

Corruption and AIDS – an overview of the issues

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Corruption is limiting the impact of efforts to control the spread of HIV and to treat people living with AIDS in many parts of the world. The nature of the disease, and the responses to it, create particular incentives and opportunities for corrupt behaviour. The stigma that is often attached to HIV and AIDS also means that the condition is not always discussed openly. This, in turn, makes it more difficult to develop transparent systems for addressing the issues.

Corruption is defined as seeking personal gain (financial or non financial) through abuse of position or influence. It ranges from high-level corruption, which is unacceptable in all societies, such as embezzlement of funds and production of counterfeit pharmaceuticals, to petty corruption such as under-the-table payments or “tips” or “gifts” to doctors and nurses, or public health workers using their time, equipment and drugs in private clinics. Although unpalatable, this petty corruption is often condoned.

Within the context of HIV there is a sense of urgency – the epidemic is escalating and people are dying. There is pressure from donors and potential beneficiaries to disburse money quickly. Some money is reaching places in severe need of treatment and prevention services, but poor monitoring, low capacity to deliver services and the development of parallel supply systems provide opportunities for corruption.

The international community needs to be aware of all the potential risks of corruption, and take steps to minimise them in order to avoid perpetuating vicious cycles of corruption and health system failure. HIV and AIDS will be a major challenge for decades to come. Experience gained in other areas of development and thinking on the need for transparency and strong domestic accountability should not be ignored if sustainable and effective approaches are to be developed.

Introduction and summary

Corruption is limiting the impact of efforts to control the spread of HIV and to treat people living with AIDS in many parts of the world. The nature of the disease, and the responses to it, create particular incentives and opportunities for corrupt behaviour. The stigma that is often attached to HIV and AIDS also means that the condition is not always discussed openly. This, in turn, makes it more difficult to develop transparent systems for addressing the issues.

This paper looks at the service providers in the public and private sector, managers and policy makers, pharmaceutical companies and the international development assistance partners that interact at the level of designing and implementing health programmes. It also examines the corruption that takes place within the informal structures that emerge when formal health systems are failing. It looks at what the impact of corruption on the HIV response might be, and finally discusses briefly what the international community should do to minimise the chances of corruption undermining the HIV response.

Most of the emphasis is on treatment programmes, because this is where the risks of corruption are the highest. There is scope in all programmes for corruption around issues such as vehicle procurement and use, workshops etc. There is additional scope for corruption around the support for those who are HIV positive (such as feeding programmes, support for school fees, etc.) because of the confidentiality that should be maintained about people's status. On the other hand, prevention approaches such as encouraging behaviour change and distributing condoms offer far fewer opportunities than programmes that are procuring and distributing high value drugs.

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The international community needs to be aware of all the potential risks of corruption, and take steps to minimise them in order to avoid perpetuating vicious cycles of corruption and health system failure. HIV and AIDS will be a major problem for decades to come, and the systems that are developed to manage it must be robust if they are to be sustained.

The nature of the disease

Some characteristics of HIV and its treatment make it particularly vulnerable to corruption.

HIV kills people slowly, often impoverishing them and their families in the process. Where the opportunities exist, the incentives may be strong for HIV positive people to 'grab what they can' whilst they are still healthy, through corruption and illicit activity. There is much speculation but little evidence of what the impact of the epidemic will be on communities that are severely affected by HIV and AIDS. Obviously it will be context specific. Some writers, such as de Waal postulate that 'short termism' will develop in the way in which communities operate¹, with major impacts on their stability and governance. One aspect of this might be an increase in corruption.

AIDS-related stigma can be intense. With notable exceptions, even people who are HIV positive are reluctant to talk about it in an open and transparent way. Most people are infected through sex or injecting drugs. Much of the sexual transmission is associated with commercial or transactional sex, or sex between men. Men infected in these ways will often then infect their wives. Girls may be coerced into sex with teachers, in order to pass exams, and transactional sex in the workplace is common. In Asia and Eastern Europe, injecting illicit drugs is a major source of infection. When the target group or target activities are on, or outside the margins of legitimacy, developing open and transparent programmes is a

¹ De Waal A. HIV/AIDS and the threat to security threat to Africa. Evidence submitted to the UN Secretary General's High Level Panel on Threats, Challenges and Change, May 2004.

challenge. In China the epidemic was fuelled in some provinces by blood donation programmes that were operating without proper infection control. Public officials who were benefiting from the schemes covered up the problems for several years.²

Within the last few years AIDS treatment has become available and accessible to some, but not all people who need it in developing countries. Those who control access to antiretrovirals are literally deciding who lives longer. The scope for corruption amongst these gatekeepers is thus enormous.

The nature of treatment and increased demand for costly treatment

The availability of relatively effective drug treatment has changed the nature of HIV in the West. Increasingly, it is now seen as a condition that people can live with. Hospitalisation and death rates have fallen. Anti-retroviral drugs (ARVs), where properly administered, offer people with HIV across the world the opportunity of several extra years of productive life. The benefits depend upon many factors, but include how early treatment is started, and on whether other conditions are properly treated. In Africa, it is estimated that on average people live for six and a half years after infection. If treatment is started at an appropriate time, life expectancy might double or triple. However very often treatment begins too late, and as a consequence the gain in survival time is much less. Over the last ten years antiretroviral treatment has gone from being something that even in developed countries some could not access because of cost, to a treatment that over 700,000 people in developing countries are receiving. The World Health Organisation is attempting to get three million people on to treatment by 2005, and at the Millennium Summit in September 2006 world leaders have committed to coming "as close as possible to the goal of universal access to treatment by 2010 for all those who need it".

Even with this massive and very rapid scaling up, treatment is not available to all who need it. This is no different from other health services in Africa and other parts of the developing world where access to health care is inequitable and many are excluded through financial or cultural barriers, or because of the distance to health services. Access to ARVs both mirrors and sharpens these issues. Decisions over who gets the treatment are controversial. In some countries there is a justified and explicit policy, in other countries decisions are made on an ad hoc basis. Where there is an explicit cut off point based on blood test results (the CD4 count), demand still frequently exceeds supply, and those whose test result is 'not quite bad enough' may still use financial inducements to get on the programme. Whatever the official system, those controlling access to the ARV programme – be they administrators or clinicians - have a valuable commodity that can be traded for financial, political or other inducements. 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'.³

Many programmes are officially providing ARVs 'free' through donor support. In some cases there is a policy of some charging in line with charges that are made for other health services. However, in both instances payment requests over and above this are common. The Malawi Network of People Living with HIV/AIDS reported: *'instances of abuse from health care professionals who may demand monetary and other material favours. At some study sites it was reported that hospital health workers demanded sexual, monetary or material favours in return for proper medication and care. Those people living with HIV/AIDS (PLWHA) who cannot afford to succumb to these requirements are either not attended to or receive substandard services. In those cases where PLWHA do report receiving high quality care this is often followed by resentment and suspicion from other health care providers and patients who suggest that those providing appropriate care are receiving additional payment or a bribe to do so'*⁴

Those that get on to programmes offering free or highly subsidised drugs receive a valuable commodity. They and their family will have other needs as well, and many will elect to share or trade their drugs to meet these other needs.

² Heather Xiaoquan Zhang The Gathering Storm: Aids Policy in China. Journal of International Development, 16(8):1166-1168, 2004.

³ Statement by CSO at the fourth ordinary African Union Summit of Heads of States, January 2005, Abuja, Nigeria.

⁴ Voices of Equality and Dignity. Malawi Network of People Living with HIV/AIDS (MANET +), 2003.

www.policyproject.com/pubs/countryreports/MALA_MANET_FGD.pdf

There is a ready market for these drugs. In places such as Tsavo Road in Kenya, huge quantities of ARVs are traded every day⁵. Some of these drugs come from patients, some leak from the health system, and a large proportion are counterfeit. People buy drugs from informal sources like this because it is convenient and anonymous. Drugs are often cheap and there is less stigma, no hassle and no waiting. Some of those who sell are selling their own drugs, as they are the only commodity of value that they have. Some are patients registered on multiple programmes, others may have access to the supply chain (central and hospital pharmacies). In some cases the products may be expired or fake. The problem with obtaining treatment in this way is that ARVs are effective only when there is rigid adherence to the treatment protocol. Buying treatment from those who know little about the drugs (i.e. appropriate combinations, side effects or dosage), and substituting one drug for another depending upon product availability, means that the treatment is likely to become ineffective and that drug resistance may develop.

Although the WHO estimated that the global market in fake and substandard drugs is worth about \$32bn (or around a quarter of all drugs taken in developing countries⁶), no one really knows how big the problem of fake antiretrovirals is. There have been well substantiated reports from Ethiopia⁷, DRC⁸ and Cote d'Ivoire⁹, but most experts expect that the scale is massive and increasing. Given the demand and the value of the drugs, faking ARV is potentially much more profitable to a counterfeiter than faking most other drugs. Most of the fake drug market is ordinary crime rather than corruption. However some fake drugs are approved by the local medicines regulatory authorities, with the inducement of a bribe. Some public officials receive substantial inducements: to procure from less reputable suppliers, 'to turn a blind eye' to the sale of fake product, or to dispense them, knowing that they are fake. The reputable pharmaceutical companies have been criticised for not doing more to address the issue of fake drugs, but their limited action in this area is perhaps not surprising, as too much emphasis on fake products may also undermine the market for their own legitimate products.

It is not only drugs that are being traded; there is also a market in diagnostic kits. There are anecdotal reports of a hospital lab technician faking test results and selling the 'real tests' to men who wanted to test their girlfriends. Donors supply diagnostic kits to support voluntary, confidential counselling and testing programmes. Some of these kits leak into the black market and are sold on. Many people perceive that they will find higher levels of confidentiality if they are tested anonymously in a private clinic, and are happy to pay private providers. The problem is that kits need to be stored and used appropriately. Positive tests need to be confirmed by repeating the test with a different kit. These safeguards are not likely to be available in the back street clinics using black market kits, and so the reliability of such testing is suspect.

Concerted advocacy by civil society groups, governments and competition from generic and research based companies has been extremely effective in lowering the price of antiretroviral drugs in the developing world. A system of differential pricing between OECD countries and high prevalence developing countries has been developed. The price differentials are huge. Currently a month's supply of Combivir, a GlaxoSmithKline product, costs about \$610 in Britain, but is sold for about \$20 in Uganda, Tanzania and Kenya. The potential profits from re-importation and smuggling are large for the vendors in developing countries and for drug brokers in developed countries. How much of a problem this is in reality is more controversial, and there have been allegations that the pharmaceutical companies are exaggerating the scale of the problem in order to dampen the pressure for differential pricing¹⁰. In addition, the competition in supply of ARV drugs has not stopped corruption in national procurement processes, which will be examined in the next section.

⁵ The Nation (Kenya), 22 January 2004.

⁶ Fake and Counterfeit Drugs. WHO Fact Sheet 275, November 2003.

⁷ "Black Market Bogus AIDS Drugs", News24, 7 October 2003.

⁸ "Counterfeit ARVs in DRC". Posted to E-Drugs discussion group on 11 February 2003.

www.essentialdrugs.org/edrug/archive/200402/msg00028.php

⁹ "Fake AIDS drugs linked to unlicensed Namibians?" Posted to E-Drugs on 7 January 2004. www.essentialdrugs.org/edrug/archive/200401/msg00004.php

¹⁰ Financial Times, 23 May 2005.

National programmes – new approaches and roles

The HIV response is being implemented through weak government systems. Where systems are weak and corruption is endemic, it is difficult to disentangle how much of the problem is corruption and how much of it is ineptitude and system failure. The Government of Nigeria's antiretroviral programme attracted much criticism in 2003 when treatment centres began handing out expired drugs and rejecting patients.¹¹ It is not clear whether the prime cause was corruption or a very weak drug procurement, supply and distribution service that was totally unable to respond to the demands that the rapid scaling up of the antiretroviral programme had placed upon it.

There are new actors and institutions involved in supporting HIV. These fresh approaches may be welcome on many counts, but the lack of experience, sometimes overoptimistic expectations of the capacity of systems to deliver, and the pressure to spend money quickly are all appreciable risks. Novel ways of working are being piloted. More than any other disease, the response to HIV has broken out of the traditional health model and is seen as a challenge to many sectors including education, security, agriculture and social services. In an attempt to co-ordinate this, National AIDS Commissions have been established. To a large extent they are seen as a donor construct, and the extent to which they have been assimilated into countries governance systems and processes is variable. New approaches and ways of working also bring new opportunities for corruption.

In an attempt to recruit high calibre staff, senior officials within National AIDS authorities are being paid salaries well in excess of civil service norms. This does not always prevent corruption. The new head of the Kenyan National AIDS Control Council was appointed on a very high salary, and was subsequently arrested on corruption charges, including falsifying her previous earnings¹²

In Zimbabwe an AIDS levy has been imposed since 2000 whereby employees contribute 3 percent of their gross salaries towards a fund administered by the National AIDS Council (NAC) on behalf of the government. It is estimated that the government collects about Z\$10 billion per month through this mechanism, but no information has ever been made public about how the fund is used and who the beneficiaries are. In March 2005, the health ministry ordered an audit of the NAC, but it has not been published.

Civil society organisations (CSOs) are increasingly being seen as important providers of services, and as such are receiving substantial grants. The sums involved are often enormous relative to the previous budgets of many of these groups. However, the transaction costs of processing and monitoring CSO applications, and sorting out the legitimate providers of services from those who perform well on paper but offer little in reality, are very high. Frequently civil servants and academics involved in HIV committees (such as National AIDS Committees) or their relatives will run a CSO. This may be entirely legitimate but does raise the risk of conflict of interest, especially when that organisation then receives substantial grants, or is appointed to a monitoring function.

In general, there are two major risks associated with the extended role of CSO. The first is that substantial proportions of the grants going to some organisations will enrich those who run them. The Zimbabwe National Network for People Living with HIV/AIDS (ZNNP+) focused on alleviating the suffering of people affected by HIV/AIDS and their dependents. The Network's director and other senior officials were suspended after allegations of corruption were made¹³. The Network received more than US\$1.8 million between 2003 and 2004 from the NAC, and it has been suggested that the bulk of this sum may have been misappropriated.

The second risk concerns the CSOs' role in holding the establishment to account and acting as advocates. Once civil society organisations become beneficiaries of grants and are being paid for service delivery, their role as advocates may become weaker. An organisation in receipt of funds from a programme may be less likely to raise allegations of corruption.

In an era of rapid change the scope for malign creativity is enormous and the chances of rapid detection and an effective response are more limited. There will be teething problems as new loopholes appear in the system.

¹¹ "Drug Shortages, Corruption Hindering Nigeria's Antiretroviral Drug Program, Advocates Say". AP/Newport News/ Daily Press, 4 February 2004.

¹² East African Standard, 25 February 2004.

¹³ The Chronicle, 3 February 2004; 23 April 2004; 19 July 2004.

The international response: more money

Whilst the international response to HIV has been criticised for being too little too late, huge sums are now being talked about, particularly relative to spending on health in general. In 2001, \$2.1bn was spent on HIV and AIDS. Within three years this has almost tripled to \$6.1bn, with an expectation that resource needs will triple again by 2008¹⁴. In relation to existing budgets in many countries, these are very large sums. Already in Ethiopia, Malawi and Liberia the money allocated by global health partnerships such as the Global Fund to Fight Aids, TB and Malaria (GFATM) represents more than a doubling of the health budget. In conjunction with other large donor funds such as a large World Bank programme and the US President's Emergency Plan for AIDS Relief (PEPFAR), the escalation of funds for HIV is enormous. 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, systems for monitoring and oversight are lacking or insufficient, and where capacity to channel the money into effective health services is limited.

AIDS is a high profile political issue and there is massive pressure to disburse funds rapidly. While the needs are undisputable, the systems to use these funds appropriately to deliver quality services to the right people and to monitor outcomes are less well developed. The fact that the 'performance' of a grant or loan is assessed in the first instance by how rapidly it is being spent, gives incentives to donor and recipient to adopt the options that shift money rapidly.

Commentators such as Stephen Knack¹⁵ suggest that development assistance may actually reduce the quality of governance in recipient countries. Large resource flows from an external source are vulnerable to corruption. Donors may set up parallel systems to avoid this, but this means taking talent and capacity away from the official government systems. Governments and officials can become more accountable to the donor than to their own constituents. In an attempt to prevent this, some donors – mainly the Europeans - are moving towards budget support, essentially putting their money through government channels. They acknowledge that there is a fiduciary risk but believe that in many countries, the benefits - improved efficiency, legitimacy in focusing on public financial management, and support to domestic accountability - outweigh these risks. The alternative view, strongly held by the Americans, is that the way to minimise corruption is through tight control ('an ability to account to US congress for every dollar'), irrespective of what is happening in the rest of the system.

Much HIV and AIDS funding flows through parallel channels, and supports separate projects in the manner that Knack is most concerned about. This is in part in the interests of getting things moving quickly, partly because of the multi-sectoral nature of the response, and partly a feature of the donors involved. PEPFAR illustrates many of the problems of the project approach: there is a political imperative to spend money rapidly, but in a manner that is tightly constrained by US politics. This means that local systems and approaches are undermined, funds are not spent in an appropriate or cost effective manner, and yet corruption is still a problem¹⁶.

The Global Fund to fight AIDS TB and Malaria (GFATM) is an example of a new way of supporting activities in the health sector. It represents that largest of the global partnerships that have developed over the last few years to increase the emphasis on a range of issues – largely communicable diseases. These partnerships have attempted to avoid setting up large bureaucracies at country level and are largely reliant upon existing systems for their implementation. In Uganda there is a strong partnership between government and donors, and donors have been successfully merging their funds into government budgets. However, even here the first tranche of GFATM money was channelled through a separate project implementation unit. This did lead to problems, and the Global Fund is now implementing through government systems in many countries. The Global Fund has been explicit about the risks of corruption and proactive in trying to deal with it.

¹⁴ Resource Needs for an Expanded Response to HIV/AIDS in Lower and Middle Income Countries. UNAIDS, 2005.

¹⁵ Knack, S. Aid dependence and the quality of governance A cross country analysis. World Bank, 2000.

¹⁶ Africa: AIDS Conference Reports. AfricaFocus Bulletin, 17 July 2004 (040717).

Are there approaches that could minimise corruption?

If HIV/AIDS and the approaches to managing it are dealt with explicitly and openly, corruption becomes more difficult. Ideally there needs to be active management at all levels to decrease both the incentives and the opportunities for corruption. This may become increasingly difficult where individuals and institutions are severely affected by AIDS.

If health worker terms and conditions were improved, in parallel with approaches to increase their accountability to communities, corruption might decrease. Merely paying health workers and civil servants more (as happened in Nigeria in 2000) is necessary but insufficient to limit corruption. Minimising the opportunities for corruption without giving some alternative source of income might just result in workers giving up and in an escalation of the human resource crisis in health.

Within countries, the general public needs to be made more aware of the eligibility criteria for ARV programmes (which should ideally become more consistent). People need to be aware of what they should have to pay and what they will receive. The quantities and values of drugs supplied to each level of the system should be well publicised, and health workers should have to account for them. There also needs to be some mechanism whereby people can complain if there are problems, without fear of victimisation.

The risks of corruption associated with pharmaceuticals have been discussed earlier. Not surprisingly there has been some action. In response to allegations of smuggling, and to minimise the risks of drugs for developing countries being re-imported, GlaxoSmithKline are re-branding and changing the colour of all their anti retroviral drugs that are sold in developing countries. An alternative approach used with malaria drugs is to develop from the start different brand and packaging for products designed for developing country use. Whilst the initial costs of doing this may be high, it is probably an effective mechanism to limit illicit re-importation.

There is also a European Commission system of registration of differentially priced products, whereby products are given a number and bar code and can be identified by customs or drug brokers when and if they are re-imported. Tight monitoring of pharmaceutical sales within the US and Europe may be an important disincentive to re- importation and needs to be maintained. However, the implementation of the recent TRIPS agreement (regarding compulsory licenses and the export and import of generic varieties of drugs) may restrict the availability of cheap generic varieties of drugs, providing additional pressure and scope for bureaucratic corruption.

Given the scale of potential rewards, those caught smuggling pharmaceuticals need to be appropriately punished. Senegal has been praised for taking its response to AIDS so seriously, including the controversial imprisonment of a politician whilst awaiting trial for buying subsidised ARVs and re-exporting them to Europe¹⁷.

The issues around procurement and the approaches to strengthen it are not different from the rest of the health sector. The sums involved, and the complications of differential pricing reinforce the importance of developing countries adhering to robust transparent procurement practices, and donors supporting this. Donor governments should ensure that their aid is used in line with good procurement guidelines, and work with their pharmaceutical companies to encourage and ensure responsible behaviour.

The Global Fund to fight AIDS TB and Malaria is unusual in its transparent and rigorous approach to procurement and corruption. Allocations and disbursement rates are published on the website. A programme in the Ukraine was suspended when there were 'serious reservations' over the management issues related to governance, management and adherence to required business practice. They have identified and addressed some of the governance arrangements that increased corruption risks in the initial phases.

If the risks of corruption are to be minimised among international development agencies, donors must be aware of them, and prepared to address them openly. This is not an AIDS-specific issue. The emphasis that is placed on corruption in the report of the Commission for Africa is particularly helpful¹⁸. One step towards getting recipient governments to behave transparently would be for donors to be completely

¹⁷"Black Market AIDS drugs proliferate in Africa". UN Wire, 14 April 2004.

¹⁸ Our Common Interest. Report of the Commission for Africa, 2005.

open and explicit around what they are giving, when, and to whom. This is already included in international recommendations, but the reality on the ground is still a long way from this ideal.

Donors need to be more aware of the risks of corruption and less nervous about discussing it openly. Whether their support is through projects or via budget support, they should be proactive in minimising the risks that their activity may encourage corrupt practices and ensure that there is appropriately severe punishment where there is evidence of their own nationals' involvement.

Ultimately, it is the responsibility of national governments to deal with corruption. Given the associated sensitivities about international action, regional pressure may be more appropriate. In Africa, for example, the NEPAD peer review system could become an important tool.

HIV and AIDS may be a public health emergency, but it is going to be a major challenge for the next two decades at least. Experience gained in other areas of development and thinking on the need for transparency and strong domestic accountability should not be ignored if sustainable and effective approaches are to be developed.

Conclusion: is HIV/AIDS different from other diseases?

Failing health systems encourage, and are perpetuated by corruption. Large sums of donor money invested in fragile environments, particularly where quality is difficult to establish and monitor, will be prone to corruption. Health and infrastructure are particularly good examples of this, and in health there is an added risk in the asymmetry of information and power between the provider and recipient of services. There additional risks associated with HIV and AIDS are in terms of the potential impact on individuals and societies, the relatively high unit cost of the treatment, and the fact that treatment is only available to a proportion of those that could benefit.

The size of the international response and the plethora of instruments and funding streams mean that the potential gains from HIV are high. The Global Fund is a good example of development practice in terms of its openness and awareness. Greater acknowledgement by other donors of the risks of corruption, and more strategic attempts to minimise these will be important if sustainable systems for HIV service delivery are to be developed and maintained, and if the monies currently being allocated to HIV and AIDS are to be used appropriately.

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