Comments in Response to the Implementation of the Global Health Initiative: Consultation Document
Submitted by The Global Health Initiative Working Group
www.theglobalhealthinitiative.org
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Introduction

The Global Health Initiative was announced by President Barack Obama in May 2009, and was heralded by many in the U.S. and around the world as a welcome indication of the U.S. government's commitment to taking a strong, active, and progressive role in addressing a range of critical global health issues. In February 2010, a "Global Health Initiative Consultation Document" was released by the Administration, and comments were invited from the global health community.

The comments below represent contributions from the Global Health Initiative Working Group, an independent coalition of 25 leading global health organizations which came together in mid-2009 to examine how the Global Health Initiative is addressing global health priorities, and to develop joint recommendations for ensuring that the GHI is ambitious and effective.

Coalition Contacts: For this paper, please contact the following lead coalition members:
Serra Sippel, Center for Health and Gender Equity (ssippel@genderhealth.org)
Matthew Kavanagh, Health GAP (matthew@healthgap.org)
Ann Starrs, Family Care International (astarrs@familycareintl.org)
Donna Barry, Partners in Health (dbarry@pih.org)
Ellen Marshall, International Women's Health Coalition (em@goodworksgroup.net)
Sue Perez, Treatment Action Group (sue.perez@treatmentactiongroup.org)
Michael Riggs, Global AIDS Alliance (mriggs@GlobalAidsAlliance.org)

Cost Effectiveness is a Poor Indicator of Success

The principle of cost-effectiveness is repeatedly used in the GHI Consultation Document. Unfortunately this principle has oft been used in public health lexicon and programming to support less-costly, but also less effective, interventions. This is particularly the case in reducing maternal mortality and treating multi-drug-resistant tuberculosis (MDR-TB) and is precisely the reason why we have made little progress in reducing maternal deaths or decreasing cases of MDR-TB.

To avert maternal deaths new interventions are required and include more trained midwives, nurses, and Ob/Gyns for deliveries in well-equipped health centers and hospitals accessible to all women who require care for complicated deliveries and are capable of providing blood transfusions, Cesarean sections, and post-partum care. Past efforts to scale-up "cost effective" interventions such as training of traditional birth attendants or risk screening have been shown to have little or no impact on reducing maternal mortality; the current emphasis on "quick win" interventions, which focus on a specific cause of death such as postpartum hemorrhage or eclampsia, must be combined with more comprehensive approaches that invest in the long-term, sustainable capacity of the health system to provide adequate care for growing populations of needy women, newborns and children.

We are especially worried about the change within the GHI document that lowers the targets for TB treatment while expanding the number of years to achieve them—both regular cases and drug resistant cases—from the Lantos-Hyde Act targets. MDR-TB treatment is more costly than treating drug-sensitive TB, however with 500,000 incident cases per year it is an increasing threat around the world. In traditional cost-effectiveness studies, MDR-TB treatment is not considered cost-effective. However, continued under-treatment of existing cases and transmission of MDR-TB are leading to unnecessary deaths and new cases. The short-sighted view of not treating costlier cases in the present will only lead to far more expensive treatment scenarios as more and more cases develop and more resistant strains develop which we have already seen with the appearance of extensively resistant TB.

Scale May Not Be Sufficient for Impact and Input Targets are Needed

Globally studies show that few donor-funded health projects—as few as 5%—are of a scale to have a significant impact on health and the health delivery system in recipient countries.[i] An essential shift occurred when US global AIDS and Malaria programs, with the advent of PEPFAR and the PMI, moved from a model in which most funding went to TA or

pilot programs to pushing sufficient funding to directly support major scale up of treatment, prevention, and care programs. This must continue, with sufficient funding, and be extended to the other GHI areas.

The focus on outcomes and success is highly welcomed. However, a great many pledges to save lives have been made previously without sufficient attention to the specific inputs needed from donors to reach them.[ii] While narrow focus on targets has at times created problems by skewing interventions toward those that can be easily counted and measured, they nonetheless are needed for accountability and to ensure that efforts are truly new and truly additional.

We worry about discussions focused on strengthening health systems that are not linked to specific inputs such as the purchase of drugs for specific numbers of people, the hiring and paying of health workers, and other concrete inputs.

The targets identified in the GHI Consultation Document raise questions about the projected funding levels and the effectiveness of the strategies to be pursued. In the area of maternal and child health, for example, the GHI sets out two targets: prevention of 360,000 maternal deaths and 3 million child deaths over its 6-year time frame. This implies a total investment in MCH of $2.5 billion to $4.8 billion, or $415 million to $800 million per year, depending on what figures are used for cost per death averted.[iii] These figures, however, assume that the full funding will be invested directly in provision of services; given the significant percentage of US funds that generally go pay the costs of technical assistance agencies, considerably more resources will be needed to achieve the targets identified. While the GHI document does not indicate how the $12 billion indicated for all non-HIV, non-malaria, non-TB health needs will be allocated, even this preliminary analysis implies that it is nowhere near enough.

To succeed the GHI must:

- Explicitly shift to projects aimed at reaching universal coverage of key interventions
- Set specific targets for US-inputs aligned with national strategies to act as guideposts, and create transparent mechanisms for reporting progress on these.
- Ensure key inputs are fully funded so that the US is truly financing the achievement of the stated goals.

Focus on Direct Services and Commodities over Consultants

Technical Assistance can be important, but the biggest needs of people living in poverty is direct support to ensure services and commodities are available, especially those delivered through the public sector health system which can coordinate large-scale programs and reach the greatest number of people most equitably. According to estimates upwards of 40% of all health aid comes in the form of technical assistance, which is too often ineffective and overpriced.[iv] Information is unavailable for most programs but upon examination by Congress, some US health aid programs have been found to be made up largely or exclusively of TA programs.[v] Anecdotes of clinics built without staff or medicines available and TA to build strong supply chains without money to buy drugs make clear the problem with this approach.

In the consultation document the lack of concrete input targets in most areas (such as health workers trained and paid) along with significant discussion of technical or system-strengthening activities leads to worries that the majority of funding will not go to direct services. This is especially worrisome outside of AIDS and Malaria programs, where questions remain but some of this shift has occurred. The GHI must focus on the most urgent needs to address the identified problems: sufficient health workforce and the medicines and supplies to provide care.

To succeed in having real impact the GHI should:

- Place explicit limits on the portion of funding that can go to consultants—ensuring that the clear majority goes to direct service.

Implementing the GHI

While the GHI Consultation document provides a framework for the GHI vision and approach, the Operational Plan section lacks clarity about the coordination and management of the GHI at the agency headquarters level as well as a specific plan for implementation of the GHI in focus countries. For example, which agency will take the lead in coordinating the GHI? How will the GHI be coordinated on the ground? How will the GHI Memorandum of Understandings align or coordinate with existing PEPFAR Partnership Frameworks, Country Operational Plans and the Five-Year Strategy, Millennium Challenge Corporation country compacts and other US bilateral development and health strategies? We request further details on when a more detailed and specific operational plan - including information about specific interventions that will be implemented to achieve the stated goals - will be available for input. Finally, given

that we are already in the third year of the GHI six-year initiative, we also request clarification on the timeframe for the GHI.

USAID and other Aid Structures Must Be Reformed for GHI to Succeed
The State Department and White House are currently completing reviews of foreign assistance, respectively the Quadrennial Diplomacy and Development Review and the Presidential Study Directive. It is unclear if any potential recommendations from these initiatives have influenced the GHI. Many of the general GHI recommendations including expanded technical assistance and extension of existing aid programs appear to be “business as usual” for US foreign assistance. Specifically we suggest:

- Cost-efficiencies, a term used widely during GHI consultation discussions, can be gained by reducing contractor overhead costs and over-priced and ineffective technical assistance. A focus on hiring local experts would significantly reduce TA and program costs as would more south-to-south collaboration.
- Increased transparency of foreign assistance should be a large part of the GHI as should significant increases in funds spent in recipient countries. All contract information including amount of funding, targets and goals, and evaluations of success and limitations should be made publicly available online.

Lantos-Hyde Act and the GHI
The Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS,Tuberculosis, and Malaria Reauthorization Act of 2008 (PL 110-293) passed overwhelmingly with broad bipartisan support, and represents a clear legislative framework for fighting these three disease. The GHI should fully implement and complement key provisions of this landmark legislation.

- TB Treatment Targets. The Lantos-Hyde Act mandates a five-year USG strategy to treat 4.5 million cases of TB under DOTS, and 90,000 multi-drug resistant (MDR) TB cases, while the GHI proposes only 2.6 million DOTS treatments and only 57,200 MDR-TB cases by 2014. The GHI plans to treat less than two-thirds of what the Lantos-Hyde Act calls for, and to do it over six years rather than five. The GHI targets are a significant step back from the clear mandate of the Lantos-Hyde Act to scale up treatment for TB, and a missed opportunity to aggressively fight the leading curable infectious killer of adults. The GHI should revise its TB treatment goals upwards to comply with the mandates of the Lantos-Hyde Act.

- Health Care Workers. The Lantos-Hyde Act mandates the training of 140,000 health care workers, which is the U.S. share of additional health care personnel required to scale up HIV/AIDS care, prevention and treatment services. While the GHI embraces the 140,000 target, it does not clarify what additional health care workers will be trained to meet additional health system strengthening goals.

Country Ownership and Civil Society Participation
The GHI Consultation document outlines four main components of its Operational Plan, one of which focuses on the promotion of country ownership. While we support the GHI's emphasis on country ownership, it remains unclear to what extent the GHI will embrace soliciting input from civil society and affected communities as an equal and mandatory partner to assess what is happening on the ground and what barriers prevent populations from accessing services and information. In particular, meaningful civil society participation in the development of country Memorandums of Understandings is essential. All too often, governments and donors seek input from civil society, as a token gesture, at the final stages of developing a plan when it is difficult to make changes to that plan. When input is sought from civil society, it is primarily from international NGOs, as opposed to grassroots, indigenous or community-based organizations, which are closest to hard-to-reach populations, including stigmatized and marginalized populations (for example women living with HIV, people who inject drugs, sex workers, men who have sex with men and other LGBT people, those with disabilitities and the incarcerated). The end product therefore becomes a government-led and -owned plan, not a truly country-led and -owned plan.

The GHI should adopt, at minimum, requirements similar to those established for civil society and community participation and involvement in the Country Coordinating Mechanisms (CCMs) of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Specifically:

- A formal mechanism should be identified—ideally making use of existing bodies—for all stakeholders to participate in the formulation of all GHI plans. The Global Fund guidelines stipulate that "the membership of the CCM comprise a minimum of 40% representation of the nongovernment sectors such as NGOs/community-

based organizations, people living with the diseases, key affected populations, religious/faith-based organizations, private sector, academic institutions." The full CCM guidelines can be found at http://www.theglobalfund.org/documents/ccm/Guidelines_CCMPurposeStructureComposition_en.pdf.

Health Workforce

It is a welcome sign that the GHI Consultation Document makes specific reference to recruiting, training, and retaining healthcare workers. We do not believe it is appopriate, however, to include only the 140,000 health workers calculated specifically, and included in legislation, to address the needs of the health system as the PEPFAR goals are implemented. This represents just 4% of the additional 3.5 million health workers that WHO estimates 49 low-income countries to reach the Millennium Development Goals.

Additional health workers will be needed throughout the GHI program areas – even as those trained and retained through PEPFAR will be able to contribute to all health goals, not only HIV/AIDS goals. Therefore, it will be important for other program areas to invest significantly in training and retaining new health workers, as well as other health workforce contributions, including to ensure their equitable distribution, and to improve their management, effectiveness, and productivity.

We are also concerned by the reference to training local health care volunteers. This suggests that the GHI will be supporting uncompensated community health workers, which threatens the sustainability of community health worker programs, and worsens retention of community health workers.
Therefore the GHI should:

- Set a goal of Increasing the health workforce in developing countries and supporting the retention by at least one million new health workers by 2015;
- Support each GHI country's national health workforce plan—ensuring it is costed, comprehensive, based on need, evidence, and human rights, and include actionable implementation strategies—and provide finanicial support to reach the goals these plans include;
- Commit to paying the salaries of health workers needed to achieve GHI goals.
- Support training new nurses, doctors, and clinical officers, and others requiring longer-term training, even if their training will not be complete until 2015 or later.

Research and Development

Implementation and operations research, as outlined in the GHI concept document, are critical components of any global health response, and we congratulate the Administration for elevating these activities. These critical areas should be given, in fact, their own strategy and budget separate from the GHI which has its goals focused on delivering services. This agenda should receive additional resources for its implementation. The administration should give a full picture of US agency initiatives on global R&D and a plan for implementing an expanded bold agenda from basic science to the development and introduction of new global health tools and technologies. Providing existing prevention and treatment tools is only one part of the battle against pneumonia, diarrheal diseases, HIV/AIDS, tuberculosis, malaria, and neglected tropical diseases. To ensure that we are winning the fight against these global diseases, the United States must also increase investment in the development of new global health technologies such as vaccines, drugs, microbicides, diagnostics, and devices, aimed at diseases disproportionately affecting the developing world, including through product development partnerships (PDPs).

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[i] Paolo Piva & Rebecca Dodd, "Where did all the aid go? An in-depth analysis of increased health aid flows over the past 10 years, "*Bulletin of the World Health Organization* 2009;87:930-939; ActionAid International, *Real Aid 2: Making Technical Assistance Work*, *2008*.

[ii] E.g. pronouncements by USAID and Dept. of State surrounding the 1994 ICPD targets: http://www.iisd.ca/Cairo/program/p08009.html

[iii] Based on two sources: for maternal deaths, figures are $2,729 (for Africa) to $5,017 per maternal death averted (http://www.dcp2.org/file/69/DCPP-MaternalDeaths.pdf). For child health, Unicef estimates are $500-$1,000 per death averted (http://www.globalactionforchildren.org/issues/child_survival1/). (For summary of findings for all health conditions/interventions, see http://files.dcp2.org/pdf/DCP/DCP02.pdf.)

[iv] Piva & Dodd; ActionAid International, *Real Aid 2: Making Technical Assistance Work*, *2008.*

[v] E.g. USAID testified to Congress that the 2004 malaria budget of the agency devoted only 5% to medicines, insecticides, and nets

devoting the majority to consultants. (Michael Miller, Deputy Assistant Administrator, Bureau of Global Health, U.S. Agency for International Development, Testimony before the Federal Financial Management, Government Information and International Security Subcommittee, May 12, 2005.