Acta Academica Supplementum 2006(1): 1-16

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Expanding access to ART in Sub-Saharan Africa: an advocacy agenda for health systems development and resource generation

Providing universal, effective and sustainable access to ART in sub-Saharan Africa (SSA) requires a broader advocacy agenda encompassing the development of health care systems and the generation of much larger resources for the health sector. Presently, health care delivery in SSA is characterised by a patchwork of poorly co-ordinated and governed public, NGO and private services, a situation which contributes to the undermining of national stewardship and coherent health planning. The challenge of expanding access to ART in SSA cannot be divorced from the challenge of liberating countries from poverty. The international public health community needs to use its voice and its authority to support ongoing campaigns to, for example, eradicate the debt burden and to raise public finance at the global level.

Uitbreiding van toegang tot antiretrovirale terapie in sub-Sahara Afrika: 'n voorspraakagenda vir gesondheidsisteemontwikkeling en hulpbrongenerering

Die aspirasies van universele, doeltreffende en volhoubare toegang tot ART in sub-Sahara Afrika (SSA) vereis 'n breër voorspraakagenda wat die ontwikkeling van gesondheidsorgsisteme en die generering van veel meer hulpbronne vir die gesondheidsektor omvat. Tans word die lewering van gesondheidsorg in SSA gekenmerk deur lapwerk van swak gekoördineerde en bestuurde openbare, NGO- en privaatdienste wat bydra tot ondermyning van nasionale rentmeesterskap en samehangende gesondheidsbeplanning. Die uitdaging van uitbreiding van toegang tot ART in SSA kan nie geskei word van die uitdaging om lande uit armoede te lig nie. Die internasionale openbare gesondheidsgemeenskap moet sy stem en gesag gebruik om huidige veldtogte te ondersteun, byvoorbeeld, om die skuldlas uit te wis en om openbare finansiering op die wêreldvlak te mobiliseer.

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The past few years have witnessed a resurgence of health activism in sub-Saharan Africa (SSA), fuelled by a campaign to provide antiretroviral treatment (ART) for people living with AIDS.

Building on a human rights discourse, the campaign has challenged the globalised intellectual property rights regime, the profiteering of pharmaceutical companies and the indifference of governments. At the global level, treatment activists have mobilised an international response to the crisis which includes the establishment of the Global Fund for HIV/AIDS, TB and Malaria; the WHO's three-by-five target; the attention of independent donors such as the Gates and Clinton Foundations; the expansion of treatment programmes run by non-government organisations, such as *Médecins sans Frontières*, and the prioritisation of AIDS treatment in official development assistance programmes.

However, with 25 million people in SSA infected with the virus and health care systems across the continent in various states of disarray and collapse, the challenge is formidable. Furthermore, in many countries, child and maternal mortality rates have deteriorated (even when controlling for the effect of HIV/AIDS), as have immunisation coverage rates (WHO, UNICEF & UNFPA 2000, WHO, UNICEF & World Bank 2002). In the face of this, the efforts to expand access to treatment must continue with single-minded determination. But treatment programmes must be carefully designed and constructed to maximise the benefits and avoid the "pitfalls" that can accompany the rapid expansion of treatment services.

1. The pitfalls of rapid expansion of ART in SSA

There are three main reasons for the pitfalls associated with the rapid expansion of ART in SSA.

1.1 The resource deficit

The first is that most health care systems in sub-Saharan Africa are underresourced and lack both the human and the financial infrastructure required to provide an effective health care service (Simms *et al* 2001). Essential health care for all is simply not feasible under the current resource constraints.

Thirty-one African countries had a total per capita health expenditures of US$20 or less in 2001 (WHO 2004). In Malawi, there is only one physician for every 50 000-100 000 people (Aitken & Kemp 2003). Such problems can only be worsened by the international brain drain of health workers and the effect of HIV/AIDS on health workers (Padarath *et al* 2003).

Additional funding to combat HIV/AIDS and increase access to ART will not change the fact that most SSA health systems are underresourced (Malawi Ministry of Health and Population 2002). In Malawi, the addition of approximately US$40 million per annum from Global Fund grants has increased the total per capita health care expenditure by nearly US$4, but this still leaves per capita health expenditure about US$10 short of what is required to provide coverage for a basic package of essential health services, excluding ART.

1.2 Fragmented health care systems

The second reason is that health care systems in SSA are disorganised and fragmented. Health care is provided by an incomplete patchwork of unregulated private providers, public sector facilities, missionaries, non-government organisations and traditional healers. Neoliberal health sector reforms and the passive privatisation of health care systems have contributed to the collapse of public sector services, while the commercialisation of health care has left patients, especially the poor, vulnerable to exploitation and bad practice in an unregulated market (Breman & Shelton 2001, Brugha & Zwi 2003, Global Health Watch 2005, Whitehead *et al* 2001).

Partly as a consequence of the inadequate skilled human resource capacity within Ministries of Health, and partly because of the bewildering array of external health initiatives upon which many countries have become dependent, efforts to bring order and coherence to these health care systems remain unsuccessful. Instead, the response to the AIDS crisis in SSA has increasingly been to rely upon "vertical programmes" capable of by-passing the systemic deficiencies of the public health care system, but thereby accentuating its fragmentation, incoherence and disorganisation. In countries where there has been rapid growth in the NGO sector, stakeholders express concerns about "briefcase" NGOs focused on a narrow and selective remit (SWEF 2005).

While partially separate and parallel funding, staffing and logistics systems, with the use of non-governmental actors, can rapidly absorb new funds, set up projects and improve AIDS treatment coverage, they can also undermine plans for comprehensive health systems development, particularly if other health services are also funded and managed through vertical programmes (Kemp *et al* 2003). There are, for example, currently about 80 global public-private initiatives (GPPIs), most linked to a specific disease or to the development of a new drug or vaccine (Sheldon *et al* 2004).

The burden of having to co-ordinate and monitor multiple non-governmental treatment services is exacerbated by the loss of skilled personnel from the public system to the better-paid independent sector. At Lilongwe Central Hospital in Malawi, a 970-bed facility authorised to employ 520 nurses, only 169 nurses are available for clinical care — many have left to work on non-governmental AIDS projects (Kushner *et al* 2004).

Although some single-focused and dedicated structures are necessary to catalyse the scale-up of ART access for AIDS, "over-verticalisation" can result in a "vicious cycle" between fragmented, unco-ordinated and poorly governed health care systems and ever-greater reliance on vertical programmes. According to the Health Economics and HIV/AIDS Research Division of the University of KwaZulu-Natal (South Africa) (HEARD), the global response to AIDS in SSA "has favoured certain approaches to scaling up care at a national level which have not benefited the development of health systems" (Veenstra & Whiteside 2006). A set of case studies on Global Fund grants notes that none of the study countries have overarching national-level strategies or plans to address human resource constraints. The plans that do exist relate to specific initiatives rather than to the combined needs of all initiatives and do not typically take into account the potential implications of such a scale-up for human resources in other programmes within the health sector (SWEF 2005).

1.3 The HIV/AIDS juggernaut

The third reason is that, notwithstanding the importance of tackling the AIDS epidemic in SSA, the international focus on AIDS treatment (and that of a few other diseases) has deflected budgets away from com-

prehensive health systems development plans as well as from services and health care needs that lack this level of international attention. This has resulted in advocates of "neglected population groups" calling for new "global funds" to compete with the HIV/AIDS lobby for attention and resources (Costello & Osrin 2005).

Under-resourced, weak health care systems are also a threat to ART programmes. The imperative to expand treatment coverage rapidly may compromise the quality and sustainability of care. Insufficient community and patient preparation, erratic drug supplies and inadequate training and support of health care providers can result in low levels of treatment adherence and the possibility of drug resistance developing. Dismantling the social barriers to voluntary counselling and testing, ensuring the existence of a functional laboratory service, establishing reliable supply and distribution systems, providing geographically accessible service points, and ensuring long-term follow-up of patients on treatment requires a health care infrastructure that cannot be effectively sustained by means of multiple, stand-alone projects. Furthermore, because of the chronic nature of AIDS treatment, any success creates ever-growing demands on health care services as the number of people undergoing treatment grows year by year.

There are no simple solutions to the challenge of balancing the priorities of treatment and prevention, or the resource needs of HIV/AIDS and those of other diseases and health priorities. Neither is there an easy solution to the tension between urgent action to expand coverage and the slower steps required to strengthen health management and to integrate services, programmes and plans.

However, this article argues that the problems described above can be minimised by a more concerted focus in two areas. First, coherent and effectively managed health care systems must be developed and more resources generated for the health care sector in SSA. Secondly, the advocacy which has catalysed efforts to expand ART must be expanded to aim with even greater force at strengthening health care systems and addressing the underlying economic and political causes of poverty.

2. Avoiding the pitfalls

2.1 Developing coherent and effectively managed health care systems

The first step in developing a coherent and effectively managed health care system is to ensure a clear vision of what a health care system should look like. The *Alma Ata Declaration* of 1978 provided such a vision. It views health care systems as more than mechanisms for the delivery of medical technologies: as developmental and social institutions intended to mitigate the unfair health outcomes of social disparities and exclusion, to empower communities in the determination of their own health, and to provide a platform for multi-sectoral approaches towards improving health, such as the provision of water and sanitation.

However, the scenarios described earlier run contrary to this vision:

- vertical programmes undermine a bottom-up approach to health systems development;
- fragmentation and donor-dependency undermine public accountability, and coherent health planning;
- selective health care focused on discrete biomedical interventions obstructs the vision of health care systems acting as catalysts for development, and
- the commercialisation of health care aggravates inequity and inefficiency.

On a more positive note, the community mobilisation efforts that have accompanied AIDS treatment programmes provide a springboard for a more systematic bottom-up approach to health systems development and the implementation of the principles of the *Alma Ata Declaration*. A concerted effort to develop this mobilisation into an organisational strategy for the health care system as a whole is now required.

The second step is for all actors to make a commitment to developing the capacity of Ministries of Health, strengthening the public health care system, and reversing the fragmentation and unregulated commercialisation of health care provision. Such a commitment should cut across all domains of health care and be shared by those focused on expanding access to antiretrovirals, those involved in TB and malaria programmes as well as advocates of child health and safe motherhood

alike. Ministries of Health and public sector workers need to be strengthened, not undermined, if they are to provide effective stewardship. And civil society in turn needs to be empowered to hold Ministries of Health to account.

However, the argument for a strengthening of the "public" within health care systems in SSA often meets two counter-arguments. One is that public sector bureaucracies are inherently inefficient and self-serving. The second is that corruption is endemic in SSA. Both these arguments are used to justify a reduced role for the state and the public sector. In recent years, government bureaucracies have been disparaged by the prevailing neo-liberal view that the private sector is "better" than the public sector and that incentives formed by the dynamics of the market result in "better" and more efficient performance.

This view is not borne out by the evidence. The record of public sector success in the health and welfare arenas is substantial. Public sector social welfare has been the bedrock of European social and economic development since World War II and many low-income countries, including Sri Lanka, Costa Rica and Cuba, have had well-functioning public health services for decades. Furthermore, a strengthened public health care system does not imply a monolithic bureaucracy. Partnerships between government and non-governmental actors can still be encouraged, but within a coherent, organised framework. Public sector health care systems can be decentralised and, if adequately resourced, can apply non-market incentives to encourage innovation, enterprise and ethical behaviour.

Although governments in many countries are tarnished by mismanagement, corruption and shortcomings in accountability, the problem of poorly functioning governments does not negate the benefits, principles and purposes of effectively functioning Ministries of Health. If corruption and mismanagement prevent this, then questions must be asked about existing and potential efforts to combat corruption and improve the accountability and efficiency of state bureaucracies. Corruption thrives when public administrations are underfunded, unaccountable or captured by vested interests. Donor investment to develop publicly accountable legal and regulatory frameworks to monitor and improve public sector functioning, including investment in civil society organisations, could do much to help "make government work" in SSA.

In addition, the broader supra-national determinants of corruption in SSA need to be tackled simultaneously. The agents of corruption and oppression in poor countries often involve actors from the developed world. The health professionals and citizens of rich countries should also monitor the complicity of their own governments and businesses in sustaining corruption in poor countries — and campaign for the full implementation of the United Nations Convention Against Corruption.

The third step involves adopting explicit principles in respect of the organisation of the health care system to reverse the fragmentation and incoherence of policy development and programme implementation. The adoption of a district health system (DHS) model offers one platform for integration on the basis of local needs assessments, but with the ability to be linked back to a national strategy. The DHS model also offers the co-ordinated management of multi-sectoral approaches to health improvement; the integration of hospital, clinic and community-based interventions; a framework for rational, equitable allocation of resources, and the development of local systems of public accountability — essential features of an effective, comprehensive response to HIV/AIDS.

Building human resource capacity at the district level is crucial if the potential of the DHS model is to be realised. Donors and governments must make a commitment to allocate budgets for the establishment of effective and adequately skilled district health management teams in each and every district. This may incorporate a strategy to decentralise more senior management posts, making them peripheral, and, if necessary, to create "exceptional" incentives or pay packages to ensure that the right people are posted at the district level in order to develop the DHS model. Decentralising capacity and authority to the district level would enable the periphery to make more effective demands for better co-ordination at the national level.

Bold and unconventional approaches must be considered. Additional support or stipends could be provided to individuals working in rural districts. Where necessary, skilled individuals from the NGO sector or from abroad could be seconded to district management structures for periods of three to five years. With central support, adequate resources and appropriate human resource capacity, district health management structures could then be held accountable for ensuring the optimal delivery of essential health care services, including the roll-out of ART.

Health systems indicators focused on the development of the DHS model could also be adopted by all relevant actors. For example, countries could set targets, such as spending at least 50% of total public health expenditure on district health services (up to and including Level 1 hospital services), of which half (25% of the total) would be on primary health care. They could also aim to ensure that expenditure on district health services was at least 40% of the total public and private health expenditure. To promote equity, a target could be set to limit the ratio of total expenditure on district health services in the highest spending district to that in the lowest spending district to not more than 1.5.

At the same time, management capacity and authority within the Ministry of Health would need to be developed to compel more integrated planning and to take the lead in defining roles and responsibilities among the various actors involved within the health care system. Sector-wide approaches to pool donor and external health financing must be revitalised. Within this framework it would still be possible to allocate funds to specific programmes and services, but with more coherence.

In order to facilitate the change from the unco-ordinated governance of the health sector, independent research organisations could be commissioned to monitor and evaluate progress towards greater co-ordination. Codes of conduct for donors and other external actors could be developed to encourage commitment towards a coherent agenda for health systems development, the institutional development of Ministries of Health and the gradual, planned integration of vertical programmes.

In many SSA countries there is great dependency on donors, non-governmental organisations (NGOs), global health initiatives and external technical assistance. For millions of people, these represent a lifeline to services that would not be provided by the state. The question is whether there is a vision, a strategy and a commitment to replace this dependency with a new system of relationships and responsibilities that allows coherent governance and management of the health care system.

Finally, a health systems development agenda must take into account the role of the private sector. Private financing, particularly in the form of user fees, constitutes a significant proportion of health expenditure in SSA. In Malawi, for example, 26% of total health care expenditure is in the form of out-of pocket expenditure by households (Malawi

Ministry of Health and Population 1999). Much of this health care is provided by a largely unregulated private provider market, which tends to be excluded from debates and discussions about health systems development.

Governments and donors must give the private sector a higher profile and develop policies and plans to shift disorganised, commercialised health care markets in a more equitable and efficient direction. The long-term goal must be a coherent primary-level health care system operating under a national framework that regulates standards and provider remuneration. Other policy instruments to govern the private sector include licensing requirements, formal accreditation and price controls.

A short-term target towards which countries could work is the reduction of the level of user-fee expenditure to less than 20% of total health care expenditure. The levels of health care provider remuneration in the private, NGO and public sectors could also be measured regularly as a means of monitoring strategies to reduce public/private provider disparities, which contribute to the "internal brain drain" and undermine systems-wide human resource planning.

3.2 Generating resources

The health systems agenda suggested above cannot succeed without broader changes at the national and global levels, to generate the resources required for health systems development.

At the national level, civil society could adopt concrete indicators and targets to increase the generation of local, public revenue. These might include:

- The level of tax revenue to be at least 20% of the national GDP.
- Public health expenditure (from government and donors) to be at least 5% of GDP.
- Government expenditure on health to be at least 15% of total government expenditure.

However, for most SSA countries, achieving such targets would still leave governments short of the resources required to provide essential basic services for all.

More effective "global political-economic activism" will be required to address poverty and ill health in Africa. Although the 2005 G8 Summit made some progress towards cancelling Africa's debt burden and improving the levels of development assistance, millions of the world's poorest people still bear the brunt of repayments for loans that they had no part in making, and did not benefit from. And much of what has been called "debt cancellation" has been funded by the diversion of development aid and grants towards creditors, who have not taken their share of the responsibility for the bad loans of the past.

Development assistance, which is still less than 0.7% of the GNP of most donor countries, is still too often attached to conditions which allow rich countries to extract a considerable price for their aid, and not only in terms of lucrative contracts. It is also used to further the economic and foreign policy objectives of donor countries. Patronage-style aid confers power on the governments of developed countries and on international institutions like the World Bank and the IMF, as well as entrench the inequitable structures of the global economic system.

The products of this power imbalance include the perpetuation of the debt crisis, the imposition of "free market" policies on the developing world, the chronic decline in commodity export prices, and international trade agreements which lock developing countries into an unbalanced market paradigm. Thus, despite the large public demonstrations in support of the eradication of poverty in Africa, neither the G8 summit nor the WTO meeting in Hong Kong in December 2005 made any significant progress towards trade justice. In the words of Oxfam, "the WTO Hong Kong ministerial meeting was a lost opportunity to make trade fairer for poor people around the world. Rich countries put their commercial interests before those of developing countries" (Oxfam 2005).

Public health professionals must also begin to question the continued adherence to the "trickle-down" theory of poverty reduction, which is clearly not working, and the false rhetoric of poor-poor economic policy. Between 1981 and 2001, the number of people living in poverty increased from 289 million to 514 million (Woodward & Simms 2006). Yet during the same period the global GDP increased by US$ 18,691 billion. Although the 1980s are widely described as "the lost decade for development", growth-led poverty reduction was worse in the 1990s. The

proportion of global economic growth contributing to poverty reduction fell from nearly 5% in the 1980s to under 3.5% in the 1990s (Woodward & Simms 2006). Not only do the benefits of economic growth accrue only very slightly to the poorest members of the global community — the costs of this growth, such as the consequences of global warming, fall disproportionately heavily upon them.

Solving the health crisis in SSA will require a movement towards policies designed explicitly and directly to achieve social objectives, rather than treating poverty reduction as a by-product of a system structurally designed to benefit the wealthiest. This would include:

- directly improving the incomes and well-being of poor households by using resources generated at the global level to strengthen public finances in order to provide high-quality free, universal education and basic health services;
- favouring local suppliers in low-income areas in procurement policies relating to these and other public programmes;
- reversing the decline of agricultural commodity prices;
- ensuring that royalties and other payments from extractive industries reflect the full cost of natural resource depletion, and
- mobilising commitment to redistribution agenda.

There has been a growing emphasis upon public-private partnerships in the international health sector, in response to the shortfall in health financing. Corporations and wealthy individuals are encouraged, coaxed and shamed into making various types of contribution. By contrast, addressing the problems of capital flight, tax avoidance and tax competition has not emerged as a prominent policy option aimed at solving the shortfall in health financing.

As a result of technological change and capital market liberalisation, rich individuals and transnational corporations can move their money freely around the world, locate their wealth and profits in offshore jurisdictions that offer minimal or zero tax rates, and avoid tax regimes which remain largely based on national laws. Accountancy firms are able to run rings around officials in developing countries, who are hampered by a lack of transparency and co-operation from the financial services industry.

The share of global wealth held in tax havens is immense, and is growing steadily. Approximately US$11.5 trillion of personal wealth is held in offshore tax havens by rich individuals in order to minimise tax or avoid paying tax altogether. If the income from this wealth werer taxed in their countries of residency or at source, the additional revenue available to fund public services around the world would be about US$255 billion annually — far more than the global aid budget (Murphy *et al* 2005). Furthermore, this estimate of revenue loss does not include tax avoidance by transnational corporations (TNCs).

Tax havens impact upon developing countries in other ways. First, the ability of TNCs to structure their trade and investment flows through paper subsidiaries in tax havens provides them with a significant tax advantage over nationally-based competitors. This biased tax treatment favours the large business over the small one, the international business over the national one, and the long-established business over the recently established one. Secondly, banking confidentiality and the services provided by global financial institutions operating offshore provide a secure cover for laundering the proceeds of political corruption, fraud, embezzlement and illicit arms trading. Thirdly, the offshore economy has contributed to the rising incidence of financial market instability, which weakens the economies of poor countries.

Faced with the pressure of the globalisation of capital movement and the threat that companies will relocate unless given concessions like less regulation and lower taxes, governments have responded by lowering taxes in order to attract and retain investment capital. The problems of capital flight, tax avoidance and tax competition have also been exacerbated by trade liberalisation policies, which have caused revenues from trade taxes to dwindle.

It is hard to escape the conclusion that tax should now be a priority among public health issues, with calls for international collaboration in creating more progressive, transparent tax systems, better control over capital flight and more effective prevention measures against tax evasion. Additional resources for development could also be generated at a global level by means of international taxation — on foreign exchange transactions, air travel and transport, fuel, and so forth.

4. Conclusion

The argument presented in this study develops the imperative of expanding access to ARV treatment into a broader set of equally important imperatives. It is argued that a complex lattice of medical, social, economic and political problems will need to be addressed simultaneously at the national and global levels if all Africans are to overcome the present and future threats to their health.

This is not to say that treatment advocates can or must address all these issues themselves, nor to imply that "treatment activism" has got it wrong. The need to expand the range of advocacy aims reflects the need to expand the range of civil society actors engaged in responding to the challenges of Africa's health crises.

While front-line doctors and nurses continue to provide health care in extremely difficult circumstances, saving and prolonging lives where they can, international agencies, policy-makers, health systems analysts and health managers must work towards long-term plans for the development of coherent, robust health care systems that are integrated, equitable and efficient. In the developed world in particular, NGOs and citizens must be mobilised beyond the simplistic rhetoric of the recent Make Poverty History campaign to reform the global political economy, highlight the hypocrisies of the developed world, demand an end to corruption, and raise the issue of wealth redistribution as a central platform for the universal fulfilment of global health rights.

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