Subcommittee on International Monetary Policy and Trade of the House Committee on Financial Services

Hearing on "World Bank and IMF Activities in Africa: Poverty Alleviation, Debt Relief, and HIV/AIDS" May 15, 2001

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Mr. Chairman, thank you for the invitation to testify before the Subcommittee on International Monetary Policy and Trade of the House Committee on Financial Services in the course of its examination of World Bank and International Monetary Fund (IMF) activities in Africa. I am honored as an African professional from Ghana to have this opportunity to present my views and recommendations on this subject.

A decade of international public health experience, focusing on Sub-Saharan Africa, has shaped these views. During this period I consulted and researched for, or provided technical assistance to, recipient countries on behalf of donor institutions including the World Bank. Prior to this, as a physician who treated patients in Ghana and Nigeria, and later as a Senior Health Planner in the Ghana Ministry of Health, my interactions with the Bank were from the stance of a recipient country official.

The invitation to testify requested that I address important issues of process such as policy and governance of, and issues of outcome, such as economic and social performance consequent to, Bank and Fund activities in Africa. I would like to focus on issues that relate to the effectiveness of development assistance provided by the World Bank and IMF in alleviating poverty, providing debt relief, and controlling HIV/AIDS. Specifically, I will respond to the following questions posed: 1) what should be the role of the international financial institutions in addressing the economic development challenges related to HIV/AIDS in Africa?; and 2) what are my recommendations regarding the proposal to establish a multilateral global AIDS Trust Fund advocated by U.N. Secretary-General Kofi Annan and World Bank President James Wolfensohn?

In my statement I will draw attention to the following:

1) Health investments profoundly impact on poverty reduction, as is substantiated by the ongoing work of the Commission on Macroeconomics and Health.
2) Low priority placed on investment in hospital facilities and by implication on curative care (i.e. treatment), reluctance to support sector budgets, and advocacy for user fees have characterized World Bank health assistance to Africa.
3) These have contributed to the un-preparedness of African health systems for the HIV/AIDS challenge.

Given the urgency of the situation, I urge that a Global AIDS Trust Fund should be granted autonomy from these institutions and their policies. This will permit the Trust Fund to assemble Rapid AIDS Response Task Forces charged with the responsibility of producing detailed country control plans that are needed for immediate disbursement of committed donor funds. I suggest that the Task Forces be composed of professionals with

in-depth knowledge of Africa as well as proven technical and managerial capacities, who are on sabbatical from their regular positions.

Some of my observations and convictions have been refined by recent analytical work undertaken as Senior Economist of the World Health Organization (WHO) Commission on Macroeconomics and Health (CMH). The Commission is an ad-hoc organization initiated by WHO Director-General Dr. Gro Harlem Brundtland in January 2000. Over a two-year period, it will analyze the impact of health on development and examine the appropriate modalities through which health-related investments could have a positive impact on economic growth and equity in developing countries. The Commission will recommend a set of measures designed to maximize the poverty reduction and economic development benefits of health sector investment. A final report if its findings will be disseminated to the international development community and to Ministers of Health at the 2002 World Health Assembly.

Current analysis of the evidence linking investments in health to macroeconomic growth and poverty reduction, support my view that the components and philosophy of the HIV/AIDS control strategy being advocated by the African community (and recently echoed in statements by the World Bank and the IMF) are those that are crucial for poverty reduction. These components are prevention, care, and treatment and the philosophy is that they must all be pursued simultaneously and rigorously in order to achieve the desired outcome. In the medium and long-term, prevention of ill health in poor societies is the key to increasing health and productivity and reducing poverty. However, in the short term, especially with regards to HIV/AIDS, access to treatment is critical. Without treatment, HIV positive parents are denied the opportunity to make financial and social provision for their children who in the future will be orphaned. Most are prevented from contributing crucial additional years to the economy as teachers, doctors, and nurses.

Until recently, the international donor community – including the World Bank and IMF – has focused its HIV/AIDS efforts on prevention with less emphasis on the decisive role of treatment. This approach ignores the fact that households can frequently accomplish prevention but they are ill-equipped to carry out effective treatment. For many diseases, household activities impacting on nutrition (such as farming) and educational status (such as home instruction) are near substitutes for preventive interventions provided by the formal health sector. To illustrate, a farming mother in a village in Ghana, informed of the role of mosquitoes in causing malaria, can dramatically influence the frequency and prognosis of malaria episodes suffered by her child. Specifically, she can augment her immunity system and that of her child by consuming high protein foods that she grows and by breastfeeding. She can also protect her child from excess mosquito bites by taking actions to repel mosquitoes.

In the case of HIV/AIDS, since aspects of its prevention hinge on products (such as condoms and treatment for STD), households cannot produce substitutes and thus formal prevention programs are necessary. However, in my opinion, to have engaged in prevention intervention almost exclusively for more than a decade, and deploying relatively meager resources for the provision of treatment, was a major flaw in the assistance program advocated by donor institutions, including the World Bank. In the case of treatment of HIV/AIDS, as is the case of most diseases, there are few, if any, effective near substitutes that a household can produce. Therefore, from the very onset of the epidemic, treatment

should have been given appropriate priority in control strategies. High priority was given to treatment in western countries including the United States of America and the result speaks for itself.

Today it is not constructive to dwell on the many reasons for this oversight. Rather, it is invaluable to recognize that prolongation of years of healthy life and average years of survival of African AIDS patients offered by antiretroviral therapy requires that the standards of African health systems be raised to basic minimal levels. Such standards are considered the norm in all middle and rich countries. The World Bank's health assistance during the past two decades almost exclusively focused on primary health care, and by implication relatively neglected the development of secondary and tertiary health infrastructure. This, in part, is responsible for the current situation in which the health systems of all poor African countries will require massive investments in infrastructure and human capacity to permit antiretroviral treatment to be provided safely and effectively. Hence, treatment of African HIV/AIDS patients will require that the World Bank revisit its past position that investment in secondary and tertiary health facilities is a low priority for African countries.

Secondly, treatments must not be offered at fees that will dissipate the scarce financial resources households have for basic consumption needs such as transportation, education, and food. The outcome of unaffordable user fees is the removal of the possibility that households maintain and eventually increase household productivity. In this regard, another change in the World Bank's health assistance strategy to African countries that will have a positive impact on HIV/AIDS and poverty is to address the Bank's long held position on user fees: the payment of out-of-pocket charges *at the time of use* of health care.

As far back as 1987, the World Bank strategy as outlined in the "Agenda for Reform"[i] called for user charges, among other reforms. Clinic and hospital charges associated with sector reforms supported by the World Bank and the IMF became widespread in Africa by the mid-1990s. Typically, in African countries, revenue from user fees recovers less than 10% of health sector expenditures but is a dominant factor in the decline of rates of clinic and hospital attendance despite growing health care needs. In recent years non-governmental organizations (NGOs) and civic societies, including "50 Years is Enough" and "Results" to name a few, concerned about access problems inherent in user fees, have campaigned to prevent institutions such as the World Bank and the IMF from approving projects in the social sector that include user fees[ii]. The campaigns have met with strong opposition, in part because analytical work originating from the World Bank in particular has maintained that the issue is no longer whether user fees should be implemented, but how to implement them[iii,iv]. The basis of this assertion has been the conviction that user fees provide the only viable means to achieve sustainability, and that if the theoretical benefits have not been realized it has been due to implementation inadequacies in these countries[v].

Yet more than a decade has passed since the introduction of user fees, and despite varied implementations, most countries have not achieved the theorized benefits from this adjunct to their health financing strategies. Review of the economic theory points to several weaknesses in the case for user fees, including its neglect of the significant positive spillover effects that are associated with curative care[vi]. The benefit to society when individuals receive treatment for a disease, tuberculosis for example, is far greater than the benefits to the individual patients because others are prevented from contracting the

disease. It is rational, then, for society to facilitate higher consumptions of such treatment by the poor than the poor themselves can afford. The user fees argument is also weakened by the fact that in the absence of evidence of *unjustified* over-utilization, this policy leads to inefficient reductions in utilization. In addition, user fee policies ignore uncertainty – both in the timing and quantity required in the future – which we know is a unique attribute of health care need and consumption.

User fee policies do not take cognizance that out-of-pocket payments are usually the most regressive means to pay for health care, and as a payment method, heavily exposes people to catastrophic financial risks. As such, they place an impossible financial burden on households in low-income countries. The uncertainty about the timing of illness and the cost of health care required for episodes of illness, coupled with the low income levels of individuals, makes it virtually impossible for households to make provision through saving for illness-related expenditures. User fees constitute a major part of such expenses. Furthermore, the majority of households cannot obtain credit from the formal banking system. Thus, in addition to the fact that user fees have been largely unsuccessful in raising significant resources, they have contributed enormously to the deplorable status of health and economic well-being of Africans. User fees hinder effective utilization of formal health services, compel sick individuals to defer visits to the health facilities until their conditions become critical, or lure them to resort to self-medication and other practices that are sometimes injurious to their health. Sadly, when emergency treatments are delayed, it often leads to serious health and financial consequences resulting in further impoverishment of the household. It is therefore of real concern to observe that many of the early Poverty Reduction Strategy Papers developed in partnership with the World Bank included user fees for health care and education.

While recognizing the above problems associated with past health assistance, it is also important to acknowledge the opportunities presented by recent World Bank and IMF statements and actions demonstrating commitment to address the HIV/AIDS pandemic in Africa. Consequently, the people of Africa and their political and religious leaders await indications that appropriate changes in these institutions' policy positions that relate to investments in hospitals and skilled medical staff and user fees will also be forthcoming. It is the hope that these changes will be manifested in granting the freedom to countries to use grant assistance to build their health sector to standards needed to ensure safe and effective HIV/AIDS therapy and remove financial barriers to treatment imposed by user fees.

From a broader perspective, recent initiatives by the Bank (for example, the Multi-sectoral AIDS Program for Africa) and the Fund exemplify the global climate of urgent concern that is now a reality among multilateral and bilateral agencies and civil society. The calls from the UN Secretary-General for a global fund and the statement issued on April 4, 2001 by Harvard faculty members calling for a pilot program to treat 1 million African patients in the first 3 years, are two more examples demonstrating this universal position. Emerging from this attentiveness is the intent and commitment in principle to make resources available to address HIV/AIDS in Africa. The most recent illustration of this is the announcement by President Bush on May 12, 2001 that the United States would contribute $200 million to a global fund to attack HIV/AIDS, malaria and tuberculosis.

Fortunately in this climate of concern amongst wealthy nations and their institutions is the profound comprehension of the enormity of the problem by, and commitment from, Africa's political and professional leaders. These are manifested by the prominence given to the pandemic in the recent African initiatives to "launch Africa on a path of sustained growth and development in this new Century" (Executive Secretary, Economic Commission for Africa [ECA]). Two important examples are the Millennium Partnership for the African Recovery Program (MAP) initiated by Presidents Bouteflika of Algeria, Mbeki of South Africa, and Obasanjo of Nigeria, and the UN ECA-led Compact for African Recovery ("the Compact").

At this moment distinct roles are emerging for the donor community, including the World Bank and IMF, and for the African political leaders. For the former, it is to be joint actors with the African inter-governmental agencies such as the ECA in international resource mobilization. Hence the global trust fund by the UN and the current World Bank AIDS program. For the latter, it is to mobilize domestic resources through their ministries of finance and health. This new role was evidenced at the first-ever AIDS summit of African leaders in Abuja at the end of April 2001 where there was a consensus that 15% of African national budgets should now be devoted to health, including a significant proportion to AIDS.

Despite the commendable manner in which all actors have taken on these roles, one important issue that has yet to be addressed is the dismal record of the effectiveness of past development programs targeted at African problems. In almost all cases a major factor in the failure has been the non-disbursement of committed donor funds and thus non-implementation of programs. In the past, World Bank projects have particularly suffered from this problem. Donors such as the EU have also experienced this constraint (of the 1.7 billion euros [1 euro = $0.92] allocated globally by the EU from 1995 to 2000 in the development and health sectors, only 17 percent has actually been spent). This is evidence of a profound paradox and dilemma now confronting the world. The paradox is that a continent intolerably burdened with HIV/AIDS and debt desires assistance and the international donor community including the Bank and IMF are committed to providing this assistance, but neither parties knows HOW. It is far from evident how available funds can be channeled into concrete and effective programs to immediately address the crisis.

I would like to submit that the fundamental problem is that there are insufficient numbers of **personnel** to engage exclusively in developing rigorous country and/or sub-regional aid response plans. The World Bank's public commitment to ensuring "unlimited" resources for well-designed national HIV/AIDS programs made at its 2000 Spring Meetings underscores the centrality of such plans, and thus the potential role of these plans in a vicious cycle. African countries have few financial and human resources and therefore cannot produce elaborate plans nor demonstrate adequate absorption capacities (i.e. the ability to use the funds accessed). Yet these plans and the absorptive capacities are the prerequisites imposed by donor regulations and conditions in order to secure the needed resources.

To a large extent the capacity problem is due to the migration of qualified talent, a recognized feature of today's globalized economy. The few African professional scientists and managers remaining on the continent and primarily responsible for developing the necessary plans, are fully occupied in the day-to-day business of running national systems

including that of health. Even without the AIDS crisis, these human resources are overstretched and therefore it is unrealistic to expect them to also accomplish extensive strategic thinking, research, and planning that is required to produce detailed country and/or regional HIV/AIDS plans.

The detailed plans that are urgent include those that would render incapacitated health systems functional, and in some cases establishing new infrastructure, in the shortest possible timeframe. This is to ensure adequate health sector infrastructure to treat, monitor, and evaluate patients. Knowledge about clinical management of patients and the control of resistance has been amassed already by rich countries that have provided treatment to their HIV population over the last decade. Planning towards this end would require the use of the knowledge, experience, and skills that are globally available to provide prevention, care, and treatment. Some of the capacities are now frequently referred to as global public goods (GPGs) for health.

While we continue to seek interruption of transmission of the virus, plans must rapidly be elaborated and tailored to the economic realities of African countries to immediately implement the following proven effective interventions.

For prevention:

- condom use as the norm, particularly by all sex workers as well as males who have sex with males (MSM) and their treatment for bacterial sexually transmitted infections,
- short courses of antiretrovirals (ARV) – such as AZT or nevirapine – during pregnancy,
- availability and encouragement of male circumcision,
- availability of voluntary counseling and testing,
- in some cases, availability of Needle Exchange Programs (NEPs).

For treatment:

- Highly Active Antiretroviral Treatment (HAART).

For care:

- health outreach services and social welfare arrangements.

Task Forces must urgently be assembled and deployed to meet this challenge for producing detailed plans and providing implementation support.

The Global AIDS Trust Fund is being formulated partly in recognition that HIV/AIDs intervention for Africa, including treatment, will need to be funded largely from donor assistance. (Particularly, as estimates suggest that HIPC debt relief might save around $700 million per year in actual debt service flows from Africa, and even if this entire sum is directed at the health sector, it will prove an inadequate source of funds.) One hopes that the formulation of this Trust is also to permit the use of a new approach to development assistance for health – an approach that is not hindered by imperfections inherent in past World Bank and IMF health assistance policies. The hindrances include advocacy for user fees, obstacles to budgetary support, exclusive focus on primary levels of health systems, and other fiscal constraints imposed as conditions. The logical role of the World Bank and IMF at this momentous juncture in the fight against the pandemic would be to (1) grant the Trust Fund autonomy to act independently of traditional Bank policies, and (2) permit the

Trust Fund to assemble country or sub-regional Rapid AIDS Response Task Forces on behalf of the African countries.

The Task Forces would ideally be composed of appropriate professionals with in-depth knowledge of African socio-economic contexts, for example, African professionals who have relevant country experience but are now working abroad. A criterion would be a proven track record in technical and managerial positions either in the private or public sector. These professionals, with the consent of their current employers, would take a sabbatical to be stationed and engaged full-time in the relevant country or sub-region. A Task Force would report to a country/regional committee consisting of government officials and civil society. Civil society in this case refers to groups that are already engaged in addressing AIDS, for example, the religious-related health providers. In many African countries, mission health facilities are major providers of health care especially to low-income households and rural areas. As a result of their devotion and convictions, these faith-based health providers have proven to be accountable to the people and are untarnished by corruption.

To be effective, Task Forces must be constituted so as to be able to combine the following:

- technical knowledge about African health problems and the health delivery system;
- knowledge and understanding of existing and emerging international donor mechanisms and politics (WB loans and EU grants) to be able to access the funds and provide donors with assurance of outputs/outcome;
- political clout to be able to take active part in the policy debate surrounding HIV/AIDS control;
- sensitivity and respect for African social values and organizational cultures.

In the long term the Task Forces would work to institutionalize the mechanisms for continued production of global public goods for health tailored specifically to the African context. These include basic medical and operational health research that focuses, for example, on vaccines and new antiretroviral drugs effective against Non-B subtypes of the HIV virus responsible for the African epidemics, and formulation of approximate combination drug therapies from existing active anti-malaria compounds and researching into new compounds.

Finally, the World Bank, IMF, and other donors must commit levels of resources that will be adequate for the phenomenal task of control and treatment of AIDS in Africa. Not least, because it represents a “global public good”. No nation or individual in the world will not benefit in some way from the success of this action. Recent studies outside Africa, in Switzerland for instance, report changes in the epidemiology of newly diagnosed HIV-1 infections revealing a predominance of heterosexual transmission and a high frequency of Non-B sub-types. Based on estimates by UNAIDS and others, approximately $10 billion will be required annually if HIV is to be tackled together with malaria and tuberculosis in Africa. Commitment and disbursement of this level of funds must be done with the confidence that the Trust Fund will assemble the most appropriate capacity available and achieve the results that the global community desires, which is to end this tragedy. Estimates indicate that $12 million annually could secure 10 Rapid AIDS Response Task Forces for Africa. There is little time to debate endlessly before taking this bold step. At worse all that may be lost is some fraction of the resource due to inefficiency and

imperfections, a normal occurrence in all human endeavors, and a price that is truly insignificant compared to the benefits. Millions of lives will be saved, and Africa could be given the opportunity to rise from the burden of disease and poverty.

Dyna Arhin-Tenkorang
May 13, 2001.

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[i] World Bank: *Financing Health Services in Developing Countries: An Agenda for Reform*. Washington D.C., 1987.

[ii] 50 Years Is Enough, *House Vote Opposes IMF & World Bank on User Fees*, Press Release, Washington D.C., July 25, 2000.

[iii] Dunne, N.: *Fees Issue Entangles US Debt Relief Plan*, The Financial Times, Washington, October 17, 2000.

[iv] Shaw, R.P., and Griffin, C.C.: *Financing Health Care in Sub-Saharan Africa through User Fees and Insurance*, Directions in Development Series, World Bank, Washington, 1995.

[v] Gilson, L: *The Lessons of User Fee Experience in Africa*, Health Policy and Planning, **12**(4), 273-285, 1997.

[vi] Arhin-Tenkorang, D.: *Mobilizing Resources for Health: The Case for User Fees Re-visited*, Paper prepared for the Third Meeting of the CMH, Paris, France, November 8-10, 2000.