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Response

From "Marvelous Momentum" to Health Care for All

Success Is Possible With the Right Programs

Intelligent Design

PAUL FARMER

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 a 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 seeds 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 "Do not 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, with that of today. Garrett

is correct to remind us that HIV/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 HIV/AIDS, in spite of declarations to the contrary. In 2007, on the other hand, there is some money for HIV/AIDS prevention and care, although it rarely makes it 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 HIV/AIDS diagnosis and care a public good for public health—that is, a service paid for by the state or rich donors, rather than by individual AIDS sufferers and their families. Although ARVs 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 HIV/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 Africa offers hope. As hospitals are refurbished and become something more than charnel houses and 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 HIV/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 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 better HIV/AIDS treatment outcomes in rural areas of poor countries than have 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 Haitian model to Boston.

In 2002, HIV/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 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 substandard 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 in Rwanda based on the Haitian model, and it is starting to have some success. More than 2,000 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 HIV/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 [nongovernmental organizations] alone." Yet by 2006, after a global campaign to bring HIV/AIDS care to Africa, less than 25 percent of Africans who needed ARVs to survive were receiving them, with the fraction dwindling to less than five percent 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 nonpoor, including a huge international "helping class." Garrett cites a 2006 report by the World Bank estimating that, in Garrett's words, "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 on health and education and even having made such restructuring of public budgets a precondition for access to the credits and assistance on which poor governments depend 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 to support it. Garrett claims that former U.S. President Bill Clinton was wrong to suggest that HIV/AIDS initiatives would "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."

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 infrastructure damaged by war, neglect, or the misguided advice of outside experts.

Those of us 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 health 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.

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There are three problems with the correlation and inferred claim of causality. First, is the correlation 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 the correlation 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, an event that led to great political upheaval, attacks on hospitals and clinics, the 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 application to the Global Fund)?

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 PIH has 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 deplores), we see that funds nominally slated for AIDS may be used to reduce maternal mortality and increase life expectancy.

Data from the first public clinics rehabilitated during the course of 2002–3, part of the very period Garrett discusses in referring to Haiti, demonstrate that money designated for AIDS, 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, for example, the provision of women's health care or vaccinations. (For relevant figures, see the online version of this response at www.foreignaffairs.org/globalhealth.) These results show that through careful program design, intentions to stovepipe funds 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 Haiti do not have AIDS. And about half of our African AIDS patients also have tuberculosis. So how could we not link our AIDS and TB programs? Malaria kills far more African children than does AIDS. 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 infections are 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.

Garrett Replies

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, the economist Jeffrey Sachs framed Mandela's battle cry in stark political terms, taking the fight to Washington and other centers of political power. 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 morality plea into dollars and sense.

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

In the six years since Sachs and Farmer, along with thousands of activists and health-care 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, still more fiscal resources are needed.)

This escalation in global generosity and programs, however, 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.

Although the Global Fund to Fight AIDS, Tuberculosis, and Malaria was created in 2002, months after Sachs' speech, it has proved 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), and so the market for these products in poor and middle-income countries remains irrational, and incentives for the development of low-per-unit-cost products are all but nonexistent.

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

In central Haiti, the PIH operation is a job creator, employing a small army of local people as accompagnateurs performing a range of jobs related to health promotion and patient supervision. Farmer believes accompagnateurs are the key to success in poor countries, where insufficient numbers of trained nurses and physicians mean that less-trained individuals must carry a large part of the public health burden. I wholeheartedly agree and, further, endorse the need to compensate community health workers for their services.

But I would go further still and insist that franchise and business models should

be incorporated in larger schemes of health. Consider the example of A to Z, a company in Tanzania that has received investment support from the New York–based Acumen Fund. In 2006, the company employed 5,000 Tanzanians to make and distribute seven million antimalaria bed nets in the country. In El Salvador, Guatemala, and India, the Scojo Foundation has trained a regiment of women as "vision entrepreneurs" to sell reading glasses. Bangladesh's microfinance organization BRAC pays thousands of people—mostly women—to provide clean drinking water, act as accompagnateurs for TB and AIDS patients, promote well-baby programs, and carry out a host of other public health activities. Key to the success of all of these efforts are two elements: paying decent wages and targeting women for the jobs.

During a visit to Haiti last year, I heard Dr. Josette Bijou, the nation's minister of health, describe what she called "the Haitian paradox": a country with the highest HIV infection rate in the Americas is managing one of the best HIV/AIDS treatment programs seen in any poor country in the world, thanks in part to U.S. government support and Farmer's PIH. But as Haiti pushes down its HIV rates and treats people with AIDS, its other health markers are deteriorating. Farmer is right to question whether there is a cause-and-effect relationship between the two and to ask what role political instability has played in lowering life expectancy. Still, the paradox persists.

More than 5,000 Haitians now get daily medication to control their HIV infections, and the prevalence of HIV has plummeted from a 2002 high of six percent in the general population to three percent today. Bijou explained, however, that Haiti has gone backward since 1985 on every health indicator except HIV/AIDS. When civil turmoil commenced in 1986, ushering in economic collapse, Haiti's medical and public health systems fell to pieces. Surveys show that Haitians are dying younger—life expectancy for men is now merely 51 years—and more women are dying in childbirth, with a national maternal mortality rate that is the highest in the Western world. Today Haiti needs 5,000 nurses and 2,000 doctors. Expatriate physicians, mostly working in New York and Florida, keep the hospitals of Haiti alive with their remittances.

"If we don't have a state system to coordinate and organize, we cannot move forward," Bijou concluded. And there is the rub. With billions of dollars on the table, we still lack clear national health governance in many of the hardest-hit countries and see no genuine international leadership. Getting to sustainable, just, and fiscally rational approaches to global health crises requires global leadership and innovative thinking. Results, Farmer concludes, can be achieved. Hallelujah! That point is not in question. What is in question is the current state of chaos, competition, brain drain, and corruption in too many global health programs. Billions of dollars ought to buy better.

For further discussion of global health and other responses to Laurie Garrett's article, visit our special online roundtable:

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