

The Case for Optimism
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I am seldom invited to be the upbeat speaker at conferences of this sort. Or of any sort, now that I think of it. But when I was asked to address the case for optimism in our struggle to improve the health of the world's poorest, I couldn't in good conscience refuse. There are reasons for hope. I will offer two examples.

Let's look back to the year 2001, not too long ago. In 2001, if we were meeting in New York to discuss these same topics, we would be arguing. And the argument would have been about whether or not it's even worth bothering to try to treat AIDS, for example, among poor people in places like Haiti or most of Africa. The drugs alone then cost thousands of dollars per patient per year. At the time there was no such thing as the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and PEPFAR, the U.S. AIDS initiative, wasn't even a twinkle in the president's eye. And yet, the world's largest charitable foundation had just declared that it would focus its vast resources on the health problems of the world's poor. (You can imagine the consternation of the world's art museums and elite universities.) Even this remarkable development didn't put an end to defeatism, although people like me were sick and tired, already, of defeatist arguments, which had gone on way too long already. To ask doctors, nurses, and other providers to give up on treating the sick because they're too poor to pay was never, ever acceptable to my co-workers in the field.

Now it's November 2005. The Gates Foundation performed CPR on international health and the patient lived. The Global Fund and PEPFAR have kept the patient stable enough to move out of the ICU. We're still arguing, it's true, but we're not arguing about the same things. Instead of arguing whether or not to treat the poor who suffer from AIDS, or drug-resistant tuberculosis, or even drug-resistant malaria (the most common kind in Africa and much of Asia), we're arguing about what drugs should be used to treat these diseases. AIDS drug prices have fallen rapidly, from an average wholesale price in 2001 of over \$10,000 per patient per year to as low as \$130 per patient per year today. I'd much prefer to argue about generics versus branded drugs than to ask if some lives are worth more than others. I'd rather argue about the best way to diagnose and treat, and not spend time arguing whether or not we should bother introducing modern medicine and public health to regions that have never known them. Anyone who thinks these are not better, more interesting, more valuable discussions than the old ones does not have to face, on a regular basis, the destitute sick. We've come a long way in four years.

But not far enough. When we finally receive orders from on high to roll-out proper treatment plans for difficult-to-treat diseases, this is a good thing. But policy makers need to understand that changing the mantra from "No, you can't fix this" to "OK, *now* do the right thing" does not lead immediately to quality health care for the world's bottom billion. Would that it were so easy. It's impossible to reverse decades of neglect in the space of a few years by saying a magic word. And the results of these past few decades of neglect are not equivalent to those that preceded them; they're worse. For one thing—and here's more optimism—many of the tools we need to prevent or treat the diseases of poverty are in existence, if not readily at hand, and when we are told not to use them on the grounds of their "unsustainability" or their lack of "demonstrated cost-effectiveness" in precisely

those places where such tools are needed most, we have before us a far higher-stakes argument than arguing over equal access to leeches.¹

Here's another example. In Haiti, where we've worked for over two decades, we wrote, again in 2001, a proposal to the Global Fund to integrate AIDS prevention and treatment into an aggressive effort to promote primary health care across central Haiti's harsh and forbidding terrain. Two long years later, we received the money to do so, and that work is going well. Our Haitian team has worked with public-health authorities to use "new AIDS funding" to re-open and revitalize seven facilities serving most of central Haiti. But we will not meet our goals. Usually when implementers like me report that they will not meet goals, this is not a good thing. But I'm delighted to tell you why we won't meet our enrollment objectives in central Haiti: because the AIDS epidemic is shrinking there. The reasons for this will be much debated by those who love debating, but I'll tell you why I think the Haitian epidemic is shrinking: a decade of prevention plus treatment plus addressing social needs equals success, whether we measure success by AIDS mortality, number of new infections prevented, or number of patients who receive, through some of these so-called AIDS programs, their first real dose of primary health care.

Some things are harder to measure. One of the organizers of this conference, a science editor for *Time*, suggested that I share with you a couple of images. Meet Joseph, dying of both AIDS and tuberculosis at the age of 26. He was lucky enough to end up in one of our Global Fund expansion sites in Haiti. After only a few months of treatment for both these diseases, he looked like a changed man. But, in truth, he was simply Joseph again. A year or so later, he *was* a changed man, because he had himself become involved in AIDS prevention efforts.

That said, there exist, right now, only two large programs for the Josephs of Haiti; we need many more. And these are not large programs by the criteria we use in meetings like this one. What those gathered here in New York want are "scale-able" projects that can provide services for tens of millions now in dire need.

There is cause for optimism on this score, too. We can meet these and even more ambitious goals. But over twenty years of work in this arena has convinced me that the only way to embrace a realistic optimism is to dispense with a series of myths and mystifications first. Let me share some of the doozies of the day.

Myth 1. "Undue focus on AIDS is weakening the struggle against other killers of the poor." This will only be true if we design silly AIDS programs. The fight against AIDS should be indissociable from the fight against tuberculosis, for women's health and primary



Joseph Jeune, an AIDS and TB patient in rural Haiti, (a) before and (b) after receiving antiretroviral therapy. He is now active in AIDS prevention efforts, (c) here speaking at a health and human rights conference with his photos projected behind him.

health care (including vaccination campaigns), for primary education, and, in short, for poverty reduction. Doing a good job in AIDS prevention and care leads to a marked improvement in many other health indices, as we've discovered in Haiti and in Rwanda, where, unlike many NGOs or "faith-based organizations," we work closely with the public health sector. But look at the latest press. Last month, the *Financial Times*, citing, of course, public health experts, had the following headline: "Focus on African AIDS, TB, malaria epidemics diverting resources from neglected diseases, study says."² But just replace the words "African AIDS, TB, malaria epidemics" with anything else. Military expenditures, say. Or video games. Or pet food. Just about everything diverts resources from neglected diseases, as far as I can tell, and so now that we finally have some resources for the "big three" epidemics, we need to follow up with more resources for other neglected diseases rather than argue that one pandemic or another is getting too much attention.

A related myth is this one: "*Too much attention is paid to AIDS, drawing attention away from chronic diseases, prevention efforts, and primary health care.*" This is more of the same scrapping for limited resources that underpinned the spurious prevention-versus-care arguments. This endless debate, informed by either-or logic and hangdog attitudes, has inflicted significant damage in our line of work. In fact, we have shown in central Haiti, in Rwanda, and elsewhere that when AIDS prevention and care are planned properly they not only reinforce one another, but also serve to improve the quality of health services in general.³ Also, AIDS and tuberculosis *are* chronic diseases and, as far as I can tell, ranking primary health care problems. Even malaria and its attendant anemia are, in the end, chronic diseases. Putting in place excellent and supervised treatment programs for these diseases can improve the quality of care for any chronic disease for which there is a deliverable, whether that deliverable be insulin or anti-seizure medications.⁴

An equally embarrassing argument is the one regarding the relative importance of basic science research and interventions designed to bring the fruits of such research to those in greatest need. Make no mistake, this is a silly argument. The tools of modern medicine come mostly from the lab, but we still need an "effector arm" to be able to use these tools equitably. We need a malaria vaccine, safe insecticides, and bednets; we need effective malaria treatment programs, which sometimes includes a blood transfusion. These cannot be either-or arguments.

The international health sector is, at the moment, balkanized and squabbling because we've been starved of funds for so long we're all competing with each other. But again, good programs to prevent the transmission of HIV from mother to child will, if planned and executed sensibly, improve women's health. And this does not occur merely by giving out prenatal vitamins; it does occur if we introduce modern obstetric care. We've tried to use Global Fund and PEPFAR monies to move this agenda forward in Haiti, where we've built, along with public officials, operating rooms and blood banks. This is the only way to stop women from dying in childbirth. AIDS and complications of childbirth are two leading causes of death worldwide among women aged 15 to 44. According to a U.N. study published last month, "More than 500,000 women died from complications related to pregnancy or childbirth in 2000, but 99% of those maternal deaths were preventable."⁵ If you're looking for optimism in the middle of this horror show, there it is: virtually all of these deaths are preventable. And the reason that AIDS and maternal mortality are the leading causes of death is because both are diseases of poverty. They affect the same group of women. Focusing exclusively on either one of these ills means we don't improve outcomes for the other.

Myth 2. "We lack the infrastructure to treat AIDS and other complex diseases." This is not untrue, but misconceived. A lack of health infrastructure is no reason for inaction but rather a clarion call to action. We can build or rebuild infrastructures as we roll out services; indeed, we need to do so. But

the first steps can be taken by capitalizing on the abundant human resources available in places like Haiti and Rwanda. In our program, every patient has, as Joseph does, an outreach worker or *accompagneur*—a neighbor who brings him his medications every day. Some people think that we’re training outreach workers because they’re all we’ve got, but this is not true. It is true that when we first went to Rwanda earlier this year, there were no physicians in the entire district to which we were assigned by the Rwandan government. But we’d do it this way even if there were plenty of doctors and nurses around. Treatment that is supervised and community-based is simply better care for chronic disease. This model of care, tuberculosis experts can tell you, is the first line of defense against acquired resistance to many antibiotics; it’s probably even a good treatment model for malaria, too, to round out the big three. In settings where unemployment is high and these diseases are lethal, we’ve found no shortage of people who would love to be *accompagneurs*.

Training outreach workers is step one in a process that can lead to improved health care infrastructure, as long as we devote adequate resources to stocking and staffing clinics and hospitals serving the poor, and as long as we stop asking cash-strapped countries to further gut social services in the name of fiscal austerity. This approach does not work in settings desperately in need of both personnel and infrastructure and *greater* investments in public health. The notorious “brain drain” will slow or be reversed if we provide our African colleagues, for example, with the tools they need to do their jobs properly and pay them a living wage—and a living wage is surely even more important for outreach workers, who live in poverty, than it is for physicians and nurses.

The thousands of American and European and Cuban doctors now assisting in Africa also need the tools of their trade. Sometimes these are medicines; sometimes, salaries and training. Last week I received a message from an American, the coordinator of an AIDS program at a rural Ugandan hospital northwest of Kampala. She had gone to Uganda to help treat those dying of AIDS and found that many of them also had TB. She also discovered that all of the patients were poor; so were the people who could serve as outreach workers. She concluded that “Our TB system is non-existent and we have yet to design a community-based monitoring system for [patients] on ARVs. I think the obstacle to our TB program is mainly a lack of pay for our volunteers who observe TB treatment and a lack of supervision and support to these people.” She added that her team “convinced the hospital management to fund the training of these treatment supporters as well as monthly meetings for them in the first three months. However we would like to provide stipends, frequent training courses, and salaries for supervisors to support these individuals.”

We at Partners In Health receive dozens of letters and emails like this one every month, and they usually say much the same thing. Many health programs have been encouraged by the bigger funders to *refrain* from paying “community health volunteers.” Volunteering sounds OK, perhaps, until you ask: How can people who themselves live in poverty be expected to work for free when people like me are offered handsome stipends for consulting at every turn? It’s not always true that there’s not enough money out there. Some Americans would be surprised, I suspect, to learn where the money goes. One commentary in the papers last month cited a study of U.S. foreign aid spending written for Congress, concluding that “at least 60 percent of U.S. foreign aid funding never leaves the U.S., but is instead spent on office overhead, travel, procurement of American-made cars, computers, and other equipment, as well as salary and benefit packages.”⁶ While we’re on this painful topic, the idea that corruption is endemic in Africa and that this is a good reason to freeze health programs is another canard. Corruption occurs everywhere, as we’ve learned in contemplating some of the industrial-strength corruption in my own country—and such scandals have never yet led to calls for freezing public-health expenditures on Wall Street or in Washington. In our own programs, we’ve learned that poverty itself weakens the ability to provide a transparent accounting of our work: how

best do we do that when there is no electricity, no computers, and when the bulk of the world's accountants work for the rich instead of the poor?

Even this sort of grumpy analysis is cause for optimism because it reminds us that, one, there are people out there who'd like to work if only they can be paid enough to feed their families; and, two, a lot of aid money never reaches its ostensible beneficiaries. And if accountants can make fake energy companies look like something other than a house of cards for quite a long while, they can surely help health workers addressing the health crises of the poor learn how better to manage long-overdue funds.

Myth 3. "People value health services more if they pay for them." To my knowledge, there is no good data to support this oft-heard claim—often heard, that is, among those who set policies or who are not themselves in danger of dying simply because they cannot pay a small user fee. Is there such a thing as a public good? Is public health one of those public goods? Or should every single health care service now become a commodity purchased in the market? Some of our discussions of "cost-effectiveness" are really calls to consecrate, as policy, a different standard of care for the destitute. So far, PEPFAR and the Global Fund have declined to lower the bar for AIDS care, and this is correct. Antiretroviral therapy is the only way to treat advanced HIV disease. But the architects of these funds should go a step further: they should speak out against user fees for public health emergencies, and what are AIDS, tuberculosis, malaria, and maternal mortality if not public health emergencies? We will remain optimistic about our ability to avert the majority of these deaths as long as folks in Washington, London, Geneva, New York, Paris, Tokyo, or wherever, would permit us to stop begging that some health services simply must be seen as basic human rights.

And then there's the food fight... which is associated with all sorts of myths and mystifications. The claim in question is that money to prevent or treat AIDS shouldn't be used to pay for food or school fees or water projects. Again, give us docs a hand here. It's a basic fact of medicine that people dying of consumptive diseases like AIDS or TB need not only the right drugs but also lots of calories; they need clean water. And their families need to eat and drink, too. International agricultural policies that even doctors see as evidently unfair are not handed down on stone tablets but created in meetings like this one. That means we can change them, especially when we contemplate, on the same small planet, an epidemic of obesity in one place and famine in another. And we can use food aid a lot more wisely. Last month, Celia Dugger of the *New York Times* wrote about a proposal now before the U.S. Congress. The proposal would permit us to insist that our efforts to feed the hungry not undermine the farmers who grow many of the foodstuffs in Africa—the very people who are numbered, often enough, among the hungry. There are obstacles to such sensible policies and you might be surprised to learn how they are built up. Dugger describes the "Iron Triangle of food aid," which includes U.S. agribusiness, the shipping industry, and charitable organizations, some of which, amazingly enough, make money by selling food. "Given that at least 50 cents of each dollar's worth of food aid is spent on transport, storage and administrative costs, selling food to raise money in, say, Africa, is an exceedingly inefficient way to finance long-term development," according to one expert who backed the proposal. "So why," asks Dugger, "is this seemingly sensible, cost-effective proposal near death in Congress? Fundamentally, because the proposal challenges the political bargain that has formed the basis for food aid over the past half century: that American generosity must be good not just for the world's hungry but also for American agriculture."⁷ One major coalition of 16 non-profit groups joined in the opposition to the proposal, but their opposition seems more related to self-interest than to social justice.

School fees are also an AIDS-related issue. Poor kids in Africa and in Haiti, kids we know personally, cannot pay them. Who is to blame? Surely not their parents, some of them long dead of AIDS, tuberculosis, or malaria. Who is responsible? Less than a month ago, Human Rights Watch charged that “government neglect of millions of children affected by HIV/AIDS is fueling school drop-out across East and Southern Africa.”⁸ But it wasn’t African governments that pushed austerity measures that weakened public health and public education. It was the international financial institutions, and they are us, here in this room.

The good news: if some years ago we gave bad advice in pushing anti-poor policies—“structural adjustment programs” or food aid that undermines hungry farmers—then it’s not God or a natural cataclysm that are to blame, it’s us humans. And we can reverse our advice and get kids back in school and make sure they have enough to eat.

I’ve had 12 minutes to convince all of you that there is cause for optimism in contemplating some grim numbers. Allow me to recap this message in an upbeat manner. Look how much progress has been made over the past couple of years. Only three years ago, someone like me would have been invited to address you in the hopes of persuading you that diseases like AIDS and drug-resistant tuberculosis should be treated in what are termed “resource-poor settings.” Today, we spend less time prolonging that debate and more time discussing how best to treat these diseases. We have arguments about where to source our drugs, but that’s a much better debate, as far as patients and doctors are concerned, than arguing about prevention versus treatment. Here are a few “take-home messages,” as they’re termed in medical school:

1. AIDS prevention needs to occur in association with AIDS treatment. The same can be said for all the other diseases of poverty. Many complementary interventions are needed at once, and they are urgent and feasible.
2. We cannot continue these funding catfights about treating AIDS versus TB versus chronic diseases versus vaccination versus whatever. We cannot argue about whether we should invest in science or in care. We need everything. It’s not that we’re dealing only with the “neglected diseases of poverty,” but rather that poor people’s problems are neglected, period. This is true whether we’re discussing diabetes or tuberculosis, mental illness or AIDS; it’s true for women’s health and for eyeglasses. We need tools that will come only from basic science; we need to invest in health care delivery. These are not zero-sum choices.
3. As with tuberculosis, supervised, community-based care is probably the highest standard of care for AIDS. We call our outreach workers *accompagnateurs*, but we don’t care, frankly, what they’re called. They are the patients’ advocates and the first line of defense against acquired drug resistance, an inevitable consequence of using antibiotics. Good, supervised care will slow the acquisition of drug resistance; trying to keep medications from the poor will not. And community-based care isn’t some sort of proprietary model, but one that we should adopt simply because it works. In the poorer reaches of the world, I don’t believe any other model will be as effective.
4. Providers who work with the destitute sick need help with food, school fees, clean water, and poverty alleviation in general. Doing the right thing for people living in poverty and facing disease will allow us to start a “virtuous social cycle,” even if we began by attacking AIDS, tuberculosis, malaria, or maternal mortality.

This is the world's great gamble. We've cast the die, and created, at long last, institutions like the Global Fund and programs like PEPFAR. Newly established foundations have awakened to the world's health crises. Billions of dollars will be invested in responding to epidemics that have spun out of control. If we want these dollars to be invested wisely, we have to link our projects to rebuilding health systems, to poverty alleviation, and to food security—both at the level of individual patients and their families and at the much more macro level. We need to continue investing in basic science and product development. With adequate resources and attention we can, I am sure, manage to work on all of these levels at once.

So let's cheer up and get going.

Thank you.

¹ Martin Luther King made the same point about poverty: "There is nothing new about poverty. What is new, however, is that we now have the resources to get rid of it" (*Where Do We Go From Here: Chaos or Community?* Boston: Beacon Press, 1967, p. 177).

² While the authors of the cited study do pay lip service to "the importance of doing everything possible to combat the big three diseases" (Molyneux DH, Hotez PJ, Fenwick A. "Rapid-impact interventions": How a policy of integrated control for Africa's neglected tropical diseases could benefit the poor. *PLoS Medicine* 2005;2(11): online), the spurious logic of the boiled-down sound bite is familiar: "Concentration on the 'big three' diseases of AIDS, tuberculosis and malaria has diverted resources from half a dozen easily treated illnesses that have a greater impact on healthcare and economic development in Africa" (Jack A. Scientists urge extra focus on 'neglected' African diseases. *Financial Times* (London), 11 October 2005, p.13).

³ Walton DA, Farmer PE, Lambert W, Léandre F, Koenig SP, Mukherjee JS. Integrated HIV prevention and care strengthens primary health care: Lessons from rural Haiti. *Journal of Public Health Policy* 2004;25(2):137-58.

⁴ An acute observer of these matters, the editor of the *Lancet* discusses these competing goals in a recent editorial and reports that "The reduction of chronic disease is not a Millennium Development Goal (MDG). While the political fashions have embraced some diseases—HIV/AIDS, malaria, and tuberculosis, in particular—many other common conditions remain marginal to the mainstream of global action on health. Chronic diseases are among these neglected conditions" (Horton R. The neglected epidemic of chronic disease. *Lancet* 2005;366(9496):1514.

⁵ United Nations Population Fund. *State of World Population 2005*. Available at www.unfpa.org/publications/detail.cfm?ID=248&filterListType=.

⁶ Epstein H. The lost children of AIDS. *New York Review of Books*, 3 November 2005. Available at www.nybooks.com/articles/18399.

⁷ Dugger C. African food for Africa's starving is roadblocked in Congress. *New York Times*, 12 October 2005, p. A4.

⁸ Human Rights Watch. *Letting Them Fail: Government Neglect and the Right to Education for Children Affected by AIDS*. 2005. Available at <http://hrw.org/reports/2005/africa1005/>.