OFFICE OF THE

Secretary-General's Special Adviser

on Community Based Medicine and Lessons from Haiti

DR. PAUL FARMER REMARKS

Economic and Social Council High Level Meeting:

Ebola: A Threat to Sustainable Development

December 5, 2014
United Nations, New York

Your excellency Ambassador Maria Mejia Vélez, your excellency Mr. Sam Kahamba Kutesa, excellencies, dear friends, especially those from Sierra Leone, Liberia, Guinea, and Mali:

I want to thank the Secretary-General and His Excellency Mr. Sajdik for inviting me to participate in today's meeting. It is very unusual, and most welcome, to be asked, in the middle of a public health crisis, what we might do to better ensure that our current efforts might have a durable and positive impact. As my friend David Nabarro said earlier-- in fact as he has been saying for months-- is that in the midst of all of our urgent efforts to respond to Ebola it's imperative that we ensure that our investments are not fleeting: and perhaps more importantly, that they don't undermine the struggling public health and care delivery systems that have been so weakened in these last months. There is no mystery about how we got here: we got here because after the last crises in the region too few resources were invested in building a health care system able to deliver on the promise of both prevention and care; we have too often failed to link emergency responses—and there were many during the latter years of the past century and first years of this one—to building local capacity and professional training programs that draw on the region's largest goldmine, which is its human capital; because over the last few decades, despite good-will efforts to accompany our partners in West Africa, we have too often failed to invest heavily in national institutions, sometimes skirting

them altogether. And perhaps we are here because the kind of policy forum we are having today has occurred too rarely. If there is one thing we have learned and re-learned—seeking to link the long-term to the emergency response in deed and in word—it is that during "humanitarian response" to crisis what appears to be the easiest solution may lead to numerous unintended and negative consequences down the road. An example that I come back to time and time again is that of the General Hospital in Port-au-Prince following the 2010 earthquake. In the months that followed, as hundreds of millions of dollars were poured into the relief effort, no major donor prioritized the strengthening of the existing public sector hospital designated to care for those in need in Port-au-Prince, in the heart of the quake zone, and to train Haiti's doctors and nurses. These resources were, however, invested in makeshift (even shoddy) field hospitals, few of which recruited and trained a Haitian professional workforce. That was 2010. Almost five years later, I am disheartened to note that the General Hospital is still not rebuilt and as in need of resources as it was before the earthquake. A similar pattern—from temporary and makeshift facilities to a failure to invest emergency aid in the public health system—was seen in the cholera response, which has been and remains inadequate in so many ways. Before we spend the estimated $3.4 billion pledged to date for the Ebola response, let's not make the same mistake. I know from my recent trips to the region, and from conversations with President Sirleaf and President Koroma and President Condé that such deficiencies are often on their minds as the latter recently said to the *New York Times*: "While shaving I think of Ebola, while eating I think of Ebola, while sleeping I think of Ebola."

This panel will focus on how best to link the emergency Ebola response to longer-term efforts to strengthen health systems. I want to thank ECOSOC for organizing it. They have asked me to spend the next two hours focusing *not* on the details of the response – I leave that in the capable hands of David Nabarro and Tony Banbury – but rather to share what we've learned about what has worked, and what has not, in efforts to create the systems and conditions that might break the cycle of poverty, disease and inequality, conditions that favor a much vaunted but little understood "resilience" which, though humbling to see in West Africa, is undone for individuals and families who are *not* offered protection from illness including epidemic disease, and injury. We know that building strong national institutions is central to such progress. I'm looking forward to hearing from my colleagues, some of them are here today and some of them who are sitting half-way across the globe, about their work to build such capacity and to allow others to become protagonists in the

fight for health and social justice, and to protect all of us, but especially those long denied access to fruits of modern medicine and from the threat of epidemic disease.

In the few minutes I have remaining, I'd like to talk about four requirements if we are serious about seeing sustained progress in West Africa and beyond.

First, we need to invest more of our resources in national institutions.

Imagine that you are the Minister of Health in Sierra Leone, Liberia or Guinea. That would mean familiarity with heavy burdens of epidemic disease but also armed conflict in the not too distant past. A health crisis like Ebola hits, and you are responsible for the well-being of your citizens. But 80 to 90 percent of the official development assistance to your country is bypassing your institutions. Your national plan is 90 percent unfunded, and a couple of leading health NGOs in your country have larger and more flexible budgets than you do.

This is not a hypothetical. Data from my United Nations office shows that this is the case in most so-called "fragile states" despite the fact that there is evidence clearly demonstrating a link between poverty reduction and investments in public systems.

In fact, among countries emerging from, or still mired in, poverty and ill health and conflict, the strongest performers on the Millennium Development Goals receive 28 percent more aid through their national systems than weak performers.

For example, over the past decade, Rwanda has made historic progress on development measures and is on track to achieve most of all of the health related MDGs by 2015. Rwanda prioritized the strengthening of its public sector, and steered donors to invest an estimated 56% of their total official development assistance directly through its national institutions. That's in stark contrast to Liberia, at 3.5%. Since the 1994 genocide, per capita income has almost tripled and GDP has quadrupled, growing at an average of 8.1 percent annually since 2000. But even more to the point, Rwanda has invested heavily in health, education and improved coordination of development assistance in order to meet such goals. It has seen one of the most dramatic reductions in premature mortality in history, including child and maternal mortality.

Second, investments in health and other social programs are not best seen as competing with other development investments; they are necessary for genuine and sustainable development.

The astonishing lack of health professionals in all three affected countries is one of the primary reasons that the epidemic has gotten so out of control. According to the Liberian Ministry of Health and Social Welfare, even before the outbreak, Liberia had approximately *50 physicians* working in public facilities serving a population of 4.3 million. Compare the 50 physicians in Liberia to the approximately 50,000 in New York state. The story is no better for nurses, community health workers and laboratory workers, and far worse for health surveillance.

Coming back to Rwanda, which invested heavily in building out a primary care network over the past decade; this included training 50,000 community health workers to link rural regions into the health care delivery system. That didn't solve all problems, however. The Human Resources for Health Program, launched in 2012, is an unprecedented seven-year strategy to address its shortage of doctors and other health care professionals. Highly skilled US professionals from close to two dozen US universities are paired with Rwandan counterparts with the aim of transferring knowledge and upgrading didactic skills to be passed on to further generations of health workers, producing tangible and sustainable benefits. The program will train over 550 medical specialists, upgrade the skills of over 5000 nurses, and introduce formalized training in health management and dentistry. This will never be achieved through brief "train the trainers" efforts.

West Africa also needs its own world-class medical and nursing school linked to robust health systems if we are to avoid another health crisis and re-establish pre-Ebola health gains. The point was made eloquently by the Minister of Finance of Sierra Leone, His Excellency Mr. Marah. I look forward to Her Excellency, Ambassador Febe Potgieter-Gqubule to elaborate on the African Union's decision to create an African Center Disease for Control and Prevention based in Ethiopia. This is the kind of thinking that needs to be supported and translated into reality and to complement even more ambitious efforts *within* West Africa's worst Ebola-affected nations, which need these institutions too.

Third, such investments, whether in health systems or in careers and training of those who will run them needs to be offered in the spirit of partnership. We need to turn from "aid" to "accompaniment."

We've all heard endless stories about inflexible donor requirements, especially in settings of poverty. We've also heard why it's "impossible" to partner with local authorities because of weak absorptive capacity and alleged corruption. In order to avoid risk, so goes the story, we build parallel systems to deliver and assess the impact of such programs.

But all too often, development professionals are mostly worrying about our own institutions rather than about the grotesques risks faced by those left behind by human progress. Ebola offers a vivid example of the extraordinary risks are faced by caregivers, professionals and family members, across much of West Africa. But we whisper about "reputational" and "institutional" risk. We need to invert dominant notions of risk and make *bold* commitments to accompanying the people and leaders who face the real risks.

I'm so pleased that we will hear from Aleesha Taylor, who is going to share her insights from her experience partnering with the Ministry of Education at the request of President Sirleaf.

Fourth, all systems strengthening must be guided by the highest aspirations.

Ebola has never yet collided with modern medicine and public health, at least not in West Africa. We are a long way from zero as World Bank President Jim Yong Kim, himself just back from West Africa, has repeatedly noted. Getting to zero will require improving clinical care *and* case findings on a massive scale. Sending patients to quarantine centers with little to no care—no food or electricity--cannot be the answer. People need safe havens which includes safe referral to centers that might treat the massive fluid and electrolyte loss so often associated with this disease. This is not about the sterile debate about prevention versus care. Much of the stigma surrounding Ebola is related to its high case fatality rate *in West Africa*. But when high quality "supportive care" is provided, fatality rates will decrease dramatically and people will no longer shun health facilities—the home base, often, of the teams who might do contact tracing and follow up, and sometimes the home base for safe burial teams. Most sites—whether run by international NGOs or the national authorities—have not been able to implement these standards to date, due to severe

staffing constraints and shortages of supplies—including personal protective equipment for health workers and the tools of our trade. Still we need "staff, stuff, space and systems."

But as many have said: Ebola is not a death sentence. When Ebola collides with modern medicine as many as 80- 90% of those who contract Ebola can survive it. Not a single American has died of Ebola. This should be our aspiration at least: to save every patient and trace every contact to bring this epidemic to an end. We also need to engage survivors in a serious and sustained way. We need to count survivors because survivors count. From them will emerge the leaders of this response. We've learned this lesson before, too.

Twenty years ago, AIDS, a zoonosis unknown until a few decades ago, like Ebola was seen as a death sentence. But the introduction of specific therapy led after the mid 90s to a dramatic plunge in mortality in the United States and Europe. Again, the epidemic was likely concentrated in Africa and moving South across national borders through long standing social fault lines. It rapidly became the leading infectious killer of young adults across the world fanning a resurgence of tuberculosis and uncounted catastrophic expenditures: these outcomes were uncounted, certainly, in early attempts to steer investments in Africa, where modern medicine and public health had so rarely collided with those most vulnerable. The cost of inaction was seldom tallied. By the end of the 90s, most countries on the continent had seen dramatic reversals of hard-won gains in child survival. I recall a conversation with a patient in Haiti around that time: "Is it true that there's a new treatment for AIDS?" And the answer was yes, there was a new treatment, but that there was no equity plan for her to get it. But these were finally elaborated and funded with, among intended outcomes, a reversal of the reversal in reductions of premature mortality. The AIDS extreme gap continued to widen until investments were made to integrate prevention and treatment which made voluntary counseling and testing easier. Millions of lives have been saved and the number of new infections is dropping.

We need to move away from thinking about health investments and social protection in a zero-sum way. This epidemic shows us how distorted our arithmetic is: President Obama is asking the US congress for $6.2 billion for emergency funding for West Africa and the US. This is in addition to the $3.4 billion already pledged globally. I think it's obvious that this funding could have been spent more wisely had we used it—and other investments including those allocated for AIDS—to better

strengthen health systems over the past decade. Rwanda did so which is why it boasts the steepest decline in AIDS mortality but also in all-cause mortality in children.

CONCLUSION

As Dr. Larry Brilliant, who helped eradicate smallpox almost forty years ago, has noted in speaking about Ebola: "Outbreaks are inevitable. Pandemics are optional." We know what needs to be done and the political will, it would seem, exists: Over $3.4 billion dollars has already been pledged for the Ebola response. The question is, will we get it right? Will we strengthen health systems as we scramble to get a handle on the crisis? Will we declare an early victory *before* we've helped to address the massive infrastructural deficits and human resource crisis in settings in which all medical and nursing schools are shuttered, and no formal and credentialed training programs in infection control exist? Will we stop the transmission of Ebola but allow the economies of West Africa to collapse? This is not a time to set our sights lower. This is, rather, a moment we will remember as will our brothers and sisters and colleagues who have too long suffered from the poverty of mean expectations. We have to get it right.

Thank you.