Aidspan
Independent observer of the Global Fund

Increasing finance for health could be the Global Fund's biggest challenge

Professor Gavin George is the Aidspan Board's newest member. He runs the Health Systems Strengthening Programme in the Health Economics and AIDS Research Division (HEARD) of the University of KwaZulu-Natal in Durban, South Africa. HEARD conducts research on the socio-economic aspects of public health, especially the African HIV/AIDS pandemic. The organisation has an Africa-wide mandate with research applicable across the region that impacts on regional policies and programmes.

Gavin is an economist and behavioural scientist specialising in health systems research. He has undertaken work on a number of projects in the field of health systems strengthening and specifically HIV/AIDS on economic, psychosocial and behavioural issues.

Tell our readers a little bit about yourself and your background.

I am South African and originally from Durban, where I studied and also now live and work. Durban is a great place, of South Africa's three major cites (the other two being Cape Town and Johannesburg) it has the most relaxed vibe.

I went to university at UKZN and joined HEARD as a junior researcher in 2000, just after it had been set up by Alan Whiteside. There were only five of us at that time! Since then, HEARD has grown exponentially and is now led by Professor Nana Poku who, as well as being HEARD's Executive Director, is also UKZN's Vice-Chancellor and Principal.

My discipline is economics so in the early years the big issue for HIV was around treatment or rather the lack of it; South Africa wasn't rolling it out at that time. Alan, Tony Barnett and I worked with the private

sector to formulate a business case for why companies should invest in the health of their employees. We researched the economic cost to businesses based on two scenarios ? provision of HIV and general health care to their employees through health insurance or providing workplace health services versus the costs of hiring new people and having to train them and wait for them to gain experience. It showed that the first option was the most cost-effective over a seven-year period.

In the past ten years about two-thirds of my focus has been on the disproportionate impact of HIV on adolescents and, in particular, adolescent girls and young women (AGYW). This has been funded, and continues to be funded, by the United States Agency for International Development (USAID). I have provided technical assistance to South Africa's Department of Basic Education (DBE), leading a team to develop their Strategy on HIV/AIDS, Sexually Transmitted Infections & Tuberculosis (TB) in Schools 2012-2016, a Learner Pregnancy Policy and Protocols on the Reporting of Sexual Abuse and Harassment. I am currently working with both the DBE and USAID on the implementation of evidence-informed sexuality and HIV prevention education programmes. We are piloting comprehensive sexuality education (CSE) in schools, including lessons plans, teaching aides for educators and training, which we rolled out in five provinces before expanding it to seven. The aim is to train 10,000 educators and reach half a million students. Our focus is based on the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) programme which is a partnership to reduce HIV/AIDS in AGYW in 10 Southern African countries. I've also been doing some political economy analysis in Malawi around CSE and adolescent services, collaborating with the African Population Health and Research Center (APHRC).

Together with partners, HEARD led the DREAMS evaluation for South Africa and we're now releasing some articles based on this including the first epidemiological study showing that CSE is having an impact on some key indicators for AGYW.

My PhD focused on something very different ? health migration from the perspective of different economic approaches such as incentivisation, purchasing power parity, what attracts the various cadres of the health workforce to which countries and why, while observing both internal and external push and pull factors. We expanded our subject group to include teachers and we now have six studies from each set of workers from two countries/one region (India and South Africa, as well as the Caribbean).

We know from the Global Fund's new Strategy that its fourth objective on Mobilizing Increased Resources is placing an increasing spotlight on health financing and advocacy for greater domestic resources for health. Tell us about your work on health financing.

I've been working with the University of Otago in Dunedin, New Zealand, on its Global Health Programme where I am the African representative, and at Lund University in Sweden, looking at universal health coverage (UHC) and health financing (HF). We already run courses on HF and UHC and this will be expanded over the next few years into a Masters on HF. Currently, though, it is taking the form of a ten-week programme piloted at Lund that can be taken online or face-to-face. Students can choose which format suits them best and can invest the optimum time for them in learning, not constrained by set lecture periods, with less didactic teaching and more independent learning. It will potentially become a module within a broader Global Health Master's programme but for now it is standalone and will continue to be offered as such.

Tell us about your work linking economics with behavioural sciences and health.

Recently I was appointed a member of the World Health Organization's Technical Advisory Group (TAG) on Behavioural Insights and Sciences for Health, which is composed of experts representing a broad range of disciplines relevant to behavioural insights and sciences, including psychology, behavioural economics, anthropology, social marketing and more. The group also brings together extensive experience in designing and implementing national health policies and programmes informed by

behavioural insights and sciences; in evaluating the impact of behaviourally informed public health initiatives in low- and middle-income countries; and in setting up or running behavioural insights units in organizations.

It ties in with my research in East and Southern Africa on behavioural issues that influence service delivery, low health services uptake and how to increase demand for particular services. In this context we have looked at differentiated service delivery for people with HIV in Zimbabwe, TB preventive treatment among children in Eswatini and TB course completion in South Africa, funded by the National Institute for Health. We have also researched HIV self-testing (HIVST) in Kenya and Uganda, supported by the Bill & Melinda Gates Foundation. We used discrete choice experiment (DCE) methodology to do this: it's a quantitative method increasingly used in healthcare to elicit preferences from participants (patients, payers, commissioners) without directly asking them to state their preferred options. We have used it with the HIVST research, and with adolescent boys and the circumcision issue in South Africa.

WHO TAG has recently been engaged in COVID-19 vaccine hesitancy among key groups, tailored messaging, etc. using behavioural insights to determine what are the most prominent deciding factors that people consider when they are deciding whether or not to vaccinate.

Behavioural insights units are growing in prominence globally. One of the more prominent 'Nudge Units' was established in the UK Cabinet Office in 2010 by David Cameron's government to apply behavioural science principles to public policy and, in doing so, develop tailored interventions to change certain behaviours. Nudge Units are now appearing across the world engaging on issues related to obesity, smoking, and antibiotic resistance to name a few.

What attracts you to Aidspan's work?

Its mission for oversight and governance, which is not only important but presents us with a great opportunity if we are able to influence and evaluate how the Global Fund utilises limited resources. Aidspan is uniquely positioned to do so, in spite of some limitations. It needs to retain its independence and neutrality on these issues, and its watchdog model would be useful for other big donor agencies to assess their influence over Global Fund spending.

How do you think Aidspan's mission is going to be affected by the donor constriction in funding?

Other organisations have had to adapt to shifts in donor priorities and Aidspan is no different. COVID-19 will further impact the availability of donor funds. Overseas development aid is diminishing in some countries. This is hugely problematic and lower-middle income countries require funds to tackle COVID-19 and strengthen their health systems failures, while non-government organisations (NGOs) are also affected, with funding priorities shifting.

NGOs will have to reassess and adjust their own strategies. Aidspan has to be forward-thinking and proactive, and try to anticipate where donors' priorities will lie in the future.

As an NGO, Aidspan also has to adapt ? do we continue to do what we do or do we make significant changes in order to remain relevant and sustainable?

COVID-19 is most the obvious thing for Aidspan to include in its areas of work and we have been doing this through the increasing numbers of articles on various aspects of the pandemic published in the Global Fund Observer. Another big issue in Africa is about vaccines: we have to be at the forefront of advocating and lobbying for resources for vaccinations in our countries.

Health financing and broader health system strengthening are crucial and the pandemic has shone a spotlight on the deficiencies now even more apparent in many countries. These issues will remain with us for some time to come, and Aidspan has to be there to investigate and report on them.

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