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Testimony of
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Health Systems Strengthening and the AIDS Pandemic
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The long-awaited availability of money for HIV prevention, care, and treatment in resource-poor settings has resulted in the real possibility of stemming the enormous death toll of HIV. However, due to decades of health system impoverishment, sickness and death among all cadres of workers due to HIV, and the flight of educated people from the developing to the developed world, there are few trained health professionals who can implement and sustain these large scale programs. This situation has been called the “healthcare worker crisis.” Yet to proffer the simple equation—“*AIDS money is greater than the capacity of professionals to use it*”—yields just a pinhole view of a much larger landscape. In fact, the AIDS pandemic has done nothing if not lay bare the fact that health systems—in terms of personnel, equipment, medicines, and physical infrastructure—in many developing countries were never adequate to address the basic primary health care needs of the population, let alone address a new, chronic, infectious disease—AIDS and its fueling of the tuberculosis pandemic. People in poor countries understand this. In

Rwanda, our patients offer the phrase “imboni ibibazo”—as a description of the AIDS pandemic— a lens through which we see reality and the larger context.

It is to this larger context to that AIDS has drawn our focus: developing countries bear 90 percent of the global burden of disease armed with only 20 percent of the world’s GDP¹ and 12 percent of the world’s health expenditures to combat this burden.² Africa is particularly hard-hit, bearing fully one-quarter of the world’s disease burden with 3 percent of the global health workforce, who are paid less than 1 percent of global health expenditures.³ With such paltry resources available in these settings, how do people get care? The answer is that they do not. For this and many other reasons, life expectancy in Lesotho is 35.1 years (compared to 76.7 years in Cuba);⁴ in Rwanda, 203 children per 1,000 die before their fifth birthday (compared to 8 per thousand in the United States) and in Malawi, 1800 women die in childbirth for every 100,000 live births (as compared with 2 in the Sweden).⁵ These rates are not unique across the continent. Some of this morbidity and mortality is AIDS-related, but much of it can be traced to inadequate health systems.

When people in resource-poor settings do access health care, approximately 60% of all health expenditures are out-of-pocket payments to private pharmacies or clinics. For the leading infectious global killers—HIV, TB, and malaria—there is no question that care should be delivered within the public sector and provided as public goods rather as commodities; the control of tuberculosis, an airborne disease, has long been seen as a public good. Yet the public

² Pablo Gottret & George Schieber, *Health Financing Revisited: A Practitioner’s Guide* (The World Bank 2006).

³ *World Health Report 2006: Working Together for Health* (WHO, Geneva, 2006).

⁴ http://www.unicef.org/infobycountry/lesotho_statistics.html Accessed September 18, 2007.

sector is absolutely inadequately resourced for the provision of basic health services, let alone chronic care for complex diseases. The majority of foreign aid directed to post-colonial African countries took the form of loans with conditions attached that were meant develop African countries' markets rather than invest public sector. Because two of the largest components of every government's responsibility are health and education, these loan conditions, termed "structural adjustment" policies, resulted in massive disinvestment in and neglect of the health and education sectors. National health budgets were set at shockingly low levels, on the order of \$2-\$5 US per capita, and included limits on the number of and compensation for public employees as well as little money for essential medicines or building and maintenance of health infrastructure. Countries subjected to these fiscal constraints had few options for responding to escalating public health needs.⁶ To compensate for the paucity of money in government coffers for health, the World Bank and the International Monetary Fund advised that public clinics should charge user fees for health services as a form of cost recovery. But in extremely poor, often non-cash economies, such fees serve as an enormous barrier to accessing care. The confluence of inadequate numbers of underpaid staff; poor infrastructure; a lack of medicines and supplies; and prohibitive user fees result in an oft seen and grotesque sight: public clinics standing empty in the midst of the worst epidemics in the history of mankind. Equally tragic are countries such as Malawi where there are no user fees for health care and clinics are full but completely dysfunctional. Lacking access to the tools of their trade and able to do no more than minister over the dying, despondent health professionals have leave and their country to work in Europe or the United States leaving only 350 Malawian physicians to care for a population of 16 million.

⁵ http://www.unicef.org/infobycountry/malawi_statistics.html Accessed September 18, 2007

New investments in global health, including the President’s Emergency Plan for AIDS Relief (PEPFAR), have given us the opportunity to treat and prevent HIV in resource-poor settings. Monies are available for drugs, for laboratory tests, and for prevention programs. But can and should new monies have a wider impact, beyond simply getting AIDS patients onto treatment? The answer is yes. Unequivocally, yes. However, the money must be used strategically—not just to fund “vertical” HIV programs (clinics and services that provide care for only one disease such as TB or HIV) but to support the rehabilitation and bolstering of public health systems. A commitment to primary health is critical, as HIV programs do not work in a vacuum: the majority of people presenting to clinic, especially in rural areas, come because they are sick, not because they want to know their HIV status. Health facilities must be accessible, well-stocked, and reliable, providing decent diagnosis and treatment of common diseases, before widespread HIV testing can occur.

Let me illustrate with an example from the work of Partners In Health, an NGO affiliated with Harvard Medical School and the Harvard School of Public Health. PIH was one of the first programs to provide antiretroviral therapy free of charge in a resource-poor setting, Haiti, where we had been working since 1983. Haiti is the poorest country in the western hemisphere and also has the highest prevalence of HIV, TB, and malaria; the highest maternal and child mortality rates and a life expectancy 52 years.⁷ Despite these grim statistics, we were able to successfully acquire medicines and launch comprehensive AIDS treatment efforts just two years after antiretroviral drugs became available in the first world. Nearly all of those early patients, carried

⁶ The negative impact World Bank and IMF macroeconomic structural adjustment policies was compounded by poor governance decisions, corruption, and misplaced spending priorities in many developing countries.

in on stretchers are still alive today, living well, farming, working and caring for their children. This was a small initiative--just 60 patients between 1998 and 2001. However, with the advent of the Global Fund to Fight AIDS, TB and Malaria and then the President's Emergency Plan for AIDS Relief, PIH made a conscious decision that changed the course of our institution, we made the conscious decision that in order to get these life saving medicines to all those who needed them, we had to deliver them through public health clinics. 2002 PIH began to expand its services throughout central Haiti by partnering with Ministry of Health clinics and hospitals. What we discovered was that bringing HIV services to a failing public sector clinic could reinvigorate primary health care if AIDS testing, care and treatment was integrated with other services—specifically—primary care of adults and children, women's health, tuberculosis control and the control of sexually transmitted disease.

The town of Hinche, Haiti, the capital of the Central Department and home to about 70,000 people is instructive. Hinche has a hospital and outpatient clinic, both of which stood nearly empty when we first visited. The clinic was seeing 10 patients per day, and the hospital had 3-6 inpatients in its 60-bed facility. Prior to the involvement of Partners In Health, only 43 cases of HIV were found—about 25% of the 176 people tested—there was no strategy for integrating health services, bolstering primary care, tuberculosis control or women's health. The testing center, which had three full time trained and paid employees simply passively waited for people to come forward for testing.

Two things about this example are striking. First of all, it was estimated that a minimum of 1,500 people were living with untreated HIV in the area; therefore, identifying only 43 new cases is

⁷ http://www.unicef.org/infobycountry/haiti_statistics.html. Accessed September 18, 2007.

appalling. One would think that the patients would be breaking down the barricades, since it was widely known that antiretroviral therapy was available free of charge. Second, the prevalence of AIDS in central Haiti is 2-4%. If 25% of the tests performed were positive, this is an indication that the test was not being offered broadly, as a screening tool, but, instead, was being offered only to those patients suspected to be infected. Broad screening is important because it offers avenues for intervention through prevention education. It also allows for earlier detection—and thus treatment—of HIV.

Recall that PIH had committed to partnering with the public sector in scaling up its work with the advent of Global Fund and PEPFAR monies. We knew that full general clinic is the best place to find HIV cases—people come to clinics because they are ill, not because they want to be tested for HIV. This is to say nothing of the fact that the availability of general health services will have a far bigger impact on the health of the community than AIDS care alone.

With these lessons in mind, PIH's support of the facilities in Hinche included refurbishing wards; providing essential drugs, supplies, and steady power; and improving telecommunications capacity. Working with local government officials, user fees for HIV patients, TB patients, children under 5, and pregnant women were waived and fees for all other patients were minimized. The Ministry of Health hired new clinical and administrative staff which PIH worked to train. Additionally, the compensation of existing Ministry of Health staff was increased. PIH trained a cadre of community health workers to perform active case finding of vulnerable families, deliver HIV and TB treatment in the home, and provide psychosocial support to all patients. Needless to say, the bolstered clinic, coupled with increased community support,

resulted in skyrocketing utilization of services. Today the public health facility in Hinche clinic sees 300 patients per day and performs 600 HIV tests per month. Out of the 8,500 tests performed last year, only 5% were positive. More than 1,000 HIV-positive patients have been identified in Hinche and are being followed by the Ministry of Health with the support of PIH, more than a third of whom are on ART. More than 400 patients have been diagnosed and treated for tuberculosis. The whole health system, let alone AIDS case detection and treatment, has been strengthened as a result of interest in and funding for AIDS.

We know that success is possible, but the constraints are many. We are convinced that health systems strengthening is the only way to address not only the AIDS and TB pandemics but other health crises as well. In the context of HIV program implementation, we must move from “Emergency Relief” to long term, sustained commitment to creating programs that are locally run and managed. To develop an adequate public sector to respond to the challenge of the AIDS pandemic should be the goal of such assistance. However, to assist in building a public sector response, it is important to adequately train, retain and compensate health workers. Yet, country offices of PEPFAR still hold to the constraint, rooted in the Foreign Assistance Act, that PEPFAR monies cannot be used to compensate public sector workers. This is not true. Currently, many PEPFAR funded projects in the field are, indeed, providing salary support for public sector workers involved in delivering AIDS care. Some experts estimate that 20% of the PEPFAR budget is spent on support for the public sector, including salaries. However, it is often the case that the interpretations of the Foreign Assistance Act result in prohibitions on public sector support. Thus, in a multitude of cases, PEPFAR money funds the private, NGO sector resulting in the development of parallel health systems—charity and public and further impoverishing the

public health system which is the most sustainable and widespread means of delivering health care to the poor. If donors, NGOs, universities, and governments are to work together to build or rebuild sustainable public health infrastructure, it is imperative that the responsibility for and the funding of these programs be gradually moved to the public sector. African leaders signed a pledge in Abuja, Nigeria in 2001 to commit 7% of their GDP to health; in a poor country such as Rwanda that is experiencing a growing economy, it is possible to imagine that, with time, the government will be able to cover much of the cost of a functional public health system. In countries like Haiti, however, 7% of GDP will not soon cover the cost of a functional health system. International donor money must help put in place the systems that can address not only HIV but also other diseases and primary health goals. Why not use the AIDS crisis to build something that will be sustained for generations to come?

In its first years, much of PEPFAR money was allocated to non-governmental organizations (like mine) with the notion, perhaps, that governments are inefficient or corrupt. The money was, based on the title of the program, geared toward an emergency. Today, programs are established, money has been well used, and people all over the world are receiving care within government driven national plans. It is time to shift the focus of aid to a second phase where our response is made sustainable. With nearly 3 million people on HIV treatment in resource-poor settings around the world, it is clear that the public sector must shoulder the responsibility for treating and monitoring this and other chronic diseases and fully ensconcing AIDS treatment into the delivery of primary health care services.

To close, I'd like to make a few general comments related to PEPFAR to improve its overall impact and effectiveness in the next phase. We applaud the new financial resources that have been dedicated to helping address the HIV/AIDS crisis thus far. The achievements which have been made in getting more patients into AIDS prevention and treatment programs are laudatory. However, it behooves us now to be more ambitious. There are more than 6 to 7 million people today alone who need ART and fewer than 3 million of those are receiving it. The set up phase has been successful, but if we keep funding at this level and targets for patients on treatment low, we are not building; we are sustaining work that is less than half done. In the next ten years, with the goal of attaining universal access to treatment, 10-12 million people will need to be started and maintained on treatment. The PEPFAR reauthorization announcement from the White House only included a target of an additional 500,000 patients to be put on treatment for the next five years. Given that the GDP of the US is fully 33% of the world's total resources, it is reasonable to expect the US to support 33% of the cost of systems to deliver treatment to these patients. This, indeed, was the goal of PEPFAR in its first iteration, targeting the US resources to cover the costs of treating 2,000,000 patients in the first five years. For the re-authorization of PEPFAR to continue in this generous and fair vein of 33% of the global AIDS commitment would mean to cover the cost of 4,000,000 people in treatment end of 10 years, not 2,500,000 as currently proposed. The target of 500,000 additional people in treatment and only 30 billion USD proposed for the second five years is less than level funding the United States' most successful international aid program. Thus, to meet the needs of the countries suffering, hold up the US share of international aid and build and sustain health systems to deal with this crisis, at least 50 billion USD over the next five years is necessary.

Today we have a choice that clearly sculpts the global epidemic and the view of the generosity and fairness of the United States throughout the world. I urge you to build on the successes of PEPFAR, to use the AIDS crisis to examine and address the illness and suffering throughout the world and not simply to preserve the first five years of PEPFAR in a museum of unrealized possibilities, but rather to continue in the visionary trajectory of using these resources to address, for the long term, the worst epidemic in the history of mankind.