Fighting the Major Diseases of Africa: Sustaining the Gains of the Last Decade

By Roger Bate

US government foreign assistance health programs are currently focused on combating the three major killers in Africa—HIV/AIDS, tuberculosis, and malaria—that account for several million deaths each year across the continent. Recent successes against malaria and HIV have been significant, but the rate of progress is slowing and the gains are fragile. Countries like the Democratic Republic of Congo and Nigeria continue to suffer insurmountable short-term problems rising from inadequate supply chains, lack of infrastructure, corruption, too few health personnel, and prohibitively high health care costs for many citizens. These diseases cannot be eradicated without major improvements in the health systems of such nations.

Health systems strengthening (HSS) efforts must be a function and a priority of the African nations themselves, not driven or funded primarily by US foreign assistance. Although small amounts of foreign aid spent on technical assistance for HSS can be effective, the US government cannot monitor major financial support effectively, encouraging corrupt and wasteful practices within recipient governments and organizations. Foreign assistance is on the chopping block in the current US budget crisis and will likely face deep cuts in the next Congress. The United States should prioritize sustaining the hard-won gains in disease control, which requires focusing on programs with proven track records of success and addressing failures within those programs.

Over the past decade, tens of millions of children, mainly in Africa, have died from HIV, tuberculosis, and malaria. This number would have been much higher without Western largesse. One of the big successes of the George W. Bush administration was combating these diseases through programs such as the President’s Emergency Plan for AIDS Relief (PEPFAR) and the President’s Malaria Initiative (PMI).

But the achievements thus far are fragile and depend on continued US funding. Problems like drug resistance are not being combated effectively due to poor policy decisions. Because foreign aid

Roger Bate (rbate@aei.org) is the Legatum Fellow in Global Prosperity at AEI.

Key points in this Outlook:

• America’s multibillion dollar investment to combat HIV and malaria in Africa has saved millions of lives over the last decade, but this progress cannot continue without major improvements in local health systems.

• Health systems development is the responsibility of emerging nations, and US funding of such systems is hard to monitor, enabling waste and corruption. The United States should target programs focused on prevention of major killers such as tuberculosis in an effort to save more lives.

• To sustain recent gains in disease control amid budget cuts, the United States must focus on programs with successful track records and address failures of accountability and low-quality care within those programs.
will almost certainly face significant cuts in coming years, it is increasingly important to reverse ineffective policies to sustain health gains.

Causes of Poor Health

Inadequate access to prevention and treatment are the most visible causes of Africa's high disease burden, but grinding poverty condemns many Africans to malnutrition, poor sanitation, and dirty drinking water. Such inferior living conditions make people especially vulnerable to fatal infections. In addition, a lack of basic health systems—clinics with trained staff, adequate and reliable medicine supplies, and other essential resources—means debilitating but nonfatal background infections often go untreated.

Colonialism deserves some of the blame for creating the conditions that have made improving health difficult. Some of its endowments, including borders that make no sense to local people and the belief that it is acceptable for the elite to abuse the rest of society, have caused political instability that has impoverished many countries. Health improvements in Africa have been slower than anywhere else on the planet.

Yet today’s interventions also contribute to the problem. Although aid programs provide enormous benefit, they enable and sometimes directly cause bad domestic policies. In countries where significant portions of health budgets come from aid, the political elite can effectively ignore large swaths of society with little consequence to themselves. Western donors are guilty of repeatedly funding corrupt, even despotic, incumbents, enabling them to retain power in the face of domestic opposition and weakening the power of the electorate.

These challenges have led aid reformers in most Western donor nations, and especially the United States, to focus assistance on developing specific interventions with measurable outcomes rather than simply handing cash to the governments of impoverished nations. PEPFAR and PMI, which are disease focused and probably the most transparent and accountable of all US government foreign health programs, exemplify this new emphasis.

History of Vertical Health Aid Programs

Vertical programs, private and public aid programs designed to combat all aspects of a specific disease, have a long history. The smallpox eradication campaign of the 1960s and '70s is the poster child for vertical programs. Its startling success actually points to why others have achieved less stellar results; smallpox eradication was possible because the disease was well understood and prevention and treatment methods were straightforward, widely known, and relatively cheap. The effort was well funded, and recipient governments were eager participants. No other eradication attempt has met these conditions with the same degree or consistency, though efforts to eradicate polio came close. The failure of that effort in Africa was largely due to Muslim clerics’ erroneous arguments that vaccination programs in northern Nigeria were a Western plot to sterilize Muslim men.

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Although vaccination programs rarely achieve the total success of the smallpox campaign, most have brought significant health improvements, often despite lack of support from the recipient country governments. Other vertical programs include massive insecticide spray programs to combat malaria and yellow fever, which have been underway for nearly a century. These efforts have frequently brought public and private donors together, sometimes under leadership of the United Nations World Health Organization (WHO). Often, leaders in recipient nations have not been involved in the planning or control of these programs, sometimes because of a lack of domestic capacity, but other times because of Western attitudes.

The leaders of many African nations found vertical programs, run primarily by Westerners and thus outside their control, unpalatably paternalistic but impossible to turn down because of their desperate need. Over time, health advocates have found that successes against specific diseases are unlikely to be sustained without domestic involvement in such programs. Good arguments exist for countries’ setting their own priorities, including that elected representatives should care and know more about their country’s needs than outsiders. However, handing large sums of money to newly created governments unconditionally or with toothless conditions has a corrupting effect.

This growing consensus led donors to focus on providing funding and technical assistance directly to African nations to use in building health systems. The focus
reached a high point in 1978, as smallpox was being eradicated. The WHO launched the Health for All campaign, marketed as an initiative designed to empower African nations. Some funding switched from disease control to financing African nations’ health ministries, with the hope that funds would be used for important activities such as building clinics, training doctors, and running seminars on the importance of hygiene. In Kenya, for example, foreign funding channeled through the government for health investment, as a percentage of the total health investment budget, grew 30 percent between the 1980s and the 1990s.2

Although such activities are important, many African nations did not spend the money as donors had intended. Even where they did, it was impossible to measure the aid’s impact, prompting aid fatigue and distrust in the West and corrupt practices in African capitals. Over time, aid efficacy dropped, with rates of diseases like malaria increasing, and the amount of aid fell.3

In the late 1990s, vertical interventions came back in vogue. The successes against malaria in the 1960s had been reversed in many places, and the disease was again killing over a million children per year. HIV was a menacing new threat; dire predictions that entire generations would be wiped out led to unprecedented funding levels. Celebrity attention to these diseases, coupled with the push to meet the newly minted UN Millennium Development Goals (MDGs), sent cheerleading into overdrive. One report estimates that only $19 million was allocated globally for fighting malaria in 1999, but by 2002 the figure had reached $418.5 million.4 Between 2002 and 2009, it increased by over $1.4 billion.5 Funding for HIV/AIDS prevention skyrocketed from a meager $215 million in 1999 to nearly $1.2 billion by 2002; by 2004, funding had increased tenfold over 1999 levels, and by 2009 it hit $6.8 billion.6

The MDGs were established in 2000 in part to garner support for, and measure improvements from, health interventions. Three MDGs directly address health targets—reducing child mortality, reducing maternal mortality, and combating the big killer diseases.

Of these, the specific disease goals received the most attention. The World Bank’s Multicountry AIDS Program was launched in 2000 with $500 million.7 This was dwarfed in 2002 by the G8’s Global Fund to Fight AIDS, Tuberculosis, and Malaria, which waded in with initial pledges of $1.7 billion and has since reached over $20 billion.8 In 2003, President George W. Bush inaugurated the President’s Emergency Fund for AIDS Relief with $15 billion to spend over five years,9 and in 2005, he launched the President’s Malaria Initiative with $1.2 billion and the aim of halving malaria in fifteen focus countries.10 New US legislation passed in 2008, H.R. 5501, built on and sustained the US commitment to global leadership in funding vertical health programs.11 Many public-private partnerships sprang up, some formed exclusively to develop medicines and vaccines for key diseases.

Cutting Aid: Maintaining Disease Control

It is impossible to know what would have happened without the substantial aid spending of the past decade, but undoubtedly, millions more deaths would have occurred. Yet these recent successes—and, more important, their limitations—have led critics to the same arguments popular in the 1970s. Although optimists in the malaria community are discussing eradicating the disease within ten years, seasoned campaigners know that without an improvement in general infrastructure and, more specifically, stronger health systems in Nigeria and Congo (collectively, home to half of Africa’s malaria deaths), malaria cannot be eliminated in the next decade. No realistic chance exists of halving malaria rates (from a 2000 baseline) by the MDG target date of 2015 for the same reason.

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Partly because progress against malaria (and HIV) is slowing, health systems experts are advocating increasing funds for health systems. Although it focuses on vertical programs, H.R. 5501 also includes three sections exclusively concerned with building health systems.12 Of course, the effectiveness of donor-funded HSS programs remains debatable.13 Yet some large multilateral organizations, notably the Global Fund, have reacted to pressure to fund health systems even though they are not competent enough to do it. The Global Fund does not have the necessary staff expertise in areas such as insurance, education, and accounting to help build systems. Although it was established specifically to run vertical programs fighting three diseases, it broadened its mission...
to include HSS so that it could expand its operations to countries where local systems are woefully inadequate to absorb the programs.\textsuperscript{14}

But to sustain gains in disease control, the Global Fund and other organizations running vertical programs must not get sidetracked into health systems work. Because their budgets are being cut, they must consolidate efforts, operate in fewer countries, and stick to their mission.

**Disease Program Problems That Must Be Addressed**

We are probably reaching an inflection point on the returns to malaria and HIV investment. US spending on malaria, and to a lesser extent HIV, over the last decade has been well directed. But for malaria, the low-hanging fruit has been picked: donors are already working with governments that are willing and able to cooperate and already have some health systems in place.

More room for improvement exists in efforts against tuberculosis, which are only just being ramped up. Programs combating tuberculosis enjoy a target-rich environment in which any reasonable program will save thousands of lives. However, the United States is the world’s largest donor to global health programs, and suggested cuts to the 2012 foreign aid budget amount to nearly 10 percent of total health expenditures.\textsuperscript{15} These cuts could be expanded further in 2013 when H.R. 5501 is up for reauthorization, presenting a major challenge to funding improvements in these efforts.

Reducing the malaria and HIV disease burden will be difficult, and the malaria community in particular is not facing up to the problems ahead. The House Foreign Affairs Africa Subcommittee’s December 5, 2011, hearing, “Fighting Malaria: Progress and Challenges,” exemplified the problem.\textsuperscript{16} The testimony focused primarily on the great progress that had been made in fighting the disease, with almost no attention on the challenges ahead. Anyone observing the hearing would assume that malaria eradication is possible with just a bit more funding, but this is simply not the case. Though numerous challenges remain, as outlined in my testimony for the hearing,\textsuperscript{17} we rarely hear about them.\textsuperscript{18}

1. **Dispersing Global Fund grants through the unaccountable United Nations Development Program (UNDP).** The United States is the largest contributor to the Global Fund, and the Fund is commendably transparent in how it allocates this money, with one exception. It has used the UNDP in at least twenty-seven countries to disperse over $1 billion in funds and medicines. Yet the UNDP refuses to allow its internal audits to be viewed by any external organization, even those from which it receives funding.\textsuperscript{19} Without any accountability or oversight, the funds channeled through the UNDP are not likely to be well spent. The United States should pressure the Global Fund to stop using UNDP as a conduit. If it refuses, the United States should withdraw funding from the Global Fund.

2. **Encouraging local production.** The push for local production of medicines is also problematic. My research demonstrates that low-cost drugs made in Africa, and to a lesser extent the cheaper producers of India and China, fail quality tests at a higher rate than those produced in the West.\textsuperscript{20} (The larger Indian generic makers are an exception, routinely producing high-quality drugs.) Encouraging production of potentially shoddy products could endanger patients.

3. **Operating in too many countries.** In lean times, the United States must ensure that its resources go where the most good can be done. US funding (including that provided through the Global Fund) should continue to focus on only countries where disease can actively be combated, avoiding countries where health systems and governments cannot effectively and transparently absorb aid dollars.

4. **Creating entitlement.** Policymakers are increasingly realizing that since there is no cure for HIV/AIDS, donors have created enormous entitlement to indefinite access to antiretroviral drugs (ARVs) in poor nations. Future resource allocations will probably be constrained by the need for US taxpayers to continue spending well over $1 billion per year on ARVs (to the delight of lots of contractors and drug companies). This squeezes funding for more arguably valuable HIV prevention activities and limits funding directed toward other deadly diseases, such as tuberculosis, which receives far less funding than its morbidity and the scope for improvement warrant.
Conclusion

Health aid has skyrocketed in the past decade, largely because of American taxpayer largesse. Millions of people should be thankful for this. Vertical programs are the best tool available for fighting killer diseases and improving health in the developing world.

However, problems remain with these programs that must be overcome to prevent despondency and complacency from setting in before diseases are eradicated, with disastrous consequences for the poorest and sickest. The hard-fought gains from the past decade could quickly be lost if funding is shifted to ineffectual efforts to strengthen health systems. As H.R. 5501 comes up for reauthorization in the near future, we should remember the serious consequences for global health its probable funding cuts could carry.

Notes


12. Ibid.


18. I imagine this was also the situation in the 1960s when things were going well and the problems of resistance—both technical, in terms of insecticides and drugs, and emotional, in terms of impatience and intolerance to having dwellings sprayed when malaria rates were low—were beginning to rear their head.
