

Summary Sheet: Corruption and HIV/AIDSⁱ

The numbers of people infected with HIV are high and rising. In sub-Saharan Africa overall, 7 per cent of women and 2 per cent of men aged 15–24 are infected.ⁱⁱ In Botswana, Swaziland and Zimbabwe, over 25 per cent of the adult population is now HIV-infected. In Asian countries the rates are generally lower, but they are rising fast. Worldwide, some 3 million people have died of AIDS-related diseases in the past year alone, a sixth of them childrenⁱⁱⁱ, with many more left as orphans. While the corruption that affects HIV/AIDS prevention and treatment does not look very different from corruption found in other areas of the health sector, the scale of the pandemic, the stigma attached to the disease, the high costs of drugs to treat it, and a multiplicity of new agencies increase the opportunities for corruption if there is inadequate monitoring.

Where does corruption occur?

Activity	Agency	Scope for Corruption
Prevention of HIV	<ul style="list-style-type: none"> • Government ministries and parastatal organisations • International and national NGOs, community-based and faith-based organisations • International, bilateral and multilateral donors 	<ul style="list-style-type: none"> • Weak inter-agency coordination • Poor accountability: cash flows and procurement, stockholding and distribution of supplies • Weak administrative capacity within and between governmental and NGO agencies • Fictitious NGOs
Treatment and care of people living with HIV/AIDS	<ul style="list-style-type: none"> • Government ministries and parastatal organisations • International and national NGOs, community-based and faith-based organisations • International, bilateral and multilateral donors • Hospitals and clinics 	<ul style="list-style-type: none"> • Poor accountability; procurement chains; border, importing and registration procedures; drug, medicine and equipment theft • Staff payments (real and fictional) • Staff needing own medicines • Vulnerable clients (orphans)
Monitoring and Measurement		<ul style="list-style-type: none"> • Falsification of records; delays • Inadequate indicators

There are, therefore, multiple opportunities for corruption in the prevention and treatment of AIDS. Specific examples include corruption in prevention programmes when false claims are presented for awareness-raising activities that never took place or for materials that were never purchased. Corruption occurs in programmes aimed at alleviating the socio-economic effects of the disease on victims and their families, such as feeding programmes or support for school fees. Corruption can also contribute directly to infection, when relatively low-cost measures, such as the use of sterile needles and the screening of blood donations, are ignored because a corrupt procurement or distribution process holds up supplies. Alternatively, health workers may use non-sterile equipment as an additional source of income by extorting illicit payments from patients who demand clean equipment. But it is treatment programmes that are most vulnerable. Money for high-value drugs can be embezzled at any number of points in the procurement and distribution chain. At the grand end of the scale is theft by senior personnel in ministries and national AIDS councils of funds allocated for treatment, and the misappropriation of medicine or involvement of counterfeit drugs. At the petty end are doctors who extort 'tips' for medicines and patients who sell their own medication because it is the only valuable commodity they have. Moreover, the individuals responsible for tackling corruption and therefore the institutions they work for may themselves be severely affected by AIDS. These factors create particular vulnerabilities to corruption.

The treatment of HIV/AIDS

In Africa, it is estimated that people live an average of six and a half years after infection. But if anti-retroviral drugs (ARVs) treatment is started at the appropriate time, life expectancy is doubled or tripled. Even with massive and rapid scaling-up of ARVs, however, treatment is still not available to all who need it and by June 2005 UNAIDS/WHO estimated that in sub-Saharan Africa, only 11 per cent of those who needed treatment were receiving ARVs. This means that even where ARVs are provided for free or at heavily subsidised rates through donor-funded programmes, requests for 'top-up payments' are common and the pressure to corrupt is intense.

A 29-year-old Nigerian father of three spoke for many across the continent in the 2005 civil society organisation statement to the OAU Summit of Heads of States: 'The ARVs that come to the centre are not given to those of us who have come out to declare our status, but to those "big men" who bribe their way through, and we are left to suffer and scout round for the drug.'^{iv} 'Scouting around for the drug' often involves buying ARVs from informal sources, which is highly problematic, as drug traders know little about the appropriate combinations, side effects or dosage. Substituting one drug for another depending upon availability means treatment is likely to become ineffective and result in the development of resistance to ARVs. Moreover, the product may be expired or fake. The great human need for ARV drugs, so often from people on low incomes, feeds the already extensive international market in counterfeit drugs, which appear to offer a cure at low cost. Faking ARVs is potentially far more profitable than faking other drugs, and finances the bribery of customs, regulatory and hospital officials.

Differential pricing of ARVs for developed and developing nations may open up further opportunities for corruption, given the potential profits to be made by drugs brokers and vendors who re-import or smuggle cheap generics. The Trade Related Intellectual Property Rights Agreement (TRIPS) of the WTO addresses this issue, though how much of a problem it is in reality is controversial and there have been allegations that the pharmaceutical companies are exaggerating its scale in order to dampen pressure for differential pricing.^v In order to address this problem, GlaxoSmithKline is currently re-branding and changing the colour of ARVs sold in developing countries. Nevertheless, competition in the supply of ARVs has not stopped corruption in national procurement processes.

Practical steps to minimise corruption in the drugs treatment of HIV/AIDS

- Governments and health authorities should increase transparency of the eligibility criteria for ARV programmes, which should ideally become more consistent within and across countries;
- Governments and health authorities should ensure that the quantities and values of drugs supplied at each level of the system are well publicised, and that health workers are accountable for them;
- Governments and health authorities should establish a mechanism whereby end users can complain without fear of victimisation;
- Pharmaceutical companies should avoid the risk of re-importation of ARVs for developing countries by introducing different branding and packaging and closely monitoring pharmaceutical sales within the United States and Europe.

Corruption in Kenya's National AIDS Control Council

A case study from Kenya shows a worst-case scenario of corruption and profligacy at the National AIDS Control Council (NACC) set up to coordinate prevention programmes. In April 2005, a report revealed that for years high-level public servants had used the NACC as their personal cash cow, to pay themselves inflated salaries and fraudulent allowances for covering private water, electricity, telephone and home security bills. Even where money had found its way out of the NACC to the community organisations it was intended to support, the report into its use was damning. The most blatant examples of corruption involved shell organisations purposely formed to cash in on the NACC windfall. In some instances, the NACC continued to finance organisations even when its own officers had expressed concerns over the accounting for previous allocations. The NACC ordered 20 NGOs to refund money that had been misappropriated, or face prosecution, but to date, none have refunded the money or have been taken to court. Meanwhile, the former NACC director was sentenced to one year in prison for fraud and misuse of office, but was granted presidential pardon only three months after she began serving her sentence. The funds squandered may seem petty especially when juxtaposed with the huge sums that HIV/AIDS attracts. Yet in their consolidated amounts, and if spent on effective prevention programmes, life-prolonging ARVs, or income-generating activities for the affected and infected; the sums are significant.

Should the international response be more money?

The WHO, the Global Fund to Fight AIDS, Tuberculosis and Malaria and other big health lenders have responded to news that the UNAIDS target of '3 by 5' for spreading treatment by 2005 was missed by a long way, by calling for spending to be ratcheted up. But while the response to HIV/AIDS must involve an increase in funds available to purchase drugs, scaling up budgets without paying regard to the anti-corruption mechanisms needed to ensure their proper use provides further opportunity for corruption. What rich nations view as the provision of funds to purchase AIDS medicines, many in poor nations have monetised upwards as a currency of street trade. The sums now being disbursed to tackle HIV/AIDS are huge compared to the existing budgets of many countries. In Ethiopia, Liberia and Malawi, the money allocated by global health partnerships such as the Global Fund represents more than a doubling of the health budget. While the need for money is indisputable, the systems to use these funds appropriately are poorly developed. The fact that the 'performance' of a grant or loan is often assessed by how rapidly it is disbursed, gives incentives to donor and recipient to allocate the money carelessly. For corrupt officials, rapidly expanding budgets offer greater scope to siphon off significant volumes without anyone noticing. This is especially true where health systems are fragile, lack monitoring and oversight, and where the capacity to channel the money effectively is limited.

It is worth recalling the five key elements that the World Bank has identified in any anticorruption strategy:

1. Increasing political accountability
2. Strengthening civil society participation
3. Creating a competitive private sector
4. Institutional restraints on power
5. Improving public sector management

Within these general objectives, several recommendations with specific relevance to HIV/AIDS can be made as follows.

Recommendations for the donor community and recipient governments

- Include all stakeholders in the design of HIV/AIDS treatment and prevention programmes, from governments and NGOs to the sufferers themselves;
- Ensure that aid is used in line with good procurement guidelines;
- Work closely with pharmaceutical companies to ensure that they behave responsibly;
- Make information about the dates and amounts of every disbursement publicly available;
- Evaluate programmes in terms of health outcomes and not on level or speed of disbursement, nor on expenditure on inputs and outputs;
- Coordinate support to programmes by using the same accounting and auditing mechanisms, to reduce transaction costs and minimise the risks of corruption.

Where such provisions are in place, it then becomes possible for donor funding of HIV/AIDS programmes and projects to be consistent with whatever pattern of aid modality has been agreed upon, either by the donor community as appropriate for that country's present administrative capacity, or according to the more general guidelines of the donor's own policies. These will tend to differ depending on whether the donor is an official body or a international non-government organisation, or whether the country concerned is in transition from major internal civil disruption. That is, the nature and success of HIV/AIDS interventions depend upon the wider context determining aid modalities, though without losing sight of the very immediate and personal needs of the men, women and children that they are intended to serve. Since 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria has developed a sophisticated set of mechanisms for the assessment, disbursement and monitoring of aid at the local level to fight these major diseases; a system which is under continual critical review and adaptation, and is described in the final box below.

The Global Fund's efforts to fight corruption

The Global Fund to Fight AIDS, Tuberculosis and Malaria was established in January 2002 as a joint public-private clearing house for receiving and distributing donor money to developing countries. It does not implement programmes but rather finances them, and is run by a Board of Directors and a relatively small secretariat based in Geneva. The Global Fund's approach has been to include parties from government, civil society, the private sector, UN and donor agencies, and people affected by these diseases, in overseeing the use of funds. This model was developed out of a recognition that adequate capacity existed at local level to scale up disease control interventions, should sufficient financing be made available. In terms of oversight, the idea is that the different stakeholders will exert peer pressure to promote more effective implementation and reduce the likelihood of money disappearing. An agency – usually the local branch of one of the big international accounting consultancy firms – provides a second tier of oversight.

Has the approach been successful in reducing risks of corruption?

While few cases of corruption have arisen and the Fund has tended to respond quickly to these by ceasing funding to the relevant country, there is evidence that control mechanisms need tightening. Funds have been allegedly abused by public officials in Myanmar, Uganda and Ukraine. Even where corruption cases have not merited cutting off aid, there is evidence that some of the country bodies have fallen prey to competing political agendas, or have not met regularly enough to ensure adequate oversight.

The Global Fund's efforts at being inclusive of all interested sectors of society are also subject to local manipulation. Governments are typically overrepresented in the local stakeholder groupings that bid for and monitor the funds. Slightly more than half of the funds dispersed by the Global Fund to date have been issued directly to governments. The NGOs charged with exerting peer pressure do not always feel free to blow the whistle if corruption or mismanagement is suspected, especially if they are linked through personal or financial connections to the government. Conflicts of interest also arise where the independent agency responsible for monitoring Fund expenditure has parallel contracts with the government.

ⁱ This working paper is based on the papers by Liz Tayler and Clare Dickinson 'The link between corruption and HIV/AIDS'; 'Accountability in a time of crisis and the Global Fund' by Toby Kasper; and 'Corruption in Kenya's National AIDS Control Council' by Kipkoech Tanui and Nixon Ng'ang'a, published in Transparency International's *Global Corruption Report 2006* (London: Pluto Press, 2006).

ⁱⁱ UNAIDS, 2004 situation report,
www.unaids.org/wad2004/EPI_1204_pdf_en/Chapter3_sub-Saharan_africa_en.pdf

ⁱⁱⁱ *The Economist* Global Agenda, 30 November 2005.

^{iv} Statement by CSO at the fourth ordinary African Union Summit of Heads of States, January 2005, Nigeria.

^v *Financial Times* (Britain), 23 May 2005.