic and therapeutic options. Generic drugs are procured directly from Cipla and Ranbaxy by the Ministry of Health. Some state governments have begun to offer their own drug treatment programs, but in accordance with federal guidelines. The country intends to offer antiretroviral therapy to 300,000 people within the next two years.

30. *Haiti* has followed a different path to antiretroviral therapy than many of the other countries, focusing on low-tech treatment options at the community level. With a per capita GNP of US \$460, Haiti is the poorest country in the Western Hemisphere and has the highest HIV prevalence rate, at approximately 6%. Co-infection with TB is a major problem. Partners In Health's unique approach to antiretroviral therapy relies on "accompagnateurs" who visit patients in their home once or twice daily, following the progress of four patients, on average. The accompagnateurs are supervised by a head nurse, who regularly meets with them and their patients to discuss medication adherence. The project is now following over 700 HIV-infected people, and treating 1500

patients with “directly-observed” antiretroviral therapy. While Haiti’s experience with scaling up has not been rapid, compared to the ambitions of other programs, it has been comprehensive, and its focus is now on building capacity in the local health clinics. The result has been a tremendous increase in community demand for public health care services.

31. Many of the specific discussions relating to countries’ experiences with scaling up programs in tuberculosis and malaria took place in the break-out sessions on the final day. However, plenary discussions did reflect a general concern that the intense focus on AIDS has drawn attention away from these two diseases, as well as health systems, more generally. Some participants were concerned that tuberculosis had not fared well in the Global Fund’s Round 4 (although Global Fund representatives were quick to point out that the distribution of the pie – 60% AIDS, 20% malaria, 20% TB – results from a demand-driven process). Participants also highlighted their concern about the increasing rates of co-infection, and emphasized the importance of learning more about how to integrate diagnostic and treatment programs. Some participants also emphasized the potential benefits to be gained from incorporating AIDS treatment into existing TB DOTS programs.

32. The cases of *India*, *Indonesia* and *Malawi* were highlighted in discussions about rapid expansion of TB DOTS programs. Scale-up is being achieved through: political commitment; strategic plans; strengthened management capacity at provincial level; accelerated training of health centre staff through mobile training teams (particularly effective in a large country such as Indonesia); increased laboratory network; uninterrupted drug supply; strong monitoring and evaluation; and collaboration between the public and private sectors. Case detection rates have increased over the past year in all countries. *India* has expanded coverage 40-fold in the last 4.5 years, with approximately 500,000 additional lives saved and 85% treatment success. *Malawi* reported treatment success of 98%. The challenge remains to maintain quality of service whilst increasing coverage. Donor funds to support TB work have catalysed action in *Indonesian* provinces where public health systems are already strong.

33. Finally, participants expressed alarm at the slow progress and neglect in controlling malaria, noting that no country has yet met, or is anywhere close to meeting, the Abuja target that 60% of children under five will be sleeping under nets by the year 2010. As one participant insisted, this is “low hanging fruit,” and that success is sorely needed to inspire a stepped up response. Some countries have made important progress, and the cases of *Tanzania* and *Eritrea* were highlighted. In Tanzania, a voucher scheme involving public and private organizations targets high-risk groups such as pregnant mothers and their infants, subsidizing insecticide-treated nets (ITNs) and providing free insecticide for retreating old nets. *Eritrea* has involved community health workers agents to promote greater local participation in malaria control activities.

Conclusions/Recommendations

34. The organizers hoped that the conference would provide both a forum for testing the limits of the ‘absorptive capacity constraints’ facing developing countries, and an opportunity for countries to share lessons derived from their own early experiences in scaling up. The findings were mixed. Participants noted that the capacity constraints on spending, technical expertise, and human resources are very real, but they also found that countries were finding creative ways to overcome these and other constraints in many areas.

35. The overriding take-home message of the conference was that countries need more and better opportunities to share their experiences and to learn from each other’s

successes and failures. The importance of including operations research, and monitoring and evaluation, as integral components of program implementation plans was also emphasized. Other general themes had to do with the value of sector-wide approaches (SWAPs) and investing in health care systems, not diseases; building partnerships at the national and local levels; strengthening country ownership; and harmonizing relationships among donors for greater efficiency and ultimately higher impact.

36. Finally, it was widely agreed that the next most critical task facing the international community is to document its successes in scaling up as a way to ensure that the current level of resources, or greater, will be available to health in the future. Next year's Wilton Park conference will thus focus on the measurement of performance and results – or, the third arm of the Global Fund's mantra to "Raise It, Spend It, and Prove It."

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Wilton Park Reports are brief summaries of the main points and conclusions of a conference. The reports reflect rapporteurs' personal interpretations of the proceedings – as such they do not constitute any institutional policy of Wilton Park nor do they necessarily represent the views of rapporteurs.

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