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Beware False Tradeoffs

January 23, 2007

by Jeffrey D. Sachs

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I agree with Laurie Garrett that there is an urgent need for improvement in Africa's health systems, but it's not clear what her solutions really are. Her article is filled with misguided aid bashing and disdain for targeted disease-control programs. I disagree on both counts. We need much more aid, not aid bashing. We need targeted disease-control programs as well as programs to build Africa's health systems. We don't have to choose between AIDS control and maternal mortality. And we don't have to choose between topping up health worker salaries and breaking the donor bank. Garrett's article highlights a serious problem — the continuing health crisis in Africa — but responds with a number of false dilemmas and false choices.

Garrett leaves the strong impression that there is ample donor funding for health but very poor use of it, mainly because it is uncoordinated and directed to single diseases. Yet near the end of the article she says that triple the current spending will be needed. She repeatedly denounces current aid funding (which she derides as "putting nations on the dole"), as if health systems can be built without financial resources.

Let me refer readers back to the 2001 report of the Commission on Macroeconomics and Health, which I chaired and which helped to lead the resurgence of financing of donor assistance for health. That report, available online at www.cmhealth.org, made clear that building effective disease control and health systems would require an increase of donor aid to about \$30 billion per year in today's prices (\$27 billion per year in US dollars at 2002 prices), or about 0.1 percent of rich-world GNP. The report helped launch the recent increases in aid for health, but the actual aid levels that have been reached to date fall far short of what was recommended then and what is still needed today.

Garrett's suggestion that I called for annual foreign aid for health of "well under \$20 billion" is seriously misleading. Perhaps she is referring to the CMH estimates for Africa, which called for country-level aid of around \$19 billion per year in 2002 dollars. She says that the aid levels that I recommended have "actually been eclipsed," but this is not even close to

being true. Actual donor aid disbursements per year for African health care are far below \$20 billion per year. It is therefore grossly inappropriate of Garrett to leave the impression that aid targets have been met or exceeded, thereby blaming the shortfalls in outcomes on poor performance.

Those of us on the front lines of this fight do not recognize her black-and-white contrasts between vertical disease-control programs and public-health-system strengthening. Health systems, including that of the United States, obviously need both kinds of programs, and most practitioners work for both. Leading health practitioners are vividly clear on the point that "vertical" programs for AIDS and TB control actually also help to build health systems. Garrett's attack on disease-control programs is passé, a straw man.

Salary levels for health workers remain miserable in Africa and the continent's entire health sector therefore remains prone to brain drain, as Garrett rightly notes. Yet her expressed doubts about raising local salaries make little sense. She argues that bolstering local salaries would be "enormously expensive (perhaps totaling \$2 billion over the next five years)," without putting the \$2 billion over five years in any perspective. Let me do so. The rich world's annual GNP is around \$35 trillion. Thus, \$2 billion over five years, or \$400 million per year, is approximately 1 penny per \$1,000 of rich-world GNP. This is obviously tiny in the scheme of things, not "enormously expensive." The U.S. Pentagon, to offer another metric, spends \$1.5 billion each day.

Let's recognize the iron laws of extreme poverty involved here. A typical tropical sub-Saharan African country has an annual income of perhaps \$350 per person per year, of which much income is earned in kind (as food production for home use), rather than as money income. The government might be able to mobilize 15 percent of the \$350 in taxes from the domestic economy. That produces a little over \$50 per person per year in total government revenues (and in many countries, much less). This tiny sum must be divided among all government functions: executive, legislative, and judicial offices; police; defense; education; and so on. The health sector is lucky to claim \$10 per person per year out of this, but even rudimentary health care requires roughly four times that amount. (In rich countries, public spending on health is \$2,500 per person or more.) Foreign aid is therefore not a luxury for African health. It is a life-and-death necessity.

Doctors and nurses, meanwhile, are — and will continue to be — extremely scarce there, even without brain drain and deaths of health workers from AIDS. There are frequently 5 doctors or fewer per 100,000 population, and often virtually none in rural areas. Of course more doctors and nurses need to be trained, and urgently. Just as important, however, will be new cadres of village health workers who should be trained for a few months each in order to help handle a host of basic health challenges within the village context (malaria control, diarrhea control, family planning, etc.). Such village health workers would work under the supervision of doctors and nurses, and would provide direct contact with households in the community. Tens of thousands of village health workers can and should be mobilized in the coming years. At the same time, health worker salaries need to be topped up significantly with donor aid, so that brain drain is at least restrained.

Africa's tropical disease ecology, finally, is particularly pernicious for several killer vector-borne diseases, the most important of which is malaria. This means that even as Africa lacks the domestic financial means to mount an effective health system, it bears by far the world's highest burden of some tropical infectious diseases.

Until Africa's economies pull Africa out of extreme poverty — something that will be powerfully assisted by disease control — foreign aid is not a whim, a matter of dole, or a

matter of avoidable dependency. It is the difference between life and death. It can also be used to do exactly what Garrett rightly wants: to build an effective health system. We have just started on the road to doing this, after decades of shocking neglect. Garrett is right to call for more coherence and better strategy, but the real answer to the problems she describes is a further scaling up of aid, combined with comprehensive efforts at training, targeted disease control, and overall public health system building. All of this is within reach, if Africa and the rest of the world can persevere.



From "Marvelous Momentum" to Health Care for All

January 23, 2007

by Paul Farmer

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The last quarter of the twentieth century saw little investment in international health or in the health problems of the world's poor. Over the past few years, as Laurie Garrett notes ("[The Challenge of Global Health](#)," January/February 2007), "driven by the HIV/AIDS pandemic, a marvelous momentum for health assistance has been built and shows no signs of abating." But after this upbeat introduction, Garrett proceeds to lay out the perils associated with this new momentum, chief among them that an influx of AIDS money has drawn attention away from other health problems of the poor, weakened public health systems, contributed to brain drain, and failed to reach those most in need.

I respond as a physician who has lived through the dry spell, seen the rains coming, and witnessed the burgeoning of the first sprouts of hope in a long time. Because many others who work in places such as rural Africa and Haiti — the examples used by Garrett in her essay — also see the threat of bad seed ruining the harvest, I will not dispute her argument about the disproportionate use of scarce health-care resources. In fact, I agree with most of her claims. I would rather focus on how the new enthusiasm about global health can be translated into efforts to close the widening "outcome gap" between rich and poor.

The stakes are enormous. It is well known in development circles that huge amounts of aid have often brought few improvements to the lives of the world's poorest. A first principle for the emerging global health movement, in fact, might well be: "Don't emulate the mainstream aid industry." That said, aid is not bad in itself, and if managed appropriately it can achieve impressive results. The end of the funding drought has been a tremendous boon, especially for the destitute and sick (and those who provide care to them).

It is worth comparing the situation in 2002, the year the Global Fund to fight AIDS, Tuberculosis, and Malaria made its first pledges, and today. Garrett is correct to remind us that AIDS is far from the only problem faced by the destitute sick in rural Africa, but it is the leading infectious cause of adult death there. At the beginning of the millennium, there was no real political will, and no money, to treat the poorest Africans with AIDS, in spite of declarations to the contrary. In 2007, on the other hand, there is some money for AIDS prevention and care, although it rarely makes it all the way to rural Africa. In 2002, there were almost no antiretroviral (ARV) medications in rural Africa, nor were there personnel to deliver them. In 2007, most African nations are working to make AIDS diagnosis and care "a public good for public health" — that is, a service paid for by the commonwealth or rich donors, rather than by individual AIDS sufferers and their families. Although these drugs are as yet reaching very few rural Africans, the past five years have seen significant investments,

at the district if not the village level, to make AIDS therapy available for those who are able to walk or find other transportation to district hospitals.

The brain drain of health-care personnel from the developing world described by Garrett has not been reversed over the past five years, but the experience of Partners In Health (PIH) in Haiti and in Africa offers hope. As hospitals are refurbished and become something more than charnel houses, as medications are made available, some doctors and nurses are returning to the rural public-sector institutions in which we work. There is a growing awareness that not only doctors and nurses are needed to deliver medical care: Many are learning that proper "accompaniment" — closely supervised home-based therapy; social and psychological support; and help with everyday tasks, including feeding families — is what poor patients with AIDS need most of all, once the demand for coffins is replaced by the demand for a continuous supply of ARVs.

Garrett notes that "Guinea-Bissau has plenty of donated ARV supplies for its people, but the drugs are cooking in a hot dockside warehouse because the country lacks the doctors to distribute them." I would argue that in no country in the world are doctors effective as distributors of medication. PIH has instead trained community health workers called *accompagnateurs*, who have achieved AIDS treatment outcomes in rural areas of poor countries much better than those registered in what is today termed "inner-city" America. *Accompagnateurs*, not doctors or nurses, are the appropriate distributors of medications — which is why we have now imported the Haiti model to Boston.

In 2002, AIDS prevention and care were considered different and opposed activities, as experts and activists fought over scarce resources. In 2007, although this struggle continues, prevention and care have been integrated in some settings with excellent results. In 2002, experts advocated what could only be described as substandard care for poor Africans with AIDS, even if these recommendations were sometimes dressed in fancy-sounding names such as "home-based" or "palliative" care. In 2007, progress has been made, since some argue that while the "home-based" part of the formula is correct, the "care" component must include ARVs, and that "palliative care" — code for helping people to die with less pain — should not be used for a disease that strikes mostly young adults and children unless that disease is untreatable. It is true that sub-standard guidelines persist in 2007, but they are being challenged by many who seek to improve the quality of care available to the rural poor.

In 2005, PIH initiated, with the Rwandan Ministry of Health and the Clinton Foundation, a new rural AIDS initiative based on the Haiti model, and it is starting to have some success. More than 2000 people with AIDS are now receiving therapy within two health districts in eastern Rwanda — districts that, prior to 2005, were served by not a single doctor. Over 400,000 people live in these districts; 60 percent of them are resettled refugees or others displaced by war and genocide. PIH did bring in doctors at first, some of them Americans, but within months of our arrival, over 95 percent of our employees were African, most of them *accompagnateurs*. And most of what we do, in Rwanda as elsewhere, has more to do with primary health care than with AIDS. We also work within the public sector so that the doctors, nurses, and paraprofessionals who work with us are not part of the brain drain at all.

Unfortunately, such practices — and such results — are the exception rather than the rule. "By one reliable estimate," notes Garrett, "there are now more than 60,000 AIDS-related NGOs alone." Yet by 2006, after a global campaign to bring AIDS care to Africa, fewer than 25 percent of Africans who needed ARVs to survive were receiving them, with the fraction dwindling to less than 5% in rural areas. Worse, new infections continue apace. So what on earth, one might ask, are all these AIDS-focused NGOs doing? That is a very good question, and we should all be grateful to Garrett for posing it so provocatively.

As Garrett notes, it is not NGOs alone that suck up resources intended for the poor; corrupt governments divert many of these resources to the pockets of the non-poor, including a huge "helping class" that is quite international in flavor. Garrett cites a 2006 report by the World Bank estimating that "about half of all funds donated for health efforts in sub-Saharan Africa never reach the clinics and hospitals at the end of the line," and this is surely true. But it is important to add that the same international financial institutions issuing such reports are contributors to the situation — having for years suggested "capping" social expenditures in health and education and even made such restructuring of public budgets a pre-condition for access to the credits and assistance upon which poor governments depended for survival.

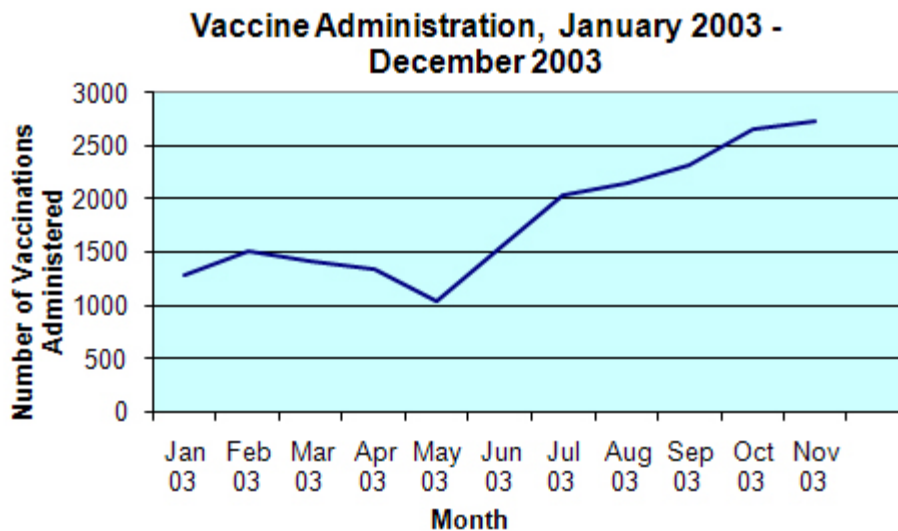
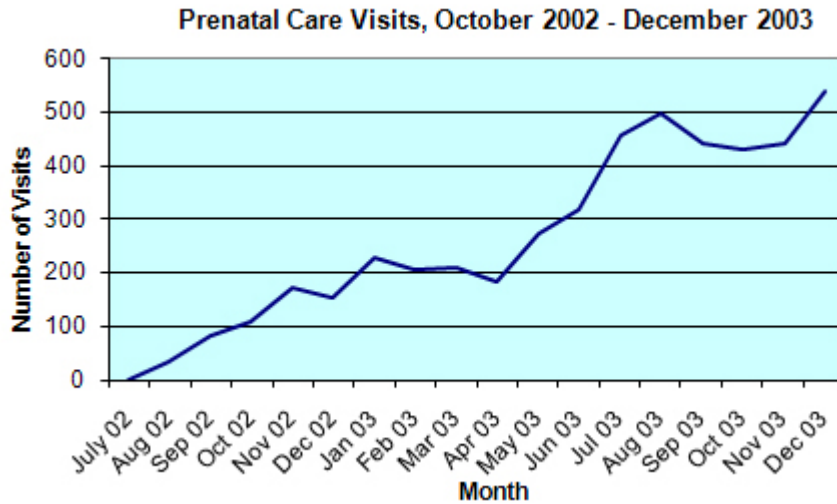
Garrett is correct to emphasize the importance of strengthening public sector health institutions and to criticize "vertical" or "stovepiped" approaches to health care. And she is to be lauded for describing the distortions that frequently ensue when large sums of money are introduced into cash-starved health systems. Our experiences at PIH, however, suggest that while her general thesis is right, Haiti is not a good example of it. Garrett claims that former U.S. President Bill Clinton is wrong to suggest that AIDS initiatives "end up helping all other health initiatives." "The experience of bringing ARV treatment to Haiti," she writes, "argues against Clinton's analysis. The past several years have witnessed the successful provision of antiretroviral treatment to more than 5,000 needy Haitians, and between 2002 and 2006, the prevalence of HIV in the country plummeted from six percent to three percent. But during the same period, Haiti actually went backward on every other health indicator."

There are three problems with these correlations and inferred claims of causality. First, are they true? The reduction of HIV prevalence has been well documented. But has Haiti actually gone backward "on every other health indicator" between 2002 and 2006? This might be true in the chaos of present-day Haiti, but the national level surveys that would provide such data have not been conducted, much less completed and analyzed.

Second, even were such a claim shown to be true, how would we know that the primary reason for such backsliding was too much AIDS funding rather than, say, the 2004 coup d'état, the country's 34th, an event that led to great political upheaval, attacks on hospitals and clinics, disruption of medical supply chains, and the effective dissolution of Haiti's national AIDS commission (which had been ably chaired by First Lady Mildred Aristide, one of the primary architects of Haiti's successful Global Fund application)?

Third, I am confident, even without the results of national surveys, that Garrett's stovepiping hypothesis, manifestly true in most countries mentioned, does not hold true in central Haiti, where close to half of the Global Fund grant went and where half of those 5,000 "needy Haitians" on ARVs live. There, as we have documented, the increased AIDS funds were spent exactly as Garrett advocates: to strengthen the public health system in general. Even if we measure, as she suggests, by maternal mortality and life expectancy at birth (rather than the "short-term numerical targets" she deplors), we see that "AIDS funds" may be used to reduce maternal mortality and increase life expectancy.

The data shown in Figures 1 and 2 below come from the first public clinics rehabilitated during the course of 2002-3, the very period Garrett discusses in referring to Haiti. They demonstrate that "AIDS money," when used as a means of strengthening health systems well beyond the stovepipes justly excoriated by Garrett, can indeed have a salutary and rapid impact on, say, provision of women's health care or uptake of vaccinations.



These results show that through careful program design, stovepiped intentions may be subverted or "horizontalized" in order to introduce new resources to the cash-starved public sector and disadvantaged rural regions in some of the poorest countries of the world.

PIH learned to do this decades ago. We found that it is simply not possible to have vertical programs in poor, rural areas, because people in those areas typically suffer from more than one disease at a time. In fact, the great majority of our patients in Africa and in Haiti do not have AIDS. And about half of our African AIDS patients also have tuberculosis infection. So how could we not link our AIDS and TB programs? Malaria kills far more African children than does HIV. Women's health must be comprehensive — from family planning to modern obstetrics to AIDS care — for prevention to be effective and ethical; it must be linked with efforts to make clean water available if pediatric HIV disease is ever to be eliminated. When you are the only hospital for miles around (because the other NGOs are in the city), and people come to you with pneumonia, broken limbs, and epilepsy, you cannot refer them to a local vertical program designed to treat pneumonia, broken limbs, and epilepsy — because such programs do not exist.

The influx of AIDS funding can indeed strangle primary care, distort public health budgets, and contribute to brain drain. But these untoward or "perverse" effects are not inevitable; they occur only when programs are poorly designed. When programs are properly designed to reflect patients' needs rather than the wishes of donors, AIDS funding can strengthen primary care. PIH has shown this throughout central Haiti, in eastern Rwanda, and in the mountains of Lesotho, and is going to use the same model in southern Malawi. In each of these settings, we work under the aegis of the Ministry of Health (and, in three of them, with the Clinton Foundation) in order to promote the notion of health as a human right. In some cases, programs have to be built from scratch; in others, it is necessary to rebuild public infrastructures damaged by war, neglect, or the misguided advice of outside experts.

Those concerned about global health must not only promote a commitment to social justice, but also teach our allies to make a careful analysis of how the global outcome gap came to be and why it continues to worsen in spite of many well-intentioned efforts to reverse it. Garrett's critique is welcome as a part of that analysis, but it should be directed primarily at the badly designed programs — lest casual observers incorrectly conclude that good results cannot be achieved, when in fact they can.



Reality Check

January 23, 2007

by Roger Bate and Kathryn Boateng

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Laurie Garrett argues that although the developed world is increasingly willing to combat global medical scourges such as AIDS and malaria, it is still failing in its efforts to provide basic health care to most of the world's population. She identifies as one of the key problems a donor preference for short-term, high-profile, disease-specific programs over support for work on less glamorous problems such as maternal health and public health infrastructure. Garrett's descriptions of the appalling symptoms of poor health systems are eloquent. But she overlooks some causes of the problem and offers an unconvincing solution.

Public health is primarily the responsibility of national governments, yet many governments in poor nations simply do not consider it a political priority. For decades, these governments neglected to allocate adequate public funds to their health systems, resulting in a severe loss of clinical capacity. This fact prompted the WHO in 1978 to launch the Health for All campaign to encourage more spending on local health systems. Before its target date of 2000, however, the ambitious campaign was quietly dropped due to broad program failures. Only now, in response to growing international criticism, are some countries increasing their health budgets.

Garrett correctly notes, "efforts should focus less on particular diseases than on broad measures that affect populations' general well-being." But more needs to be said on why such holistic population-targeted initiatives have failed previously and how the pitfalls of the past can be avoided this time around.

For example, to combat the very real problem of "stovepiping," Garrett wants donor interests coordinated by a body with proven competence and she favors the WHO for the job. But it is unclear that the WHO is up to such a task, or can even follow through on its own organizational goals.

The WHO's "3X5" campaign to bring antiretrovirals (ARVs) to three million people by 2005 was ill considered. It set unrealistic country treatment targets, often without even consulting with the relevant countries; it promised funds that never materialized; and it mismanaged drug supply and testing. The campaign put tremendous pressure on precisely those fragile local systems the WHO wanted to strengthen. Its failure was inevitable from the beginning. Garrett's claim that the WHO is "the only organization with the political credibility to compel cooperative thinking" must thus be taken with a grain of salt. Many WHO-led health programs have succeeded in raising considerable funds, and when dealing with informational exchange, such as with SARS and now bird flu, its important role cannot be ignored. But its capacity-building efforts must be stepped up before it can assume the role of coordinator for any multilateral aid health initiative.

Garrett is also understandably concerned about the exodus of well-qualified health workers from the developing world to western hospitals. Brain drain is a problem, but any action to penalize the medical personnel who choose to emigrate would be misguided. In our increasingly globalized world, health workers may receive training in a foreign country but then choose to return home to use their skills. They may also repatriate a lot of the funding they receive while abroad. According to a study undertaken by the Hudson Institute, in 2003 alone remittances from foreigners living in the United States totaled \$35 billion dollars. Far from destabilizing countries' economies, these capital inflows have come to be relied on heavily in some places, particularly Zimbabwe. Efforts to make it more attractive for such workers to stay in their own countries, meanwhile, are few and far between; Garrett discusses some, but more do exist — such as the franchise of nearly 70 private clinics in Kenya, backed by the HealthStore Foundation, which provides local nurses with up to twice the government salary and keeps them in country — and still more could be encouraged.

Garrett hopes to "witness spectacular improvements in the health of billions of people, driven by a grand public and private effort comparable to the Marshall Plan." But evoking the memory of the Marshall Plan is a double-edged sword. This legendary reconstruction aid effort after World War II was given to well educated, well governed, previously wealthy countries that needed to rebuild their destroyed infrastructure. Today's developing nation recipients would be, broadly speaking, poorly educated and poorly governed. Given the poor track record of foreign aid in developing countries, one can predict that unless drastic changes are made, simply sending more aid would be counterproductive (a point that Garrett herself recognizes).

In the end, therefore, Garrett demonstrates a superior understanding of the complexities of the global health enterprise, but past experience and current realities show that there are more problems associated with even well-intentioned policy objectives and programs than she acknowledges.



Major Challenge, Minor Response

January 23, 2007

by Alex de Waal

Alex de Waal is program director at the Social Science Research Council and working group co-chair of the Joint Learning Initiative on Children and AIDS.

How to establish an effective and sustainable health system in a poor country? This is a formidable and complex challenge, long neglected in development theory and practice, which has re-emerged into the mainstream debate only recently — notably with the 2001 Commission on Macro-economics and Health (CMH, headed by Jeffrey Sachs) and the 2004 Joint Learning Initiative on Human Resources for Health (JLI-HRH, steered by Lincoln Chen). American scholars have been at the forefront of both these efforts, but U.S. public and private aid efforts have actually lagged behind those of Europe in integrating disease-specific responses into comprehensive plans for public health. Laurie Garrett's essay is thus very welcome: she has identified one of the central challenges of global health policy.

Garrett is enthusiastic in pursuit of her prey: how well-intentioned and well-funded stand-alone initiatives run the risk of undermining national priorities and setting up distorted and hence unsustainable health systems. And she makes a number of telling points about how national health systems are starved of resources and subject to the distorting priorities of foreign donors. But her chase is not systematic, and so, diverted to a final recommendation that fails to address the main problem she has identified, she doesn't catch her quarry.

Garrett identifies many shortcomings of stand-alone disease-specific initiatives, shortcomings that reflect the wider problems of policy coherence arising from the dominance of program- and sector-specific development assistance. (The World Bank's Poverty Reduction Strategy Papers, introduced in the late 1990s, represent perhaps the most systematic attempt to grapple with this problem.) But such narrow initiatives emerge for understandable reasons that cannot simply be brushed away.

Sachs' CMH has put some figures on what it would cost to deliver an overall health package globally — an average of \$34 per person per year. The funds needed to reach this target are small by global standards, but huge in comparison to existing aid budgets. It has proven very hard to generate political backing and raise money for comprehensive programs. Stand-alone disease-specific targets, in contrast, have provided a way to generate focused effort.

The Millennium Development Goals, for example, adopted by the UN General Assembly in 2000, are an impressive and wide-ranging set of comprehensive health objectives of the sort Garrett favors. But they haven't inspired as much political momentum as, say, the WHO's "3 x 5" initiative (now superseded by a plan for universal access to AIDS treatment). Those who select and promote the narrower goals, meanwhile, recognize and are frank about their shortcomings and seek ways to bridge the gap between such efforts and truly system-wide ones.

Garrett's chosen new targets — life expectancy and maternal mortality — are already within the international development mainstream. Increasing life expectancy means dealing with the causes of death, which means focusing on child mortality and infectious diseases. Reducing child mortality by two thirds is accordingly Millennium Development Goal number 4. There is now broad consensus that the great majority of childhood deaths can be prevented with the proven technologies of the child survival revolution — vaccination against childhood diseases, clean water sources, oral rehydration therapy, and bed nets to prevent malaria. The last fifteen years' surge in adult mortality in sub-Saharan Africa that Garrett notes, meanwhile, is overwhelmingly due to HIV/AIDS and its associated TB pandemic, so life expectancy should increase soon thanks to today's efforts to grapple with AIDS and TB.

Reducing maternal mortality by three quarters is Millennium Development Goal number 5. This can be achieved by increasing the number of births attended by a health professional. Garrett is correct that an effort to bring down the maternal mortality rate requires a system-wide approach to health system. But here her quarry softly and silently vanishes away: her proposed response focuses on the equipment rather than the people required to operate it, and might be better named "box-for-a-doc." Experience shows that providing the infrastructure is the easy part: the hard bit is the training and retaining the competent staff.

Garrett has raised important questions about the direction of global health policy. But her essay neither does justice to the efforts to address this issue currently underway nor offers better alternatives.



Honesty is a Virtue

January 24, 2007

by Roger Bate and Kathryn Boateng

Roger Bate is a Resident Fellow and Kathryn Boateng is a Research Assistant at the American Enterprise Institute in Washington, D.C.

Efforts to improve global health are often crippled by a state of denial. Failure to consider unfashionable modes of disease transmission or use proven but politically unpopular methods in disease prevention and control is illogical, dishonest, and should be exposed.

There was a great deal of media coverage recently denouncing Moammar Gaddafi's regime for condemning to death five Bulgarian nurses and a Palestinian doctor. The Libyan government alleged that these health workers had deliberately infected children with HIV in a hospital in Benghazi. The media graphically detailed the personalities in the case and their tragic circumstances (the nurses were allegedly sexually abused and tortured by the prison guards). But certain crucial parts of the story were only briefly illuminated, such as the fact that the unfortunate Libyan children received the virus not through sexual transmission but through poor clinical and hygienic practices.

Such "iatrogenic infections" account for an unknown but possibly large proportion of HIV infections in the poorer parts of the world. A recent study in the *British Journal of Obstetrics* noted: "There is mounting evidence that rapid HIV transmission is fuelled by parenteral exposures in health care settings, especially medical injections but also including transfusion of untested blood and others The common belief that 90 percent of HIV transmission in Africa is driven by heterosexual exposure is no longer tenable." Some studies have shown that as many as 40 percent of African HIV infections are linked to unsafe injections. This means that donor-supported vaccination programs, and possibly even HIV treatment programs (through increased testing), have helped spread HIV.

Far from being highlighted as a logical target for advocacy and action, however, such issues are neglected. Western HIV prevention programs, meanwhile, revolve around promoting safe sexual practices. Depending on what generates the least controversy at home, donor organizations promote policies varying from abstinence to effective condom use. These programs are not pointless, but they are an example of how funding is skewed towards what people in the West want to deliver.

And in their bid to keep the aid flow lines open, at all times and at any cost, host governments in poor countries often simply adopt these policies without paying proper attention to revamping their dysfunctional and severely under-funded health systems — the same systems that too often force medical personnel to re-use needles and transfuse unscreened blood. For lack of safe needles and blood-screening equipment, in other words, health workers have no option but to resort to unsafe health practices in an attempt to save patients' lives. The real culprits are undoubtedly government leaders like Gaddafi who do not admit that their own clinics and outdated practices are to blame for these misfortunes. But

almost as culpable are those in the West who know about a major cause of infection and do nothing about it.

There are myriad other examples of failure to adopt sound approaches to disease control. Consider the use of the pesticide DDT in malaria control: Until the WHO and USAID recently reversed their positions on it, DDT's use had been discouraged by Western agencies for over 20 years. Alternative methods of malaria control (such as the use of bed nets) can work, and it is simpler for donors to promote one tool. But the best way to help those dying from the disease is to aggressively use all the weapons in one's arsenal, and there is strong evidence that indoor spraying of DDT can control malaria admirably. Yet given the chemical's poor image, the advocacy community has been slow to support its use.

More foreign aid, both public and private, can help promote public health in poor countries. But that will happen only if care is taken to make sure the aid is directed at appropriate targets and used wisely. No one wants to help spread HIV or combat malaria ineffectively, but that is unfortunately where many aid efforts stand today. This is why, as Laurie Garrett suggests, any credible global health aid effort must involve measures aimed at strengthening local health-care capacity. And developing nations themselves must also do better — for example, by doing away with the large regressive tariffs they impose on the import of essential medicines and medical devices, trade barriers that end up keeping the medicines from reaching the poor.



Pick the Right Targets

January 24, 2007

by Alex de Waal

Alex de Waal is program director at the Social Science Research Council and working group co-chair of the Joint Learning Initiative on Children and AIDS.

Where should international efforts to improve global public health go next? The contributors to this roundtable share optimism that much can be done and agree on the importance of building local health systems. Much of our disagreement is on what steps should be next, and is based on differing assessments of what is politically possible.

I want to focus here on the craft of political engineering: creating the necessary political incentives to ensure that both national governments and donors deliver what they can. A corollary of this is making sure that the huge enterprise of delivering aid-for-AIDS supports democracy rather than threatening it.

The last five years have shown the importance of picking the right targets and mobilizing the right constituencies. Goals that are too ambitious or too complex can be confusing or become excuses for inaction. But well-chosen targets, envisioned as steps toward larger objectives rather than ends in themselves, can do much to focus energies.

The complicated interrelationship between poverty and ill health is unsuited to simple numerical indicators of progress, which is why the Millennium Development Goals attempt the difficult balancing act of crystallizing simple measures that span different sectors. Like any policy designed by an international committee, the MDGs are full of the compromises and ambiguities necessary to obtain consensus, leaving them with inevitable shortcomings. We all have our criticisms of the indicators chosen and doubtless a better job could be done today if health and development experts were to reconvene for a year's deliberations. But that isn't feasible. So the challenge is to identify subordinate targets that can become the focus for mobilization by activist constituencies and that can be used to hold governments and aid donors accountable.

The first such target I would highlight is reducing HIV incidence among young people. This is already a component of MDG six, and there are some encouraging signs that it may be happening. But the improvement is modest and what accounts for it is unclear. Doing better will require examining how political incentives for HIV prevention are structured. There is currently no good indicator for assessing and rewarding success. HIV prevalence, which is universally used, is problematic because it is a product of many factors: the history of the epidemic, new infections, deaths, and treatment availability. As more patients are put on anti-retroviral therapy, HIV prevalence will increase. As more die, it will decrease. A true decrease in new infections, meanwhile, will take six to eight years to feed through into

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Response by Laurie Garrett

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prevalence data — far too long for any office-holding politician to get the credit for a successful policy. Measuring incidence regularly and rapidly, however, could help greatly, and new testing technology makes this possible. With annual or semiannual measures of the level of new infections in a population, debates on prevention would take on a new dimension as the success of policies and programs could be assessed in real time.

Another target, extracted from several of the MDGs, would be ensuring that all children have access to a basket of essential services — health, education, and welfare. Certain categories of children (for example, those affected by HIV and AIDS) warrant priority attention, but specifically targeting children orphaned by AIDS is a mistake because it might lead to stigmatization. The Joint Learning Initiative on Children and AIDS is grappling with this challenge and will doubtless identify its own preferred indicators.

A third target would be human resources in the health sector. In 2004, the Joint Learning Initiative on Human Resources for Health estimated that sub-Saharan Africa needs a million more health workers. That is a real target to be aimed at, and it can readily be broken down into sub-targets for specific countries and skill-sets.

Jeff Sachs notes that what is needed is more aid, not more aid-bashing, and he has a point. But it is still important to be vigilant about aid's undesirable side-effects. There is a sorry history of foreign aid propping up undesirable regimes (sometimes deliberately, as during the Cold War) and undermining local initiative. Power goes with the purse strings, and an aid-dependent country has lost control over important questions concerning its national life. Yet something interesting has happened to the aid industry in the last fifteen years: It has become much more open and participatory, with the efforts to combat HIV/AIDS in the vanguard. AIDS activists, many of them from poor countries, are now networked into international civil society and represented on the boards of key international institutions.

My fourth goal, therefore, would be to help continue this trend. It is impossible to design out all the actual and potential problems of a big aid effort. But the effort can be subjected to democratic scrutiny, which should at least ensure that the problems are mitigated. In recent years, the aid encounter has become more transparent, but within poor countries the conversation is still mostly confined to urban elites. Key debates on aid need to include the public at large, through the media and through local consultative mechanisms. People who are poor often have much more insight into their plight than outsiders. Setting up channels through which the targets of aid can voice their concerns is not only a democratic imperative but will improve the quality of the assistance that is provided.



Midway in the Journey

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by Laurie Garrett

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Six-and-a-half years ago, former South African President Nelson Mandela rallied the troops in the AIDS war, summoning them to a twenty-first century campaign for justice and survival. The fight to get anti-HIV medicines to people in poor countries, he told the XIII International AIDS Conference, was a matter of morality.

A few months later, economist Jeffrey Sachs framed Mandela's battle cry in stark political terms, declaring at a Harvard University press conference, "I have a plea to our administration and members of Congress: Go ahead, have debates about our fiscal future. But take 15 minutes out of your schedule and vote \$1.5 billion into the budget for global AIDS and save millions of people. And then go back to the debates." Sachs continued, challenging President George Bush: "We have to understand that the highest priority right now is to knock on the door at the White House. That's where the sticking point is, bar none, right now."

A few days later, in a speech to the Aaron Diamond AIDS Research Center in New York, Sachs told HIV scientists that they needed to take the battle up a few notches, addressing not only treatment for HIV but also a broad panorama of public-health crises. "One can cost out the scale of resources needed to address these interlocking crises, from measles to AIDS," he said, giving the following annual donor expenditure figures for conquering public health crises in Africa: \$2-3 billion for malaria; tuberculosis, \$2-3 billion; child mortality diseases — "with major infrastructure development" — for \$3-4 billion; HIV prevention and treatment, \$2-3 billion; community support for AIDS orphans, \$1 billion. For a grand total of \$10 to \$14 billion per year, Sachs argued, "I believe that this really can happen."

Sachs is a hero. He pushed and shoved — and, frankly, embarrassed — the wealthy world into taking action on a previously unimaginable financial scale, translating Mandela's moral plea into dollars and sense.

Giving backbone to his 2001 calculus, meanwhile, was the experience Paul Farmer and his Partners In Health had in building health programs and distributing anti-HIV and tuberculosis drugs in Haiti and Peru. Farmer is also a hero. He pushed public health and medical communities to go beyond hand waving toward actual implementation of vital life-saving programs in the most desperate, war-torn nations.

In the six years since Sachs and Farmer, along with thousands of activists and healthcare workers, started their campaign, the results have been remarkable: Billions of dollars are now on the global health table where a few years ago there were only millions. (Of course, I

wholeheartedly agree with Sachs, de Waal, and Farmer that still more fiscal resources are needed.)

But this escalation in global generosity and programs has come at a breathless pace, with no time for collective reflection or serious assessment. The war on AIDS has — thankfully — propelled the entire global health movement to a grand scale. But it is being executed chiefly by devastated local government systems, underpaid and overburdened health-care workers, and a plethora of previously miniscule NGOs and faith-based groups.

"Across Africa," de Waal writes in his book, *AIDS and Power*, "people suspect that coercion is lurking, and retain a deeply embedded resistance to external citadels of expertise and their projects of extending bureaucratic power. The future AIDS response may be part of a project of liberalization-through-aid, but equally it could become another doomed-to-fail foreign intrusion or a prop to authoritarianism."

In his landmark speeches on AIDS, Sachs implied a vision quite different from what has occurred to date. He spoke of the need for a global scale of management, leadership from the U.S. Centers for Disease Control and National Institute of Health, a central drug procurement fund for bulk purchasing, and the idea of "Donors, rather than putting money into their pet projects here and there . . . pool[ing] their resources into a common global fund."

Although the Global Fund to fight AIDS, Tuberculosis and Malaria was created about 18 months after Sachs' speech, it has proven unable to select a new leader and represents only a small percentage of the overall global-health budget, targeting just three diseases. There is no central drug-purchasing center (nor one for medical supplies and diagnostics), so the market for these products in poor and middle-income countries remains irrational and incentives for development of low-per-unit-cost products are all but nonexistent.

With so much money and human energy on the table, why are we still thinking so small? Farmer is correct in saying that a holistic view is not only possible, but also required. I recall him proclaiming at a 2002 meeting in Heidelberg, "If you want to stop HIV in Haiti, give women jobs."

Getting to sustainable, just, and fiscally rational approaches to global health crises requires global leadership and innovative thinking. On this point I must take issue with Roger Bate and Kathryn Boateng, who doubt that the WHO can step up to the plate. Although it is certainly true that the WHO is a weak institution that has made serious miscalculations in this arena, what alternative leader or organization would they suggest take the reins? The very suspicions and fears that de Waal eloquently describes lurking in the minds of health leaders in recipient nations mandate that the WHO — and only the WHO — take the lead, for it is the only health institution that tries to give equal voice to all countries, rich and poor alike.

But to do the job properly, the WHO needs serious reconstruction work. It is too soon to assess Margaret Chan's leadership, but even if it is impressive, the WHO is likely to remain an imperfect institution. Still, it could exercise the power of the pulpit to corral well intended but often competing NGOs, donors, philanthropies, and local government agencies into following a shared strategic vision.

To be successful, in turn, any such vision must draw from the business world and think on a scale commensurate with a multi-billion-dollar budget. To that end, de Waal misses the point

of the Doc-in-a-Box concept: It is a mental exercise, intended to imagine a way to integrate community health workers (or Farmer's accompagnateurs) on the ground into a massive global system of volume purchasing and distribution, data retrieval, training, and management.

A final note on what I believe is an unfair swipe by Bate and Boateng against poor countries for allegedly under-spending on health. As I pointed out in my essay, nearly every one of the targeted countries has significantly increased the percentage of its GDP spent on health over the last three years. So their criticism is out of date.

As health budgets have risen to 4-5 percent of GDP in many countries, I am compelled to once again quote a prescient Jeff Sachs from 2001: "Since 1980 Africa has experienced virtually a total collapse of its public health systems. Even if these countries, despite debts, mobilized 4-5 percent GNP for public health we would be talking about the princely increase of \$10-\$12/year. This is, in essence, a continent of 600 million people that has been living without public health systems for a generation or more."

The world's poor and sick do need help, and the world's rich should continue to give and even increase their giving. But they should do it in such a way as to produce the beneficial results everyone is eager to see.