

**STATE, FOREIGN OPERATIONS, AND RELATED
PROGRAMS APPROPRIATIONS FOR FISCAL
YEAR 2008**

WEDNESDAY, APRIL 18, 2007

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:30 a.m., in room SD-138, Dirksen Senate Office Building, Hon. Patrick J. Leahy (chairman) presiding.

Present: Senator Leahy.

UNITED STATES AGENCY FOR INTERNATIONAL
DEVELOPMENT

BUREAU FOR GLOBAL HEALTH

STATEMENT OF DR. KENT R. HILL, ASSISTANT ADMINISTRATOR

OPENING STATEMENT OF SENATOR PATRICK J. LEAHY

Senator LEAHY. I apologize for being late. It's not often we have this distinguished a panel. We had votes that were supposed to have been earlier today, partly to accommodate this hearing, and then as sometimes happens in the Senate, things slipped.

This hearing focuses on the aspects of our global health programs which address the core public health needs of the world's poorest people. I think of when children of people in my office, or my own grandchildren, get immunizations and it is a routine thing, and I think of so many children around the world where this does not happen, for them or their families.

The chart on my right shows funding for HIV and AIDS, which has—for obvious reasons, and with bipartisan support of this subcommittee—increased dramatically in recent years, but funding for maternal and child health, and family planning and reproductive health, has languished.

I don't want this to be an either/or thing, by any means. But, I am concerned, when you consider what a difference these programs make, and what we take for granted in our own country.

Over the past 30 years, expanded immunization programs, often costing only pennies a child, have saved millions of lives. Family planning and reproductive health programs have also made enormous differences in child survival and women's health. USAID has been in the forefront of these efforts.

But despite the great progress and countless lives saved, 11 million children—11 million children under age 5—die each year, mostly from easily preventable and treatable causes, like diarrhea, pneumonia, or measles. Eleven million children each year—that’s about 20 times the total population of my State of Vermont. Twenty times. That’s each year.

The administration’s fiscal year 2008 budget request for these programs is \$373 million, but that’s compared to \$420 million in fiscal year 2007. An estimated 200 million women still lack access to family planning. Half a million yearly maternal deaths would be prevented with basic reproductive health services. The administration’s budget request for these programs is \$325 million, compared to \$436 million in fiscal year 2007.

What I worry about is we’re short-changing the programs that have a proven and long history of success. We’re also witnessing an alarming exodus of health professionals from developing countries, to higher-paying jobs in industrialized countries. The short- and long-term consequences of this brain drain, coupled with the deaths of countless health workers from AIDS, are staggering.

I think of a country as great and powerful as the United States, and a country that has great economic means, that spends far less on maternal and child health, and on family planning and reproductive health for the world’s 2 billion poorest people than we spend for the same purposes in the State of Vermont, with 625,000 people. We are far from being a wealthy State. I think most Vermonters would find that unacceptable, and I hope most Americans would find it unacceptable.

Dr. Hill, who is the Assistant USAID Administrator for Global Health, will describe the administration’s request.

Dr. Helene Gayle is currently the President of CARE, one of the country’s leading organizations fighting global poverty. She previously headed USAID’s HIV/AIDS programs, and at the Gates Foundation she was the Director of HIV, TB, and reproductive health. Dr. Gayle and I have had discussions before, and my wife has, too, with her, and we consider that a privilege.

Laurie Garrett is Senior Fellow for Global Health at the Council on Foreign Relations. Her Pulitzer Prize-winning book “The Coming Plague”, and her recent book “Betrayal of Trust, the Collapse of Global Public Health”, should be read by every Senator, and every House Member, for that matter.

Dr. Nils Daulaire is an old friend from my own State of Vermont, he’s President of the Global Health Council, and after serving as USAID’s Senior Health Advisor, he has been a friend and advisor to me and to others.

So why don’t we start with Dr. Hill, and place your full statement in the record. I wonder if you might sum up in 5 or 6 minutes. Then we will go to Dr. Gayle, and Ms. Garrett, then Dr. Daulaire.

SUMMARY STATEMENT OF DR. KENT HILL

Dr. HILL. Thank you, Chairman Leahy. I want to thank you, first of all, for holding this hearing, for your personal passion on these issues, which has been evident for so many years, and for the op-

portunity to testify with my esteemed colleagues and friends about these important issues.

As you're well aware, over many years USAID has contributed to impressive reductions in child and maternal mortality, and in helping women and couples achieve the size of family they desire. In the process, we have strengthened health systems, built the capacity of developing countries to reduce maternal and child deaths, and provided basic health services.

Maternal and child health, and family planning are often seen as separate and distinct, vertical and disconnected. But USAID is working very hard to integrate our programming, an approach that promotes efficiency and sustainability.

I will talk about maternal and child health, and family health planning separately, but I do so only for ease of presentation—as they are, in fact, implemented in an integrated fashion in our country programs.

Mothers and their young children bear a disproportionate share of the burden of diseases and preventable mortality in developing countries each year. More than 500,000 women die of complications of pregnancy and childbirth.

Women in sub-Saharan Africa have more than a 150-times greater risk of dying in childbirth over a lifetime than women in the United States. Our programs focus on interventions targeting the high mortality complications of pregnancy and birth that account for two-thirds of maternal mortality; this would be hemorrhage, hypertension, infections, anemia, and prolonged labor.

In USAID-assisted countries, skilled birth attendance has increased from an average of 37 percent in 1990 to 50 percent in 2005. Ten USAID-assisted countries have reduced maternal mortality by 33 percent on average over a decade, demonstrating that substantial progress is achievable.

In this chart, which I won't detail for you, you can see all the lines going down; these are all countries that, over 10 years, have seen a substantial decline in maternal mortality.

But, every year, 3.7 million newborns fail to survive even the first month of life. Newborn mortality has not been reduced as much as mortality among older infants and children, making it the unfinished agenda of child survival.

Let me now turn to child survival. Twenty years ago when USAID and UNICEF launched the Child Survival Revolution with the support of Congress, an estimated 15 million children in the developing world died every year. Without action, the number of deaths today would be more than 17 million each year.

Instead, as a result of global child survival efforts, by 2005, the number of child deaths was reduced to about 10.5 million—still far too many, but representing more than 6 million children's lives now being saved every year.

Over the past 20 years, the United States has committed more than \$6 billion to this effort, which has yielded public health successes at an unprecedented global scale. For example, almost 1 billion episodes of child diarrhea are treated with oral rehydration therapy each year, reducing deaths from diarrhea by more than half since 1990. More than 100 million children receive basic immunizations every year. More than 75 million cases of child pneu-

monia receive treatment. Child malnutrition has been reduced by 25 percent, from 1 in 3 to 1 in 4. An estimated 5 million children have been saved from death from paralysis through the polio eradication initiative. Finally, 500,000 children were saved last year by micro-nutrition supplementation.

These accomplishments are not attributable to USAID alone. Yet, as the graph to my left shows, in almost 30 countries with sustained USAID investment in child survival, we have seen significant reductions in mortality of children under the age of 5. The takeaway here is that the lines that are higher, in blue, are 1990, and the red shows what it's been reduced to. Wherever we've had a chance to work on these issues, we have been able to make a tremendous difference.

These are great accomplishments. But even greater challenges remain, such as saving the lives of the more than 10 million children who still die each year. I appreciate the chairman mentioning that fact—we must focus on the work left to be done.

As the next graph shows, over two-thirds of the remaining child deaths—6.5 million—are preventable. Now, I want to make a point here. You saw the 15 million that were dying in the Eighties; you can see how many would be dying today if we did not act and that is 17 million. You see the number, the 10.5 million that are still dying. Despite saving the lives of 6.5 million, the point I want to make is the next one. Of that 10.5 million, two-thirds of those deaths can be averted through proven interventions. Only 4 million of that 17 million represent things that would be very tough for us to get at.

Now, to be sure, a lot of that remaining work is in remote areas and would cost a bit more, but it is what we ought to aim at. By replicating our best practices, I hope some of this came through. Anyway, by replicating our best practices and new approaches and interventions, we believe that it is possible to achieve reductions of 25 percent in under 5 years and maternal mortality in most of these countries by 2011.

Now, let me turn to family planning for a minute. USAID and Congress's joint support for family planning has resulted in many successes since 1965. The use of modern family planning methods in the developing world has increased by a factor of four, from less than 10 percent to over 40 percent in the 28 countries with the largest USAID-sponsored programs. The average number of children, per family, has dropped from more than six to less than four. Enabling women and couples to determine the number and the timing of their births has been crucial in preventing child and maternal deaths, improving women's health, reducing abortion, preserving often scarce resources, and ensuring a better life for individuals and their communities.

To be sure, the United States is the largest bilateral donor and the acknowledged world leader in advancing and supporting voluntary family planning services.

Because of our success, we are now able to address those countries with the greatest need for family planning and have strategically shifted our resources to do so. Many countries in Africa, for example, are characterized by low rates of contraceptive use, high fertility, and high unmet need for voluntary family planning.

Between 1994 and 2000, there were nearly 39 million unintended pregnancies in Africa, and 24 percent of the women there expressed an unmet need for family planning. Nearly half of the world's maternal mortality occurs in Africa. As you can see in this particular chart, the unmet need is highest in sub-Saharan Africa, but it is very great in areas of Asia, the Middle East, Latin America and Central Asia. To be sure, we try to graduate countries, and we have done so successfully.

One final issue, perhaps, deserves our attention and that has to do with the "brain drain." One challenge that faces us is the movement of trained healthcare providers away from the developing countries into more developed countries, commonly referred to as a "brain drain."

USAID is trying to deal with this, and deal with health worker retention, in almost every country in which we work by strengthening in-service training, by reinforcing supervision systems so that they provide positive support to these workers, and by instituting quality improvement methods. This won't completely solve the problem, but this is what we have to work very hard on. There has been an increase in retention in places like Ghana, Namibia, and Uganda.

PREPARED STATEMENT

USAID-supported maternal-child health programs and family planning programs have a proven success record. Our support has reduced under-5 mortality in almost 30 countries and maternal mortality in 10 countries. USAID-supported family planning programs have been successful in increasing access to and use of modern contraceptives in all regions of the world. We now have program approaches and interventions that will allow us to build on these successes. We have the experience to do it, and with the continued support of Congress, we will be able to contribute to further gains in maternal and child health, and family planning throughout the developing world.

Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF DR. KENT R. HILL

INTRODUCTION

Chairman Leahy, Senator Gregg, and other distinguished members of the Committee, I would like to thank you for convening this important hearing and for inviting me to testify. U.S. development assistance has brought dramatic improvements in health, income advancement, and education to much of the developing world in the last 50 years. Average life expectancy in low and middle-income countries increased significantly during this same period. Good public health underpins these advances. Indeed, research findings and country experience have demonstrated an inextricable link between investments in improving individual and collective health status and a nation's economic development and performance. Many of these advances are due, in large part, to your continued support for maternal and child health and reproductive health programs.

USAID has a proven track record that has contributed to impressive reductions in child and maternal mortality and in helping women and couples achieve the size of families they desire in all regions of the world. Our support has helped to reduce under-five mortality in almost 30 countries and maternal mortality in ten countries. USAID-supported voluntary family planning programs have been successful in increasing access to and use of modern contraceptives in all regions of the world. In the process, we have strengthened health systems and built the capacity of devel-

oping country institutions to reduce preventable maternal and child deaths and provide basic health services. Your on-going commitment and support for maternal and child health has been and is critically important. As I often remind my staff, it is a great privilege to have work to do which matters, which saves lives of children and mothers, and it is you in the Congress whose compassion and support makes this work possible. And I want to express my great appreciation to you for this.

In talking to you about our work in improving maternal and child health (MCH) and family planning and reproductive health (FP/RH), I would like to focus on five key points:

- Our programs have a proven record of success.
- Despite real progress, our work is not done.
- We have pioneered program approaches and continually develop new interventions that have made and will make a difference in our progress.
- There are crucial opportunities to accelerate progress.
- We can take advantage of these opportunities by capitalizing on existing resources and by focusing on key countries.

Maternal and Child Health and Family Planning are often seen as separate and distinct—vertical and disconnected. But USAID is working to integrate our programming to the fullest extent possible, an approach which increases the affordability and sustainability of our global efforts to tackle these important public health challenges. For example, we are making substantial progress integrating our programs for women and children and building consolidated platforms such as antenatal care and community-based distribution approaches for family planning, child vaccinations, and other important health interventions. Most of our missions already support integrated MCH/FP programs and help to build broad-based health systems. These programs strengthen drug management, supervision, community outreach, and other critical systems needed to deliver basic public health services.

In all our health programs, including MCH and family planning and reproductive health, we work to build human and organizational capacity, including taking steps to address the so-called “brain drain.” Our programs help strengthen human resources to implement quality health care services through workforce planning, allocation, and utilization; strengthened systems for sustained health worker performance on the job; and training of health professionals. While, as a development agency, we cannot affect recruitment policies of the developed world, we are working on ways to keep health workers in their countries by working with governments on developing appropriate incentives, providing clear and equitable career paths, and offering continuing education and professional development. Other projects also work to strengthen management systems and increase leadership capacity.

By strengthening and building upon common service delivery platforms, we help to support the specific goals of new high-intensity initiatives like the President’s Emergency Plan for AIDS Relief (PEPFAR) and the President’s Malaria Initiative (PMI), and therefore advance countries’ ability to deliver the full range of health services.

I will talk about MCH and FP in separate sections, but I do so only for ease of presentation, as they are implemented more and more in a fully integrated fashion in country programs.

Using cost-effective tools and approaches, USAID and its international development partners have an unprecedented opportunity to accelerate progress in MCH and family planning, leading to further reductions in maternal and child mortality and unintended fertility.

MATERNAL, NEWBORN, AND CHILD SURVIVAL AND HEALTH

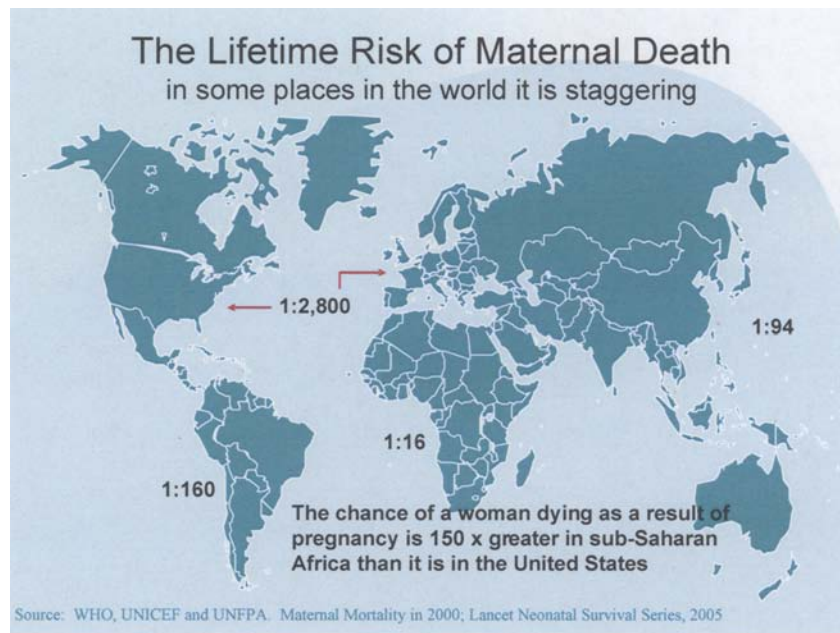
To achieve impact in maternal, newborn, and child health, USAID has consistently applied an approach that focuses on:

- working with countries having high burdens of maternal and child mortality and malnutrition;
- developing and delivering high impact maternal and child health interventions such as increasing skilled attendance at birth, control of post-partum hemorrhage, oral rehydration therapy (ORT), immunization, and vitamin A;
- bringing these interventions as close as possible to the families who need them;
- supporting results-oriented research to develop new interventions and strengthened programs;
- monitoring progress; and,
- strengthening the capacity of countries and communities to save the lives of their own women and children.

MATERNAL AND NEWBORN HEALTH

The burden of maternal and newborn mortality and disability

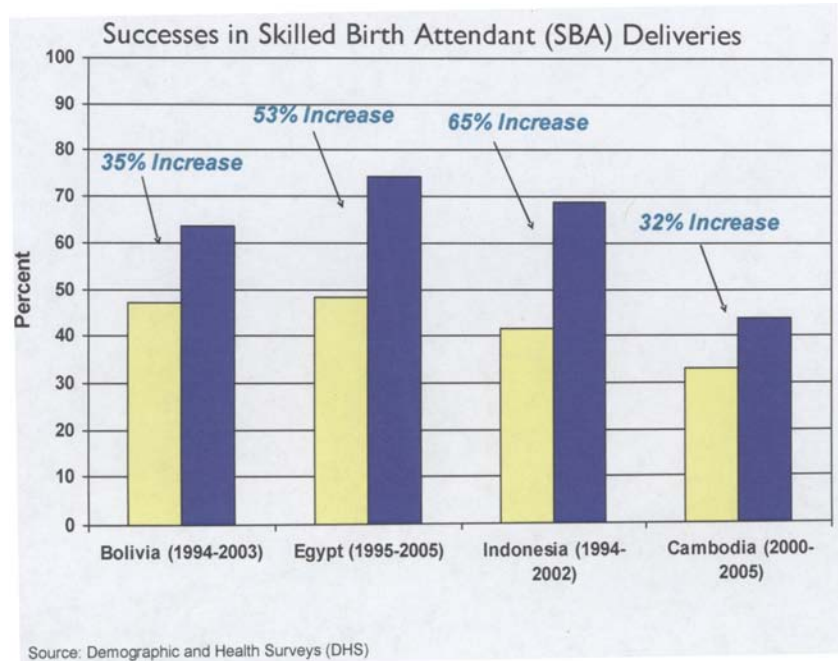
Each year more than 500,000 women die of complications of pregnancy and childbirth. Indeed, this is the second most common cause of death of women of reproductive age. While the number of deaths is disturbing enough, it is estimated that an additional 15–20 million women suffer debilitating consequences of pregnancy. Pregnancy-related mortality shows the greatest inequity of all health indicators between the developed and the developing worlds. For example, the one-in-16 chance over a lifetime that a woman in sub-Saharan Africa has of dying as a result of pregnancy is more than 150 times greater than the one-in-2,500 risk of a woman in the United States. In many Asian and Latin American countries, improved national averages often obscure the substantial risk of pregnancy that still remains for women living in poverty.



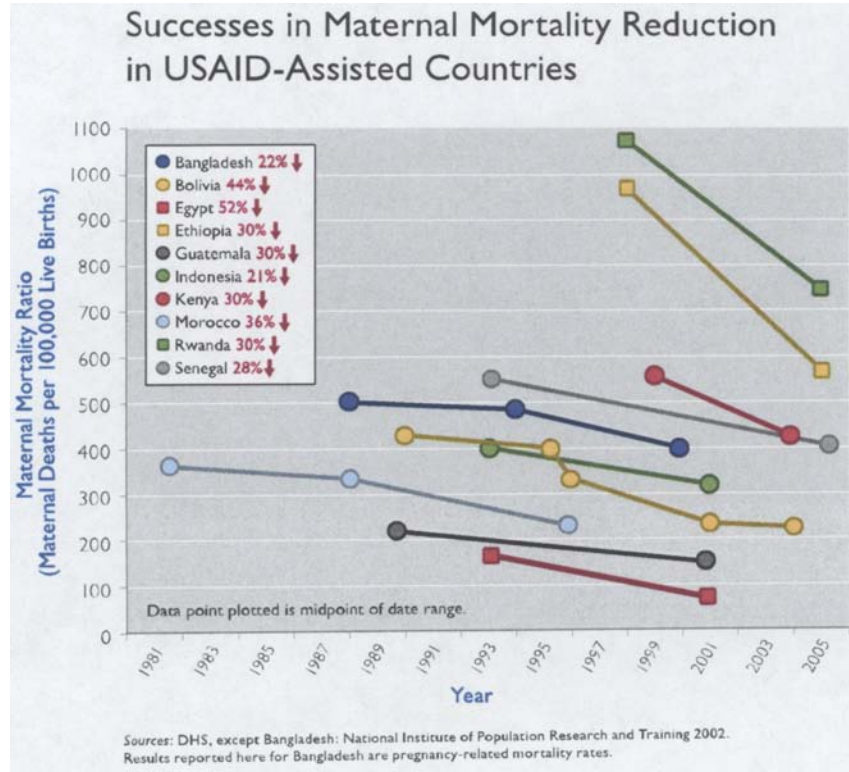
In addition, 3.7 million newborns die annually, failing to complete even the first month of life. As noted, newborn survival is inextricably linked to the health and nutritional status of the mother before and during pregnancy, as well as her care during labor and delivery. For this reason, USAID's programs always link mother and infant. As we make progress in reducing under-five mortality in general, the deaths of newborns in the first 28 days of life comprise a greater proportion of under-five and infant deaths. Globally, newborn mortality represents over one-third of all mortality among children under age five; however, in countries which have made greatest progress in child survival, newborn mortality can be more than half of the remaining deaths of infants and children. Thus, further progress in child survival must emphasize reduction of newborn deaths as a critically important element.

We have shown that substantial progress can be made in reducing maternal and newborn deaths

Despite the challenges faced in reducing maternal mortality, USAID has helped demonstrate that real progress can be made. Because maternal mortality is normally measured every 5–10 years, the globally-accepted proxy for maternal mortality is coverage at birth by skilled attendants. Across all USAID-assisted countries, skilled attendance has increased from an average of 37 percent in 1990 to 50 percent in 2005; the greatest progress has been in the Asia and Near East region, where coverage has more than doubled, increasing from 21 to 47 percent.



Most important, although global progress in reducing maternal deaths has generally been slow, ten USAID-assisted countries have achieved average reductions of maternal mortality of 33 percent over a decade.



Family planning also makes a substantial contribution to saving the lives of women by reducing the number of unintended pregnancies (each of which exposes a woman to risk) and by reducing abortions.

For newborn mortality reduction, USAID funded-research has documented a 33 percent decline in newborn mortality in Sylhet, Bangladesh with a package of home-based essential newborn care, and a 50 percent decline in Shivgarh, India with a similar program. Such programs have the potential to produce widespread impact on newborn survival in settings where most births take place at home, and they are now being scaled-up. In large controlled trials, community-based programs for detection and antibiotic treatment of life-threatening neonatal infections have also demonstrated the potential to reduce newborn mortality by almost half. We and other partners are replicating these trials and—if they are successful—will work with countries to apply the results in MCH programs. Neonatal interventions are relatively new in such programs, so we do not yet have examples of national-level mortality reduction. However, very recent analyses suggest that, as these interventions are scaled-up, we are beginning to see overall declines in newborn mortality at the global level.

This success can be scaled-up through expanding the use of proven, low-cost interventions

Our work demonstrates that many of the major causes of maternal death are substantially preventable and treatable with low-cost interventions. USAID has sharpened its focus on a set of highly-effective interventions targeting specific high-mortality complications of pregnancy and birth—hemorrhage, hypertension, infections, anemia, and prolonged labor. Together, these complications account for two-thirds of maternal mortality. Hemorrhage alone accounts for almost one-third, and USAID has been in the forefront of promoting “active management of the third stage of labor,” a highly-effective technique for preventing postpartum hemorrhage.

USAID has recognized that attention to the newborn is essential to success in our child survival programs. Increasing evidence and program experience indicate that

we can significantly reduce newborn mortality by combining focused antenatal care, a package of essential newborn care that enhances the survival of all infants, detection and treatment of serious neonatal infections, and community and facility-based approaches to special care for low birth weight babies. These approaches especially target newborn infection and birth asphyxia, which together account for more than 60 percent of newborn deaths. USAID is presently supporting introduction or expansion of newborn care programs based on these elements in 20 countries.

Accelerating progress

While we have been able to demonstrate important progress in maternal survival in a number of countries, we recognize that sub-Saharan Africa has generally made little progress and represents a special challenge. In response to this stagnation of progress in sub-Saharan Africa, USAID has initiated a new “Safe Birth Africa” initiative to increase skilled attendance at birth, beginning in Rwanda and Senegal. This initiative includes a focus on decreasing financial barriers for families so that they will be more likely to bring expectant mothers for skilled care at birth. It also involves expanding the mandate of frontline providers so that they can perform life-saving measures, along with quality improvement approaches to ensure that good clinical practice standards are systematically applied. USAID plans to expand this work to other high burden countries in order to increase skilled attendance at birth and coverage with life-saving care.

In all countries where maternal mortality is high, as well as in countries where there is wide disparity in birth outcomes between rich and poor, USAID is intensifying its work to spotlight specific life-saving interventions. To expand the use of “active management of the third stage of labor” to prevent postpartum hemorrhage, USAID launched the Prevention of Postpartum Hemorrhage Initiative in 2002. As of 2006, this approach had been introduced into MCH programs in 15 countries. In support of this intervention, we are working to get oxytocin, the drug that contracts the uterus to reduce bleeding after birth, into single-use UNIJECT injection devices, so that it can be provided by skilled birth attendants to women in peripheral health centers and homes. Because oxytocin is sensitive to heat, we are also exploring a time/temperature index to be put on the oxytocin vial, similar to the Vaccine Vial Monitor, to ensure that medication given to women is potent and that health workers do not unnecessarily discard oxytocin that has not been refrigerated.

In addition to further expansion of essential newborn care at birth, USAID is applying research results on treatment of sick newborns with antibiotics in the community. One step is testing the delivery of antibiotics in UNIJECT devices, so that treatment can be administered easily and safely by frontline-care providers. These newborn activities represent the combination of technical leadership and program application that USAID brings to MCH programs, working in partnership with other donors and recipient countries.

Reversing maternal disability

While our efforts continue to emphasize safe births and prevention of maternal mortality and disability, we are also providing compassionate care for women who suffer the devastating problem of obstetric fistula, a consequence of prolonged labor that can cause a woman to leak urine or feces, often resulting in divorce and social isolation. In 2004, USAID began a program to provide surgical treatment for such women. By the end of 2006, USAID was supporting eighteen fistula repair centers in eight countries of south Asia and sub-Saharan Africa. This support included physical upgrading of centers, training of surgeons, nurses and counselors, and mobilizing more than 5,000 community agents to change norms to delay pregnancy, reduce stigma of affected women, and promote use of family planning and maternity services. Over 2,000 surgeries have been completed.

CHILD SURVIVAL

Let me now turn to the child survival component of our MCH program. This is one of the cornerstone components of USAID’s health programming. Arguably, the quantifiable, at-scale results generated by the child survival and family planning programs helped build the confidence that paved the way for later investment in other global health programs, from TB and malaria to HIV/AIDS and Avian Influenza.

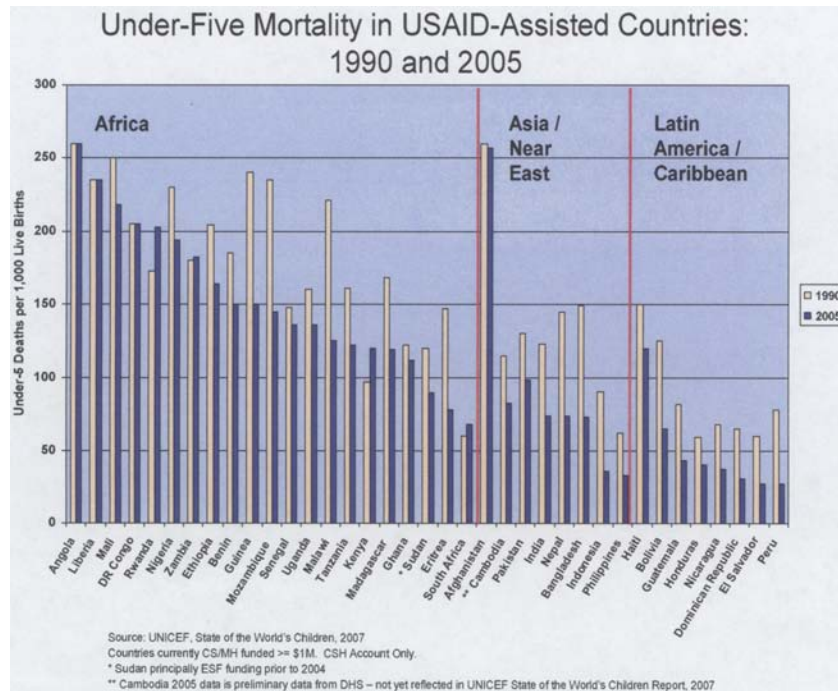
The child survival program has a proven record of success, achieved by delivering high-impact interventions. Twenty years ago, when USAID and UNICEF launched the “child survival revolution” with the support of Congress, an estimated 15 million children under age five in the developing world died from common, preventable diseases each year. Across the developing world, more than one in 10 children did not survive to see their fifth birthday; in some countries, it was one in five. If the same

rates of infant and child mortality existed today, the number of deaths would be more than 17 million each year. In contrast, for 2005 WHO and UNICEF estimate the number of children under five who died to have been reduced by more than one-third, to 10.5 million—this is still far too many preventable deaths, but it means that more than 6 million children's lives are now being saved every year through global child survival efforts.

Over the past 20 years, the United States has committed more than \$6 billion in support of USAID's global child survival efforts. In collaboration with international, national, and private sector partners, this effort has yielded public health successes on an unprecedented global scale:

- Almost a billion episodes of child diarrhea are treated with lifesaving ORT each year, reducing child deaths from diarrheal disease by more than 50 percent since 1990.
- More than 100 million children receive a set of basic immunizations each year, and tens of millions more receive supplemental immunizations against polio, measles, and other killer diseases.
- More than 75 million cases of infant and child pneumonia are taken for treatment by trained health workers.
- Malnutrition among children under age five has been reduced from one in three to one in four, a 25 percent reduction.
- The Polio Eradication initiative has saved an estimated five million children from death or paralysis.
- Half a million children are estimated to have been saved last year alone by micronutrient supplementation programs.

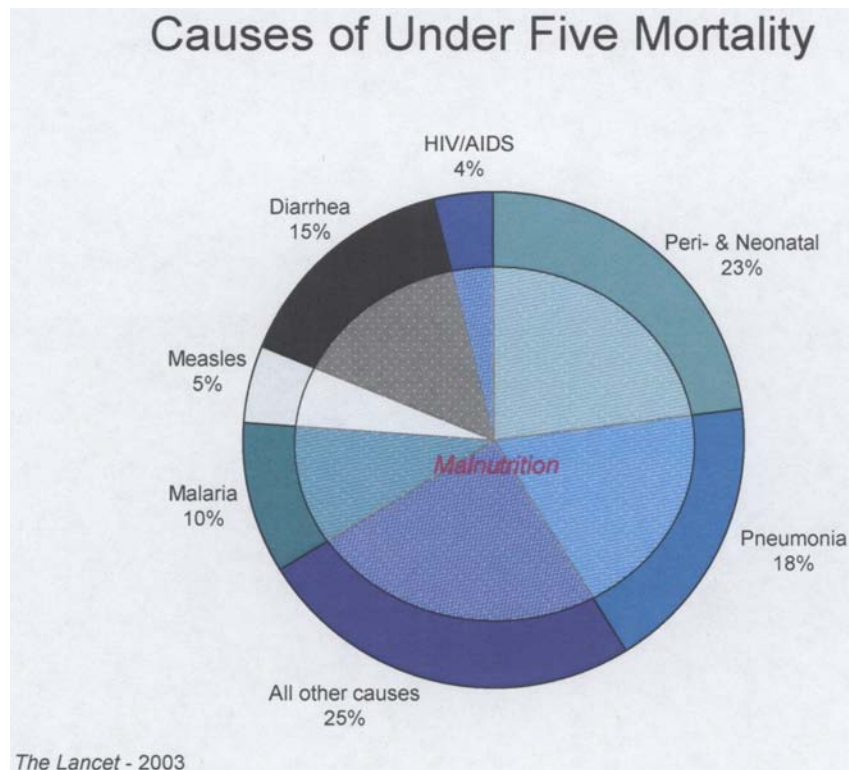
These accomplishments are not attributable to USAID alone. In virtually all countries where it carries out child survival and maternal health efforts, USAID invests its resources in ways that best interact with and leverage the contributions of other donors and of the country itself. Yet, as the attached graphic demonstrates, in almost all the countries where USAID made an average annual investment of at least \$1 million of child survival and maternal health funds each year during 2003–2005, we have seen significant reductions in mortality of children under age five.



Despite real progress, there is still a substantial job left to do

Sustaining this progress is itself a challenge, especially in the poorest countries with the weakest governments and health systems. A greater challenge is saving

the lives of the remaining 10.5 million children who still die each year. As shown in the graph from the 2003 authoritative review of Child Survival in the medical journal *The Lancet*, the causes of most of these child deaths continue to be malnutrition, the common infections of newborns and young children—diarrhea, pneumonia, infections of newborns, and, especially in Africa, malaria—and other life-threatening newborn conditions.¹



The *Lancet* analysis indicates that over two-thirds of these child deaths are preventable with interventions that are available or in the pipeline, including Oral Rehydration Therapy for dehydrating diarrheal illness; basic treatment of serious infections including pneumonia, malaria, and newborn sepsis; improved nutrition through breastfeeding, better child feeding practices, and management of acute malnutrition; and delivery of micronutrients, especially vitamin A and zinc, which improve children's ability to resist infections or help them fight them off when they occur.

Countries and the global community—with USAID playing an important leadership and program role—have been able to make substantial progress in delivering these high impact interventions. In addition to our substantial contributions to increased global coverage of interventions including immunization and oral rehydration therapy, there are several areas where USAID's contribution has been especially important. One of these is vitamin A. USAID supported a large part of the research demonstrating that vitamin A deficiency was widespread among young children in developing countries, and that preventing or repairing this deficiency could reduce overall mortality among children under age five by about one-fourth. Since then, integrating vitamin A supplementation into maternal, newborn, and child health programs has been one element of our work in most countries, working with UNICEF and the Canadian International Development Agency. One result is that by 2004 (the latest year with complete estimates) almost 70 percent of children

¹“All other causes” includes principally congenital anomalies, malignancies, all other infectious diseases, and injuries & accidents.

in the developing world had received at least one semi-annual dose of vitamin A supplementation, and almost 60 percent had received both doses needed each year for full protection. This achievement, combined with the increasing coverage of micronutrient fortification programs, of which we are also major supporters, means that tens of millions of children are receiving this important nutritional intervention.

Another area worth special comment is breastfeeding, because malnutrition underlies over half of all under-five child deaths. Breastfeeding is one of the highest impact child survival interventions, but improving feeding practices and children's nutrition is one of the most challenging areas of child survival. The global rate of improvement in exclusive breastfeeding of children for the first six months of life is less than one percent annually. However, USAID demonstrated that this challenge can be effectively addressed through a multi-pronged approach that incorporates community workers, media, health services, and policy changes. Using this approach, seven USAID-assisted countries have made at-scale improvements in exclusive breastfeeding of as much as 10 percentage points a year, well above the global trend. We are now working with partners to apply this experience in additional countries.

A major challenge is that many of the remaining child deaths are occurring in places where existing services often do not reach: in the poorest countries and countries emerging from conflict (like Sudan, Afghanistan, and the Democratic Republic of Congo), in the huge rural areas of countries like India and Pakistan, and increasingly in the slums of the developing world's rapidly growing urban population.

We have new program approaches and new interventions that will make additional impact

Our response to these challenges is not just to do more of the same. Bringing high impact interventions to additional children who need them requires new approaches. One of these is our increasing emphasis on community-based programs, learning from our extensive partnerships with U.S. Private Voluntary Organizations and our experience working with countries that have pioneered these approaches as part of their national program strategies.

One example is community treatment of pneumonia. At the end of the 1990s, our analyses showed that progress in delivering simple oral antibiotic treatment to children with pneumonia—a treatment that research had shown reduces mortality by at least one-third—had leveled off, with only about 50 per cent of children needing treatment actually getting it. The reason was that in most countries, this treatment was restricted to formal health facilities. With the support of USAID and others, a few innovative programs in Nepal, Honduras, and Pakistan had, however, implemented treatment through trained community health workers. In Nepal, this approach more than doubled the number of children receiving treatment for pneumonia, and did so with excellent quality of care. We documented and presented this program experience to international partners including WHO and UNICEF, with the result that this is now the recommended approach to pneumonia treatment for countries where formal health services fail to reach many children. USAID itself has helped introduce this approach in Africa, beginning in Senegal; six additional countries are now implementing this community-based approach, and several others are introducing it.

Similarly, we helped pioneer "Child Health Weeks," which are outreach approaches that bring vitamin A, immunization, insecticide-treated nets, and other health interventions to underserved areas. The aim is to get basic interventions to all children possible now, while building countries' systems and capacities to do so through more systematic approaches in the future.

Our program has also played a key role in developing, testing, and introducing new interventions and technologies that will save additional lives.

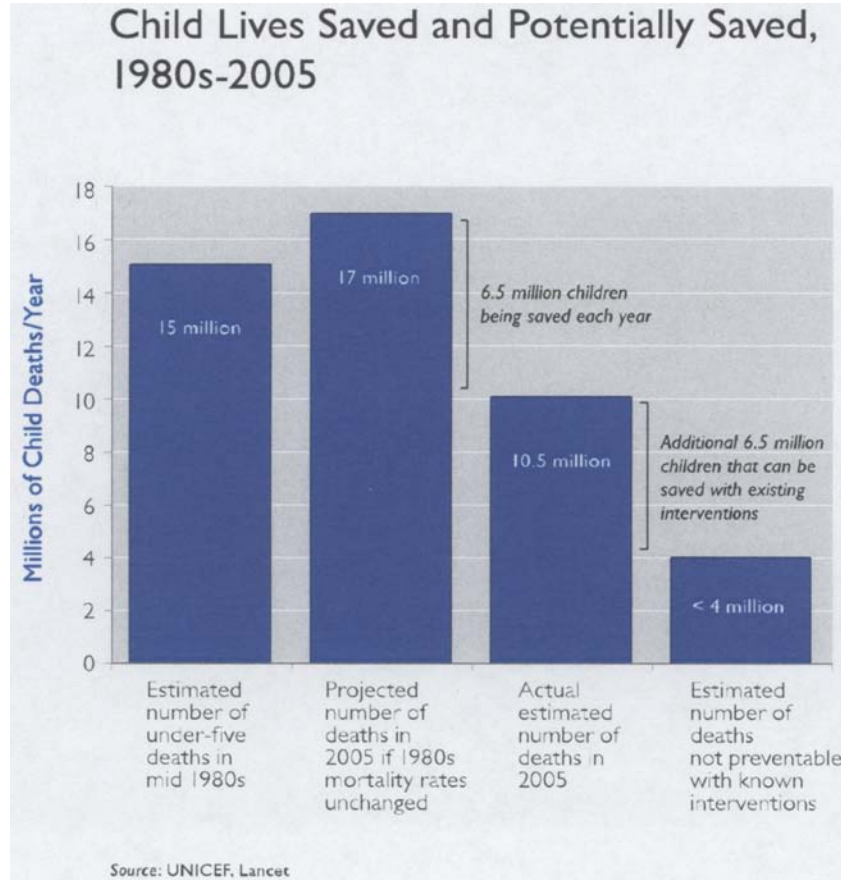
One of these is zinc treatment for child diarrheal illness. Research—much of it supported by USAID—has clearly shown that zinc treatment reduces the severity and duration of these illnesses; as a result, zinc is now recommended by WHO and UNICEF as part of the treatment of diarrheal illness, along with oral rehydration. To implement this recommendation, we are supporting introduction of zinc treatment in countries including India, Indonesia, and Tanzania. We are also collaborating with UNICEF and potential zinc supplement producers to assure the availability of safe, standardized, high quality products to supply these new programs.

Another example is "point-of-use" (POU) water disinfection technologies. These simple and cheap methods were first developed and used through collaboration of USAID and the Centers for Disease Control and Prevention (CDC) during cholera outbreaks in Latin America in the 1990s. Subsequent research showed that "POU" water treatment can reduce diarrheal and other water-transmitted illnesses by one-

fourth or more. Since then, we have collaboratively developed programs for their production and distribution in twelve countries. In some countries, like Indonesia, this is a purely private sector partnership, with the United States providing just the technical know-how. In poorer countries like Madagascar and Zambia, we are using social marketing approaches that involve some degree of subsidy to make sure they are available to low-income households (often most impacted by bad quality water). In emergencies—including the 2004 tsunami—these “POU” technologies have played an important part in reducing disease transmission, especially among children. Because over a billion people in the developing world still live without access to safe water, these simple technologies can play an important role in reducing the disease burden on young children.

One other important new intervention is “community therapeutic care” (CTC), an innovative approach to therapeutic feeding and medical treatment of children with acute severe malnutrition in field environments with few human and medical resources. Many families impacted by emergencies cannot reach therapeutic centers, or cannot spare the family members needed to accompany a child in such a center for the days or weeks required to reverse malnutrition. In response, USAID has worked with non-government agencies and international relief organizations to develop this approach for children with severe acute malnutrition. A central innovation of CTC is the use of ready-to-use therapeutic foods such as Plumpy’nut, an energy-dense peanut paste. Plumpy’nut can be safely given by parents in the home, eliminating the need for a prolonged stay in feeding centers. CTC has already been introduced in several African countries as well as in Bangladesh. USAID is now working with WHO and UNICEF to endorse CTC as the standard of care in all countries for managing acute malnutrition.

My testimony on child survival may best be summarized by the following graph.



As I noted early in my statement, global efforts to improve Child Survival now result in the saving of over 6 million children's lives each year. This is a tremendous accomplishment, and one that needs to be sustained. At the same time, authoritative analyses tell us that we can save at least an equal number of those children who still are dying unnecessarily, using the tools and program experience that are already available to us. It is our intention to do our utmost with the resources provided to us to accomplish this important goal.

There is now an important opportunity to accelerate progress in maternal, newborn, and child survival

During the past few years, we have seen new commitments that we believe can lead to a "second wave" of global effort to improve maternal and child survival. There are new resources appearing from private sector partners like the Bill and Melinda Gates Foundation, from bilateral donors like the U.K. and Norway, and from multilateral partners including UNICEF. One of the largest increases is through funding from the International Funding Facility of the U.K. and Europe for immunization, through the Global Alliance for Vaccines and Immunization (GAVI). The European Union is providing substantial amounts of new funding to several countries to support maternal mortality reduction.

The Millennium Development Goals (MDGs) are stimulating increased international attention to the need for accelerated progress to reach the child and maternal survival goals; this attention is producing new international cooperation, like the inter-agency "Countdown 2015" collaboration to monitor and report on progress toward these goals and the inter-agency "Partnership for Maternal, Newborn, and Child Health." The African Union has recently developed and approved a new

“Framework for Accelerated Progress in Child Survival” as well as a new reproductive health regional strategy; work on a similar regional framework for maternal, newborn, and child health is beginning in Asia.

Partly in response to the MDGs, and partly in response to their understanding of the need to accelerate social development, some countries themselves are substantially increasing their own investments in maternal and child health. One impressive example is India, whose Prime Ministerial “National Rural Health Mission” and new second stage Reproductive and Child Health Project represent the commitment of over \$2 billion a year to improved health status among the underserved. There is also increasing public visibility, including ongoing attention by The Lancet to child survival, maternal and newborn health, and global public health in general.

Against this background, we have a strategy to use our existing resources to substantially reduce maternal, newborn, and child mortality and malnutrition in a focused set of high burden countries

To take advantage of this opportunity, we plan to focus resources on a set of countries which have the highest need, in terms of both the magnitude and the severity of under-five and maternal mortality; that is, countries that have the largest number of preventable deaths as well as the highest rates of mortality. We will focus on countries that have strong commitment to improving MCH and the capacity to program resources effectively, and wherever possible, offer the potential for interaction with other USG investments, including the President’s Malaria Initiative and GAVI funding. We believe it is possible to achieve reductions of 25 percent in under-five and maternal mortality in most of these countries by 2011; and in many of them, we also believe it possible to achieve reductions of 15 percent in the number of children who are below weight-for-age.

We will do this by applying our successful lessons from the past and the new approaches and interventions we now have. We will work with countries and partners to identify the most important maternal, newborn, and child health and nutrition problems, and the most important interventions that can be implemented at scale to address those problems. We will support those interventions through appropriate integrated delivery approaches, involving the public health system, private sector providers, NGOs, and community-based approaches. We will identify the best fit of our resources alongside those of other initiatives, partners, and the countries themselves. We will join with countries and partners to monitor progress in terms of improved coverage, and ultimately improved survival, health, and nutrition status. And we will identify and invest in developing the capacity of communities, health systems, and human resources to achieve and sustain progress.

Our belief that such rapid progress is possible is not hypothetical. It is based on the real recent performance of a number of USAID-assisted countries, shown in the following table.

RAPID REDUCTION IN UNDER-5 MORTALITY BY USAID-ASSISTED COUNTRIES

Country	Under-5 mortality (deaths/ 1,000 births)	Year	To	Under-5 mortality (deaths/ 1,000 births)	Year	Percent reduction
Bangladesh	116	1996	→	88	2004	24
Cambodia	124	2000	→	83	2005	33
Ethiopia	166	2000	→	123	2005	26
Malawi	189	2000	→	133	2004	30
Madagascar	164	1997	→	94	2003	41
Nepal	139	1996	→	91	2001	23
Tanzania	147	1999	→	112	2004	24

Most of these recipient countries are still very poor. Yet they have demonstrated that through commitment to effective programs and to bringing needed services to children and families, rapid progress can indeed be achieved. These achievements, along with those I have already presented in maternal mortality reduction, give us confidence that our continuing work with countries and partners can produce equally important results during the next 5 years.

Finally, the question comes up of determining when a country is ready to go on its own in MCH, without continued USAID support—the “graduation” question. We plan to approach this process in a phased approach. By looking at past experiences and current conditions; progress on key indicators including under five and maternal mortality; and such factors as equity of health status, we will develop and apply graduation criteria and analyze each country receiving MCH assistance against

these criteria. Based on this analysis, we will identify countries that have strong chances of successfully graduating in the near term. We will then work with the country to focus our program investments and to address institutionalization of health systems, including human resources, financing, drug management, quality improvement, and information systems and evaluation, that will promote sustainable capacity. This process will produce a 3- to 5-year phase down plan developed with the country. In this way, we plan to have a responsible process for dealing with countries that make good progress, while at the same time keeping our eye on the unmet need of countries with continued high burdens.

FAMILY PLANNING AND REPRODUCTIVE HEALTH

The United States is firmly committed to promoting the reproductive health and well-being of women and families around the world. Over the years, USAID has become the acknowledged leader in implementing the U.S.'s global voluntary family planning assistance program. Our portfolio of interventions strongly emphasizes method choice and includes a mix of contraceptives that are country appropriate and can include long-acting methods, injectibles, and fertility awareness options, sometimes known as natural family planning. We are fully committed to informed choice and to ensuring that family planning users know the risks and benefits of the method they choose. USAID supports these contraceptive options with a range of activities to advance service delivery, the quality of the medical care and counseling, and the effectiveness and sustainability of family planning programs. Our work includes helping to create an enabling environment for family planning programs, support for research on improved contraceptive methods, training of health care providers, and helping nations create a commodities logistics system.

Since our program began in 1965, the use of modern family planning methods in the developing world, excluding China, has increased by a factor of four, from less than 10 percent to 42 percent. In the 28 countries with the largest USAID-supported programs, the average number of children per family has dropped from more than 6 to 3.4. Moreover, abortion rates have declined in Eastern Europe and Eurasia. Using Romania as an example, abortion was the primary method of family planning through the early 1990s, with women having as many as four abortions in their lifetime. When modern contraceptive use more than doubled between 1993 and 1999, the abortion rate decreased by 35 percent and abortion-related maternal mortality dropped by more than 80 percent.

USAID's program is unique in a number of ways: it is comprehensive in its support (with activities ranging from contraceptive development, to community-based delivery of FP/RH services), it works through multiple channels of delivery (including private sector and NGO sector—while other donors tend to focus on public sector and increasingly on basket funding), and it has on-the-ground health experts that direct, oversee, and manage bilateral activities. We have pioneered program approaches and continually develop new interventions that will accelerate progress.

- Our efforts have made family planning services accessible to people in hard-to-reach areas. These include door-to-door distribution, clinic-based services and employee-based programs.
- USAID introduced contraceptive social marketing. These programs privatize contraceptive distribution and marketing, using the commercial pharmaceutical sector to reach more people at lower cost, decreasing countries' dependence on the donor community for supply and distribution of affordable commodities.
- We support the world's largest information/education programs that use in-country media and local entertainment outlets, performers, and groups to educate millions of people about contraception, child care, and health.
- USAID created and standardized the largest repository of fertility and family health information, the Demographic and Health Survey, which is used by policy makers and program managers in developing countries and the donor community to assess impact and make informed decisions about program design and management.
- We are the major donor in developing new and improved contraceptive methods and supporting research to improve existing contraceptive technology. These innovations provide couples in developing countries with superior and safe methods of family planning. Americans also profit from USAID-supported improvements, such as the introduction of low-dose oral contraceptives and the female condom.
- USAID has always given high priority to providing contraceptive supplies and related assistance in logistics and quality assurance. USAID provides 50 to 70 percent of all contraceptive assistance in the developing world and nearly all logistics management assistance.

We have successfully graduated numerous countries and others with mature programs are on the road towards graduation from family planning assistance, allowing us to respond to countries where unmet need is still critical. Currently we are strategically shifting family planning resources towards sub Saharan Africa. The fiscal year 2008 budget request targets 43 percent of family planning resources to the region.

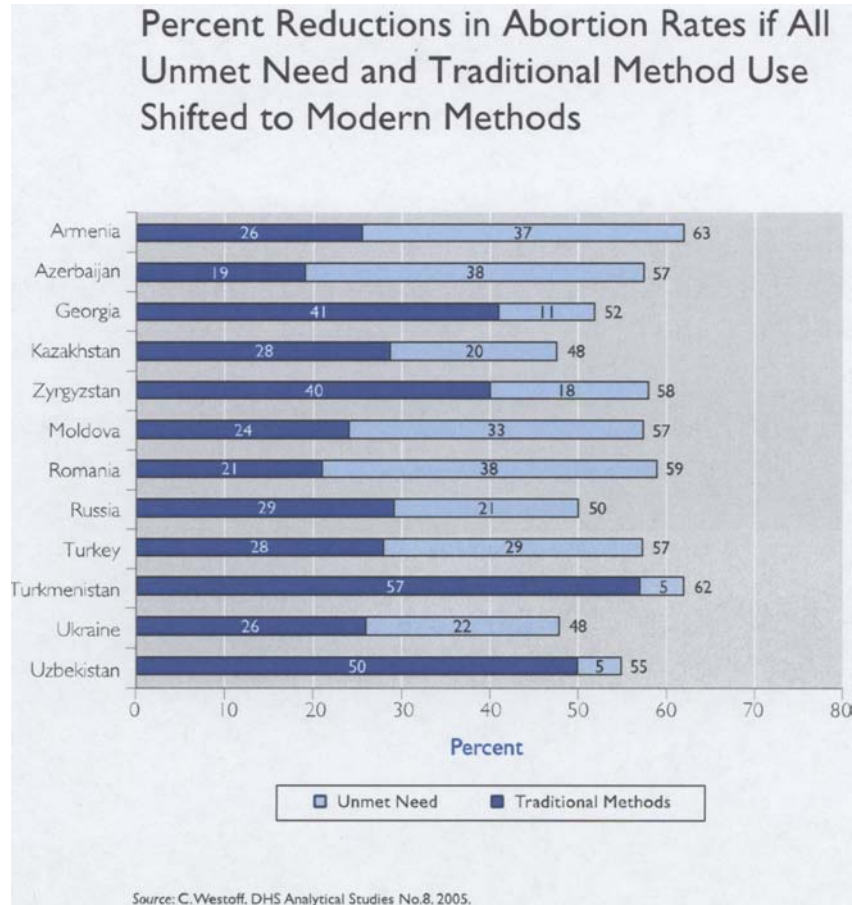
Graduation of several countries from U.S. government assistance for family planning also is an indicator of USAID's success. In addition to the overall measures of lowering fertility and high levels of contraceptive use across income groups, successful graduation from family planning assistance requires that a number of specific elements are in place, including national commitment to family planning, adequate financing for programs, contraceptive security, sustainable leadership and technical skills, availability of high quality information, appropriate engagement of the private sector, and attention to access of underserved populations.

The Asian countries of Indonesia, Thailand, and Turkey have graduated from family planning assistance. Egypt will graduate by 2010. In Latin America, Brazil, Mexico, Colombia, and Ecuador are no longer receiving family planning assistance. Family planning programs in the Dominican Republic, Jamaica, and Paraguay are on track to graduate from USAID family planning assistance in the next few years. In Europe and Eurasia, programs in Kazakhstan, Kyrgyzstan, Moldova, Romania, Russia, and Uzbekistan have successfully increased contraceptive use and thereby reduced abortion.

As the world's largest bilateral donor, USAID delivers assistance in more than 60 countries through bilateral and regional programs. Each year, U.S. reproductive health programs deliver services to more than 20 million women, including clinical services as well as non-clinic based approaches to deliver services to the hard-to-reach. The Agency works directly with hundreds of non-governmental organization partners, the majority of which are foreign NGOs, to provide technical assistance to family planning programs at the local level. Assistance is also provided through U.S.-based universities, and private sector companies and organizations.

Despite our strong record of achievement, our work is not done. Women's health burden remains great:

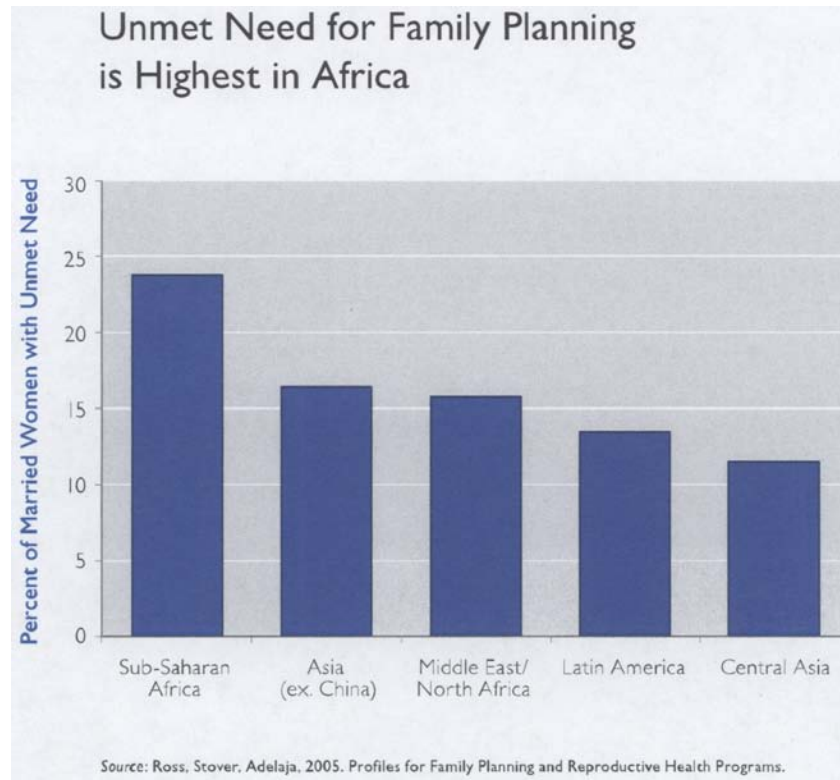
- More than 500,000 women die annually from maternal causes, almost all of them in the developing world. Family planning helps reduce maternal mortality by reducing unintended pregnancy and the perceived need by many to resort to abortion, as well as by ensuring that the proper spacing is achieved between wanted pregnancies.
- Of these annual pregnancy-related deaths worldwide, about 13 percent (or 78,000) are related to complications of unsafe abortion. The United States believes one of the best ways to prevent abortion is by providing high-quality voluntary family planning services and providing assistance to prevent repeat abortions through the use of family planning. As a result, USAID-supported family planning programs in Eastern Europe have resulted in significant declines in abortion as contraceptive use has increased.



Unmet need continues to be a challenge

There remains a great need—and desire—for family planning. While more than 400 million women in the developing world are now using family planning, there are an estimated 137 million with an unmet need and 64 million using traditional, rather than modern, contraceptive methods.

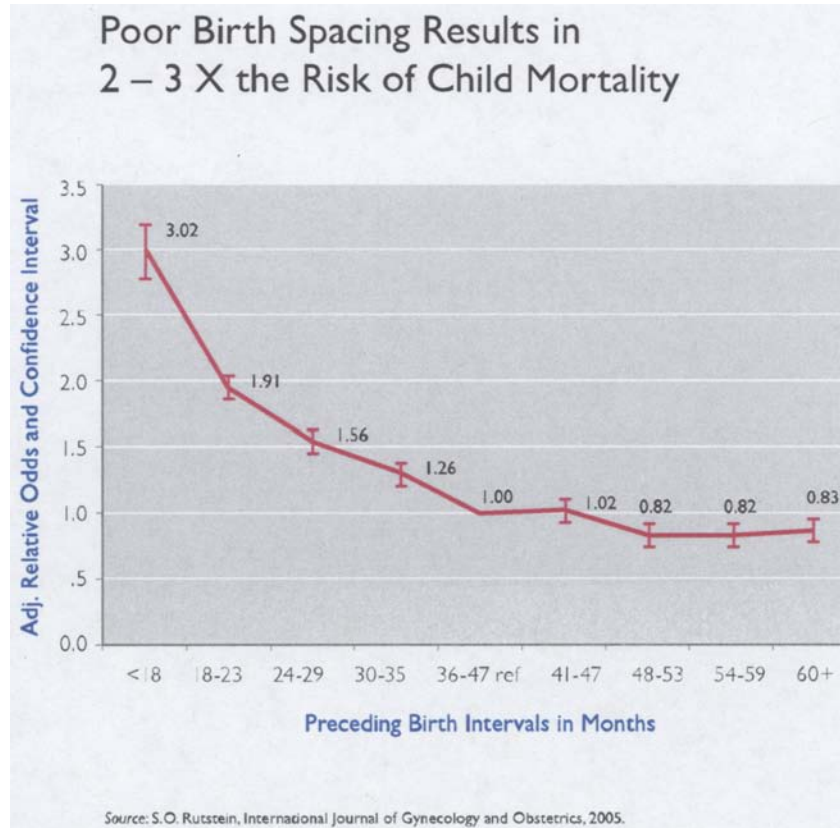
Unmet need is particularly great in Africa. There, nearly half of the world's maternal mortality occurs and on average only 15 percent of married women use contraceptive methods. The desired fertility in the region is considerably lower than actual fertility, which remains high at 5–7 children per women in most countries. Although demographic and health surveys reveal that a high proportion of women and men—well more than half in many African countries—said they wanted to wait at least 2 years before having their next child or that they had the size family they wanted, there were, in fact, nearly 39 million unintended pregnancies in Africa between 1994 and 2000—clear evidence of the need for family planning. In too many African countries, attention to family planning has declined and donor and government funding has stagnated.



There are significant opportunities to accelerate progress

Though family planning is primarily viewed through the prism of women's health, research has shown that the women themselves view family planning in broader terms. They believe that having smaller families and spacing births not only improves health, but increases opportunities for education as well as for greater domestic and community involvement. Their instincts are right—women are critical to achieving development goals.

The impact of family planning on children's lives often is not considered. More than 10.5 million children under the age of 5 die every year in the developing world. Many of these deaths can be reduced by expanding access to family planning. Births that are spaced too close together, too early, or too late in a woman's life decrease both the mother's and infant's chances for survival. Children born too close together face increased risk of contracting and dying from infectious diseases and can suffer high rates of malnutrition. By helping women space births at least 3 years apart and bear children during their healthiest years, family planning could prevent many of these deaths. Research done in 2003 has shown that if women had not had any births at intervals less than 24 months, almost two million deaths to children under age 5 could have been averted. Additional deaths also would have been averted if mothers had spaced births at least 36 months apart.



The education of women is critical. Research has shown a strong link between girls' literacy and many other development objectives. Women who start families before age 20 are less likely to finish school than those who wait even a few years. Early and frequent childbearing can limit women's education. The importance of family planning in allowing women to stay in school goes beyond the women themselves. Mother's education is an important predictor of children's educational attainment and therefore of their future earnings. Conversely, education also improves use of family planning services. Studies show that women with as little as 2 or 3 years of formal schooling are significantly more likely to use reliable family planning methods than women with no formal education.

Employment allows women to earn income, which increases life options and involvement in the community. Family planning users often are more likely than non-users to take advantage of work opportunities. In addition, high levels of female labor force participation and higher wages for women are associated with smaller family size. As women enjoy greater economic opportunities and as family income rises, they spend more money on the education and nutrition of their children, continuing the cycle of opportunity. This in part explain why micro-finance is such a powerful tool today in development, both economic and social development.

Working with key international partners, family planning has now come to embrace a broader mandate.

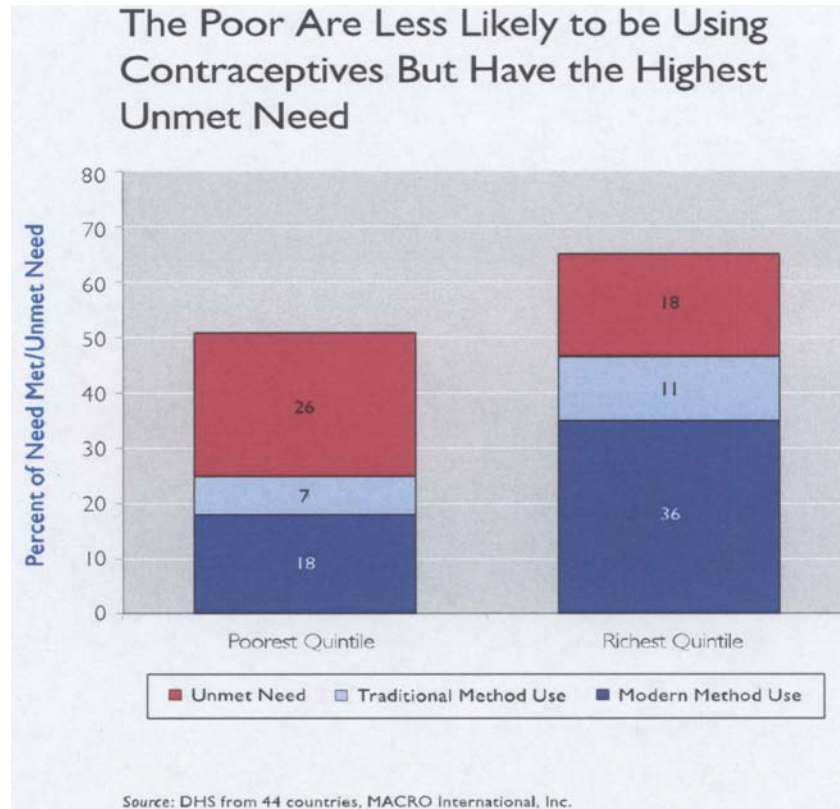
- Ensuring that family planning is introduced into policies, programs, and services whenever there is a natural link. At the country level, this aims to ensure that there are no missed “good” opportunities.
- Recognizing that program development is situation specific, USAID will draw on the best current programmatic evidence to determine priority interventions and conduct further research to identify the best approaches that can be scaled up.

- Programming for impact: underscoring that opportunities and challenges differ in each country, local data and experiences will be used to help determine which approach to strengthening family planning will have the greatest impact.
 - Exploring strategies to reduce the large inequities—among the poor and hard to reach—in family planning access, method choice, and information among population subgroups.
 - Promoting national ownership and responsibility for the strengthening of family planning services despite current shifts in priorities and economic environments.
 - Ensuring optimal allocation of resources and strengthening of technical and managerial capacity as prerequisites for sustainable family planning programs.
 - Multisectoral approaches: strengthening linkages between health and other sectors so as to make use of all available entry points and opportunities to introduce family planning and address unmet need.
- USAID also has several special initiatives that broaden our work beyond “bread and butter” family planning programs. Among them:
- Reproductive health programs can be effective partners in HIV/AIDS prevention in developing countries. Incorporating education and counseling to promote condom use and other HIV/AIDS prevention methods in reproductive health programs can contribute to the fight to stop the spread of the epidemic. In addition, research shows that adding family planning into programs for the prevention of mother to child transmission of HIV (PMTCT) can greatly reduce the number of orphans while saving the lives of thousands of women and children.
 - Slowing the rate of population growth gives nations time to develop sustainable solutions to other development challenges. Access to reproductive health programs can contribute to preserving the world’s endangered environments by conserving scarce resources. Currently, more than 505 million people live in areas already experiencing chronic water shortages, a number that is expected to increase to 2.4 billion in the next 20 years. In addition, in the past 3 decades, growing populations have caused 10 percent of the world’s agricultural land to be lost due to residential and industrial needs. When reproductive health and family planning information are widely available and accessible, couples are better able to achieve their desired family size. This not only directly impacts the well being of families, but also contributes to both better management and conservation of natural resources.
 - The Office of Population and Reproductive Health has other special initiatives that address women’s health and status in society in innovative ways. These include working to bring about the abandonment of female genital cutting; increasing male involvement in family planning; gender violence; health equity which is how to ensure the poorest of the poor receive our services and programs; the reproductive health of refugees; the availability and sustainability of health commodities including contraceptives and condoms; and repositioning family planning as attention and resources to this crucial health intervention are sometimes neglected because of the understandable focus on such pressing health concerns as HIV/AIDS.

We can take advantage of these opportunities by capitalizing on existing resources and by focusing on key countries

USAID must address the great unmet need for family planning that continues to exist by:

- Maximizing access to good-quality services;
- Emphasizing communication;
- Focusing on men as well as women;
- Increasing our efforts to reach the very poor.



Also, family planning programs can develop better links with other services for new mothers and young children. Making common cause among such programs should be efficient because unmet need is concentrated among women who are pregnant unintentionally or who have recently given birth. We are developing approaches to address high levels of need in the poorest countries of the world. I have spoken of the profound need to expand our programs in Africa. Significant need also continues to exist in low contraceptive prevalence countries in Asia, such as Afghanistan, Cambodia, northern India, Pakistan, and Yemen, where prevalence is below 25 percent. In Latin America, USAID is concentrating its family planning resources in Guatemala, Bolivia, and Haiti where contraceptive use ranges from 22 to 35 percent.

However, USAID's targeted countries, particularly those in Africa, face a number of challenges in their quest to meet the family planning needs of its population. Among these are weak health systems, poor access to family planning commodities, the non-involvement of men in family planning interventions, and inefficient utilization of resources.

We also must employ interventions that will ensure family planning remains on the agenda of all sectors and continue improving access to all services. Other interventions include strengthening national capacity for sustainable programs, strengthening community participation, addressing family planning needs of vulnerable populations, and conducting operations research.

BUILDING CAPACITY WHILE SAVING LIVES

Our programs are aimed at achieving impact in saving the lives and improving the health of mothers and children. At the same time, we are a development agency—we therefore believe that everything we do should also build the capacity of countries and people to improve their own situations. To do this, our program investments aim to build integrated, sustainable approaches and develop key compo-

nents of the health systems countries need to deliver all basic health services. Let me touch on several specific areas of particular importance.

Integration

As I noted in my introduction, we recognize the important positive connections among voluntary family planning and birth spacing, good maternal care, and child health and nutrition programs in terms of health outcomes for women and children. To achieve these synergies, and at the same time build strong and cost-effective platforms for broader primary health care services, we implement integrated maternal-child health and family planning programs in almost all countries where we work.

One example is the delivery of antenatal, delivery, and post-partum care services. We know that good antenatal care—including promotion of adequate nutrition and anemia prevention, detection and treatment of infections and complications, and planning for adequate care at birth—can have important positive effects on outcomes for both women and their babies. It is also an important opportunity to begin discussing family planning options for women who want to delay a future pregnancy, which will help preserve their health and that of their infants. In areas where malaria is prevalent, we promote antenatal care as a key opportunity to provide antimalarial treatment and promote use of insecticide-treated nets, protecting women from anemia and illness, and protecting their unborn children from the low birth weight caused by maternal malaria infection. In high HIV environments, antenatal care is one of the best opportunities to offer testing and counseling services and identify mothers requiring anti-retroviral treatment or prevention of mother-to-child transmission of HIV (PMTCT). High quality care at delivery is one of the most critical interventions for the survival and health of mothers and newborns; it prevents or resolves life-threatening complications and provides essential immediate care to newborns who need it. It also provides a key opportunity for PMTCT. We are now increasingly extending care into the post-partum period, allowing for the detection and treatment of serious maternal and newborn complications and better promotion of breastfeeding and essential newborn care. This post-partum period is also one of the most important opportunities to counsel women in voluntary family planning methods. Thus, in practice, our MCH-FP programs are delivered holistically, giving greater impact, greater sustainability, and greater support for other important health programs.

The same is true for the community-based program approaches that we support in areas where formal health services cannot meet all basic health needs. We support outreach programs that often deliver multiple interventions including immunization of mothers and children, vitamin A and iron supplements, insecticide-treated bednet distribution, and antenatal care. We support community health worker and social marketing programs that often deliver family planning advice and commodities, condoms and information for HIV prevention, oral rehydration, and increasingly treatment for malaria and other child illnesses. We support programs for women's groups that promote family planning, breastfeeding and child nutrition, and birth planning; these groups often engage in income-generating and micro-finance activities that enhance their effectiveness and influence in their communities.

Such integrated approaches reap the benefits of synergies among specific interventions and parts of our health programs. They also maximize the potential for sustainability by making the most effective use of each contact of services with families.

Strengthening Health Systems

Achieving impact while investing in health systems is challenging, given the low levels of resources available in most countries with high fertility and mortality, and thus the huge number of potential claims on additional resources. As has been seen in some countries where a broad focus on health systems has replaced a clear focus on health outcomes (Zambia in the 1990s, Ghana recently), investment in systems not linked to outcomes will not necessarily improve the survival and health of women and children. USAID is recognized as a major contributor to approaches that strengthen key elements of health systems, while doing so in ways that link these investments to outcomes. Our efforts have made important contributions in several critical dimensions of health systems, including:

Quality improvement.—USAID has been a global leader in the application of modern quality improvement approaches to health and family planning programs in developing countries. The Agency's "Maximizing Access and Quality" initiative has impacted every country we assist and has even further reach. For example, quality improvement approaches have led to the development of a Global Handbook that documents protocols and best practices for family planning services. This document,

which has been translated into eight languages, is published by the WHO and is used by USAID funded programs in more than 60 countries through WHO's reach. Quality improvement approaches have led to the development of "standards of care" for maternal and child health services and the use of these standards to measure and improve quality of services. These approaches are being used to improve basic services, such as reducing delays in management of life-threatening obstetric complications and improving care of severely ill children; in hospitals in Nicaragua, this approach reduced child deaths from malaria by 86 percent, from diarrhea by 57 percent, and by pneumonia by 38 percent.

Drug and Commodity Supply and Logistics.—USAID is a major supporter of systems that provide, distribute, and track contraceptive commodities and other essential public health commodities. Last year, shipments for contraceptives and condoms were provided to 52 countries and additionally, many of these countries also received anti-retroviral drugs and diagnostics. Additionally, technical assistance pharmaceutical management and/or supply chain strengthening was provided in at least 39 countries. For maternal and child health, where most drugs and commodities are parts of routine health systems, efforts have focused on making MCH drugs parts of "tracer" systems that evaluate the functioning of overall logistics systems by tracking the availability and use of selected drugs. For new products, like zinc for treatment of diarrhea, USAID works with the U.S. Pharmacopoeia to develop quality and manufacturing standards needed to allow international procurement by UNICEF and countries, and also works with manufacturers to assure adequate quantity and quality of products required by programs.

Financing.—USAID worked with WHO and the World Bank to develop "National Health Accounts," tools that for the first time allow country governments and their partners to see all the resources available for health—not just from government, but from donors and from families themselves. These important decision-making tools are now being utilized in approximately 70 countries, with direct USAID assistance to 26 of these. Another important area of USAID engagement is support for "risk pooling" approaches that remove cost barriers to care. One important approach is technical assistance to community-based insurance plans, or "mutuelles," which is an innovative way to finance health care in Africa. These community-based plans now exist in about a dozen African countries; in Rwanda alone, where USAID is providing assistance, by 2006 there were over 300 community-based plans serving over 3.1 million people (or 40 percent of the population).

Human Resources and "Brain Drain"

One challenge which faces virtually all of our health programs is the movement of trained health care providers away from developing countries and into more developed countries—commonly referred to as the "brain drain."

As a development agency, USAID has little influence on the policies of wealthy countries that receive emigrating health professionals, the demand side of this issue. Our strategy in this area focuses on retaining trained providers in their countries' health systems, the supply side of the issue.

The in-country factors affecting the healthcare human resource supply are more than a shortage of workers or absenteeism due to training. Low salaries and poor working conditions drive workers to other types of employment even within their own country. Weak human resource management systems do not support workers. The recruitment, deployment and promotion of workers are often politicized and not performance-based. Additionally, an inappropriate alignment of the workforce means that tasks are often assigned to the wrong types of workers causing overly burdensome workloads.

USAID is actively engaged in multiple efforts within countries to increase retention and contribute to greater worker productivity. Specifically, in almost every country where USAID has programs, USAID is developing and/or strengthening in-service training systems to provide workers with the knowledge and skills needed to do their jobs; often utilizing innovative learning approaches, such as distance learning and self-directed learning, in order to minimize the time workers are out of post for training. USAID is collaborating with Ministries of Health to strengthen supervision systems so that they provide positive support to workers, and is instituting quality improvement methodologies that encourage workers to take an active role in ensuring the quality of the services they provide.

Keeping workers on the job is essential to increasing the number of workers. In five African countries, several approaches are being tested and implemented in USAID programs, including: piloting financial and non-financial incentives; developing clear and equitable careers paths; offering continuing education and professional development. There has been an increased retention of workers in Ghana,

Namibia and Uganda with improvements to the working environments and benefits such as transportation reimbursements.

Improved management and modern quality improvement approaches are affordable and have the potential to improve dramatically the way health systems manage their human resources, helping to retain workers. USAID provides support for workforce planning and rationalization in six countries. Human resource (HR) managers are assisted to develop the skills needed to scan and analyze HR data, determine relevant policy questions, and make policies to ensure that workers with appropriate skills are available when and where they are needed. In several countries, HR Directorates in Ministries of Health are being strengthened through training of key staff and through secondments of HR experts who then share their knowledge and skills so as to create strong HR managers. In a number of countries, USAID is assisting MOHs, licensing and certification bodies, private-sector organizations and other stakeholders to develop the human resource information systems they need.

Sustainability

Sustainability of MCH and family planning programs is a critical goal of USAID. To this end, we aim to:

- Increase funding by host governments of national MCH/FP programs.
- Increase diversification and long-term funding of MCH/FP activities by donors and international organizations.
- Improve the quality of national MCH/FP activities and establish critical masses of health workers competent in MCH/FP interventions.
- Achieve high and sustained national coverage rates for MCH/FP interventions.
- Reduce inequities in access to health care and in health outcomes.
- Involve community, voluntary and private sector organizations in MCH/FP activities at national, district and community levels.

With progress on each of these elements, MCH/FP programs will become more effective and sustainable. More importantly, national leaders, health managers, and the general population will expect and demand effective, nationwide MCH/FP programs and will help to make this happen. There will also develop an international mandate that no country will suffer stock-outs of essential MCH/FP commodities. This has already occurred for child vaccines. Finally, national governments and international donors and organizations will be judged by the quality and coverage of their MCH/FP programs.

There is now evidence that USAID, other donors, and national governments are helping to make important progress on all these key elements of sustainability. For example:

- There is evidence that host government contributions to MCH/FP programs have increased in real dollar terms over the past 10 years.
- Coverage rates for key MCH/FP interventions are steadily increasing. For example, the worldwide coverage for the third dose of the DPT vaccine is 74 percent and for vitamin A is over 50 percent.
- As highlighted above, there are major new commitments of international partners to MCH/FP and some new funding mechanisms that promise long-term support for the sub-sector.

Complementary Funding and Global Development Alliances

USAID funds have complemented over \$4.6 billion from partners to advance development objectives worldwide.

USAID provides leadership in the Reproductive Health Supplies Coalition (RHSC), a coalition of 21 members—multinational organizations, bilateral and private foundation donors, low and moderate income country governments, civil society, and the private sector—that works to increase political commitment and public and private financial resources, as well as more effective use of resources to ensure sustained access to quality reproductive health supplies through public, private, and commercial sectors.

USAID supports the Global Alliance for Improved Nutrition (GAIN) to accelerate micronutrient fortification programs globally and to mobilize the private sector to deliver fortified products to the poor. The Alliance includes 14 governments; three donors; the United Nations; the private sector including Procter and Gamble, Unilever, Danonoe, and Heinz; development agencies such as the World Bank; education and training institutions; and civil society. The Alliance has supported 15 national food fortification programs projected to reach 446 million people.

Between fiscal year 2001 and fiscal year 2006, USAID contributed \$352.5 million to GAVI as one of the largest government donors representing nearly 20 percent of GAVI's funding. Since GAVI's inception in 1999, the Gates Foundation combined with a variety of donor governments has contributed a total of \$1.9 billion.

CONCLUSION

USAID sees improved health for the world's poorest people not only as a moral imperative but also as a pragmatic investment of U.S. funding for peace, security, and world-wide economic growth. USAID-supported MCH/FP programs have a proven record of success which is helping to save lives and build health systems. Our support has helped to reduce under-five mortality in almost 30 countries and maternal mortality in ten countries. USAID-supported family planning programs have been successful in increasing access to and use of modern contraceptives in all regions of the world. We now have program approaches and new interventions that will allow us to build on these successes and make additional progress. We also have valuable experience in delivering these interventions and approaches in a fully integrated and cost-effective manner at district, health center, and community levels so that these life-saving services can be affordable and sustainable. With the continued support of Congress, we will be able to contribute to further gains in maternal and child health and family planning throughout the developing world. Thank you for your support.

Senator LEAHY. Thank you very much. I read your testimony last night, and I know your personal commitment to this.

Dr. Gayle, thank you for being here. I've heard you speak many times before, and I just appreciate you taking the time here.

STATEMENT OF DR. HELENE GAYLE, PRESIDENT, COOPERATIVE FOR ASSISTANCE AND RELIEF EVERYWHERE

Dr. GAYLE. Thank you very much, Chairman Leahy, and thank you for having us here, and thank you for your consistent and passionate commitment to these issues.

I'm really honored to be here in front of you, and with the other witnesses here who, also, as you said, bring a lot of experience, and are very distinguished in this area.

I represent the organization CARE, which is committed to reducing global poverty, and have broadened from what I was doing in the past, focusing on health issues, because I believe strongly that poor health and poverty are very intertwined. And so, that's the context in which our work is done, where we feel that health has such an important contribution to our work in eradicating global poverty, and vice versa.

I'm not going to go through a lot of the facts, I think people have put those on the table, and I think have very eloquently pointed out that there are very unacceptable gaps in maternal mortality and child health and child survival around the world, and important unmet needs in family planning and contraception.

Also, I think the testimony that Dr. Hill gave pointed out the incredible advances that the U.S. Government, particularly through USAID, has made, and the real leadership role that we have played around the world on these important health issues. I think—if nothing else—I would say our message is that we would like to continue to see the United States play that kind of global leadership role in these issues, and that we have an opportunity to continue to build on these incredible advances that have already been made.

So, important progress has been made, but I think as has been pointed out, there is still a lot that remains, and that in some ways, we've become complacent about basic public health issues, like maternal and child health, and family planning as we have moved to focus on very key, specialized issues, like HIV and malaria and others, where we have seen incredible, and important, growth. But, I think, in the meantime it means that we've kind of

let our eyes off of some of these very basic and core issues, where we have such a basis for continuing to build.

Let me just make a few points from our experience, and then some recommendations. I'll make first, four points. First of all, that technical solutions alone will not bring about lasting results. Obviously, it's important to continue to look for better and new technologies, but for health impacts to be sustainable, they must also address the underlying causes of poor health, and the reasons why people don't have access to these technologies to begin with, and making sure that we have a focus on that.

So, for example, we had a project in Peru, in an area in rural Peru, where CARE found that only one-third of women who needed obstetrical services actually accessed them. I mean, this is in an area where mortality—maternal mortality was about 15 times higher than it is here in the United States.

But, by working to understand the needs of the rural women, for example, giving respectful attention from staff to speak to women in local language, provide access to transportation, provide basic facilities that met the needs of those women, and by connecting health workers at various levels, and really looking at, how do you distribute health services at different levels, and removing blocks to emergency referral care and services, CARE was able to reduce maternal mortality by half.

So, even if the services are there, if they're not appropriate, if they don't take local circumstances into consideration, the needs won't be met. And so, we have to look at coupling our technology with ways to get it to people that are appropriate.

Second, we learn that by being marginalized and powerless within a society, is often closely linked to one's ability to access healthcare services, and is linked to overall health status of the most vulnerable. The—less power means that people have less voice, and often less access to services. In most developing countries, women and youth are the least powerful, and the roots of health problems they face are often hidden.

An example, from our work in Bangladesh, where CARE is working on a Safe Motherhood Initiative, we found that domestic violence was really the—one of the greatest risks that women faced during pregnancy, and that if we didn't address the domestic violence issues, and look at women's needs in a holistic fashion, that our obstetrical care programs didn't work. We were able to modify our approach to incorporate efforts to prevent violence against women in our Safe Motherhood Work, and found that our programs were much more effective and were actually able to reduce maternal mortality.

Third, and Dr. Hill mentioned this as well, we've learned that dividing public health into various categories—while it may be convenient for allocating donor funding—that it really doesn't, is not the most effective way to approach health services.

So, for example, maternal mortality and child survival are not separate activities. In some countries, if the mother dies, the risk of death for her child and her children under 5 doubles or triples. Sometimes, as with HIV/AIDS, and reproductive health, we not only pursue them as separate issues, but also build parallel sys-

tems to develop services, so that we're not wasting resources that make our services more ineffective.

So, by providing HIV information and testing to reach women, within the context of reproductive health, we obviously have much more effective programs.

Then finally, we at CARE are dismayed by what seems to be a tendency to move away from evidence-based programs within the U.S. foreign assistance programs, particularly as they relate to sex and reproductive health. So, for example, the abstinence until marriage earmark in the Global AIDS Act of 2001 is a concern, whether or not it impedes the ability to have comprehensive and evidence-based programs that focus on the best programs and the epidemiology within local circumstances.

Let me just wrap up by saying a few things that we would like to recommend. First, investing more, and more strategically in reducing maternal mortality and enhancing child survival. Over the past 5 years, the commitment to maternal and child health funding has not kept pace with the unmet needs or growth in other international health accounts, as has been well outlined. We urge you to provide strong funding levels for international maternal and child health programs. In particular, CARE strongly supports the U.S. Fair Share levels that Nils Daulaire will outline shortly.

Second, a recommitment to the importance of family planning. This is one of the most cost-effective investments the United States can make in the future of women, children, communities and nations. The administration's budget request proposes a 23 percent cut in family planning funding for 2008, noting that these efforts do not require as much U.S. investment, because they've been so successful. Well, this is obviously the case, and we urge you to, not only restore those cuts, but to increase funding levels for international family planning.

Also like to draw attention to the reports that the World Bank's new Health, Nutrition, Population Strategy that's going to be discussed here in Washington, appears to diminish their commitment to family planning, and we see this as an area of great concern.

Third, commit to evidence-based reproductive health programming for youth. With the impending youth bulge that is going to occur, that's anticipated by demographers, the needs for reproductive health services that are tailored to the conditions for youth are critical and important.

Fourth, removing any legal barriers that get in the way of evidence-based, effective programming in reproductive health and HIV. As mentioned, our concerns about any particular earmarks that don't provide for comprehensive funding.

PREPARED STATEMENT

Finally, investing more globally in global health and development, in ways that help to strengthen the health infrastructure. As is previously noted, the importance of building a workforce capacity, without that, and without a strong commitment to the overall health infrastructure, none of these individual programs will be successful.

[The statement follows:]

PREPARED STATEMENT OF DR. HELENE GAYLE

Chairman Leahy, Senator Gregg, Subcommittee Members. I am honored to be here, discussing issues that are vital to the future of millions of people. For the past 61 years, CARE has worked across a spectrum of poverty-fighting arenas—from child survival to clean water, and from basic education to HIV/AIDS. We believe that poor health and extreme poverty are intertwined, and that one cannot be overcome if the other is neglected. That is why we work on a broad range of health issues, including maternal and child health, infectious diseases, ranging from HIV/AIDS to avian influenza, and reproductive health. My testimony today reflects CARE's experience in thousands of poor communities throughout the world over the course of half a century.

We are here today to consider some basic, yet heart-wrenching, questions. Why does one woman die every minute of every day from complications related to pregnancy and childbirth? (99 percent of these deaths occur in developing countries, and the reasons are basic: women hemorrhage to death, they lack access to antibiotics to prevent infection or they don't have the option of a cesarean section.) Why do 10.5 million children die each year before their fifth birthday (greater than the number of adults who die from AIDS, malaria and tuberculosis combined), when most of these deaths are preventable? Why, at a time when contraception is cheap and effective, do 120 million couples have an unmet need for family planning? Why, when some 70 percent of young women in Africa become sexually-active as adolescents and more than 20 percent have their first child by 18, do we hesitate to confront that reality?

Despite the magnitude of unmet need that remains, the U.S. Government can be proud of the difference it has made in the global health arena.¹ For example, American leadership in family planning has contributed to some impressive gains. In 1960, only 10 percent of married women in developing countries used modern contraception. By 2000, this figure had risen to 60 percent—and the average number of births per woman had fallen from six to three. More broadly, in the past 50 years, life expectancy in the developing world has risen from 40 to 65 years, and a child's chance of living to the age of five has doubled.

We have learned that large-scale improvements in public health are achievable. We have seen the real difference made in lives saved and economies strengthened. Sri Lanka's long-term commitment to a range of safe motherhood services has, over four decades, decreased maternal mortality from 486 to 24 deaths per 100,000 live births. In Egypt, a national campaign that promoted the use of oral rehydration therapy helped reduce infant diarrheal deaths by 82 percent between 1982 and 1987. China's national tuberculosis program helped reduce TB prevalence by 40 percent between 1990 and 2000, and translated directly into social and economic benefits: for each dollar invested in the program, \$60 was generated in savings on treatment costs and increased earning power of healthy people.²

Even though important progress has been made, the need remains enormous and urgent. The knowledge and experience we have already gained position us to invest resources more wisely—and the partnerships formed reflect greater capacity to turn resources into effective action. Yet, even as efforts to fight HIV and AIDS are receiving greater attention and resources (as they should), we are becoming too complacent about basic public health issues like maternal and child health, family planning, and adolescent reproductive health. And we are not paying sufficient attention to building the strong, accountable health systems (both infrastructure and workforce) required to support any health interventions, be it neonatal care, family planning or AIDS treatment. Ultimately, CARE's experience in poor communities strongly supports both the need for increased investment of resources, and better use of those resources.

Our first, and most important, insight has been that "technical solutions" alone don't bring lasting results. For health impacts to be sustainable, they must address underlying causes of poor health, be tailored to each cultural context and be broadly owned by local communities. For example, emergency obstetric care is vital to reducing maternal mortality, but lasting improvements in maternal health are not achieved simply by making such care available.

In rural Ayacucho, in Peru, CARE found that only one-third of women who needed obstetric services actually accessed them; and of every 100,000 live births, 240

¹A recent analysis of six projects funded by USAID's Child Survival and Health Grants Program indicates that mortality of children under 5 has been reduced by approximately 8 percent in project areas due to interventions supported by the program.

²Center for Global Development, *Millions Saved: Proven Successes in Global Health*, 2007 edition.

women died (by contrast, in the United States, this ratio is 17 of every 100,000 live births). CARE did not approach this challenge as an exclusively medical problem. Rather, we tried to understand the health system in Ayacucho as a unique social institution embedded in a specific community. We found that women did not seek care because health center staff often did not speak Quechua (the local language) and women did not feel welcome there. Health center staff felt inferior to regional hospital staff and often felt ridiculed by them when they referred an emergency case; they also did not have means to transport emergency cases. Hospital staff were frustrated that emergency referrals were often misdiagnosed or came too late to save women's lives.

By working to understand the needs of rural women and health workers at various levels, and removing blocks in the emergency referral system, CARE has helped to reduce maternal mortality in Ayacucho by half. Now, all health centers in our project area and the regional hospital have Quechua-speaking staff, a friendly environment, and culturally-appropriate options for childbirth (such as vertical birthing chairs, preferred in Ayacucho). Emergency obstetric protocols were developed by collaboration among doctors, nurses, midwives and Ministry of Health staff, drawing from ideas and realities of rural health personnel. As a result of competency-based training provided to rural health personnel and cost-effective resources like two-way radios and ambulances, women's conditions can now be diagnosed more accurately and they can be transported to hospitals quickly. Currently, 75 percent of women who need obstetric services can access them. A key aspect of CARE's approach was building broad political will to address the exceedingly high maternal mortality rate. As a result of Ayacucho's success, in January 2007, the Peruvian Minister of Health established new national clinical guidelines for obstetric emergencies, based on those developed by this project.

Second, CARE has learned that individual and collective empowerment has much to do with access to health care services, accountability of health systems and the ultimate health status of the most vulnerable. Less power means less voice and less access, and that inequity results in poorer health. In most developing countries, women and youth are the least powerful, and their needs are often neglected. The roots of the health problems they face are often hidden, but we must strive to uncover, understand and address them.

In Bangladesh, where CARE had been implementing a safe motherhood initiative, we concluded that domestic violence was one of the greatest risks that women faced during pregnancy. Even the best prenatal, obstetric and post-partum care could not fully help these women, unless the phenomenon of rampant violence against women was also addressed. CARE's modified approach, of incorporating efforts to prevent and respond to violence against women into safe motherhood work, holds much more promise not only of helping women have healthier pregnancies but also of securing safer societies. In isolated southern Maniema province, in the Democratic Republic of Congo, local health systems were devastated by war and women had encountered brutal violence and rape in war-time. Many women had married young and had multiple pregnancies, and CARE's promotion of family planning and birth spacing was welcomed as a respite—a chance to control at least one aspect of their bodies and lives. A young woman named Anifa told us: "Normally, I'd be pregnant again, and able only to concentrate on my new baby, and not my other children. Now that I can control my pregnancies, I can be sure that my kids go to school. I will see a better life through my children."

Third, we have learned that dividing public health into various categories may be convenient for allocating donor funding, but these inherently related issues have to be understood and addressed within a broader and more integrated context. For example, we talk about maternal mortality and child survival as separate issues, but we know that they cannot be separated. In some countries, if a mother dies, the risk of death for her children under 5 doubles or triples. When women cannot space the births of their children, both they and their children are less likely to be healthy. Sometimes—as with HIV/AIDS and reproductive health—we not only pursue them as separate issues, but also build parallel systems to deliver services. This is ultimately a less efficient investment of resources as well as a barrier to effectiveness—for example, HIV information and testing could reach many more women, in ways that are potentially less stigmatizing, if they were made available through family planning or prenatal care services. Even within CARE, which is considerably less complex than the U.S. government, maintaining a system-wide view and integrating across various sectors and technical specialties is a challenge. We are constantly trying to do better.

Finally, we at CARE have been dismayed to witness the increasing politicization of U.S. foreign assistance related to programs that deal in any way with sex or re-

production.³ For example, the abstinence-until-marriage earmark in the Global AIDS Act of 2003 requires that one-third of all HIV prevention funding be spent on abstinence programs. Administrative guidance issued by the Office of the Global AIDS Coordinator translates this earmark into a requirement that fully two-thirds of funding for preventing sexual transmission of HIV be spent on abstinence and fidelity programs. It also permits condoms to be provided only to sexually-active youth, with little recognition of the fact that those who are not sexually-active today may be so tomorrow (no matter how much we urge them to be abstinent) due to economic pressures driving transactional sex or vulnerability to sexual violence. Although the earmark governs only the U.S. Government's HIV/AIDS responses, the message that A and B are the priorities have strongly influenced U.S. reproductive health programs—especially those working with adolescents. The spillover effect is that reproductive health programs targeting youth are increasingly constrained in terms of the information and services they can provide—as a result, U.S. funded programs are less effective at protecting young people from pregnancy, or HIV and other STDs.

From CARE's perspective, family planning and women's reproductive health have become too politicized and are losing ground on the U.S. global health agenda. The Mexico City Policy, in particular, is symbolic of this politicization and has caused much difficulty for implementers of reproductive health programs. Much of the work of international NGOs like CARE is done in partnership with local organizations. In the reproductive health field, many of the best local organizations provide comprehensive family planning services, sometimes including counseling on safe abortion. The Mexico City Policy prohibits organizations like CARE from working with such organizations, and in some cases, prevents us from working with the only organizations that are capable of providing the most basic family planning services. Thus, it diminishes not just the availability of these services but also their quality.

These are just some of CARE's experiences that are pertinent to the matters at hand today. Given what we have learned, I want to urge you to consider the following:

First, invest more—and more strategically—in reducing maternal mortality and child survival. On this, the twentieth anniversary of the global safe motherhood movement, the slow progress on reducing maternal mortality undermines America's deeply-held commitment to strengthening health and well-being throughout the world. We must gather the will and do much better. Over the past 5 years, United States commitments to maternal and child health funding have not kept pace either with unmet needs or with increasing growth in other international health accounts. I urge you to provide strong funding levels for international maternal and child health programs in 2008. In particular, CARE strongly supports the requested United States "fair share" levels outlined by Nils Daulaire on behalf of the Global Health Council for maternal and child health, and I urge their adoption by this committee in the coming appropriations process.

The vast majority of maternal deaths are due to hemorrhage, infection and obstructed labor and can be easily prevented or treated. For each of the half a million women who die of complications during pregnancy and childbirth, 30 others are injured, many of them in seriously disabling and socially devastating ways. Women with obstetric fistulas, for example, are often abandoned by their families and condemned to isolation. The lifetime risk of dying in pregnancy or childbirth is 1 in 16 for women in developing countries, as compared to 1 in 2,800 in developed countries. In Afghanistan, where 95 percent of women deliver their babies at home, without a skilled attendant on hand, the lifetime risk of dying in pregnancy or childbirth is 1 in 6.

We must invest more strategically, not only to strengthen and expand all levels of health care (particularly speed of emergency referrals and quality of emergency obstetric care) but also to remove barriers to women's access to health systems and services. We must strive to ensure that all pregnant women have a skilled attendant at delivery; this need not be a doctor, but must be someone who can diagnose complications, administer drugs to manage them, and (where possible) refer women to emergency obstetric care. Drugs like misoprostol, which are cheap and easy to administer, can help strengthen contractions and control post-partum haemorrhage, and could ultimately increase the effectiveness of skilled attendants and reduce maternal mortality.

³In addition to the abstinence-until-marriage earmark and the Mexico City Policy, increased politicization is also evident in the requirement of the Global AIDS Act of 2003 that organizations must adopt a policy opposing prostitution and sex trafficking in order to be eligible for HIV/AIDS funding authorized under the act.

Maternal health and child survival go together—this is why funding to reduce maternal mortality is such a smart investment. Four million babies die each year in the first month of their life; that is roughly the equivalent of all babies born in the United States in 1 year. Simple interventions like promoting breastfeeding, oral rehydration therapy, vaccinations, clean water, and insecticide-treated bed nets could make a huge impact on child survival, even where health systems are weak. USAID's Child Survival and Health Grants Program has done excellent work in this area and deserves your increased support.⁴ In partnership with this program, CARE has worked in the extremely poor far-west region in Nepal to reduce under-5 mortality by 53 percent. A key approach in Nepal was community case management, whereby volunteers are trained to provide an antibiotic to treat pneumonia. This intervention effectively prevents pneumonia deaths in communities where many families do not have the money or means of transportation to see a doctor in time. In settings as diverse as Nepal, Mozambique and Sierra Leone, CARE has achieved significant reductions in under-5 mortality for a cost per life saved of between \$740 and \$980.

Second, recommit to the importance of family planning. Access to family planning services represents one of the most cost-effective investments the United States can make in the future of women, children, communities and nations. Family planning returns enormous value in improved health outcomes, economic development and national security. Yet, the administration's budget request proposes a 23 percent cut in family planning funding for 2008. I urge you to not only restore the cut, but also provide significantly increased funding levels for international family planning, as the request outlined by the Global Health Council indicates.

The ability to decide when, with whom and how often to have children is key not only to the individual futures of women and girls, but also to the development of countries struggling to overcome poverty. Although methods for avoiding unwanted pregnancies are cheap and effective, every year, 80 million women have unintended pregnancies. The unmet need for contraception is closely related to maternal mortality: if every woman who needed contraception had access to it, an estimated 20–35 percent of maternal deaths could be averted. However, with other health priorities taking precedence, family planning seems to be declining in importance. Between 1995 and 2003, donor support for family planning (commodities and service delivery) fell from \$560 million to \$460 million.

The rationale provided by the administration for the 23 percent cut in family planning funds for 2008 is that these efforts have been so successful that they don't require as much U.S. investment going forward. Unfortunately, that is hardly the case. Large pockets of substantial unmet need still remain, and gains are reversed all too quickly when they are not reinforced. Kenya, for example, had a fertility rate of about eight births per woman in the 1960s. After decades of investment in family planning services, the fertility rate had fallen to 4.8 births per woman in 1998. In the past few years, however, attention has shifted away from family planning. As a result, availability of contraceptives at health facilities declined, as did outreach services. Sadly, between 1998 and 2003, the proportion of births reported by mothers as unwanted rose from 11 percent to 21 percent.

On a related note, I also want to register our concern about recent reports that the World Bank's draft health, nutrition and population strategy omits any commitments to family planning. This strategy is under review as we speak today and, if approved, could deal a serious blow to reproductive health programs all over the world. CARE urges the United States, as the largest shareholder of the World Bank, to underscore the importance of family planning and reproductive health in achieving progress on multiple fronts, including economic development, basic education and public health.

Third, commit to evidence-based reproductive health programming for youth that is grounded in sound public health practice. The impending "youth bulge", anticipated by demographers, demands that we act effectively, realistically and rapidly. Sadly, the new strategic framework for U.S. foreign assistance fails to highlight the specific needs of youth, and places their critical needs underneath a broader umbrella. Although the intent to "mainstream" youth reproductive health is laudable, our observation is that fewer and fewer U.S. funding opportunities are addressing youth issues—and we believe this important issue may be falling through the cracks.

Young people, especially girls and young women, are vulnerable on many fronts, but especially when it comes to pregnancy, STDs and HIV/AIDS. They are less likely than older people to protect themselves, either because they are not aware of—

⁴The analysis referenced in footnote 1 indicates that these projects saved more than 16,000 lives of children under 5.

or cannot access—the protective measures that can keep them safe or because they have less control over the terms of sexual relations. We must ensure that the needs and rights of the most vulnerable young people are protected: for example, adolescents at risk of inter-generational or transactional sex; girls at risk of child marriage; young people who are victims of gender-based violence; and youth in conflict or post-conflict settings. Many young people fall into the category of orphans and vulnerable children (OVCs), orphaned or made vulnerable due to HIV/AIDS, other diseases and conflict, and are left without parental guidance and are particularly vulnerable to sexual exploitation. These young people are at risk of unplanned pregnancies, HIV/AIDS and other STDs, and therefore, are badly in need of comprehensive reproductive health services.

Fourth, eliminate legal barriers that impede evidence-based programming in reproductive health and HIV/AIDS, especially related to vulnerable women and adolescents. I urge Congress to repeal the abstinence-until-marriage earmark and request the Office of the Global AIDS Coordinator to revise its ABC guidance in a way that promotes (rather than discourages) comprehensive sex education. I also urge Congress to repeal the Mexico City Policy—there is no evidence that having this policy in place has reduced the number of abortions performed. In fact, by cutting off funds to foreign family planning organizations that reject its conditions, the Mexico City Policy has most likely increased the number of unplanned pregnancies and led to increased numbers of abortions sought.

In some of the countries in which CARE works, we see the implementation of the ABC approach translating into the operational message that abstinence and fidelity are the most desirable and moral options, and positioning condoms as something used only by people engaging in risky sex or as a “last resort”. When Uganda first developed the ABC approach, it was compelling because it demystified HIV/AIDS and communicated that individuals had the power to protect themselves by choosing among A, B or C options. Delaying sexual debut and partner reduction is absolutely vital to preventing HIV and other sexually transmitted infections, but that does not mean that A, B and C should be broken up into parts and promoted to different segments of the population. In settings where risk of HIV infection is high, it is a disservice to not provide comprehensive information and prevention methods to young people who are not yet sexually active. The young girl who we counsel today about abstinence may be married tomorrow (or coerced into transactional sex), and we have an obligation to prepare her for the future.

Finally, invest more broadly and strategically in global health and development. The U.S. leadership on HIV/AIDS has been admirable, but it must be accompanied by broader investments that promote community-led development, strengthen health care systems and build workforce capacity. We cannot save babies from contracting HIV only to see them dying of diarrhea or languishing without access to basic health and social services. Our investments in drugs, tests and other health interventions will be constrained if there are not enough health workers to administer them. If all boats don’t rise at similar levels, the bold investment in HIV/AIDS may fail to deliver on its promise—and other areas in which gains have been made over several decades may be undermined. We cannot let that happen.

I want to thank you for inviting me here today and I look forward to answering your questions. CARE has been a partner in the fight against global poverty with the U.S. Government and the American people for more than half a century and we are grateful for what your support allows us to do in thousands of poor communities around the world. We look forward to a future of productive partnership and exchange.

Senator LEAHY. Thank you, and I think you understand, Doctor——

Dr. GAYLE. No, no, that’s fine.

Senator LEAHY. No, I think you understand, also——

Dr. GAYLE. Yeah.

Senator LEAHY [continuing]. From my background that you preach to the converted on many of these issues.

Ms. Garrett, again, as I said earlier, your writings have been extremely illuminating. It was recommended to me by my staff to make sure to read your testimony, which I did, but please, go ahead.

STATEMENT OF LAURIE GARRETT, SENIOR FELLOW FOR GLOBAL HEALTH, COUNCIL ON FOREIGN RELATIONS

Ms. GARRETT. Thank you very much, Senator, and thank you very much for your interest and concern in this area.

I was going to remark that most Senators don't have a constituency that provides them with an advantage to taking on these issues, they're not make or break issues, but I think that may be different for Vermont.

I'm happy to say that, with my colleague here to the right.

Speaking of my colleagues, the two prior talks—

Senator LEAHY. Dr. Daulaire is rarely to anybody's right, but please, go ahead.

We don't need that—we don't need that in the transcript, I'm sorry. It was just too easy, it was just too easy.

Go ahead.

Ms. GARRETT. Well, of course from your vantage point, he's to my left.

Senator LEAHY. There you go. In fact, Dr. Daulaire is one of the most respected health professionals I know—by Democrats and Republicans.

Ms. GARRETT. My colleagues have done a wonderful job of laying out some of the key issues. What I'd like to do is, you have the written text, let me just see if I can hit some key points here.

We are in an age of such fantastic generosity, we have seen the amount of money, as your chart indicates, skyrocketed, as being dedicated to global health, but it isn't just U.S. Government funding, it is across-the-board in increase in the amount of generosity pouring into global health. This is a skyrocketing that, literally, has occurred in the 6 year's time.

Six years doesn't provide us with a big window to reflect, to try to ascertain whether the way we're spending the money, whether it's coming from philanthropic sources, such as the Gates Foundation, or individuals with great celebrity cache, such as Bono and Angelina Jolie and Brad Pitt, or coming from a whole host of other Government agencies around the world, akin to our USAID.

It is a phenomenal amount of money, but it has not been suddenly flooded in with some overview, with some perspective put behind it.

So, what we're doing is, we're increasing charity, we're not building anything. We're increasing charity. One of the key pieces of why the charitable incentive has risen so much, is because we now have evidence that certain diseases can be held at bay with seeming quick-fix drugs, with medicines that can be applied to them, and of course, HIV is the big landmark turning point, with the 1996 innovation of antiretroviral combination therapy.

But the problem here is that the notion that we can simply flood a treatment modality on top of a very, very weak public health infrastructure, and suddenly medicalize a public health infrastructure overnight, this is—6 years is overnight—and turn it into a medical delivery system, that can instantaneously get antiretrovirals out to people in rural areas all over sub-Saharan Africa, get tuberculosis drugs out all over Haiti, get malaria bed meds out all over West Africa, this is an absolutely asinine notion. We cannot, overnight, scale up, switch our public health format into a

medicalized treatment intervention format, without having casualties, all along the way.

What are the big casualties? Women and children. Because the safety and survival of children under 5 is really, absolutely a public health mission. What kills children? Dirty water. Getting into their bodies through water, a whole host of microbes that shorten their poor little lives.

What kills those mothers? Not having any kind of health delivery infrastructure, so that when they're in labor, and when all of the crises of childbirth hit, there's nobody to help, there's no where to go. Or, they get there, and because it's so grossly underfunded, they are treated with unwashed hands, non-sterile instruments, and succumb to infectious outcomes from that childbirth.

We, just, we've talked about the brain drain, but let's just really think carefully about what this means. You put that much more money overnight into global health, you make the priorities of that money about getting pills out the door for a variety of different things, or quick-fix technologies, just shove them out there, but you don't have enough healthcare workers to do any of it.

Indeed, we have a shortage of well over 4 million healthcare workers—sub-Saharan Africa alone is short 1 million. By the way, I'm not just talking about doctors, this is doctors, nurses, lab technicians, health administrators, people who know how to do drug procurement, process supplies, the logistics, the whole infrastructure that is the essence of both public health and medical delivery. That is so weak, it was already fragile to the point of breaking, and now all of a sudden we put this surge of funding in, but it is funding with the priorities set in the wealthy world, not in the poor world, with the sense that it's all about "we" in the rich world, we'll have bragging rights and feel terrific, because we saved X number of lives by shoving these pills out the door.

What's happening in practice, on the ground, is that because the healthcare worker crisis is so acute, we're seeing healthcare workers skewed towards the places where the money is.

So, I am here wearing a red ribbon, which—as everybody knows—is the insignia of the fight against HIV/AIDS. I'm wearing that, partly, because I don't want anyone to misread what I'm saying to indicate that I somehow oppose the largesse that the American taxpayers have put behind PEPFAR and other HIV efforts—I am all for it, I think we need more money directed to HIV/AIDS.

But, in the absence of sufficient health systems, of real training of people who know how to do health management, and corral these meager, weak resources, and fragile infrastructures as wisely as possible, what we're going to end up doing, and we're already seeing it in some countries, is see an increase in child death. An increase in maternal mortality, even as we're saving millions of people suffering from HIV/AIDS and malaria. Because we're just skewing the programs the way we want that money spent.

So, finally, my main message is, we really need to step back and think—how do you fund systems management? We're not going to instantly, overnight, get 4 million healthcare workers, it's impossible. We do need to be grossly increasing the amount of money we put into healthcare worker training, but we're not going to fill that gap overnight.

PREPARED STATEMENT

What we need to do is think, how do you train those people who are on the ground, in the skill set that is about managing meager resources, and doing it wisely to save all lives? Lift all boats at once, not just those targeted disease-specific boats.

[The statement follows:]

PREPARED STATEMENT OF LAURIE GARRETT

Senator Leahy, Distinguished Members of the Senate Appropriations Subcommittee on State, Foreign Operations and Related Programs, and Committee Staff: It is a distinct honor to be invited to address you today on the subject of global health priorities. I would especially like to thank the Committee for expressing interest in this matter. I recognize that few of you have constituents clamoring for your attention regarding the general health needs of people living far away, in desperately poor countries. These are not electoral make-and-break issues. It is, therefore, all the more laudable that you are devoting time today to their consideration. Again, I thank you.

My esteemed colleagues preceding me today have done an excellent job in describing exactly who is currently under-served by U.S. foreign aid and investment, as well as the generous philanthropic, private support of the American people. I will not reiterate. I will build on their comments, highlighting some critical fault lines in current global health funding and directions, and offering some suggestions for fresh directions for the Committee's consideration.

Some of the basic principles, and data, I will mention are delineated in a piece I authored for Foreign Affairs¹ earlier this year.

AGE OF GENEROSITY COMMENCES: STILL NOT ENOUGH, BUT RAPIDLY INCREASING

We are in an age of fantastic generosity. Globalization has brought the plights of the world into every living room, and onto every computer. As the world public's response to the 2005 Tsunami illustrated this internet-driven sense of the immediacy of catastrophe—even in places as remote as Aceh, Indonesia—spawns remarkable outpourings of finances, donations and goodwill. As little as 6 years ago global health commitments totaled a few hundred million dollars: Today—combining all government and private sources—we see donations exceeding \$18 billion. This is not enough, but it constitutes a dramatic, even astounding, increase in generosity, realized over a short period of time.

But there are dangers in throwing billions of dollars about in emotionally-driven responses to news events, and disease-specific campaigns that capture the collective imagination of the wealthy world citizenry.

First, let's be blunt: most of this generosity reflects our interests: causes we care about, our national security, and our moral concerns.

Second, for obvious political and, in the case of the private donor sector, self-promotion reasons, we want bragging rights. We want to be able to say that X amount of money, after 2 years, saved Y amount of lives. Most of the health-related legislation signed by President Bush and created by the House and Senate is rife with short term, mandatory timelines. In order to achieve measurable health targets in 1 or 2 years, we necessarily have to set extremely narrow, pinpointed goals. And on the ground, to achieve such goals, U.S. supported programs must corral all available resources, funneling them into one channel of health.

TREATMENT, YES: BUT NOT WITHOUT PREVENTION

Let me give you an example. About a year ago I was in a small town in Haiti. The people in this town were overwhelmed with infectious diseases. Their illnesses swamped the beleaguered clinics, where long lines of mothers and children stood in the tropical sun for hours on end, waiting to see a doctor. The children's growth was stunted; mothers couldn't produce enough milk to feed their babies; long-infected teenagers fought to keep their eyes open in class. In the parking lot of the town's main hospital sat two rusted-out, broken USAID jeeps, the American insignias clearly evident. Though American charities were helping to subsidize the medical training and services in the hospital, nobody—no Haitian government agency and no foreign donor, looked at this town and asked the obvious question: "Why are so

¹ Garrett, L., "Do No Harm: The Challenge of Global Health," Foreign Affairs Jan/Feb 2007, pp 14–38.

many people sick with dysentery, typhoid fever, and intestinal problems? Why are so many children in this town dying before they hit their fifth birthdays?"

The answer: Water. The colonial-era water filtration and pumping system had long ago broken down. For about \$200,000 the system could be fixed, children would drink safe water, and the disease and death rate would plummet. But no donor chose to take on that water problem. Instead, at the cost of far more lives, and dollars, the donors—including USAID—funded treatment of entirely preventable diseases, and supported the operation of a very busy morgue.

The emphasis my colleagues placed on maternal and child health is wise. What is killing babies and toddlers? The lack of essential public health services: clean water, mosquito control, basic nutrition, healthy moms.

What is killing their moms? The lack of medical systems: No safe C-sections, no sterile equipment for episiotomies, no prenatal care.

Public health systems keep babies and children alive. Medical delivery systems keep their moms alive.

Systems: Not individual, disease-specific programs—health systems are the key. Those targeted programs, such as PEPFAR (the President's Emergency Plan for AIDS Relief), are terrific, but without functioning public health and medical systems in place, PEPFAR and its like are just big band-aids that barely cover gaping wounds.

We—Americans and the wealthy world, generally—have given, and given, and given for decades. Yet the gap between longest and shortest lived societies has widened, now a full five decades long. And despite mountains of foreign aid from the OECD nations, basic health markers such as life expectancy and child survival have barely budged over the last 60 years in any sub-Saharan African country—except, thanks to HIV, to go backwards in a few.

GOING BACKWARDS ON HALF A TRILLION DOLLARS

Senators, your counterparts in the Canadian Senate recently issued a startling report, entitled, "Overcoming 40 Years of Failure: A New Road Map for sub-Saharan Africa." The report estimates that over the last 45 years the United States, Canada and the rest of the wealthy world has spent more than half a trillion dollars in aid and investment in sub-Saharan Africa. Yet the World Bank Office in Nairobi estimates, "that in 1948 Africa had a 7.5 percent share of world trade; in 2004 that share had decreased to 2.6 percent. A single percentage decrease represents United States \$70 billion."

"Africa is diverging from the rest of the world at the rate of 5 percent per capita income each year," The Canadian Senate report concludes.²

Even in parts of the world we have credited as economic success stories—where the Asian Tiger roars, and the Latin miracle twinkles—health remains a striking challenge. The world nervously watches the spread of H5N1 influenza—"bird flu"—in Asia, largely in the same locations that featured SARS in 2003. Yellow fever, dengue, and malaria have all returned to Latin America. Indeed, Jamaica is at this moment battling the first malaria outbreak on that Caribbean island in more than 60 years, spiraling out of control right in the capital city. That is a public health failure. And as the previous speakers told you, maternal health is going backwards in much of the poor world—women are dying in childbirth in many of these countries at a far greater rate than they were half a century ago. Recent United Nations findings on maternal mortality show that a woman living in sub-Saharan Africa has a 1 in 16 chance of dying in pregnancy or childbirth. This compares with a 1 in 2,800 risk for a woman from a developed region, and a more than 1:28,000 risk for a mother in Scandinavia.

Every effort to battle diseases—from bird flu to HIV—comes up against the same set of problems. Congress has, over the last 3 years, approved some \$8 billion of spending—about 5 percent of it overseas—to make Americans safer in the face of threatened pandemic influenza. But in the big picture the danger has over that time only increased, both because of mutations in the evolving H5N1 virus, and because quick-fix approaches to disease surveillance and control won't work in countries that have no adequate systems of public health and medical care.

Even the Bush administration's laudable PEPFAR program, which started out with a fairly minimal mission of providing prevention, care and treatment for a single disease, now finds itself forced to build medical delivery systems simply to get anti-HIV drugs to the patients who need them.

² Canadian Report by the Standing Senate Committee on Foreign Affairs and International Trade, "Overcoming 40 Years of Failure: A New Roadmap for sub-Saharan Africa," Feb 2007.

A just-published critique of the Global Fund to Fight AIDS, Tuberculosis and Malaria³ charges that unless the Fund starts to directly underwrite the salaries of healthcare workers, including minimally-educated community providers, the effort will become nothing more than “medicines without doctors,” an unsustainable program for tossing out drugs without providing any actual healthcare.

THE WORLD NEEDS HEALTHCARE WORKERS

The world is desperately short of health professionals, and the severity of that gap promises to increase sharply in coming years. The World Health Organization estimates the shortage breaks down currently as follows:⁴

- In 57 countries the deficit is labeled by WHO as “severe”;
- The world needs, immediately, 2.4 million medical service providers;
- 1.9 million laboratory workers, health managers, and administrators;
- A total of 4.3 million healthcare workers are needed at this moment.

Sub-Saharan Africa faces the greatest challenges. While it has 11 percent of the world’s population and 24 percent of the global burden of disease, it has only 3 percent of the world’s health workers.⁵

The World Health Organization says:

“There is a direct relationship between the ratio of health workers to population and survival of women during childbirth and children in early infancy. As the number of health workers declines, survival declines proportionately.”

This is going to get much worse. Why? Because the wealthy world is aging, therefore requiring more health attention. At the same time, wealthy nations are trying to reduce rapidly inflating health costs by holding down salaries, and increasing work loads, making the practices of nursing and medicine less attractive. Unless radical changes are put in place swiftly in the United States and other wealthy nations the gap will soon become catastrophic. Studies show that the United States will in 13 years face a shortage of 800,000 nurses and 200,000 doctors.

How are the United States and other wealthy nations filling that gap? By siphoning off doctors and nurses from the poor world. We are guilty of bolstering our healthcare systems by weakening those of poorer nations.

Here is an example: due to healthcare worker shortages, 43 percent of Ghana’s hospitals and clinics are unable to provide child immunizations and 77 percent cannot provide 24-hour obstetric services for women in labor. So the children die of common diseases, like measles, and the mothers die in childbirth. In all of Ghana there are only 2,500 physicians. Meanwhile, in New York City, alone, there are 600 licensed Ghanaian physicians.⁶

There are a number of bills pending in both the House and Senate that seek, in various ways, to increase domestic education and staffing of healthcare workers, and bolster training in poor countries. Though this committee deals with foreign operations, it is vital that you concern yourself with the progress of measures that would decrease the drive to drain the health brain power of the poor world by enhancing education and incentives here in the United States. In the House, for example, H.R. 410, the United States Physician Shortage Elimination Act of 2007, seeks to create incentives for physicians to serve in under-allocated areas of America.

Senate Bill 805, sponsored by Sen. Richard Durbin, is the “African Health Capacity Investment Act of 2007.” It seeks to amend the Foreign Assistance Act of 1961 to provide funding for medical training, and retention of healthcare staff in sub-Saharan African countries. I urge the Senate to pass S.805.

Fund Programs for Systems Development

But let’s be clear: Even if we put the brakes on the brain drain this instant, and the United States of America no longer imported foreign doctors, nurses, and lab technicians, there would still be a crisis. And even if Senator Durbin’s bill passed, fully funded, there would still be a crisis.

We are in an ugly mess. If we want to do the right thing, and get millions more people in poor countries on anti-HIV medications, our U.S. tax dollars have to be put to use skewing health services towards AIDS, and away from general maternal

³ Ooms, G., Van Damme, W., and Temmerman, M., “Medicines without Doctors: Why the Global Fund Must Fund Salaries of Health Workers to Expand AIDS Treatment,” *PLoS Medicine* 4:0001-0004, 2007.

⁴ World Health Organization, “The global shortage of health workers and its impact.” Fact sheet No. 302, April 2006. <http://www.who.int/mediacentre/factsheets/fs302/en/index.html>

⁵ *ibid.*

⁶ Kretev, N., “World: Maternal-Mortality Numbers Still Climbing,” *Radio Free Europe* July 2006. <http://www.rferl.org/featuresarticle/2006/07/10d24de4-cc8d-459c-9eed629ee1bccc4c.html>

health and child survival. Why: Because there aren't enough healthcare workers to do both.

If we want to spend U.S. taxpayer dollars—as we should—on campaigns to wipe out malaria-carrying mosquitoes and get children under insect-barrier nets at night, then the public health workers who will implement such programs have to come from somewhere. Perhaps there will be fewer of them trying to clean the children's drinking water or teaching teenagers how to avoid getting infected with HIV. Why? Because there aren't enough trained public health experts.

The only way American tax dollars can save lives, across the board—without robbing healthcare workers from one disease area to implement disease combat in another area—is if we start funding systems management. The expertise for disease prevention and treatment is sparse: the talent pool, along with their supplies and patient loads, must be carefully managed. Novel incentive systems to defy corruption and bring quality health to vast constituencies must be put in place.

At the request of Prime Minister Tony Blair, this question of the relationship between wealthy world priorities, and the health—or the lack thereof—in Africa was studied by Lord Nigel Crisp. His recently-released report⁷ concludes that single-disease-specific programs can damage other health interests. He calls for direct funding of systems development and management, with far longer-term commitments than had been the norm for the UK. The Crisp recommendations are now being implemented.

But what about the United States? Well, we do have a health systems management program nested inside USAID. It is working to professionalize health management in poor countries. It's budget? Just over \$3 million.

FISCAL YEAR 2008 BUDGET: INTERNATIONAL AFFAIRS

As you look over the White House fiscal year 2008 budget requests—for a total Foreign Operations request of \$20.3 billion—please pay close attention to the following:

- More than half of all funding for Africa will focus on 8 strategic states.
- Overall health spending in designated African countries would more than double compared to fiscal year 2006 actual spending.

Of the nearly \$4 billion requested for health in Africa, \$3.4 billion would go for HIV/AIDS in 12 countries (under the Global HIV/AIDS Initiative or GHAI, formerly known as PEPFAR). The remaining \$700 million would be spent on the President's Malaria Initiative, Tuberculosis and a host of modest child survival and health initiatives.

- Nearly all programs are heavily ear-marked, with little or no monies designated for general health threats or health systems management and support. Health management and personnel training is not stipulated clearly in any budget lines, either under disease-specific programs, nor in overall global health budgets.
- Only \$34 million is requested for water systems, sanitation, or general public health threats.
- Under the Global War on Terror 2007 supplemental the President requests \$161 million, in addition to the general budget \$100 million, for pandemic influenza surveillance and control, through USAID. The supplemental request is listed under Child Survival and Health Programs.

I do not believe that we are guilty of over-spending in any global health initiative. Rather, we are guilty of under-valuing the necessity of building genuine, well-managed public health and medical systems. The paltry \$3 million now spent on USAID's Management Sciences for Health program should increase dramatically, reflecting this gap. Further, current caps⁸ on human resources development and training that exist for PEPFAR funds should be lifted, for training of indigenous—not American NGO or FBO—personnel.

WHAT IS THE GOAL?

I think the appropriate goals for U.S. foreign aid in support of global health ought to be twofold:

⁷Lord Nigel Crisp. "Global health partnerships: the UK contribution to health in developing countries." February 2007. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065374

⁸Under PEPFAR, spending to train local healthcare workers cannot exceed \$1 million per country per year. That is absurd.

- Build sustainable infrastructures in poor countries that shift the paradigm towards fantastic improvements in maternal health, child survival and overall extension of life expectancy.
- And, second, ensure the safety and security of the American people by lowering the global disease burden, both in terms of infectious threat and detrimental impact on nations' and global GDP and economic growth.

The current channels of spending, though in the billions of dollars, will not accomplish either of these goals.

Systems and infrastructure aren't sexy, cannot be built in short funding cycles, and are tough to brag about to constituents. But without viable systems of medical delivery and public health infrastructures all we will manage to do with our billions of dollars is save some lives, at the expense of others; achieve short term targets without fundamentally leaving anything in place that allows nations ultimate dignity and self-reliance.

Let me close with this final story. During the 1960s, at the height of the Cold War, the global community committed to the astonishing goal of completely eradicating smallpox. The virus had killed more people during the first six decades of the 20th Century than all wars, combined. In order to accomplish this remarkable feat the World Health Organization and our Centers for Disease Control set up an unprecedented worldwide infrastructure of community health workers, public health advocates, disease detectives, laboratories, vaccine manufacturing, specialized infectious diseases clinics and hospitals and international-scale leadership and management. It was a breathtaking scale of effort. And it worked. By the end of the 1970s smallpox was eradicated.

But then a tragic, inconceivable mistake was made: The entire worldwide smallpox infrastructure was simply shut down. Unable to find funding, or international interest, the infrastructure that defeated smallpox was, itself, eradicated at precisely the same time as a new scourge emerged: HIV. Since 1981 AIDS has killed more people, in 25 years, than smallpox did in the 20th Century.

As the late, great Kurt Vonnegut would say "So it goes."

Thank you for your time, attention, and concern.

Senator LEAHY. I was discussing your testimony with my wife who is a registered nurse, now retired, except for children and grandchildren, she's traveled with me to a number of places around the world where we've used the Leahy War Victims Fund. She's been in some of these places, and she said our first-year nurse's training 40 years ago was more advanced than what they had available. We've brought thousands of sterile disposable gloves and needles.

We're not trying to build the Mayo Clinic in these places. We're not talking about major surgery, we're talking about the preventive measures that we take for granted.

I'm glad you raised the brain drain. I worry, also, though, that we don't have the basic—very, very basic—infrastructure. Where I see medications that are supposed to be refrigerated, there's no ability or knowledge of doing it. A pill a day for 20 days, but, well, why not take 20 today and get it over with, and that kind of thing.

Dr. Daulaire, as I said before, you and I have been friends for decades, and I'm delighted you're here. I'm delighted the Global Health Council is based in Vermont. There's some days when I'm down here I'm envious of you being back home.

Please go ahead, sir.

STATEMENT OF DR. NILS DAULAIRE, PRESIDENT, GLOBAL HEALTH COUNCIL

Dr. DAULAIRE. Thank you, Senator Leahy, in turn I'm delighted to be one of your enthusiastic constituents, as are our staff, headquartered in Vermont, some of whom are Senator Gregg's constituents as well, right across the river.

But I'm here today, not as a Vermonter, but as the head of the Global Health Council, an organization representing health professionals and service organizations working in more than 100 countries. This is the issue of the moment, and I'm more delighted than I can tell you that you are hosting this hearing today.

As you well know, I'm a doctor and a scientist, I've worked in the field for over 3 decades, and I believe deeply, as Dr. Gayle mentioned before, that what we do in global health has to be evidence-based. So, both in the submitted testimony and what I'm going to talk about over the next few minutes, we have hard facts to back up everything that we're talking about.

I'd like to make five points—first, this is a huge issue; second, we have done an enormous amount, we, the United States, to improve the situation, and we know what to do; third, over the last 10 years, our investments have lagged; fourth, we can make a world of difference with modest additional investments, starting this year; and fifth, this would be good, not only for the women and children of the world, but it would be good for America.

So, let me take those five points in order. We've already heard quite a number of the statistics, let me just put one chart up here—this is a huge issue. In many of the countries where I've personally worked, 1 out of 5 children do not survive to their fifth birthday. Take a classroom of 16 adolescent girls, one of those girls is not going to make it through her fertile years, because of a death due to pregnancy or childbirth, and 1 out of 4 pregnancies around the world is unintended.

These are staggering statistics, when we consider our own lives and our own children and our own families, and they're simply unacceptable. Sitting in the Dirksen Building, I'm reminded that he once said, "A million here, a million there, pretty soon you're talking about real money." In this case, you're talking about real lives. You've heard the lives—over 10 million child deaths, over half a million women dying in pregnancy and childbirth—and as well, more than 200 million women living around the world with an unmet need for family planning.

Some people have asked, why does the Global Health Council concern itself about family planning? That's a population thing, not a health thing. But, family planning is fundamentally a health intervention. It prevents abortion—I don't need to make that argument with you, sir, you've been clear on that, and you understand that well—but in addition, we know from the data that it saves the lives of young children, the older siblings. A child born more than 3 years after the prior birth has a one-third lower chance of dying than a child born within 2 years.

Children born to teen mothers have a 30 percent higher rate of infant and child mortality than do children born to older mothers, so—family planning saves mothers' lives, and it saves childrens' lives.

But this is not only about death, but also about lives. I have to say that, in addition to the ones dying, there are 40 million children living stunted lives physically and intellectually each year. There's more than 20 million women who suffer lifelong consequences of complicated deliveries, and there are 60 million

women a year making agonizing choices about pregnancies that they did not intend.

The second issue, we've learned a lot, and we know what to do. We've talked about that already, and Dr. Hill, I think, made the case beautifully, that this has been an area of enormous scientific growth and operation growth, but it didn't just happen. It happened because of considerable U.S. Government investments in maternal and child health, and in family planning. Investments led to knowledge, led to application, and led to millions of lives saved.

Why have our investments lagged over the past decade? We have this chart up here that your staff prepared, let me take those bottom lines that you can barely see, and show you that in maternal and child health in nominal dollars, the line has been more or less flat. Adjusted for inflation, we're actually spending 22 percent less than we were 10 years ago, and that's in a world that has 19 percent more children.

In family planning, the situation is also very sobering. Again, adjusted for inflation, our investment in the past 10 years has declined by 14 percent, and that's in a world with 30 percent more women in need of family planning services.

So, this is critical in terms of making an important change in the delivery of services. What do we need today? What U.S. leadership is called for? Well, analysis has shown that it would take \$5.1 billion of global investment, not just United States, to save 6 million children's lives, the figure that Dr. Hill pointed to before. Another \$3.9 billion to save, to provide family planning services for 200 million women, so we're talking about a global need of \$9 billion in which the United States fair share would be about \$1.6 billion for child health, \$2 billion for maternal health, and about \$1.3 billion for family planning.

Now, as much as our community would love to have that investment made this year, we recognize that you have to deal with a difficult appropriations process. So, I'm going to tell you what you can buy for every \$100 million that this committee, in its wisdom, decides to invest in maternal and child health and family planning.

If you invest \$100 million in child health and survival, you will save 113,000 to 200,000 lives every year. Nearly a million children will be provided with the 16 essential interventions that programs like CARE and others carry out.

If you invest \$100 million in mothers, you will prevent 12,000 maternal deaths, 15,000 newborn deaths, you'll provide 4 million women with basic, essential care, and 140,000 women will be treated for life-threatening conditions.

Last but certainly not least, if you invest \$100 million in family planning, there will be another 3.5 million additional family planning users, 2.1 million fewer unintended pregnancies, fewer infant and maternal deaths, and not incidentally, 825,000 fewer abortions around the world.

Senator LEAHY. So, as you're talking about that chart, the amount of money—it's a large amount of money—but its almost as much as we had spent by Tuesday morning of this week in Iraq.

Dr. DAULAIRE. There we go.

Senator LEAHY. Not to put too fine a point on it.

Dr. DAULAIRE. I—

Senator LEAHY. Or to indicate my feelings on that, but really, starting Sunday morning, we spent more than that by Tuesday noon in Iraq. We did last week, and the week before, and the week before, and we've been there for 5 years, longer than we were in World War II.

Dr. DAULAIRE. Mr. Chairman, this is indeed a matter of making decisions about national priorities.

Let me wrap up—Laurie Garrett has talked about the importance for health systems. What builds health systems capacity is the delivery of routine services on a daily basis, and what does that the most effectively and efficiently is maternal and child health services, and family planning, because those children and those mothers come through the door every single day. You can build other programs on top of that infrastructure, but that is the core of daily activities that is essential for infrastructure.

Finally, I think it's self-evident, I'm preaching to the converted here, but this would be good for America, not only because healthy families lead to more stable societies, less turmoil, and fragmentation in the world, but because the United States desperately needs a more positive face overseas. United States programs invested in maternal and child health and family planning have been among the most effective and appreciated around the world.

Senator, I know your children, you know mine, I know your wife, you know mine—we would not tolerate these levels of risks in our own family, and this is our family writ large. Women and children are at the center of global health and it's time for us to take action.

PREPARED STATEMENT

I call on you and your committee to boldly re-establish that commitment, with real dollars measured in the hundreds of millions. Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF DR. NILS DAULAIRE

Chairman Leahy, Ranking Member Gregg and members of the subcommittee, thank you for inviting me to testify before you today on Maternal and Child Health, Reproductive Health and Family Planning. I am Dr. Nils Daulaire, President and CEO of the Global Health Council, the world's largest membership alliance of health professionals and service organizations working to save lives and improve health throughout the world.

Before I begin my remarks, let me thank you, Chairman Leahy, for your service to our home State of Vermont and your longstanding commitment to global health. You have been a proponent and champion of U.S. investment in global health for more than 30 years. Long before PEPFAR, the Global Fund, PMI and other welcome global health initiatives, you fought for basic health services in developing countries, committed to meeting the needs of the poor and most vulnerable. I applaud you, Chairman Leahy and you, Senator Gregg, for your bipartisan collaboration, recognizing that saving lives knows no party lines. On behalf of the Council's 350 member organizations working in over 100 countries across the globe, and the millions whose lives are improved by U.S. Government investments, we thank you.

The Global Health Council's members include non-profit organizations, schools of public health and medicine, research institutions, associations, foundations, businesses and concerned global citizens who work in global health—delivering programs, building capacity, developing new tools and technologies and evaluating impact to improve health among the poor of the developing world. Our members work in a wide array of areas, including child and maternal health, family planning, HIV/AIDS, other infectious diseases, water and sanitation, primary health care and health systems strengthening. The members of the Council share a commitment to alleviating the great health disparities that affect the world's most vulnerable peo-

ple. The Council serves its members and the broader community of global health stakeholders by making sure they have the information and resources they need to fulfill this commitment and by serving as their collective voice.

It has been my privilege to be part of the global health movement for over 30 years, and much of my career has been spent as a physician and program manager in some of the world's poorest countries. Working in countries such as Nepal, Mali and Haiti, I have had the good fortune to participate in the development and introduction of some important child survival interventions, notably in treating childhood pneumonia and Vitamin A deficiency. I have also had the honor of serving in Government as a senior policy advisor in USAID. My remarks today derive from these different perspectives and experiences, as well as the evidence and experience of our membership.

THE WORLD'S WOMEN & CHILDREN

The link between the health of the world's women and children is well-established, as is the link between their health and the well-being of the larger community. Because of these connections, we must view the challenges, interventions and investments as contributing to a continuum of care that has mutually reinforcing benefits from the individual all the way through global society.

Child Health

Today, as every other day, nearly 30,000 children under age five will die—1 every 3 seconds. In many countries, 1 of every 5 children born won't live to see their fifth birthday. If death rates of this magnitude were happening to the youngest and most vulnerable here in the United States, we would declare a state of national emergency. It is happening, perhaps not in our backyard, but in our world, and we must do more.

This year, more than 10 million children under 5 will die, mostly from preventable and treatable conditions—about the same as the total number of American children under 5 living east of the Mississippi River. Almost 4 million of these deaths will occur during the first month of life. Two million children will die from pneumonia; 1.8 million from diarrhea; nearly another million from malaria and almost half a million from measles. Virtually all of these deaths can be prevented—easily and cheaply.

As American parents, we take for granted that our kids will live and thrive. We recall when a skilled medical provider coached us through the stages of labor. We remember when our babies were whisked away to be dressed with head caps and swaddled to keep them warm. We have all taken our children in for their immunizations to protect them against measles, diphtheria, pertussis, tetanus and polio, diseases which, as a result, are today practically unknown in our country. If my daughter developed diarrhea, she was hydrated and her risks were very low. If my son developed pneumonia, rapid cure was ensured through antibiotics. These are all simple, basic practices that kept our children alive, and we are blessed to be able to take them for granted.

In the developing world, however, too many parents live with the very real fear that death will take their children. The interventions that I have named are neither difficult to administer nor expensive. The cost of some, such as oral rehydration salts, vitamin A supplements and even antibiotics, are measured in cents, not dollars. Breastfeeding and kangaroo care, where mothers hold newborn babies to their breasts to keep them warm, cost nothing at all beyond educating parents. Yet children are still dying because these basic interventions are not reaching them. I couldn't imagine that expectation when my children were born. No parent should have to.

Maternal Health

In the United States and other developed nations, the risk of death from complications of pregnancy and childbirth is extremely low. Although the risk of a woman in a developed country dying is about 1 in 2,800, the lifetime risk of sub-Saharan African women dying from complications in pregnancy or childbirth is 1 in 16. Over half a million women die each year from pregnancy-related causes, and up to 20 million develop long-term physical disabilities each year because of complications or poor management of pregnancy or childbirth. Almost 4 million newborn deaths are closely linked to poor maternal health care, especially the absence of a trained provider during and immediately after birth. And each year, more than 1 million children are left motherless.

Reproductive Health/Family Planning

Notwithstanding the progress in making family planning services available, over 200 million women still have an unmet need for family planning. These are women who are at risk of becoming pregnant, who wish to delay or end childbearing and yet do not have effective access to family planning. This is a denial of the basic right of every woman to decide if and when she will become pregnant. It is utterly meaningless to declare support for the human rights of women and yet fail to provide them with the information, services and commodities that will allow them to make a free, informed and safe decision about whether and when to become pregnant. Women cannot fulfill their potential or assert their rightful place in economies and societies unless they have such access. The decline in United States support for family planning flies in the face of our stated national commitment to overcoming the second class status of women in much of the world.

What is less well understood but equally important is that family planning is essential to protecting the health of mothers and their children. Family planning helps young women delay or space pregnancies. Family planning helps all women avoid high risk pregnancies; approximately 215,000 maternal deaths will be averted this year alone thanks to the family planning that is available.

Debate over abortion continues to create stark political divides. Yet, there is one thing we can agree upon—family planning reduces recourse to abortion by enabling women to avoid unintended pregnancies. Every year, there are more than 46 million abortions. 68,000 will also end in the death of the mother. Increasing access to family planning is the surest path to decreasing the number of abortions.

Speaking as a physician who has devoted years to improving children's health worldwide, let me make this clear: family planning is also critical to saving children's lives. Closely spaced births and births to young mothers dramatically raise the risk that the infant will die. A child born less than 2 years after a sibling is 67 percent more likely to die than a child born after a 3 year interval. The child of a teenage mother is 30 percent more likely to die than that of a woman aged 20 to 29. Between 20 percent and 40 percent of all infant deaths could be prevented if all women had access to family planning.

Lives, Not Just Deaths

I should point out that the issues of maternal and child health as well as reproductive health are not limited to averting deaths. They are also cause for diminished lives. For every woman who dies during pregnancy, childbirth or immediately following, another 30 suffer debilitating life-long consequences. Each year, nearly 40 million children who suffer early childhood illnesses but do not die become physically or mentally impaired. All of this contributes to the cycle of poverty and the failure of poor countries to develop.

U.S. INVESTMENTS—PROGRESS UNDERMINED

The United States is a tremendously important force in global health. Its decisions about priorities, resource allocation, policies and technical leadership have profound consequences—that is the privilege and burden of our country's unique role. It is widely acknowledged that the United States has made very important and enduring contributions to global health. Yet today, U.S. global health policy is marked by two trends that are in stark opposition and mutually inconsistent. On the one hand we see the rapid expansion of U.S. programs in HIV and malaria; on the other we witness the neglect of maternal health, child health and family planning. This makes no sense.

Contradictory Trends

The U.S. Government (USG) investment in global health has grown and evolved dramatically in just a decade. In fiscal year 1997, USG spending on global health sat just below \$1 billion. Ten years later, global health spending is well over \$5 billion from the foreign operations budget alone, with additional investments from the Department of Health and Human Services and the Department of Defense. However, the devil is in the details.

Most of the exponential growth in global health spending over the past decade is due to USG investments in HIV/AIDS—over \$14 billion since the advent of the PEPFAR, the President's emergency program for AIDS relief—an important commitment that the Council applauds. More recently, the President Malaria Initiative (PMI) has joined PEPFAR as a priority program of this administration, with a \$1.2 billion pledge over 5 years. PEPFAR and PMI speak to the USG's generosity and ability to make a difference and, through these programs, many lives are being saved. The USG deserves tremendous credit for its global leadership.

But the U.S. Government has not seen fit to increase in a similar way its historic leadership in maternal and child health and family planning. Once the investment in AIDS and malaria is subtracted from current spending totals, investments in child health, maternal health, family planning and the remaining infectious diseases remain at about \$1 billion, roughly where they were a decade ago. There has been level funding in most program areas and cuts in others, which means a decrease in programming power once adjusted for inflation and the increase of the number of people in need. This is most notable in the areas of child health and reproductive health and family planning which, when adjusted for inflation, have declined 22 percent and 14 percent, respectively, over the past decade. To this must be added the impact of a 19 percent increase in the number children under five and a 30 percent increase in the number of reproductive age women in the 43 least developed nations. So while the dollars have gone down, the need has gone up. Reduced investment translates into lives—millions lost unnecessarily.

Complements not Contradictions

Let me say again, the Council enthusiastically applauds the growth in spending for AIDS and malaria and the leadership President Bush and the Congress have shown in these areas. But while funding flows through independent and issue-specific channels, these health threats do not occur in isolation. The same communities where individuals are living with AIDS are also those in which non-HIV infected women are at very high risk of dying during child birth from lack of family planning and basic obstetric care. The same young children who now sleep under bed nets to guard against malaria are no less likely to die from diarrhea or pneumonia. We have confused the laudable objective of fighting disease with the fundamental goal of saving and bettering lives, and our investment is undermined by an excessively narrow perspective. Fortunately, relatively modest increases in USG investment in these neglected areas can save millions of lives through simple, cost-effective interventions.

That is the good news—solutions are within easy reach at low cost. In the past 30 years, thanks to the investments and efforts that have been undertaken, the child mortality rate in the poorest parts of the world has declined by 40 percent. Because of family planning efforts, birth rates have also declined by 40 percent. What an incredible moment: For all of human history, people have lived with the expectation that many of their children will die young and that women will endure one pregnancy after another, regardless of the impact on their health and survival. The 40 percent decline in birth and death rates is a stunning change. The advent of simple, inexpensive vaccines, antibiotics, oral rehydration salts, anti-malarials, micronutrients and contraceptives have radically changed expectations and reality in many parts of the world. What a tragedy it would be not to finish a job so well begun.

This progress makes the choice not to increase our investment in women and children intolerable. Allowing women and children to die from easily preventable causes is just that—a choice. We are at a loss to understand how this administration, so generous in the response to HIV/AIDS and malaria, now proposes substantial cuts in maternal and child health and family planning.

IMPROVING HEALTH, SAVING LIVES

As I have described, U.S. support for basic maternal health, child health and family planning services has been declining. This must be reversed. The United States must reassert its historic and essential leadership in saving the lives of women and children. Providing these basic interventions for women and children is the cornerstone for securing improved health and is at the heart of building sustainable public health systems. The record is clear. Every time the United States has approached a major global health problem with tenacity and at the requisite scale, our country has had a tremendous positive impact.

On the scale of global need, the amount needed to achieve important gains in child health and family planning is manageable. Six million children could be saved every year if the global budget for child health were increased by \$5.1 billion. Providing essential obstetric care to 75 percent of women in 75 countries would cost an additional \$6.1 billion; 200 million women with an unmet need for family planning could receive these services for an additional \$3.9 billion per year. So the math is simple. If—from all sources: United States, other donors, developing nations—the world devoted an additional \$15 billion per year, 6 million children would be saved annually, most women would have maternal health care and 200 million more women would have access to family planning. I urge this committee and the Congress to move the United States into the same leadership role on family planning, maternal and child health that it has shown in AIDS and malaria.

MODEST INVESTMENTS, MAXIMUM IMPACT

To illustrate the potential impact of a heightened U.S. commitment, I'd like to reflect on what even a modest ramp-up in investments could return. The U.S. share of the additional global investment needed to reduce child mortality is roughly \$1.6 billion. The United States should add \$2 billion per year to its spending on maternal health. The United States should increase its contribution to family planning by \$1.3 billion per year. We have a long way to go. However, we can take modest steps and still see great gains. The projections I share with you are based on solid scientific analyses by the Council and others.

Investment Scale-Up

Every \$100 million in attacking the most common causes of child death with the most cost-effective interventions would have the following impacts:

- At least 113,000, and perhaps as many as 200,000, young children's lives saved
- Over 812,000 children provided with 16 essential interventions, at an average cost of just over \$12 per child

Every \$100 million devoted to maternal health programs would:

- Avert nearly 12,000 maternal deaths
- Avert more than 15,000 newborn deaths
- Provide basic and essential care for 4 million women
- Treat 140,000 women with life-threatening conditions
- Treat an additional 880,000 women with serious pregnancy and childbirth-related conditions

Every \$100 million invested in family planning would have the following impacts:

- 3.6 million more family planning users
- 2.1 million unintended pregnancies avoided
- 825,000 abortions prevented
- 970,000 fewer births
- 70,000 fewer infant deaths
- 4,000 maternal deaths averted

These are remarkable outcomes for relatively moderate additional outlays. Each increment of \$100 million would yield proportionate gains, the virtuous cycle writ large. We therefore urge this committee to approve a significant increase in the budgets for maternal and child health and family planning with investments on par with the other global health priorities.

BUILDING CAPACITY WHILE SAVING LIVES

There is the misperception in some quarters that U.S. assistance for maternal and child health has been an example of charity or created dependency. This is far from the truth. Improving health is not merely a matter of delivering pills and vaccines, though pills and vaccines are essential. It's about improving health equity by putting in place sustainable systems for delivering essential care. Improving health means supporting educational programs to foster new attitudes and behaviors; building community leadership and organizations committed to improved health; strengthening the capacity of health providers and institutions; better measurement of what programs accomplish; and, adopting better health policies and health financing schemes. The United States role has been to strengthen the capacity of national health systems to deliver essential maternal and child health care. Achieving long term sustained change requires patience and sustained investment, but the record of building capacity while achieving gains in health outcomes is clear.

Another invaluable U.S. contribution has been to invest in technical leadership and research and development, areas where the United States has historically excelled. These core functions support the development of new technologies and innovative means of delivering services, which have enduring impact. The overall decline in resources has seriously affected these core functions, a consequence exacerbated by the declining percentage of available resources devoted to technical leadership and research and development. I am greatly concerned that the technical leadership role of the United States has been starved of resources and I urge the committee to be sure it is adequately funded.

IN THE U.S. INTEREST

The United States has a compelling national interest in saving the lives of the most vulnerable women and children. The stated goal of U.S. foreign assistance is "To help build and sustain democratic, well-governed states that respond to the needs of their people, reduce widespread poverty and conduct themselves responsibly in the international system." There is no more dramatic marker of this goal than saving the lives of millions of women and children.

Poor maternal and child health indicators are viewed by many as evidence of the failure of governments to provide basic services. Conversely, alleviating the burden of disease among women and children is clear evidence of improving governance through concrete, specific gains. Even low income societies can achieve dramatic gains by providing widespread access to essential services and information. Improving access to basic health care for women and children is an exercise in good governance, meets a basic need, redresses pervasive inequities and creates a model for other essential services.

Poor maternal and child health also brings economic ruin to families and households. What truly marks poor households is vulnerability. A childhood illness or complications from pregnancy force a poor family into excruciating choices, when they must choose between buying seeds or paying for basic health care. Preventable illness and death can tip a poor family over into destitution as they divest themselves of meager savings and borrow money to pay for health care or funerals. Efforts to alleviate poverty must address this underlying cause of household vulnerability.

Mr. Chairman, it is no secret that the international reputation of the United States is at low point. Multiple surveys reveal the widespread negative perceptions of our country. One could argue whether these perceptions are justified, but there is no arguing with the urgent need for effective public diplomacy. But public diplomacy is more than words and promises, it is deeds. The most powerful statement our country could make is to save the lives of the world's most vulnerable women and children. This is an enormous opportunity for constructive engagement with much of the world. Most importantly, a renewed commitment to saving women and children will express the values of a decent and generous American people, who invariably support effective efforts to alleviate needless suffering.

A CALL TO ACTION

Chairman Leahy, Senator Gregg, members of the subcommittee and colleagues, my most fundamental message to you today is of hope and possibility. We know how to save millions of women and children through simple, inexpensive means. We know what works. We know how to deliver the interventions. We know what they will cost and we know what will happen once these services are provided: lives will be saved; communities strengthened; futures built and countries developed.

The responsibility for improving maternal and child health does not rest principally with the United States. That responsibility for meeting basic needs rests with national governments. Non-governmental organizations, faith communities, multilateral institutions and other donors all have a role to play. As I speak before you today, global partners are gathered in Tanzania under the invitation of the Partnership for Maternal, Newborn and Child Health. An increasing global commitment guarantees that the United States is not in this alone. But there is no substitute for U.S. leadership or for active U.S. partnership in a global compact for women and children.

Mr. Chairman, we need a bold commitment on the part of the U.S. Government and the American people—a commitment to the world's most vulnerable families so that they may enjoy the same expectation we have for our children's survival, planned pregnancies and mothers' safe deliveries. We simply must decide that this is the right thing to do in partnership with other governments and the communities in need. Relatively modest yet sustained increases in resources will make a significant difference in the lives of millions of women and children. And this clear commitment to the well being of families also will make a significant difference in popular perceptions of the role of the United States abroad.

I appeal to you to boldly reestablish that commitment with real dollars, measured in the hundreds of millions. It's time to act.

Thank you for your time and for hosting this hearing. I look forward to addressing any questions you have, and to working with you to continue to save and improve lives.

Senator LEAHY. Dr. Hill, let's go into this a little bit. The Millennium Development Goals. I read that one of the goals is to reduce by two-thirds the mortality rate among children under 5 by the year 2015. That's 8 years from now. You pointed out a half a million women die in pregnancy and childbirth each year. That's one per minute. Ninety nine percent of those are in the poorest countries. Another one of the Millennium Development Goals is to re-

duce by three-quarters the maternal mortality rate by the year 2015.

The United States has affirmed these Millennium Development Goals—how does the fiscal year 2008 budget request, which doesn't increase resources for either child health, maternal and reproductive health, fit into a strategy to reduce child death by one-half, and maternal deaths by two-thirds by 2015, realizing as Dr. Daulaire, and others, have pointed out, the world's population is increasing?

Dr. HILL. You raise important issues, and it's very clear that you don't make the kind of progress towards reaching those MDG goals as you would like without sufficient funds.

One of my problems, of course, is that I wear a very partisan global health hat, and I tend to view things as my colleagues on this committee do, thinking about what we could do with money and do with more money. Yet, I must acknowledge that we're part of a bigger budget process. That process is trying to limit resources that they're willing to ask Congress for, to make very tough decisions, and get at the same table at the same time all of these different sectors—peace and security, economic growth, and democracy.

Senator LEAHY. What you're saying is that you've lost the OMB battles.

Dr. HILL. We've won some battles. I doubt if there's any part of the budget process that is fully satisfied with the end product. But there are a lot of tradeoffs. I do have to acknowledge that, as has been said by my colleagues, malaria and HIV have huge increases, avian influenza is in the budget at \$100 million, and you folks are considering a \$161 million supplemental. I know that overall health money being spent and being asked for by the Congress is more than in the past. But, it is certainly true that the way that it is prioritized within the health portfolio has left these two units upon which we're testifying today with less money than they have had in previous requests or appropriations. Those are very difficult tradeoffs.

Senator LEAHY. But, on these tradeoffs, for example, the World Bank has 54 countries designated low-income countries, and USAID has programs in many of these.

Let me give you an example. In the fiscal year 2008 budget, where some of these tradeoffs are, there's an increase in funds for Liberia, and I strongly support that.

Dr. HILL. Right.

Senator LEAHY. But, Mali, which also has similar problems, receives less. So, is this robbing Peter to pay Paul?

Dr. HILL. I think you have pointed out an issue that's come up in this first year of the new system, which is problematic, and it's been noticed, and we're going to address it in two ways.

As you know, the budget was put together by country teams, looking at and trying to prioritize within their countries. But when you look at the final product, you've got some inequities where some countries with greater need had less money than was being spent in the countries that needed the money, but not as much. Therefore, I think we're going to have to look at these 2008 appro-

priations by country, and make some adjustments, but that's only part of the answer.

The second part of the answer is to ask the question, what can you do about the process for 2009 that would make fewer adjustments necessary? The answer seems to be this—to ask the three pillar bureaus at USAID to look globally at big issues and give some input to the Office of the Director of Foreign Assistance and say: “If you have to spend *X* amount of dollars on, say, child and maternal health, this is the priority of the countries you ought to spend it in.” That will affect the amount that they set for the country team to consider. They will say to the country team: “Be aware that we are setting this amount,” partly keeping in mind that they have an unusual global need in this area. So, that may help us some.

Senator LEAHY. May help some, but you still have a limited—

Dr. HILL. A limited pot.

Senator LEAHY. Yes.

Dr. HILL. Now, there's one other thing I should say, and that is that it's probably inaccurate to describe the work in HIV or malaria, not suggesting you did this, but some might conclude this, that there's no connection to these other interventions. Eighty-five percent of the malaria deaths are to children under 5, so if we succeed there, it will actually help in child survival as well.

Senator LEAHY. But, it's not 85 percent of the children. For example, we've—I understand that USAID has cut funding for the oral rehydration salt program, which stops diarrhea—

Dr. HILL. Right.

Senator LEAHY [continuing]. I mean, that doesn't seem right. Should the HIV/AIDS and malaria initiatives, which I strongly support, should they be the foundation of our global health strategy?

Dr. HILL. I think it's fair to ask questions about how a pot of money for health ought to be divided up. I can tell you the experts at USAID and elsewhere strongly disagree with each other from time to time about what those priorities ought to be, measuring how many people will die in a particular intervention. The experts don't always agree, so it's always a tough process, even among the health experts to decide, with limited money, where you'll get the most bang for your buck.

On HIV, the argument often goes, if that gets out of control, you get a lot more parents dying. This fact that a parent is alive is a huge factor in whether a child lives, and the quality of their life, so they argue that you don't have the children to work with if you fail, so these are the kinds of arguments—

Senator LEAHY. I understand.

Dr. HILL [continuing]. Of these people.

Senator LEAHY. I've visited a number of these countries, and I've encouraged improvements in HIV/AIDS programs, but, I worry that Secretary Rice spoke of the U.S. health strategy as primarily being implemented through the HIV/AIDS and malaria initiatives, and there is much more to public health than those two diseases.

Dr. Gayle, how would you respond on that?

Dr. GAYLE. Yeah, well, I think, you know, people have made the, several points about how we have to look at this in a much more integrated fashion. So, for instance, if we do a much more com-

prehensive approach in our HIV work that really looks at, what are some of the underlying reasons why some people are more at risk than others? Women, particularly who oftentimes are at risk for HIV because of sex, gender-based violence, or lack of economic opportunities. If we address some of these underlying causes as well, I think we will go a much longer way towards helping strengthen health and the root causes of poor health to begin with.

So, I think, first and foremost, it's looking at these things in a much more integrated fashion. We do HIV testing in the context of reproductive health programs, and treat other sexually transmitted diseases for women who come for reproductive health services. I think we can do this in a way that supports building a much broader, and more comprehensive approach to poor health and poor nations.

But we can't do it only by focusing on specialized programs. We have to do it in a way that looks at both the root causes, what are some of the things that are in common, including access to services, a strong health infrastructure, and do it in a way that recognizes that we can't let go of our core competency in programs that save the lives of children and women and families around the world, while we're continuing to focus on these other programs. It has to be integrated, or else in the long run, we're not doing service for HIV, malaria or any of the other issues, if we don't do it in a way that builds the platform upon which we can make health better overall.

Senator LEAHY. Ms. Garrett, do you want to add to that, and then I'm going to ask Dr. Daulaire the same question.

Ms. GARRETT. I think if we have two strategic targets for our global health/foreign aid, they would be to create sustainable infrastructures that can address a broad range of disease issues, and not be too narrowly focused, and that they would—in the process—ensure the safety and security of the American people by lowering the disease threat burden external to the United States. I think that we can accomplish both, but that the way we're going about it right now, we will fail to accomplish either goal.

It is appropriate that we elevate the level of funding directed to H5N1, or Avian flu. That is an elevated risk, and I do very strongly believe that the odds are reasonably high, that this particular bird flu strain may make, what we now know, is only two amino acid changes necessary in its entire genome to turn into a rapid human to human transmitter.

It is appropriate that we very heavily address concerns about HIV and that we have this PEPFAR, or now GHAI infrastructure in place to deal with specifically HIV. But, they—each one of them comes up against the same identical problem. If you talk to the people dealing with flu, and we've put out—I think our total expenditure now is if the fiscal year 2008 are approved, is going to top \$8 billion, domestic mostly. But, if you look at the flu problem, and you talk to those people, they all say, you know, "Our problem is that we can't find human cases of flu on the ground fast enough because there isn't a health infrastructure. There aren't people there watching, and there aren't places for the patients to go."

Senator LEAHY. You also have some countries that don't want the information to come out, and you don't want—

Ms. GARRETT. Well, that's a separate issue, transparency is obviously a huge problem. HIV tells us the story of the lack of transparency, because country after country after country denied that they had an HIV problem, or then said, "Oh, it's only foreigners," or "It's only homosexuals," or it's only this or that, until they had a generalized threat.

But I don't think that—and I know that this is going to come up when you hit the appropriation on the PEPFAR funding—I don't think that the PEPFAR infrastructure can be scaled up to become "the" infrastructure we're all looking for. I'd be happy to go through all the reasons why, it's a very long story, but bottom line is, it is an infrastructure that is primarily designed to address the health needs of a small population of adults, ranging between roughly 15 and 35 years of age. It is not—though it has a pediatric component—it is not a child health program. Though it deals with women of pregnancy age, it is not a maternal health program.

In fact, you have this odd possibility that as you enhance PEPFAR, a woman can get Nevirapine to prevent her from transmitting HIV to her child, but the next time she's pregnant, she will die in childbirth, because she can't get a cesarean section.

Senator LEAHY. Dr. Daulaire?

Dr. DAULAIRE. Well, let me first endorse what Laurie Garrett just said. There is no question that these programs for HIV/AIDS and malaria are, have an impact on the health of children and the survival of children, and of some women, but they are not the first and primary route for making a change in terms of their lives. They are, in a sense, necessary, but not sufficient.

I think the question here that we often get trapped into in the social sector in international development, is run a first assumptions. If we had accepted the assumption in 2001 that the cap on U.S. Government spending in global health was going to be, as it was then, about \$1 billion, we would be having arguments today about whether we could possibly do anything at all with HIV.

You've made the case that we spend lots of money on things that we consider to be important National priorities, so the argument made that, by Secretary Rice, that this addresses the issues of child health and maternal health do not hold water. They certainly are supportive of children's health and women's health, the kinds of programs that we're talking about today are the ones that are fundamentally important to make this change.

Senator LEAHY. Let me ask about some of those fundamental things. We keep going back to this question of safe water, especially for child and maternal health. Now—and you've spoken, Dr. Gayle, about CARE and the broad things it does, all the various aspects, you're basically saying there's no magic bullet, it's everything.

What has been the impact of USAID's Safe Water and Sanitation Programs?

Dr. GAYLE. Thank you, and I don't have the specific numbers off-hand, clearly there has been a major impact. We've been very supportive of the Safe Water Act in Senator Simon's name that we feel really ought to be strengthened and supported even more. Clearly, having safe water where a sixth of our population today does not have access to clean and safe water, means that not only will basic

hygiene not be available for much of our world population, but it also means that things like diarrheal diseases are only going to continue to be prevalent.

I've been in village after village in our work, where I've seen what it means to a family to have clean, safe water, where not only does it cut down the diarrheal diseases, and the under-5 mortality, but it means that children can go to school for the first time in their lives, and start to think about a different kind of future for themselves and for their families and communities.

So, yeah, I think the basic ability to supply clean and safe water, while some don't think of it as a health intervention, is one of the most basic interventions, and is something we feel is one of those cornerstones upon which a health—looking at improving health is critically important, and needs to be build upon. We think that there is more that needs to be done, and it is one of those areas that gets second shrift, because it isn't seen as one of the visible issues that is currently on the front lines.

I would just say, with some of the concerns around climate change, we think that the issues of clean and safe water are only going to become more and more urgent, and particularly for the poor, who will be facing more erratic climate conditions, more drought affecting agricultural productivity and nutrition, et cetera. So, this issue of safe water, clean and safe water, is a critical one.

Senator LEAHY. Dr. Hill, and I might say, when I ask some of these questions, I'll be the first also to say that USAID has done some tremendous things around the world, and I'm just trying to figure out how to make it even better. What do you say about the importance of clean water?

Dr. HILL. We agree with Dr. Gayle, that those who insist on separating water projects from health miss the point. For example, we have a three-part response to the question of small kids who die from diarrhea, and the first part of the strategy has to do with point-of-use water projects, second, the sanitation message about washing your hands; and third, dealing with feces. Much of this has to do with water; so we view the water projects as integral to what we need to do to have a big impact on under-5 mortality.

Senator LEAHY. Ms. Garrett, you talked about direct funding for systems development and management, and you say USAID is doing that, but they're doing it on a budget of \$3 million a year. Do you want to address that? I'm going to follow up with another question, but go ahead.

Ms. GARRETT. I keep forgetting to push the button, so sorry. Yeah, we, if you were a CEO of a major corporation, and the revenue for your corporation suddenly jumped, from say, \$800 million to, say, \$18 billion. You wouldn't want to imagine that your \$800 million management infrastructure was up to snuff to handle \$18 billion appropriately.

You would be even more concerned about that jump, if you knew that you had almost no health personnel to execute this giant new corporate venture. Worse yet, it's projected that by 2013, we will have a deficit here in the United States of 800,000 nurses, and 200,000 doctors. I, you know, I want to say a little on the side here, that I know that we're here dealing with foreign relations, but if there's one place where I feel that there is a need to see a con-

versation between—conversation between foreign operations and domestic—it is on this healthcare issue, healthcare resources issue.

Senator Dick Durbin has a bill that would try to rapidly increase the number of healthcare workers we're training in developing countries—

Senator LEAHY. In fact, Senator Durbin was going to be here but he was not able to because of what's happening on the floor.

Ms. GARRETT. Understood.

Senator LEAHY. He's a whip, and you're talking about his African Health Capacity Investment Act—

Ms. GARRETT. Exactly.

Senator LEAHY. I'm co-sponsoring that and we've all touched on this a bit. As doctors and nurses leave for better paying jobs, and I think of our own country when I see the ads for nurses. Bringing them here from other countries to make up for our failure as a Nation compounds the problem.

To go back to my earlier comment, I'm not suggesting the Mayo Clinic in these countries, but I am asking why can't we have nurse practitioners? Why can't we have people who have at least basic skills, and the kind of infrastructure to handle basic health needs.

Ms. GARRETT. Right.

Senator LEAHY. There are certain things we do almost unconsciously, for hygiene, but they need to be taught. How do we do this?

Ms. GARRETT. Well, I'm so glad you're asking that, because it goes back to your original question to me, how do we get to reasonably managed health systems?

As I was saying, I really think there needs to be a conversation between your counterparts dealing with domestic health funding, and international on this question. Because if we reach the point where we are trying to suck away from the poor world 200,000 doctors, to offset our deficit—I'm not even sure there are 200,000 out there—but if we go after everything we can get, sure, we might be able to deal with our health problem, but at the expense of killing people in poor countries.

So, I see that—

Senator LEAHY. Is there a way we can do both? To take care of our health problem and also help take care of theirs?

Ms. GARRETT. Well, actually, as it turns out, with the nursing crisis and the physician crisis here, in terms of our really mediocre level of domestic production of our own indigenous personnel, so that we don't need to suck the talent away from the poor world, it turns out the disincentives are less about pay, salaries at the, once you are a professional, than they are about access to the actual training.

We've had bills come consistently before this body and the House, requesting subsidies for State support of nursing training and physician training, and they have consistently failed to even get out of committee.

One of the biggest problems that we have right now in nursing training is that a typical nurse earns more as a practicing nurse than she can earn as a Professor of Nursing. Most nursing training is done by land grant and State-supported institutions, they are underfunded, and their faculty are underpaid. Most of the States,

a State like Michigan, for example, which has quite a number of nursing schools, as you know, Michigan is a hard-hit State right now. Its economy is in deep trouble. They cannot afford to even match the salary level that a nurse can make as a nurse, versus as a professor, without Federal support.

We need to really say, I think, in no uncertain terms, that the foreign operation side of the Senate is saying to the domestic operations side, "Unless you create the incentives for us to produce sufficient healthcare personnel, domestically, so that we do not need to absorb the talent from the outside, we're in an immoral position."

Senator LEAHY. Dr. Daulaire, Dr. Gayle and Dr. Hill on this?

Dr. DAULAIRE. Senator Leahy, there's two sides to this question, there's the push side, and there's the pull side. And the pull side is what goes on here in the United States in terms of our healthcare deficits, and in Europe for that matter.

I think it's appropriate for this Committee to particularly focus its attention on the push side—why is it that healthcare workers are leaving, or not getting trained to begin with? There are a number of different issues here. One is very often the wrong kinds of people are being trained in these countries. As a physician myself I hate to say it, but what the world does not need more of is lots more doctors, what the world needs lots more of is nurses, paramedics and auxiliary health workers who can address the healthcare needs at the communities where they're taking place. My own experience in the field has reinforced this many times over. So, that needs to be a focus in terms of both National priorities and donor assistance from the United States.

Second, if the United States in its donor-assisted programs, HIV/AIDS, malaria, TB and all of the rest, if it simply recognizes the fact that there has to be a health systems overlay, you don't just say, "Well, you do the health system, and you train the people, and then we'll give you the money or the drugs for specific interventions," there has to be incorporated into the framework of international assistance in healthcare. Third, on a very practical basis, in Africa where this crisis is at its worst, recently a group of African leaders got together and established a 15 percent target—they decided it themselves—of their national budgets to be used for their health systems. We need to encourage and reinforce this. This is not just a United States problem, but we can help by providing incentives through our international assistance for those countries that are actually moving forward on getting to that 15 percent, which, I would note, I believe no African country has currently reached.

Senator LEAHY. Dr. Gayle?

Dr. GAYLE. Yeah, just to basically support, I think, the issue—in addition to thinking about how we can make sure that we're not being a drain on the workforce in poor countries, but also that we look at what are the needs? That we are very, that we reinforce the kinds of health workers that will have the greatest impact on the lives of people in poor countries.

As Nils said, it's not necessarily doctors or even sophisticated nurses, it really is, developing a core of people who are the auxiliary health workers, on the ground people who come from those

communities, and understand those communities, who are really, the cornerstone of health interventions. By supporting the interventions, they are much more focused on the preventative side of health services, the public health approaches, I think we will get a lot—much more bang for the buck than by supporting tertiary care focus and technology fixes that oftentimes lead to short-term fixes, but not looking at the longer-term impact on lives.

We also would like to endorse the Durbin workforce bill, and be happy to help in any way as that continues to move forward, and think about what are the best ways in which to build that kind of health capacity on the ground that meets the needs of people where they are.

Senator LEAHY. Senator Durbin and I feel very strongly, I'm following his leadership on it, but we feel very strongly about that.

Dr. Hill?

Dr. HILL. Three quick points—there is one piece of good news here. When I travel to Africa or talk to doctors here who came from Africa, I've been pleased to find that the overwhelming majority did not come here primarily because they would get a higher salary. They often report that they came here because they had a chance to work in the field they were trained in, and they didn't have the chance at home. It is generally only a secondary motive—that is they did have the chance, they couldn't feed their family and do it.

Which leads me, and leads us, to the conclusion that we need to focus as Nils said, Dr. Daulaire said, on making sure that out there in the field the systems improve, so they can hold onto the people that are trained.

There is also a second point that addresses some of the points that Dr. Garrett was bringing up about infrastructure and health systems, because it's all related. I think as good as the CBJ may be in terms of communicating some things, at 2 inches thick you would think it could communicate a lot, but there's an awful lot it doesn't communicate.

There aren't a lot of projects. There's not a category for infrastructure or health systems, et cetera. But as a matter of fact, at USAID—and at PEPFAR too—there's a strong sense that these issues that have been raised simply have to be dealt with. The surge is a big problem, and they know that we have to work on systems.

But the way it tends to get done is that it is a component within a project that might be HIV or malaria or tuberculosis or contraceptive health or whatever it is, and any good program is going to have a component to it that specifically deals with this issue.

Now, there are two questions that Ambassador Tobias always asks at a review of programs. One, "Show me how this correlates with the work of other donors, so I know it's not duplicative." Number two, "Show me how this is going to produce sustainability," which means it has to get at the issue of health systems, et cetera. So, we're aware this is a problem.

The third simple point is that we are trying to ramp up, within all of the specific interventions, a component that will address precisely the question about what can you leave in place there that will allow them to do this work when we are gone.

Senator LEAHY. You know, in the article Challenge of Global Health, that Ms. Garrett wrote in Foreign Affairs, she quoted a Zambian doctor who said maternal death is the biggest challenge in strengthening health systems, if we get maternal health services to perform then we're nearly perfecting the entire health system.

Without going into great detail, let me start, Dr. Hill, with you. Would you agree with that?

Dr. HILL. Sorry, that there's a health systems problem in Zambia? Is that—

Senator LEAHY. No, that maternal death is the biggest challenge in strengthening health systems. If we can get maternal health services to perform, we're nearly perfecting the entire health system—that's what a doctor in Zambia said.

Dr. HILL. Yes, my health experts would probably disagree and have a big debate about that. It is certainly a critical component, and one of the most important. Whether it's the very most important, I don't think I'd be prepared to say, but it is a lynchpin, a critical piece of the puzzle.

The problem with a lot of this is that—however you decide to prioritize, the bottom line is, if you're not basically doing them all, just the top ones, whatever you choose is going to be undermined by what you didn't do. So, you almost have to find a way to take the top three, four or five, and find a way to do them, and to do them as well as you can, or you're going to undermine your successes wherever you did work.

Senator LEAHY. Which goes back to my prior oversimplification, my concern about robbing Peter to pay Paul, and making them all work.

Dr. Gayle, how would you—

Dr. GAYLE. I wouldn't add a lot to that, only to say that while it may not be the thing that can fix the overall system, it is something that we know we can do a lot about, there's a lot of examples of making a difference, and I think it is totally unacceptable that today with all that we know and all that we can do that we continue to let 500 million women die every year from maternal mortality—something that ought to be a normal part of life, and that we continue to have 150 times greater mortality rates in poor countries, than we have here. So, it is one of those issues that we can do something about, that would strengthen the infrastructure.

I would just go back to the point, the chart that Nils Daulaire showed earlier, when we look at, and the point that you made—when we look at talking about \$100 million and what that does in terms of saving lives—\$100 million is a small amount of money for a huge return in lives saved.

So, I think, again it is a choice of where do we put our resources, what do we want to be known for as a Nation, where do we want to show our leadership, and start making some of those choices?

When I headed the program for USAID program for, or Global AIDS Program, we at that time had \$250 million in our total program. You know, we are now in the billions of dollars. It is possible, with the right kind of leadership and the right kind of commitment to take the cap off and stop making unnecessary limitations for things that we know can make a huge difference in peo-

ple's lives around the world, and put us back in the global world as a compassionate Nation that does care about these things.

Senator LEAHY. You talk about the \$100 million. It's just about noon, we spent that much today in Iraq.

Whether one is for or against the war, just so we understand where the money is being spent.

Ms. Garrett, did you agree with the Zambian doctor you quoted?

Ms. GARRETT. I did. I think that we use the phrase "canaries in the coal mine" to refer to what is the marker of a potential risk or threat.

To me, the big canary in the coal mine for whether or not you have a public health infrastructure is dying children under 5, and a big canary in the coal mine for whether or not you have a functioning health delivery system is dying mothers in childbirth, and childbirth-associated deaths.

I'll give you an example from a few years ago, when I was in a rural clinic in Zambia, probably about an hour's drive from Lusaka. A woman came in with two children, one strapped to her back, and one trying to walk at her side. She had had to walk for 2 days to get to this clinic, and was doing so because the baby on her back was terribly sick. But, along the way the child became sick as well, the one that was ambulatory, and she ended up, for the last mile or so, carrying both children.

When she staggered in, the doctor felt that the larger child looked like the more crisis case, so she left her baby with me, on a straw mat on the floor, and went in to see the doctor with the larger child. As I held the baby, it died in my arms, and its cause of death was measles—completely preventable. The larger child died of malaria, and the mother broke out sobbing, describing how hard it had been for her to give birth both times, and how frightening it was, the prospect of what she would have to go through just to have two children to replace the two she had just lost.

To me, that anecdote has lived with me my entire professional life, it has been a guiding anecdote. I can't think of any better way to look at what we're trying to do with U.S. foreign aid than to focus on how we could save both of those babies, and make it safe for that mother to give birth to future children.

Senator LEAHY. Have both the mother and the child live.

Dr. DAULAIRE. The question that you asked, Senator Leahy is, I think, a very important one, and it underlines some of the challenges that we have in addressing all of these issues in a substantive way.

I can certainly create for you a model in which maternal mortality could be dramatically reduced in which other major causes of illness and death probably wouldn't be affected. You can design a health delivery system that focuses on that. So, the point is that you should not confuse cause and effect. A well-functioning medical care delivery system will reduce maternal deaths, but a maternal death-reducing system will not necessarily be a good medical system, and I reinforce what Laurie Garrett just said about keeping some distinction between public health and medical care.

On the other hand, an awful lot of children who die around the world, die not only because they lack preventive services, but because they don't have access to the basic care that would get them

antibiotics for their pneumonia, that would get them treatment for their malaria, where you actually need a trained healthcare provider, so there's a mix in all of these. I think, though, that the bottom line is, if we made the kinds of investments that each of our panelists has been talking about, it is a reasonable presumption that we would see dramatic reductions in both child death and maternal deaths.

Senator LEAHY. Thank you. I want to thank each of you for being here. Some of the questions I asked may have seemed self-evident, but I'm also trying to prepare a record for other Senators.

I don't want to leave the impression that I simply feel that more money cures all things. There are very dedicated men and women who are out in the world, from the United States as well as a whole lot of other countries. Some very dedicated men and women from those countries, that are trying to make a difference. Sometimes in areas with no infrastructure, or in the midst of civil war.

I think of one African country where I went with my wife where we were using the Leahy War Victims Fund. She had helped the nurses to bathe and care for a boy who was probably 10 years old, with terribly distorted limbs. As she was bathing him, she didn't see a mark on him, she asked why, they said he had polio. She asked the obvious question, "Why polio?" She knew that we'd sent polio vaccine to that country, making it available? They said the people who would do the polio immunization could not get to his village because there were so many landmines around, they couldn't.

I mention that only because too often—and I think Dr. Hill you were trying to point this out, there is no magic thing that we can do, but we should start with the health needs of women and children.

ADDITIONAL COMMITTEE QUESTIONS

There will be some additional questions which will be submitted for your response in the record.

[The following questions were not asked at the hearing, but were submitted to the witnesses for response subsequent to the hearing:]

QUESTIONS SUBMITTED TO DR. KENT R. HILL

QUESTIONS SUBMITTED BY SENATOR TOM HARKIN

POLIO ERADICATION

Question. Polio Eradication efforts are clearly working as we have seen the number of countries with indigenous polio drop to four, 2 billion children have been immunized, 5 million have been spared disability and over 250,000 deaths have been averted from polio. However, until the world is polio-free, every child, even those in the United States, is at risk.

In fiscal year 2007, both the House and Senate included \$32 million for polio eradication in their respective Foreign Operations Appropriations bills.

What amount is included for polio in your fiscal year 2007 projections?

Answer. USAID intends to provide \$31,680,000 for polio eradication in fiscal year 2007, which meets the House and Senate report level minus a 1 percent rescission.

Question. What is included for polio in your fiscal year 2008 budget submission?

Answer. The administration will fund polio eradication but specific funding levels are still under consideration.

QUESTION SUBMITTED BY SENATOR RICHARD J. DURBIN

MATERNAL MORTALITY

Question. The statistics are devastating—1 in 6 women in Angola or Afghanistan is likely to die from the complications of pregnancy or childbirth. UNFPA has a strong track record in this area, but the administration has refused to provide the funding for them that Congress has allocated. Women giving birth alone without access to the most basic care or life-saving drugs that could prevent post-partum hemorrhage should not be a hallmark of the 21st century, but in too many countries it is all too common. What are the most effective ways to reduce maternal mortality?

Answer. Maternal mortality can be reduced in two major ways: (1) reduce the number of high-risk and unintended pregnancies and (2) address the life-threatening consequences of pregnancy, which can include hemorrhage, infection, eclampsia, obstructed labor, and unsafe abortion. By promoting healthy timing and spacing of births, reducing unintended pregnancy, and reducing abortion, voluntary family planning is one of the most effective ways to decrease the number of maternal deaths. Once a woman becomes pregnant, USAID's strategy focuses on high-impact interventions. These include active management of the third stage of labor to address post partum hemorrhage; tetanus toxoid immunization during pregnancy, clean delivery practices, and treatment by antibiotics to address infection; administration of magnesium sulfate for eclampsia; monitoring the duration of labor and taking action in the event of prolonged labor; and provision of post abortion care. The over-arching strategy to deliver these and other maternal interventions (such as nutritional support and intermittent presumptive treatment for malaria to address indirect causes of maternal death) is to increase women's access to skilled attendance at birth, emergency obstetric capability to deal with complications, antenatal care and post-partum care, and family planning information and services. Essential to successful maternal care programs are reduction of financial barriers for families, appropriate deployment and retention of skilled frontline workers, and institutionalization of quality improvement systems. USAID has a very strong track record in maternal mortality reduction, including demonstration of effective approaches in community mobilization and behavior change, policy formulation, financing of maternity services, effective life-saving skills training, quality improvement, and contribution to reduction of maternal mortality by 20–50 percent within 10 years in 10 countries.

QUESTION SUBMITTED BY SENATOR PATTY MURRAY

HEALTHTECH AND THE CHILD SURVIVAL AND HEALTH ACCOUNT

Question. Under current funding levels, successful programs such as HealthTech have been cut to the skeletal remains. The administration's proposed budget calls for further cuts to the Child Survival and Health account, which funds HealthTech. These cuts are proposed while the administration comes to the Hill and touts HealthTech's successes such as the UNIJECT injection device and thecine Vial Monitor. The Senate budget resolution recognizes how important these programs are, and has added additional funding. That being said, please explain how further reductions could inhibit USAID's ability to fund such proven programs with demonstrable successes at the full obligated level?

Answer. Reduction in funds to HealthTech is not due to Agency funding cuts, but due to completion of certain activities. Further, sufficient money is already obligated to HealthTech for current needs. USAID is currently funding HealthTech to help develop several technologies—including antibiotics in UniJect and newborn resuscitation devices—which will improve the health of impoverished people.

In this and other key health investments, USAID focuses its programs and efforts on the highest impact activities, works closely with other donors, and continues public-private collaborations to help fill gaps. By these means, we expect to meet our objectives with requested Child Survival and Health account levels.

QUESTION SUBMITTED TO LAURIE GARRETT

QUESTION SUBMITTED BY RICHARD J. DURBIN

AFRICAN HEALTH CAPACITY/BRAIN DRAIN

Question. The issue of health capacity is critical to addressing all of the problems raised today. The whole world, including the United States is experiencing a shortage

of health personnel, but in Africa the shortage is far more dire. The math is devastatingly clear: as you testified, "As the number of health workers declines, survival decreases."

Along with Senator Coleman, Senator Leahy, and others, I have introduced legislation to authorize a concentrated effort to help Africa build the health capacity that it so desperately needs, from personnel—doctors, nurses, and community health workers—to infrastructure. Africa needs both health systems and the ability to train and retain personnel. Our legislation is also part of an effort to combat the brain drain of health professionals, including the need to train more nurses here in the United States so that we are not dependent on the poorest countries in the world to supply our health workforce. Ethiopia has 3 physicians per 100,000 people but there are more Ethiopian physicians in Chicago than in all of Ethiopia (Tobias).

What are the most effective ways to build health capacity AND fight this brain drain? This is an enormous problem—where can a U.S. contribution add the most value?

Answer. Thank you very much for posing this critically important question. I am, of course, well aware of your important initiative, and praised it in my testimony, and during Sen. Leahy's questioning. When you initiated the process of drafting this bill there were few analogous efforts going on in the world, and the U.S. leadership in this area was desperately needed.

I am happy to report that several potentially blockbuster efforts are underway, augmenting your efforts in this area. I will try to briefly describe the status of this situation, and suggest some efforts the United States can, and should, make.

First of all, in the last few months there has been a striking sense of global recognition of this problem. Recognizing a problem, and understanding its roots and nuances, is always the first step. Two real heroes in this aspect of the situation are Mary Robinson and Tim Evans. Robinson, the former President of Ireland and former head of the U.N. Commission on Human Rights, is now heading an international group that is trying to find ways to slow the exodus of health care workers from poor countries to the rich, without violating their individual human rights. Her group is meeting as I write these words in Geneva, in tandem with the 59th World Health Assembly.

Dr. Tim Evans, a leading Canadian health expert, now holds a top position in the office of WHO Director-General Margaret Chan. Together with Harvard's Dr. Lincoln Chen, Evans authored the groundbreaking analysis of the global health care workers situation, publishing 2 years ago, that estimated current deficits at 4.3 million. Evans' high level position in WHO's new leadership signals Chan's appreciation of the dire severity of the situation, reflected in her marvelous remarks at the opening of the Health Assembly this week. Chan is clearly the sort of Director General the global health community has been waiting for, and I have no doubt that she will take this health crisis issue by the horns.

On an entirely different front, the Prime Minister of Norway instigated a high-level meeting of foreign ministers, which convened in Oslo earlier this spring. The goal of the meeting was to better understand the links between national security and health, and the elevate discussion and action in the arena far beyond mere financial commitments. There is a growing recognition, as I outlined in my Foreign Affairs piece in January, that simply throwing billions of dollars at targeted global health problems, without any structural framework or support for public health systems development, will kill more people than are saved. (The one-page Oslo Ministerial Declaration is attached below.) The Oslo Summit promised a series of actionable steps.

The first of those steps will be launched this September in New York, during the U.N. General Assembly: "A Business Plan to Accelerate Progress Towards MDG 4 and 5". It's not a pretty title, but the concept is important. The Plan recognizes that the real victims of health care worker and health system deficits are mothers and children, and seeks to create an out-put based business strategy for investment in developing country health systems. The Oslo declaration estimates that 10.5 million mothers and children die annually from preventable causes, nearly all of them directly resulting from lack of sufficient medical care or basic public health services, such as water filtration and sewage treatment.

The Oslo group seeks to find business solutions to the crisis, creating better management of available personnel and resources, linking standards of care to financial rewards for providers, and moving the global community away from single disease targets for support and financial aid.

Secretary General Ban ki-Moon is also interested in finding ways to move the entire U.N. system towards a health systems approach for achievement of the MDGs (Millennium Development Goals), hoping to bring the health targets of various agencies into greater harmony.

Angela Merkel has signaled that she wants the G-8 to look at this issue in its upcoming Summit in Germany. Merkel has also instructed Germany's current leaders of the EU to examine EU foreign aid to global health, with an aim of building sustainable health systems.

Meanwhile, the World Bank and its IFC are moving in a very different direction—at least, for now, under Wolfowitz's imperiled leadership. Though the IFC recognizes the crisis in healthcare workers and paucity of health systems, it is not interested in building local capacity. Rather, it has announced a \$200 million program that would bring massive healthcare corporations from the wealthy world into poor countries, providing fee-for-service healthcare delivery to the nations' elites. The notion is that quality care for the elites will have a trickle-down effect, setting a standard that the entire Ministry of Health operation will strive to achieve for the population, as a whole.

As my tone may reveal, I do not accept this thesis. I was in Moscow when the U.S. Government built such an elite care facility inside the Kremlin Hospital, specifically to ensure that Boris Yeltsin received state-of-the-art cardiac care without having to leave Russian soil. The fantastically expensive effort was described in precisely the "trickle-down" terms now used by IFC. But in the years following construction of the elite facility, the Russian healthcare system deteriorated further, life expectancy for Russian men spiraled downward, drug resistant TB and HIV spread across the region, the live birth rate reached an all-time low for Russia and the overall health status of the country plummeted: So much for "trickle-down".

Here is the problem with how the United States funds these issues (to be followed by some suggested solutions):

(1.) Nearly the entire foreign aid budget for health and development is earmarked for disease-specific programs. Under the President's fiscal year 2008 State Department "Strategic Framework" funding is further funneled according to global political exigencies, targeting specific countries that the Administration believes play crucial roles in maintaining regional stability or in the War on Terrorism. Funding does not reflect on-the-ground needs.

(2.) The Administration (and many AIDS activists) argues that PEPFAR has created a health infrastructure in the 15 targeted countries that may now be solely for provision of HIV-related services, but can serve as a template for all health needs. In debates over reauthorization of PEPFAR this argument will be made. PEPFAR has become sensitized to the negative impact the massive AIDS-specific health program is having on other health services in targeted countries, and hopes to convince Congress to reauthorize PEPFAR, giving it more money, and a larger mandate.

(3.) The United States is not now engaged in the multilateral efforts to address the healthcare worker and health systems crisis, such as Mary Robinson's plans or the Oslo Declaration. As you well know, the Bush Administration has not played on the global health stage in partnership with other wealthy nations, and has set moral standards for execution of health programs (e.g. sexual abstinence, faith-based solutions, etc.) We are not part of the global efforts to solve these problems.

(4.) Overall, the U.S. foreign aid budget shares with other wealthy nations the problem of having been designed as a massive charity program. We have failed to invest in health, though we consistently use the term, "invest". Therefore, nothing is sustainable. There are no local profit centers, no genuine stakeholders.

(5.) The Republican-controlled Senate, under the leadership of surgeon Bill Frist, favored solutions to the healthcare worker and health systems crises that flowed from the fundamentally charitable view of U.S. foreign aid. Frist introduced bills that would underwrite the costs of faith-based and medical societies-run programs that dropped American doctors (and maybe nurses) into foreign countries for short time periods, during which they would theoretically perform surgeries, and supplement the services of indigenous healthcare workers. Criticized as "Safari Medicine," such vacation programs for American doctors tend to do more good for the Americans than for those they seek to serve, opening their eyes to the needs of the poor. Successes are limited to a handful of healthcare needs that are truly amenable to one-stop interventions, such as removal of cataracts, heart surgery, or limb replacement. Even acute humanitarian care interventions suffer if the health professionals limit their participation to time periods too short to allow them to learn some basic elements of the local language and culture.

(6.) There is no linkage in our government currently between the dire healthcare worker situation overseas and our shortages of doctors, nurses, lab technicians and other health professionals domestically. Government functions as if the two issues were entirely unrelated. There is no official recognition that American companies and hospitals actively recruit doctors and nurses from poor and middle income countries to offset our gaps in training of domestic personnel. Institutionally, the federal

agencies and Congressional committees that have oversight of the domestic and overseas issues share no lines of communication, whatsoever.

SOLUTIONS

(1.) A joint session should be convened of the Senate Foreign Relations Subcommittee on Foreign Operations and the Senate Committee on Health, Education, Labor and Pensions. This should be a well-orchestrated, and well-publicized full day joint session, aimed at revealing:

a. Twenty year forecast on U.S. healthcare worker needs and shortfalls for all health professionals.

b. Twenty year forecast on developing country healthcare worker needs and shortfalls for all health professionals.

c. Recruitment and immigration trends of foreign healthcare workers, filling United States needs, and estimated damage done in home countries.

d. Policies enacted by other wealthy countries to address brain drain.

e. Reasons the United States is currently unable to fulfill its domestic healthcare worker needs through training and employment of Americans.

f. Identification of legal instruments and budget initiatives that could be enacted by the House and Senate to radically enhance both the training of Americans and their conditions of employment, domestically.

g. Identification of legal instruments and budget initiatives that could be enacted by the House and Senate to provide incentives to poor country healthcare workers for remaining in-country, based on the identified reasons for their departures to rich countries. (For many doctors, dentists, pharmacists, technicians and nurses, money is not the primary driver: The lack of coordinated health systems, reliable supply chains of medical equipment and drugs, lack of meritocracy within Ministries of Health and general political conditions rank far higher as reasons for immigration.)

(2.) As a result of above Joint Session, corrective bills should be forwarded that seek not only bipartisan support, but also support that bridges the gap between domestic and foreign committee and agency foci.

(3.) The Senate should push the State Department to radically increase its currently mere \$3 million commitment to training in overseas health systems management. Even if your healthcare workers bill is passed, and fully funded, a surge in the numbers of community healthcare workers will have little positive impact if these individuals are not managed properly within an overall system of public health and clinical care.

(4.) Attention should be given to the remarkable successes of BRAC, the Bangladeshi micro-financing program that has deployed vast networks of paid, trained community healthcare workers to villages in pursuit of cholera, tuberculosis, failures in child immunization and maternal health. BRAC has proven that community healthcare workers, including semi-literate individuals, can save thousands of lives if they are (1.) given a finite and clear mission to accomplish, backed by adequate training, and (2.) paid for their work at a rewarding scale, linked to success, and (3.) are part of a transparent, well-organized health system, in this case independent of the government.

(5.) The foreign aid budget needs to move away from charity, towards support of business models and financial incentives of health. America cannot afford to put 20 million people on anti-retrovirals for HIV care, and foot the bill for their continued treatment for the next 30-to-40 years. Even if we were, as a Nation of taxpayers, interested in underwriting the healthcare needs of the world, we could not afford to do so. Therefore, we have no choice but to move away from the charity model of foreign aid, towards a model that provides incentives for creation of local business solutions. This should not follow the apparent IFC model of providing support to foreign health corporations, to go into poor countries, and extract profits from their health needs. Rather, the Senate should look to the BRAC model and consider how providing low-interest seeds can lead to the blossoming of genuine, sustained health businesses in poor countries.

(6.) The Senate should put pressure on HHS to radically speed up approval of appointments of federal employees for overseas health positions. Currently the majority of CDC overseas positions, and deployment of health personnel from other agencies within HHS, is mired in Secretary Leavitt's office, pending political litmus tests aimed, apparently, at finding scientists, experts and physicians who meet the Bush Administration's moral and political standards. At the very time when the world is, as a community, trying to hammer out radically new approaches to these health crises, America's voice on the world stage is diminishing. This should stop, immediately.

(7.) When considering large initiatives for healthcare worker training, such as is envisioned in your bill, the Senate should also imagine the toolkit that these workers will draw from. With what supplies will these new healthcare workers execute their efforts? No doubt supplies will, in early days, also require outside support. To minimize such costs and build in incentives for performance standards and sustained commitment to maintaining community health practices we have favored exploration of franchise models, a la MacDonald's: Each community health worker, after some identified set of training and work excellence have been achieved, is given very low interest micro-finance loans for purchase of his or her own franchise, which would include a physical clinic and basic tools and supplies. All of the franchises would be overseen by the hub of the network, monitored closely for performance quality; volume of services provided and inventory needs.

Senator, we are at your service for any further clarifications, brainstorming or information needs you may require. We are honored to be of service.

OSLO MINISTERIAL DECLARATION: GLOBAL HEALTH—A PRESSING FOREIGN POLICY ISSUE OF OUR TIME

Under their initiative on Global Health and Foreign Policy, launched in September 2006 in New York, the Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand issued the following statement in Oslo on 20 March 2007:

In today's era of globalisation and interdependence there is an urgent need to broaden the scope of foreign policy. Together, we face a number of pressing challenges that require concerted responses and collaborative efforts. We must encourage new ideas, seek and develop new partnerships and mechanisms, and create new paradigms of cooperation.

We believe that health is one of the most important, yet still broadly neglected, long-term foreign policy issues of our time. Life and health are our most precious assets. There is a growing awareness that investment in health is fundamental to economic growth and development. It is generally acknowledged that threats to health may compromise a country's stability and security.

We believe that health as a foreign policy issue needs a stronger strategic focus on the international agenda. We have therefore agreed to make "impact on health" a point of departure and a defining lens that each of our countries will use to examine key elements of foreign policy and development strategies, and to engage in a dialogue on how to deal with policy options from this perspective.

As Ministers of Foreign Affairs, we will work to:

- increase awareness of our common vulnerability in the face of health threats by bringing health issues more strongly into the arenas for foreign policy discussions and decisions, in order to strengthen our commitment to concerted action at the global level;
- build bilateral, regional and multilateral cooperation for global health security by strengthening the case for collaboration and brokering broad agreement, accountability and action;
- reinforce health as a key element in strategies for development and for fighting poverty, in order to reach the Millennium Development Goals;
- ensure that a higher priority is given to health in dealing with trade issues and in conforming to the Doha principles, affirming the right of each country to make full use of TRIPS flexibilities in order to ensure universal access to medicines;
- strengthen the place of health measures in conflict and crisis management and reconstruction efforts.

For this purpose, we have prepared a first set of actionable steps for raising the priority of health in foreign policy in an Agenda for Action. We pledge to pursue these issues in our respective regional settings and in relevant international bodies. We invite Ministers of Foreign Affairs from all regions to join us in further exploring ways and means to achieve our objectives.

NEW INITIATIVE SEEKS PRACTICAL SOLUTIONS TO TACKLE HEALTH WORKER MIGRATION

Geneva.—The health worker migration policy initiative held its first meeting today at the headquarters of the World Health Organization (WHO) in Geneva. The initiative, led by Mary Robinson, President of Realizing Rights: the Ethical Globalization Initiative, and Dr. Francis Omaswa, Executive Director of the Global Health Workforce Alliance (GHWA), is aimed at finding practical solutions to the worsening problem of health worker migration from developing to developed countries.

WHO Director-General Dr. Margaret Chan said, “International migration of health personnel is a key challenge for health systems in developing countries.” The new initiative has a Technical Working Group housed at WHO.

The Health Worker Migration Policy Initiative is made up of two groups that will work closely together over the coming months to develop recommendations. The Migration Technical Working Group, which is being coordinated by WHO, brings together the International Organization for Migration, the International Labour Organization, professional associations, experts and academics.

The Health Worker Global Policy Advisory Council, under the leadership of Mary Robinson and Francis Omaswa and with Realizing Rights serving as its Secretariat, is made up of senior figures from developed and developing countries, who will develop a roadmap and a framework for a global code of practice for health worker migration and seek high-level political backing for its recommendations.

A recent study has shown that the number of foreign-trained doctors has tripled in several OECD countries over the past three decades. The number of foreign-trained doctors from countries with chronic shortages of health workers is relatively small (less than 10 percent of the workforce) in developed countries. However, for some African countries, the migration of a few dozen doctors can mean losing more than 30 percent of their workforce, even as basic health needs remain unmet.

Other health professions are also affected by this phenomenon. The study showed that in Swaziland, 60 to 80 nurses migrate to the United Kingdom each year, while fewer than 90 graduate from Swazi schools. GHWA partner and member Save the Children UK estimates that the United Kingdom saved £65 million in training costs between 1998 and 2005 by recruiting Ghanaian health workers.

Mary Robinson summarized the need for urgent action: “We cannot stand alone as individual countries continue to address their own increased needs for health workers without looking beyond their shores to the situation these migrating workers have left behind in their homelands. We cannot continue to shake our heads and bemoan the devastating brain drain from some of the neediest countries on the planet without forcing ourselves to search for—and actively promote—practical solutions that protect both the right of individuals to seek employment through migration and the right to health for all people.”

One of the initiative’s first priorities will be to support WHO in drafting a framework for an International Code of Practice on Health Worker Migration, as called for by a resolution of the World Health Assembly in 2004. This framework will promote ethical recruitment, the protection of migrant health workers’ rights and remedies for addressing the economic and social impact of health worker migration in developing countries. The Code of Practice will be the first of its kind on a global scale for migration.

The initiative will also promote good practices and strategies to enable countries to increase supply and retain their health workers more effectively. The new tools and policy recommendations developed by the initiative will support better management of migration through North-South collaboration.

Dr Francis Omaswa emphasized the importance of addressing both the “push” and “pull” factors simultaneously. “Health workers are a valued and scarce resource. Demand is increasing worldwide, but not enough are being trained—in the developed or the developing world. Developing countries must prioritize health and health workers, with better working conditions and incentives so its workforce can stay and be more efficient, while developed countries must train more of their youth and try to be self-sufficient.”

The Health Worker Migration Policy Initiative is due to make initial policy recommendations by the end of 2008. Its operations are co-funded and coordinated by Realizing Rights, the Global Health Workforce Alliance, and the MacArthur Foundation.

HEALTH WORKER GLOBAL POLICY ADVISORY COUNCIL

Co-Chairs: Hon. Mary Robinson, President, Realizing Rights
Dr. Francis Omaswa, Executive Director, GHWA

MEMBERS

Hon. Major Courage Quarshie, Minister of Health, Ghana; Hon. Erik Solheim, Minister of International Development, Norway; Hon. Patricia Aragon Sto Tomas, Minister of Labor and Employment, the Philippines; Hon. Rosie Winterton, Minister of State for Health Services, United Kingdom; Dr. Lincoln Chen, Director, Global Equities Initiative, Harvard University; Dr. Anders Nordström, Assistant Director General, Health Systems and Services, WHO; Ms. Janet Hatcher Roberts, Director, Migration Health Department, IOM; Mr. Ibrahim Awad Director, International Mi-

gration Programme, ILO; Lord Nigel Crisp, co-Chair, GHWA Task Force on Scaling up Education & Training; Dr. Percy Mahlati, Director of Human Resources, Ministry of Health, South Africa; Huguette Labelle, Chancellor, University of Ottawa; Dr. Titilola Banjoko, Managing Director, Africa Recruit; Prof. Ruairi Brugha, Head, Department of Epidemiology & Public Health, Ireland; Ms. Sharan Burrow, President, International Confederation of Free Trade Unions; Ms. Ann Keeling, Director, Social Transformation Programs Division, Commonwealth Secretariat; Mr. Markos Kyprianou, Director General, Health & Consumer Protection, European Commission; Mr. Peter Scherer, Directorate for Employment, Labour and Social Affairs, OECD; Prof. Anna Maslin, Nursing Officer, International Nursing & Midwifery Health Professions Leadership Team, Department of Health, United Kingdom; Dr. Mary Pittman, President, Health Research & Education Trust, American Hospitals Association; and Dr. Jean Yan, Chief Scientist for Nursing & Midwifery, WHO, chair of the Migration Technical Working Group.

HEALTH WORKER GLOBAL POLICY ADVISORY COUNCIL SECRETARIAT

Ms Peggy Clark, Managing Director, Realizing Rights
Dr. Ita Lynch, Health Advisor, Realizing Rights

SUBCOMMITTEE RECESS

Senator LEAHY. So, I thank you all very much for being here. The subcommittee will stand in recess.

[Whereupon, at noon, Wednesday, April 18, the subcommittee was recessed, to reconvenne at 10:30 a.m., Thursay, May 10.]