and private expenditure; identifying and pruning unproductive public expenditure; raising additional domestic revenue; creating an enabling environment for private health sector growth; and boosting health development governance to curb corruption, they would have a high probability of succeeding in this century, i.e. in the next 92 years.

In their commentary, Ooms and Van Damme attempt to argue that none of the above-mentioned strategies would singly enable African countries to raise the US$ 40 per person required to provide an essential package of health interventions. They do not propose an alternative set of strategies that would enable African countries to mobilize the US$ 40 per capita without depending solely on donor funding. Instead, they make a rallying cry for sustained international health aid.

The commentators mistakenly assumed that our proposed strategies are mutually exclusive. Of course, none of the five strategies alone would be able to raise enough domestic resources needed to wean countries off donor funding. However, our argument is that the five strategies, depending on each country's context, should be implemented in tandem.

Our argument was that 8 countries (Algeria, Angola, Botswana, Gabon, Lesotho, Namibia, Seychelles and South Africa), whose current military spending is above the regional average of US$ 16 per person, may have scope for savings. Ooms and Van Damme argue that this strategy would not make a difference to Liberia, Madagascar, Malawi, Mozambique, Rwanda, Sao Tome and Principe, Sierra Leone and Zambia. This is tautological since the military expenditure of the latter set of countries is below our assumed US$ 16 per capita threshold.

Concerning the strategy on raising additional revenue, we argued that 13 countries whose tax share of GDP is less than 15% have scope for raising additional revenue by improving efficiency of their tax administration systems. Commentators argue that countries such as Madagascar and Rwanda would raise merely an additional US$ 1.5 and US$ 0.8 per person per year. When multiplied with the total population, those seemingly small figures would yield an additional US$ 36.15 million per year for Madagascar and US$ 9.68 million per year for Rwanda. Those amounts are not insignificant in these countries where more than 60% of the population live below the international poverty line of US$ 1 per person per day.[1]

We concur with the WHO Director-General's call for increased and more predictable international aid for Africa which adheres to the principles of the Paris Declaration on Aid Effectiveness.[2] In our opinion, the effectiveness of international aid should also be judged on the extent to which it helps recipient countries to develop and implement strategies for weaning themselves off external donor funding before the end of this century. ■

Response to Ooms and Van Damme

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The thesis of our base paper is that if African Region countries armed themselves with a strategy for weaning themselves off donor funding for health, which is backed up by effective programmes for improving economic efficiency in public

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