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XVII International AIDS Conference Strengthening Health Systems Through the AIDS Response August 7, 2008

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RICHARD HORTON, M.B.: Okay. The music disappears. Silence pervades the atmosphere and it is time for the best session of the day. So all of you who are here are really smart. You could have gone shopping. You could have gone sightseeing but you are the smartest people at this conference because you come to the future of this movement. You have read as I hope you have, the 2008 UNAIDS Report, at least the executive summary. The agency explicitly says page 19 of the executive summary, that its weaknesses in health systems that are slowing the scale-up of antiretroviral treatment programs.

They emphasize that it was an intensification of work on strengthening health systems. It was bound to take us to the next phase of ART rollout and if you had also been really smart and come to the symposium that we did on Tuesday on HIV prevention, you would have heard some fantastic people say exactly the same thing around prevention services.

So we got remarkable agreement and we do not often get remarkable agreement that, across a range of global health initiatives today, it is the health system that is the critical obstacle for progress.

Now on Monday evening Julio Frenks shared a fantastic symposium launching, I am sure we are going to hear more about it from Carissa Etienne, a WHO program called "Maximizing Positive Synergies" and it is an effort to ensure that, to take

the example of HIV/AIDS, the funding around HIV/AIDS also delivers health gains in other sectors. Now sometimes, when we are discussing this issue of vertical programs and health systems, vertical, horizontal, diagonal, whatever these words mean, the language used in debates can get a little bit heated. I have seen people talk about a wall between these different camps and that is not very helpful.

So this symposium is going to explore in some depth what might be possible, how can increased resources around HIV be managed in the best way for health system strengthening? What do we agree on? What do we not agree on and what data do we need to get in order to settle our disagreements? When we do pack up our bags and leave Mexico City, what are we going to do?

So the way we are going to work this symposium is this man here, Gorik, is going to give you 15 minutes about where we are and options for the future and then we are going to ramp on this wonderful panel. I will introduce them as we go, to give five-minute responses to what Gorik has said. Then we are going to have a bit of fun. We are going to have some question and answer and if we have enough time, you too will have a chance to ask some pointed questions, I hope, and then we will finish. Then you can go shopping.

So let us start off, Gorik, would you like to give us your 15 minutes, this issue where we are. Please welcome him [applause].

GORIK OOMS, PH.D.: Hi everyone. Thank you. First of all, I would like to acknowledge Dr. Hungan [misspelled?] here. Dr. Hungan was the Minister of Health in Mozambique when I was working there and he launched the first AIDS treatment program against the will of most of the donors at that time. They were really reluctant and the reason why is that they said that it would distort an already fragile and weak health system. They said it would actually kill more people indirectly than save lives.

Now today, I believe there are 90,000 people on a treatment in Mozambique, alive because of AIDS treatment and so I wonder if somehow on the way we indirectly killed 90,000 people somewhere else.

Those arguments that were used then are coming back. This is the heading of a recent article showing that massive AIDS projects are threatening African health and they are depleting other African health programs that may have a much greater impact or effect on public health.

Is this true? It is a very harsh accusation but it is a serious one. That is what we try to find out in the workshop. We call it now the Antwerp in Geneva Workshop. Initially it was planned to take place in Antwerp but we moved it to Geneva

because it became a kind of pre-meeting to the first Expert Consultation on Positive Synergies.

The objective at this workshop was to review the evidence of the effects of the AIDS response on health systems and services particularly in high-prevalence countries. So the findings might not always be relevant to our own countries.

Participants involved research institutions, representatives of ministries of health, NGOs involved in the implementation of AIDS response to kind of trying to bring those two tribes at war together and discuss under Shedom House [misspelled?] rule and that was really helpful to get some of the information that you usually do not get when everyone has to be politically correct.

What are the findings? First of all, there is a whole discussion that AIDS money or AIDS funding has taken away money for general health services. Now if we look at the facts, at the evidence that is not true. These are figures of the period 2001, 2005 when PEPFAR and the Global Fund were created. We see a doubling of development assistance for HIV/AIDS, \$1.4 billion to \$2.6 but at the same time, health sector development increased from \$2.3 to \$4.7. So actually it increased just a little bit faster in that period. If PEPFAR and Global Fund were displacing money, we would have seen it here.

Now there are some worrying findings that in some countries at least, international funding for disease-specific

intervention is crowding out domestic health financing. This domestic health financing is most often used for the recurrent health expenditure, the salaries, et cetera.

Now why is this happening? Probably because of health expenditures dealings imposed by the IMF. So it is a real issue. It is really problematic but we should be careful not to blame the wrong people for this or the wrong institutions for this. I mean it is not the AIDS response that created those ceilings. In fact, AIDS activists have been among the most prominent challenging the IMF on this and to house, more flexibility or the removal of those dealings.

Then findings on implementation, implementation on the ground, the first finding is that the AIDS response contributed and continued to contribute to increased investment in all the building blocks of health systems, the health workforce, supply system, lab facilities, and information system.

However, there are countries where this increased investment is used or devoted exclusively to disease-specific outcomes. This is first of all, a missed opportunity as potential spillover effects and for other health services have not been fully realized yet, let us hope but even in some situations, other health services might have been weakened as increased disease-specific investments are using the building blocks of the health system.

Now there is something strange about this discussion. Sometimes it sounds as if people with AIDS have to justify that for every doctor and nurse they are using, they have to show that they brought additional money for an additional nurse or doctor. Let us not forget, it is their health system as well and it is normal that part of this health system is used for their treatment.

Now what we find also is that there are a few key factors that seem to make the difference between positive and negative synergies and perhaps the most, the one that came out the most forcefully of this discussion is the health workforce crisis.

This is really the critical factor wherever the AIDS response has contributed to more human resources for health and more professional health workers or including communities in the delivery of services. There seems to be a positive spillover effect but the opposite is true as well. Wherever the AIDS response has neglected the health workforce crisis and has not tried to improve it, the impact on other health services seems to be negative.

Now what we find also is that this does not seem to depend that much on the attitudes of donors, Global Fund and PEPFAR, are willing to fund the health workforce. It was interesting to see in the meeting that some people explained what they were doing with Global Fund money to strengthen the

health workers. Then people from other countries said oh, we did not know that we could use Global Fund grants for this. So sharing information about what is possible would be a first step to solve this.

Now the way forward, the global AIDS response has created a renewed momentum for what is fundamentally a shared and uniting paradigm of comprehensive primary health care, which includes AIDS prevention and treatment, so no more selective primary health care. This is really a paradigm or an intention that can bring those two tribes together.

There are lessons to be learned from this fight against AIDS that can and should be a fight in the fight for comprehensive primary health care. I listed just a few of the most important came out of our discussion really acknowledging that health is a human right and health care is an entitlement, that programming and financing of health care should be adapted to needs, to real needs and not to the alleged scarcity of resources.

Concerns about sustainability of health care, not only AIDS treatment, should be considered at the global level not only at a national level. Macroeconomic policies by the IMF and to some extent, also by the World Bank must be adjusted to vital needs and not the other way around.

Last but not least, people have a right and a duty to be involved in all decisions about their health. The way

forward, I mean, we are living in a world where the average economic product is about \$7,500 per inhabitant of this planet. So the global economy could easily afford to spend \$300 per person per year on health care.

That is only four-percent of the GDP and most rich countries are spending a lot more, yet in this world in some countries, the government health budget is still less than \$15 per person per year. The difference is huge and somehow the fight against AIDS created some kind of [inaudible] resolution in health economy by saying that yes, AIDS treatment might be too expensive for national economies but it surely is not too expensive for the global economy.

Now this is a new perspective on sustainability, on financing, on health economy, and if we can use this new perspective for comprehensive primary health care, perhaps 30 years after [inaudible], we can realize that.

Now the way backward, I just want to put in a very recent quote from a discussion in Mozambique about health sector salary reform. When donors say yes, sustainability is an important issue in the sense that in the longer run, the national economy should be able to pay for increased levels of salaries.

Why should it be the national economy? Why can we not rely on national and international funding? If health is a human right, if we are serious about it, then there is a duty

for all human beings and all countries to contribute to it and to help the poor countries. This is really a new way of looking at health economy.

So some recommendations might seem obvious but again, governments must live up to their promises. There is a very old promise by rich countries to spend 0.7-percent of their GDP to international solidarity. Well if they would do that and if they would spend 15-percent of that to international solidarity in health, we would have \$37 billion per year, which is much more than what we have today. It is an old promise but it is about time that it is fulfilled.

It is not only the governments of high-income countries, also the governments of middle-income countries and low-income countries must live up to their promise, a promise in [inaudible] a couple of years ago to elevate 15-percent of government revenue to health expenditure. Well they have to do that and let us hope they will not need three decades like which countries are needing and we are still not there.

So as a conclusion, comprehensive primary health care for all is possible. It can include universal access to AIDS prevention and treatment even in the poorest countries within this new paradigm created by the fight against AIDS. When two tribes go to war together rather than against each other, it is possible. Now I was planning to sing this like Peter Piot sung Bob Marley but I am not going to do that. Thank you [applause].

RICHARD HORTON, M.B.: Great. We will get you to do it before the end of the session. That was great. Visionary thoughts about how we might make this work. Now let us go down the panel. Carissa Etienne is a relatively new Assistant Director General at WHO and she has been given the hot job of fixing this issue around health systems and she has already started with incredible energy to make WHO make a big difference. So it is a real pleasure to introduce Carissa to give some thoughts and reflections after hearing [inaudible]. Carissa, you are very welcome [applause].

DR. CARISSA ETIENNE: Thank you Richard for this introduction. I am going to use my five minutes strategically. So I am going to speak about health systems and the future as it is envisioned. Certainly, WHO is seized of the fact that weak health systems are limiting the progress to the outcomes that could be achieved by disease-specific programs.

We concentrate on meeting the millennium development goals and, even as we are aware that we are not on track in many countries to meet these M.D.Gs, we also recognize that the HIV/AIDS epidemic is also having a negative impact on our ability to meet the other M.D.Gs and particularly health-related M.D.Gs.

We recognize that there is growing consensus that several aspects of health systems are in fact responsible for significant limitations in terms of the health outcomes.

So what it is when we speak about health systems, how could we define it and what are we speaking about? There is a WHO definition of 2000 that has been adjusted to read all organizations, people, and actions whose primary intent is to promote, restore, or maintain health. This is what we refer to when we speak of our health system.

It is sometimes useful to think of the health system as consistent of six building blocks that are interrelated and interlinked but very importantly, that people are at the very center of those. These blocks are health workers, financing, medical products and vaccines, and technology, service delivery, health information, leadership, and governance.

It is clear that health systems must deliver on some very important functions. A health system must deliver services to a whole population, so the emphasis on universal coverage and universal access.

A health system should provide clients with services to meet clients' needs and expectations, comprehensive care that is oriented around clients' needs and expectations. A health system must deliver services in a way that is equitable and must address the needs of the poor, vulnerable, and marginalized, the question of equity.

A health system must deliver services of good quality. A health system must be robust enough to respond to existing needs but also to complex and emerging challenges. And at first

we have had a series of meetings, was regional consultations and indeed the emerging vision for health system strengthening is that health system strengthening must be based on primary health care, that indeed the core values and principles are as they were Alma-Ata.

The principles of equity, social justice or human rights, and solidarity are all relevant today as they were 30 years ago. This must be formed, the underpinning of the organization of health system strengthening.

What we are seeing is the emergence of four sorts of reforms within the health system strengthening. A reform that speaks to universal access, that speaks to health for all, that speaks to reaching the unreached, and to achieve this level of access, obviously the attention to social protection in terms of risk pooling and pre-payment skins but we need to make a point that primary health care is not just for poor countries, that it is relevant for the rich, the middle-income, and low-income countries.

Indeed if we are to achieve this, when we must undergo primary care reforms as well and primary care that is not necessarily the first level of care but it is care that is organized around a patient's needs and expectations, care that is comprehensive, integrated, that sticks to address continuity of care and high quality. Indeed where the client, the patient, his family and his community are at the very center of that

organization of care but must also be an equal participant in the decision making process about their care.

So we also begin to see that there is a need for public policy reforms, reforms that speak to the social determinants of health and seek to incorporate the all of government approach and also the participation of all sectors in the restoring health and well-being.

Then of course, this needs a level of leadership and governance that will call for a degree of reform as well, a leadership that is open to inclusiveness, to sitting around the table with private sector and civil society organization, a leadership that is open to greater transparency and accountability and will utilize evidence for decision making.

Certainly my five minutes is almost up, so I want to see, we will have time to talk about positive synergies and what we are doing but I want to see that we must never forget the big picture. You think I am young. I am not. I have been in this work for a long time, almost 30 years and I have watched the pendulum swing from health systems strengthening to disease-specific programs and it seems that we want to swing it again to health systems.

We must learn from our errors of the past. It is not either/or. We must pay attention to both, to strengthening health systems and improving and investing in disease-specific programs. I think we have an opportunity now and I think that

we need to get it right for ourselves but also for the children of this world. Thank you [applause].

RICHARD HORTON, M.B.: Thank you. Thanks Carissa. Now UNAIDS has really embraced this message as part of its core program of work and we have seen that all week this week. It has been a vital protagonist in the debate between vertical and horizontal and I know that Peter Piot has been very much involved in those discussions.

Slightly anxious, I know he has been about the use of diagonal and perhaps the dangers of drawing resources away from HIV/AIDS in an exceptional response to HIV/AIDS and which might be diluted by a focus on health systems. Getting this balance right is very difficult so we are very fortunate today to have Prasada Rao from UNAIDS to give us a steer about UNAIDS' views about how we might guide ourselves in the future. Prasada, you are welcome. [Applause].

J.V.R. PRASADA RAO: Thank you Richard for the introduction and for giving me this opportunity. I also thank Gorik for those observations in his presentation, which are very much evidence-based and much [inaudible] support what I am going to say in the next few minutes. I have been involved with HIV/AIDS in three different capacities during the last 12 years.

First as the Program Director of the India's National Program, then as the Prime Minister of Health [misspelled?]

with the government of [inaudible], where I had an opportunity to look at the entire health sector and now as the UNAIDS representative in a relatively less prioritized region like Asia and the Pacific. So my observations will be based on the understanding these three perspectives that [inaudible].

I do not see and I agree with Carissa, this as a debate [inaudible] AIDS and health system. It is not one against the other but much of this debate on AIDS versus health system, it is not mostly because of the experience in some generalized development countries and mostly of Sub Saharan Africa.

In the rest of the developing world, where the opportunities are lower concentrated, it is still a problem of inadequate resources [inaudible] AIDS programs due to low levels of political commitment. This is also true of the health sector as a whole. So what are we talking about that these countries are not rolling riches as far as AIDS programs are concerned but there are enough to [inaudible] somewhere else.

It is now largely [inaudible] that AIDS has in fact, it had a pool effect on the health sector, which was otherwise languishing at the bottom of the ladder in terms of political priorities and [inaudible] priorities in many of these countries.

AIDS has brought dynamism and activism in the development agenda. It opened dialogue on taboo subjects, which mainstream society has pushed into a closet for centuries. AIDS

has strengthened the concept of health as a public good and established the relationship between health, development, and global security.

The benefits, therefore, have far outweighed the losses in terms of resources, so-called [inaudible] resources in much of the developing world but how would [inaudible] be in generalized epidemic countries, the shortage of human resources for general health programs has been dropped. How much of that can be apportioned to AIDS? It is also a matter of debate.

The reality today is that while the million to billion shift has occurred in AIDS spending, a disproportionately small amount has gone into prevention, into substantially reducing incidence. That is the new infections occurring still on a large scale in much of Asia, Central Europe, and other regions.

In other words, high impact prevention programs, which address most at-risk populations including men who pay for sex and their female partners have still not received the new set of resources.

It is also an [inaudible] fact that the high level of stigma and discrimination [inaudible] populations who are criminalized under national laws from accessing health systems, or from prevention and treatment programs. I am here to see a day there are men who have sex with men, injecting drug users, sex workers line up before a district hospital for antiretroviral treatment or for condoms.

As the Commission on AIDS in Asia has recommended, it is only the community-owned and community-run programs, which can effectively reach out to these populations. Evidence shows that if new infections still are [inaudible] to paid sex and drug use in much of the developing world are not substantially reducing the next three to five years, many of the countries would be missing their universal access and the unreached targets.

That is enough resources from AIDS. There is [inaudible] funding and pursuing AIDS exceptionalism and [inaudible] program on AIDS can prove disastrous to scaling up of prevention and treatment programs at this critical state of global response.

Instead, I would advocate for a more prudent approach of building on the success of AIDS movement to attract largely the sources for the health system development. We need to take a real look at the way we think about health systems. We need to examine the human and social aspects of the health system rather than focusing only on infrastructure and logistics, which [inaudible] point.

AIDS has also shown the way on how to secure private sector and civil society participation in [inaudible] programs, how to secure community involvement, how to establish a base for vital social sector reforms in areas, which go even beyond health sectors like women and [inaudible] rights,

decriminalization of sex workers, same and gender-based violence, violation of human rights, et cetera.

All in all, health sector has many lessons to learn from the way AIDS-related issues have been projected with solid evidence before national governments of developing countries for gaining political support and attracting larger resources.

Finally, AIDS has provided a historical opportunity to project health as a priority for human development. The onset therefore is not to divert resources from AIDS programs but for generating activism around health sectors as a whole, by building a strong evidence base to project the interminable link between health and human development and help countries garner larger resources for health sector both domestic and international.

The message is we should try to raise the bar for total health spending, which in many developing countries, hovering around 1-percent for the last several decades. Thank you [applause].

RICHARD HORTON, M.B.: Thanks very much Prasada. Now, when you look at why it is that the AIDS movement has been so successful in generating resources and doing the things that we have heard it has succeeded in doing, the absolute quintessential part of that success has been the leadership from NGO and civil society movements.

Our next two speakers are going to reflect that and give their perspective on how this emerging discussion is evolving. First, I am pleased to welcome Eileen Stillwaggon from the International AIDS Economic Network. Eileen [applause]?

EILEEN STILLWAGGON, PH.D.: Thank you Richard. I will save some time and say I agree with that, all of that [laughter] okay. Here is another message. As an economist, it is my job to bring you the good news that integrating HIV prevention and treatment into primary health care makes economic sense because it takes advantage of the biological synergies among diseases and utilizes economies of scale and scope.

Although vertical programs have sometimes been very successful, that is not generally been the case for HIV programs, at least in poor populations. AIDS exceptionalism has even distorted HIV research, prevention, and treatment. AIDS did not arise in a vacuum. The worst HIV epidemics are found in countries with multiple epidemics, multiple endemic diseases that increase vulnerability to HIV and increase contagiousness of HIV-infected people in sexual or vertical transmission.

For example, we know that malaria increases viral load as much as 10-fold, increasing sexual and vertical transmission for several weeks after febrile episodes. Preventing HIV and malaria endemic populations requires that we also prevent

malaria. Even effective treatment of HIV will require an integrated approach.

A forthcoming article in AIDS reports on the double-blind, placebo-controlled study demonstrating the CD4 counts can be increased in HIV-infected persons coinfecting with the [inaudible] by giving them deworming medication that costs about two U.S. cents. Thus, it may be possible to postpone first-line antiretroviral therapy in these persons for a considerable length of time, protecting them and preserving first and second-line therapies.

The third example of a common disease that interacts with HIV is urinary schistosomiasis, which affects over 200 million people in Sub Saharan Africa. Genital lesions of schistosomiasis increase sexual transmission of HIV in women three-fold but that additional risk would be eliminated for ten U.S. cents per year. Moreover, people infected with schistosomiasis often cannot tolerate antiretroviral therapy because the parasite impairs liver function just as TB treatment precedes ART, deworming should be part of the ART protocol.

Trying to roll out ART without treating widespread, easily curable conditions like worms wastes lives and squanders first-line therapy. How did we get to this place where conditions as widespread as malaria, worms, and malnutrition and remedies as obvious as basic health care have been ignored?

The fault lies in both the biomedical fields and in the social sciences for evaluating diseases and interventions isolated from their context.

Cost-effectiveness analysis usually looks at single inputs and single outputs and is best suited to comparing similar interventions. It can identify only local maxima or minima but the landscape of HIV transmission is very complex.

If we only want to advise policy makers whether it is better to hand out condoms with or without lollipops or let us be fair, in a factory or a community center, the current methods are adequate but it is not much help if the larger reason that HIV spreads so rapidly, sexually and vertically in poor populations is the high prevalence of malaria, schistosomiasis, or filariasis, in that case, cost-effectiveness analysis gives us very precise even correct answers to the wrong questions.

We need new economic tools if we cannot see that. Trying to solve one health problem at a time is doing things the hard way. It throws away the many opportunities to solve multiple problems simultaneously and using lower costs, higher impact readily available actions.

In response to calls for broad-based health spending, Dr. Jim Kim has been quoted as challenging what would you do with the money next week? This is not rocket science. We know

how to make people healthier and less vulnerable to infectious diseases.

In 2006, the World Health Organization established the protocols for integrated treatment of multiple tropical diseases capturing tremendous economies of scope.

Pharmaceutical companies have committed themselves to contributing, free-of-charge, for as long as it takes, the drugs needed to eliminate many of the diseases that interact with HIV.

PEPFAR and other donors just need to accept that offer to integrate treatment of HIV and cofactor diseases. AIDS is very important and that is why I dedicated the last ten years to HIV and its coinfections but we can achieve our goal of healthy individuals and healthy populations only if we stop chasing after, one virus one person at a time. Thank you [applause].

RICHARD HORTON, M.B.: Thanks very much indeed Eileen. Our next speaker, please welcome Aditi Sharma. Aditi is the International AIDS Policy and Campaign Coordinator for Action AID and she also represents the International Treatment Preparedness Coalition. Aditi [applause].

ADITI SHARMA: Thanks. This debate has been declared sterile, outdated, and unnecessary at this conference by health activists, AIDS activists, and health ministers alike. So why

do we need this debate? I think this debate is important because it does not just mean health by academics.

The danger of this debate is that it is being used as a shroud to cover up a litany of broken promises by the donor governments, by the G8 and other donor governments. First in aid, Gorik mentioned the 0.7 target. Then on Africa, we have gone and doubled aid to Africa and most importantly in this context, on HIV/AIDS. Just a few years ago we promised universal access to HIV/AIDS services by 2010s and all of you sitting here know where we are at.

So while the donor community is busy promoting new health initiatives, creating and setting up new partnerships, they are shortchanging even existing initiatives like the Global Fund to fight AIDS, TB, and malaria and they are not promising more funds for health system strengthening. So these initiatives come cheap.

Among the donors, AIDS is no longer in fashion. Health systems is in as we know for the G8 summits in Japan and Germany before but for HIV-positive women in India, and you see data reports of this, to go from hospital to hospital and are refused treatment, who are refused the provision to deliver their baby in hospital, these debates are a matter of life and death. That is why we need to continue to have them.

So I want to talk about let us move forward. So what does a strong health system look like? We are talking about strengthening health systems. What does it look like?

As Prasada said, in how many countries does the health system really deliver health care equally, equally to women and children, equally to prisoners, to drug users, equally to sex workers, to gay men, equally to migrants, to refugees. So if it were not for activists like us shouting from the rooftops, would we even bother to check?

Health care is political. It is social. It is cultural. Just providing or ensuring funding and building more primary health care centers does not equal access. It does not equal access for rural women in Latin America, in Africa, in Asia.

Deep rooted patriarchy, gender inequality, violence against women will stand in the way of health care access. Good AIDS programs recognize this. So let us build on this. We cannot afford to lose this and go back and revert back to old style public health strategies. Feminists in this room and there are many, remind us of their struggle and the damages of old style public health strategies.

Remember family planning, which meant forced sterilization and toxic therapies for thousands of women. We cannot afford to go back there. So yes, let us step up together to campaign for universal access to health care for all but let us learn all that a woman, to enjoy her right to health,

requires no primary health care centers near her so she does not have to travel far, does require [inaudible] who are there in those primary health care centers. We need to hire them. We need to retain them. We need to pay them a living wage but it also requires that the health care system identifies and tackles [inaudible] of gender violence.

It also requires that that health care system prioritizes sexual and reproductive health. It also requires that the ITPC programs that offer her treatment for her lifetime not just to help her deliver that baby.

Finally, I would like to talk about this issue about AIDS distorting or what are the benefits of the AIDS response on health systems. I disagree that AIDS response has distorted health systems. While the AIDS epidemic has certainly exposed the chronic, underfunding in health systems and the fragility in health systems in all our countries, ITPC's six-country research recently launched reveals mainly positive impacts of the scale-up of HIV services and health care. A colleague of mine has copies of the research if you are interested back there.

Let me tell you about the four key benefits. We have done research in six countries and we found, generally, the AIDS response has meant a building up of infrastructure and systems. It has raised the bar on the quality of health care. Most importantly, it has, as I said, the [inaudible] has

extended the reach of health care to socially marginalized groups and it has engaged health care consumers in planning and delivering of services. And as Gorik said earlier, this is critical. So let me end with three examples from the report.

In Zimbabwe, HIV/AIDS services particularly the provisions of ARVs, have become a lifeline in the virtually collapsed health delivery system I do not need to explain anymore. In Uganda, [inaudible] programs for people living with HIV/AIDS have benefited whole communities. This is also strengthening a health care system.

Medical personnel, clinics that have been funded by HIV programs are not just there to treat HIV/AIDS. They are there to treat other diseases.

In Argentina, HIV strategies have improved access to health for stigmatized populations, specifically for drug users, sex workers, transgenders, and migrants.

So these are real examples, this is evidence on the ground. So as ITPC, we believe that the global mobilization on AIDS has not diverted resources but greatly expanded total health funding. The AIDS movement has opened up a sense of possibility of change for progress in providing health care to all who need it. This was what Alma-Ata is all about. Thank you [applause].

RICHARD HORTON, M.B.: Thanks very much Aditi. If we are going to make this vision a reality, we have to have the

support of those major funding agencies, PEPFAR, the World Bank and the Global Fund to really back this vision of a comprehensive primary health care strategy and we are very fortunate today to have Daniel Low-Beer with us. Daniel will be well known to many of you as the Director of Performance and Effectiveness at the Global Fund. Daniel, please come and tell us the Fund's view [applause].

DANIEL LOW-BEER: Thank you Richard. It is a great pleasure to be part of this discussion. I want to make two main points. First of all, we very much subscribe, and I want to say this loudly, to the two-tribe approach funding AIDS but also funding the necessary health systems and doing this together. I want to show you a little bit about flexibility and explain how that can be done in our programs.

Second point is the comment whether AIDS treatment kills people. I want to show some of the increasing evidence that to strengthen health systems, it is necessary to have strong disease control programs both for healthy human resources for health and because the large burden on health systems in Africa, of the cases of AIDS and the cases of malaria.

The further point I want to put up for question is we need to think through the systems that deliver prevention. This goes beyond a little bit delivering services to the quality of engagement with communities and very much the NGO and the

community networks that are essential for this quality engagement to people at risk.

So first of all, Global Fund role in health systems, I want to say very strongly that we fund those and we fund the necessary health systems' actions or we would like grants to include that in their proposals.

We focus on results for AIDS, TB, and malaria but we allow countries to decide how best to achieve them and if UNAIDS mentions that the better [inaudible] health systems, this should be included.

So if a country needs to train, it needs to invest in procurement, any supply systems, there is the flexibility in this funding. I am going to give you three examples to illustrate that on our portfolio.

First of all the [inaudible] AIDS Program. initially, it funded AIDS work as in communities to provide AIDS services. [Inaudible] in the grants, it was found that people did not want to visit an AIDS worker in their communities. So we moved funding to support 30,000 health workers in communities who provide AIDS, TB, malaria, and other health services.

Second example is Malawi delivering a very ambitious AIDS treatment program, very poor health setting. After 18 months when we reviewed this in our performance system, it was clear the bottleneck was human resources for health. We moved \$40 million from the program into the general human resources

for health strategy of the government alongside the donors [inaudible] made a very large contribution. This is necessary for the performance of the grant.

A third example is our Rwanda AIDS grants, where we support health workers and also [inaudible] of some of the worst hospitals in Rwanda and the outcomes have been increasing AIDS treatment together with TB and malaria. There are also health visits for all health conditions that double in these hospitals.

Certainly more needs to be done in our portfolio and these are some of the best examples but we certainly say very strongly to programs to include this flexibility to fund AIDS and to fund the necessary health systems.

So we have become a major funder. We estimate 35-percent of our funding is in health systems and we have also brought an increasing flexibility over time. In 2007, we introduced the ability to fund strategic health systems' actions that go beyond the single disease, \$360 million was agreed to this in 2007.

So countries that include these actions in their proposals and in bottlenecks securing grants, we program funds to try and improve that performance. We need the two tribes' vision, the double vision of AIDS and health systems.

That could include in the proposals AIDS, TB, and malaria, strengthening actions or as a separate annex for more

general measures beyond the single disease. It should be then in the context of national disease and health plans but clearly, the financial needs go beyond what would just be provided by the Global Fund. So we also ask countries to use other funding.

We realize this is a new approach, which is why I am also mentioning it very loudly to try and include in our grants AIDS and health systems and it has not been fully and evenly introduced in our grants.

The second point is, I think, there is increasing evidence that strong disease control programs are necessary to strengthen health systems particularly in the high burden countries in Africa.

First of all, healthy human resources for health, we need to ensure that more health workers do not die of AIDS than we can train in a year. I think the numbers here are critical and becoming quite clear. In Malawi, to deliver the HIV treatment program, it requires 250 health workers, which is certainly a major effort. There are also over 1,000 health workers on ARV treatment who would have died without the AIDS program.

So to begin to be clear that the return in terms of human resources for health is positive and many times for many of these AIDS programs.

And on second, we need to recognize the huge disease burden on African health systems, having worked in [inaudible] in South Africa in the gastroenterology or the psychiatry department, you find 50-percent of cases are AIDS-related and outpatients clearly malaria is a major issue.

To tackle this disease burden, which overwhelms the African health systems, it is essential if we are going to strengthen and to have strong disease programs.

I am just now going to give you an example from the Ministry of Health in Botswana and this is not occurring in many countries but while we have had successful disease programs the effects it can have on health systems.

She quotes, "You go to the medical ward and there are half of the beds now occupied, before they were mushrooming. A manager came to me as the Minister of Health and said you are bad for business, our funeral business is going down."

In Tanzania, for the first time in a decade doctors are saying hospitals can become hospitals again with AIDS treatment. So, we clearly need to think of strong disease programs along side health systems strengthening. It is for health conditions like obesity in the United States or AIDS in the lower we need to ensure we have programs in place to deal with the disease courses as well as the strong health systems actions.

And, now my final point is we need to think through carefully the systems needed to deliver prevention and the size of health outcomes of declining prevalence, behavior changes we have seen in a few countries. And, these systems may look very different.

They certainly have a strong [inaudible] community engagements into communities, engaging with communications with behaviors. AIDS survival and mortality is important at local level and the political system extends debates on AIDS down into these communities. They have often occurred in some of the poorest situations and with some of the weakest health systems and we need to ensure that these systems for prevention are also built.

So, in conclusion I [inaudible] the global fund funds AIDS and also the necessary strengthening health systems measures. If there are problems with these issues talk to my [inaudible] manager, talk to myself because we need to ensure this is more strongly built into our programs. As our funding increases two to three times over the coming years we would like to see the health systems components increasing at least at that level.

Secondly, we need the two trials approach. We need strong disease programs along side health systems if we are going to reduce the burden on health systems certainly in Africa. And, then finally more for discussion we need to think

through the systems of prevention and this involves a very strong wealth for community and your groups and strengthening. Thank you very much [applause].

RICHARD HORTON, M.B.: And, Daniel promised that he would give you his email address at the end so you can contact him directly to repeal those grants that might just get turned down from time to time. Our next speaker is Francisco Songane.

Francisco will be well known to those of you in the Maternal Newborn and Child Health Communities in particular. He is the Foreign Minister of Health in Mozambique and most importantly now he is Director of the Partnership for Maternal Newborn and Child Health based in Geneva.

His work in this area has been critical in identifying health systems as a major obstacle to advancing the health of women and children and we are very pleased to have him with us this afternoon to give us his observations on this critical issue, Francisco [applause].

FRANCISCO SONGANE, M.D., M.P.H.: Thank you, thank you Richard and the other colleagues on the panel. I should like to start by thanking the organizers for setting this session. It is a very important one. It is hitting the core of the problem when we deal with the world to the [inaudible] phase.

HIV, in fact, was a wake up call. I am starting by saying this to address this issue whether HIV programs are taking money from the health systems or not. When the economic

began to take its toll we were all scared because it was revealing that most of the countries were not prepared to deal with such a problem. That was a wake up call so we learned from that, we are still learning from that.

So, it is better that we build from what we learned so far and see how we can approve our approaches together with other players who are addressing the other health problems.

This is just one issue. As well as addressing malaria, maternal health, and other health problems we will end up talking about health systems. That is the call. We are 30 years now from the proclamation of Alma-Ata on primary health care. And, we are realizing that somehow with age that proclamation that we should be comprehensive, to be holistic, getting the [inaudible] between the different departments and institutions and to see health as a whole, not just as a separate program particularly. I think this is the context we should get our discussion going in addressing the health systems and how we will build on the synergies of different programs, not the programs talking to HIV and AIDS and to reinforce the health systems within the perspective off of the primary health care and the holistic approach of each.

I would like to propose one approach. There are several to take women and children [inaudible] we can address, prevention of mother controlled transmission. If we assess how we are doing in terms of maternal care we realize that in the

countries where the burden is highest in this regard 90-percent of the pregnant women get at least one contact with the health services or the health provider to go for the elemental cleaning.

When it comes to delivery, only half of the women are getting still care attendance at delivery. So, we lose considerable number of pregnant women. That could be a very good entry point. If we want to address PMPCT, we could start from the first contact that pregnant women make within the health system or the health provider and will be involved until she delivers with the proper care and with care after the newborn and herself afterwards.

Gorik and other speakers said it very well. That is not just to treat the PMPCT as a way of preventing the transmission of HIV to the child, at least to look at the woman as a human being. She has got her own needs that after the delivery whatever need she has had to be taken care of.

If we do not have a very good working system to be comprehensive and to look at this comprehensive approach we cannot succeed and be humane in our treatment. This is a very important human right approach we will have to take into consideration. There was no progress in terms of deprivation of transmission of HIV from mother to child.

From 10-percent to 23-percent in 2004 to 2005, but most of the women are not having those services. That could be our

challenge, what we needed to do together. People addressing maternal and child health issues, people addressing HIV AIDS and other problems, how we can work together to see what are the bottlenecks, what are the obstacles, address them in order to reach those women we are not reaching.

In terms of the newborn, one at a time are getting the treatment in terms of ARVs and the other nine are not having it. Prophylaxis, using basic antibiotics, only one in 20 children are getting those services. Not surprising. When we assess how well we are doing in terms of the provision of clinical services to tackle children's problems we realize that we are treating less than half of children who have got diarrhea.

We are treating one-third of the children who have got pneumonia, one of the major killers amongst children because of what we are not able to respond, our systems are weak. Let us take this part where we can get the synergies between the two groups and build the system.

Another element I would like to address is the synergies between the different initiatives. One colleague will say many partnerships, many initiatives, many re-invented initiatives that is true. The complex is overcrowding, it is confusing somehow for the countries. They do not know where to look, which direction to follow. My true position is let us make one distinct way at the country level.

Build an initiative on HIV, AIDS, on malaria, on maternal health, on any other problem. The one who should express is at the country level. We have refracted these out of the country plan and the ownership of the government and we will work together and the back burner will be how well we are doing to tackle the countries problem, how well we are doing to address the country plan, which would have all these elements together.

And, there are many resources from the different initiatives and the partnerships, those partnerships and initiatives able to fund. If we would reflect this to address the country plan, we have to make much more strides than what we are doing now.

And, the last element I would like to bring is the issue of solidarity. We are all discussing whether AIDS is taking money from the health systems, whether malaria is taking money from the health systems whether we are addressing this or not because of one reason, investments in health are not enough.

[Inaudible] to the countries that are doing it domestically, be what the international community is doing as international solidarity. If we recall what was proposed on the report on microeconomics in health is that [inaudible] per capita for health for under \$40 to address the basic problems, which are afflicting most of the people in these many

countries. What are the countries that are having to live with is between \$5, \$9, up to \$12 per capita in most of the countries. And, this vast contribution 60-percent or more is external money.

So, we needed to invest at the donation of the challenge, not piecemeal it's here and there. We should not wait to respond to activism alone. This generalized approach should compel on all of us, the domestic, the international community that we have got a moral duty to face the problems we are facing today in terms of the health and invest accordingly because one thing is certain it is not shortage of money.

If it were a shortage of money we would not be starting major challenges, which are [inaudible] distractions and costing 10, 15, maybe 20 times more what we are asking for to tackle the basic problems.

The international solidarity with a big "S" is what is called fall and balance by the right approach, political leadership, and drive from the countries and get this to it midway and really tackle the problems. That possibility is there. That is my proposition. Thank you [applause].

RICHARD HORTON, M.B.: I think Mozambique's losses are our gain Francisco, fantastic. Thank you very much indeed. I am very pleased that our final speaker was able to be with us this afternoon. Rolake is going to speak on behalf of positive

action for treatment access so please welcome Rolake
[applause].

ROLAKE ODETOYINBO: Good afternoon. Thank you. My name is Rolake and today we are talking about strengthening health systems through the AIDS response. Specifically I am looking at the role of GPA in strengthening health systems and to do this we need to ask ourselves exactly what is GPA. I think we need to remind ourselves really what does this mean. We have had different definitions and for some of us it is NEPA, it is GEPA, it is CEPA. You know we just totally ask ourselves what really.

So, we should go back to the basics and say really when we say GPA what do we mean. This we know was something that the declaration that came out of the Paris Summit and it is the International AIDS Summit in Paris in 1994 and it is talking about the role, greater involvement of people living with HIV and AIDS.

Now, we have gone further and what they are saying is cheaper really. Is it just about people living with HIV is that the only opportunity we have. Ten years ago when I tested HIV positive, my greatest source of strength were my parents, my family.

So whatever it is as a person living with HIV those who are directly affected really do need the support, which is why GPA had to deal with saying GPA means greater involvement in

people living with HIV and people directly affected by HIV and this means our spouses, our parents, and our children.

What then should be the rule of GPA? Looking at this on top's great resource we have, what should be the role of GPA in strengthening health systems?

If you go back and look at the GPA, there is a document that has been produced by IPASO, by [inaudible] and it has taken up monitoring GPA and if you look down you have different roles that living with HIV can play. And, the question is what then is our current truth.

Right now a lot of us, patients and service recipients will volunteer counselors and somehow it is like we are really talking about volunteers. That is the only thing we are destined to be. We have worked tirelessly, we have made great impact of volunteers and it is an unpaid position.

Suddenly there is a partner who is willing to support and fund that position and then we are suddenly never good enough you know. We need to have the facts ready. We need to have all these schools set and all of the qualifications you need to get that role, to get that volunteer has played that role effectively for the past four or five years.

When it suddenly becomes a paid position then you have to remember that the criteria to employing civil service and to go back what are your basic qualification educational.

We have also become images on leaflets so it is good to have a face of a person living with HIV and that is really all. To some people, that is worth GPA just put the faces there. Also, we have become testimonial to keep up sentiments.

So, we have our children on this beautiful poster as talking about what is happening with PMTCT and you have our faces all over the place and it helps with the sentiment and it also helps get the money in really. Because, when you see those faces and those pictures then it means that there is a great problem and we need to send the money there.

Also, we have also become spokesperson for behavioral change. I have been invited to a church to come talk to young women on HIV and AIDS and the pastor's wife wants me to talk about use of condoms and abstinence. Ultimately what she was telling me, she wanted me to come say to the young people if you have sex before marriage you will end up like me.

That was not really the message because she wanted the person living with HIV to come talk about, well she said we are not wed we do not talk condoms, we do not talk all of that, just abstain and be faithful. And, she wanted a person living with HIV to do with that. What message was I supposed to be passing?

So, ultimately the question we are asking ourselves well what then should be our rule? We should right now, what

are the rules that are we are playing, we advocate, and I am sure everybody in this room would agree to that.

But, for people living with HIV and directly affected by HIV we probably would have moved, the movement and what movement particularly would be actually very, very little. We are also working in various countries and I am excited and I feel highly honored when I am called an activist because suddenly you are doing something and those are the rules we having as watchdog.

Also, we are program managers. We are involved in planning, designing, monitoring, and evaluation and we participate in decision making bodies or to what level and where. Where exactly does this happen? It happens at all the global levels, but in country, apart from very few countries like Mexico where else do you happen to live with HIV [inaudible] at the highest level.

For GPA to become meaningful, for GPA to make an impact in health care strengthening we have to go back again. I just learned this and to meet my mantra. And, if you leave this AIDS conference with nothing please let us learn that what we are asking is that GPA should go from greater involvement to greater investment. You need to invest in people living with HIV to get the meaningful involvement you want. So we need to bridge the gap between better involvement and people living with HIV.

Also, stigma and discrimination must be addressed. We need the involvement, we need to have us involved in our existing capacities so if we are going to talk, if you are looking for somebody to manage a program look at the totality of my human being.

Before HIV, I was someone, I did something, I had a life. Do not just put me in a group of HIV box and that is the only role I am supposed to play forgetting that I have other existing capacity. And, that is one of the roles where I think we really are losing out on these untapped resources, people who did great things before HIV came into their life and let us move them out of this PLHIV box and move onto other things.

Finally, we must create a living environment for our professionals who are infected, doctors, nurses, health care workers who are living with HIV have it extremely tough because on all fronts it is like a no win situation. The patient says no, the hospital says no, it is just appalling. We need to find places, we need to find a way to bridge the gap and make sure that this untapped resource really, really is affected. Thank you very much [applause].

RICHARD HORTON, M.B.: Okay, now we are going to have some discussion. Because you have had a lot of views there and there are some similarities, a few little differences, and I am sure you have all got your thoughts as well. So, I am going to

kick off with a question for Carissa and then we will see how others want to respond to that.

We all remember Alma-Ata well you may not remember it as a reality 30 years ago, but there it was 30 years ago and we are going to celebrate the anniversary September and October this year. It was a fantastic, compelling vision just like the compelling vision that Gorik laid out for us, but it did not work.

What were the lessons that we have to learn from that incredible vision of Alma-Ata 30 years ago, which stumbled almost immediately after it was born, how are we not going to make that same mistake now? Carissa and then anybody on the panel who wants to come in. And, all of you out there think of some questions because I am going to ask you for some contributions in a minute.

DR. CARISSA ETIENNE: Thank you Richard. Alma-Ata 30 years ago was also a development approach and that is the big part of Alma-Ata that was forgotten. Very, very soon after Alma-Ata it was relegated to selective primary health care and first level care. And, we completely forgot that it was about human development within the broader developmental agenda.

And, I think that is one of the things that we need to learn from and not make the same mistake. Very often, I hear people say it did not work and the question I ask what is it? Because the it what was implemented was not what was described

within Alma-Ata. And, so we have evidence of countries that pursued with the goal of universal access and these countries can now demonstrate that the health systems are better place to respond to emerging epidemics and to chronic conditions.

So, we have to be careful when we say that it does not work. What are the lessons of the past that we can learn from the past? Certainly the lessons that, our ultimate goal must always be upholding the health and wellbeing and dignity of human beings.

If we stray from this ultimate goal than we accept our arguments that say we cannot afford, we cannot afford to insure comprehensive care for all individuals. And, once we accept those then we begin to go into selective care process, visit specific programs that are not related to our people's needs and to their human developmental needs.

I think we have to be careful as well that the whole debate on health systems and delivering on universal access does not remain a Ministry of Health agenda. That indeed it must transcend and include an all of government approach and certainly involve the international community, but very importantly that community participation and decision making and know as it is also represented and strengthens civil society organizations must be important because they must play the watchdog role.

We must also guard against the international organizations that continue to defend policies that are contrary to the health and well being of all individuals and I will stop here.

RICHARD HORTON, M.B.: [Laughter] Very good [applause]. Francisco as a Minister in Mozambique, he was a Minister 30 years ago in Mozambique, but you will remember I am sure and as a minister grappled with some of the principles from Alma-Ata as you were an important political steward of the health system. What lessons do we need to learn from that as we revision things today?

FRANCISCO SONGANE, M.D., M.P.H.: Thank you, thank you Richard. Well, I was born into the primary health care. I [inaudible] I went directly into this. That was I was credited with a medical doctor I was placed as a District Medical Officer at the beckoning of the primary health care. I think leadership from the country is critical.

Membership from the international institutions particularly the institutions with the mandate to steer the process is paramount. If we do not get those things working together there is no way we can improve this. In the case of Mozambique, it was a success of applying Alma-Ata principles and in the '80s was quoted by WHO and the UNICEF as one of the examples in Africa where the primary health care workers were

having very good coverage of humanization, where expanding the primary health services with addressing the equity situations.

And, the spirit in which people were trained was the spirit of Alma-Ata. You were in this a doctor, a pharmacist; you were taught when you started to work you were involved in the processes of discussing the program implementation policy setting. You grew with the spirit of Alma-Ata.

No wonder why Mozambique, even after ravaging a 16 year old world, destroying everything would manage to come out of it quickly and now we are at a good platform to rebuild the system to try to match what we had in the '80s because of the spirit, our approach which was taken in the training of the people. This is critical.

Membership locally and internationally and that element I would like to bring is that we have to start searching for results tomorrow. One of the things that [inaudible] is looking for results tomorrow. You invest today you want the results next year. That does not work like that. You need reasonable time to see the results.

And the other elemental link to this is the different players, the different stakeholders they wanted to say this happened because of institution A, because of institution B. This happens because the country together with the players, this is a mind shift we have to get that when are in a field, in a country we have to embrace that country and our goals are

[inaudible] is the goal of that country no matter how many institutions we are in the field. These are critical elements.

RICHARD HORTON, M.B.: Can I ask of Aditi because you gave some very good examples of how AIDS programs have strengthened health systems and in the report you quoted what added value could a comprehensive primary health care strategy give you when you look at the evidence from those country case studies in your report?

ADITI SHARMA: I think if we have a comprehensive primary and we were moving toward Alma-Ata was all about we would not need necessarily disease specific funding. You know, if we had the systems in place, if we had invested in health workers we would not need to intervene. AIDS as you said was a wake up call and it exposed the lack of funding and the lack of investment in health systems.

So, I mean to mean there is still an opportunity because access to treatment has, I mean many people on this panel have listed it has meant hospitals going back to being hospitals. So, this is an opportunity for us to go back to comprehensive primary health care. And, people living with AIDS rely on primary health care and rely more so on primary health care because they are living longer lives thanks to antiretrovirals so it is about comprehensive primary health care.

RICHARD HORTON, M.B.: Who else on the panel would like to comment on this question. Yes Prasada.

J.V.R. PRASADA RAO: When we look at Alma-Ata we should also look at the political situation of the world at the time. This is a time of democratic socialism, which is the ruling political philosophy in the world and it is a nice thing to say that after all it is a nice word. But, two basic differences which are common in the wake of Alma-Ata and one is there are absolutely no political commitment. It was just signing a declaration and everybody came back home and it was business as usual.

Secondly, there is no defining of resources. What are the type of resources that are needed to secure universal access. At no point of time, there was any attempt to spell it out. So, when we looked at our own country's policies at a later time we find these two glaring deficiencies and added to it the third one is there is absolutely no monitoring.

Look at Ungas [misspelled?], look at the way 2001 we had a recession and in five years we came back and said let us see what we are doing. There is no Alma-Ata II so it was just left to the countries and some have done well, some have not done so well, and some have done very poorly. I think that is the basic problem with Alma-Ata.

RICHARD HORTON: Yes, Eileen and then Daniel.

EILEEN STILLWAGGON, PH.D.: I would like to say it seemed your question was why did comprehensive primary health care fail and I think it was not really tried. I would like to emphasize that I think monitoring and evaluation are extremely important, it is our responsibility to spend our money wisely. It is not only the efficient thing to do, but it is also the compassionate thing to do to save as many lives.

But, we have to be really careful about what we are comparing when we do monitoring and evaluation. There was a very important cost effectiveness study that was done in around '78 or '79 just after Alma-Ata and just after the declaration of the water decade for the 1980s when we were going to put clean water and sanitation in every village across the world. And, that was going to be the thing for the 1980s. But, simultaneously there was one of the most important inventions or discoveries of the 20th century, oral rehydration therapy.

It was absolutely a wonderful invention and has saved millions of infant lives. But, there was a cost effectiveness study of oral rehydration therapy that said that it was more cost effective than sanitation or clean water. That kind of comparison was inappropriate because oral rehydration therapy saves infants from specific diarrheas with clean water and sanitation you are protecting the whole village from all kinds of waterborne diseases.

That comparison should never have been made. Yes, we should have had oral rehydration therapy in the hands of every mother and father across the world, we should not have stopped putting clean water and sanitation in all of those villages. If we can put it at say 4,000 meters, last week I was climbing in the Colorado Rockies and there are actually latrines above 4,000 meters for hikers and climbers. If we can do it there with solar powered decomposition systems we can do it in villages.

RICHARD HORTON, M.B.: Okay, now before Daniel answers I would like to invite if you have got burning questions please come up to the microphone and then Daniel go ahead. Let Daniel answer and then we will come to questions from the floor.

DANIEL LOW-BEER: Just briefly, I mean I think there are two interesting movements in the last 25 to 30 years, one is the primary health care, but the other one is the AIDS movement. Many of the gaps you mentioned, political commitments took a long time in AIDS, the resources, the monitoring, the involvements of people with communities. I think there is a lot to be learned by bringing those two together in a dual vision of health care, but it will always require strong disease programs as part of that.

RICHARD HORTON, M.D.: Okay, now I want to invite you to come and make your comments brief so we can get as many of

them in as possible and then I am going to take a sequence before we have some responses from the panel, so please go.

MALE SPEAKER: It is very important for all of us to put our heads together to realize that health workers are an endangered species because they are trained and then ignored. And, this perpetuates their nomadic behavior jumping from health center to the program and from program to program and then overseas.

While we are debating this it is very important to help countries to be able to retain the trained people and also not to ignore the private sector because now it is deteriorating because when training is done of health care workers the private sector is ignored.

RICHARD HORTON, M.B.: Very good, thank you.

RONNIE ZACARIAH: Ronnie Zacariah [misspelled?], [inaudible] Brussels. On behalf of nurses in Sub-Saharan Africa I want to make a comment and then I would like to ask a question to the panel members.

Today, in Thyolo District in rural Malawi where I work and where we have achieved universal access a nurse working in a health center keeps at least 400 patients alive, but she earns \$3 U.S. a day. When we ask donors, donors entrust her with up to \$7,500 worth of drugs, HIV AIDS drugs each month and when we speak to donors about her conditions of service they

say it is not an option, otherwise some even say it is not their business.

Nurses are the pillar of the health system in Africa and if we are serious ladies and gentleman if we are serious about universal action now we need universal action now for our nurses. Please, please tell us panel members what exactly are you going to do to improve the conditions of our nurses and please, please give us the courage to hold you accountable for it, thank you.

RICHARD HORTON, M.B.: Okay, thank you very much [applause].

MALE SPEAKER: There are multiple donations for our health system strengthening, one or some are related to the provision of inputs like money, human resources, drugs, and that is something that we kind of take for granted given that health system is an entity characterized by adjoined production processes, but what about donations of health system strengthening.

I am referring to improving leadership or governance or accountability and Dr. Songane highlighted the importance of national leadership that underpin all our success stories in the health system reform. Our AIDS programs and in particular global health initiatives making a useful contribution also in that respect or by being relatively or very successful are they

providing an excuse for governments to shy away from their primary responsibilities. Thank you.

RICHARD HORTON, M.B.: Thank you very much. Please.

FEMALE SPEAKER: Hi, I represent an AIDS service organization called ASAP serving salvations in Toronto, Canada and I commend Aditi for her presentation. I recently visited India as part as a stigma study and I was appalled by the lack of human rights, the lack of health care access to some villages in India that are just a few hours drive from the global city of Mumbai.

Women have to kind of go walk miles for a pot of water, local tribals are not admitted to the schools there, and women have had no opportunities to discuss sexual health, health, condoms, and as such have no knowledge of HIV AIDS. So, my appeal to this panel is that global funders not only need to look at endemic nations, but also countries like India where HIV AIDS is growing steadily, but also not to work in partnership with governments, but to maybe mobilize and compel them to provide a holistic and all inclusive health care system.

And, I also appeal to all of us gathered here whether we are AIDS activists, researchers, clinicians, in general all those who care about HIV AIDS to hold our governments accountable for every dollar that is spent or not spent on HIV

and for every debt that occurs due to lack of prevention or lack of health care. Thank you.

RICHARD HORTON, M.B.: Thank you very much. Please.

NADA ALI: Thank you, thank you all for putting this important panel together. My name is Nada Ali [misspelled?] I am with the Women's Rights program in a Human Rights in New York. I just would like to highlight an important issue that both Aditi and Mr. Songane mentioned and this is the importance of integrating a human rights approach to any interventions to strengthen health care facilities and health care systems in general and especially programs to enable one to benefit from some of the programs that are available.

Last year we conducted research in two provinces in Zambia where we identified a second abuse such as gender based violence and insecure property rights that actually undermines women's ability to access testing to start ARVs or to [inaudible] ARVs.

So when we also interviewed health care providers in different facilities providing ARVs we found out that they actually do not screen for gender based violence and there are no interventions to enable health care workers to help women or to refer women to organizations that could help them.

So, I think that one way to strengthen health care facilities is to introduce programs and initiatives that would enable health care providers to detect and respond to gender

based violence and other abuses and also to provide programs that would empower people living with HIV and AIDS in patients in general to seek redress for any violations including within the health care system. Thank you.

RICHARD HORTON, M.B.: Thank you.

HENRY KANSIMBI: My name is Henry Kansimbi [misspelled?] I am coming from Zambia. I work in the Minister of Health, the planning department.

I am trying to contribute to the debate with respect to contribution of international funding initiative on the health systems strengthening. Maybe a better question to ask ourselves especially the panel is what is the source of the complaint from our developing countries because otherwise we will end up just justifying ourselves and thing that we are actually building systems when we are not.

From my perspective, I think that maybe we can search for the answer by looking at the building blocks, you know, their systems, and looking at them one by one and see what do they impact of this initiative of each one of them. In Zambia, for instance, while we swap arrangement where encourage all donors to pull funds.

And I can say here that for instance global funds [inaudible] arrangement but withstand that the planning cycle for the global fund is not aligned to the planning cycle for the rest of the ministers working the country.

They also credit ability of producing funds, you know, funds can be approved two years alone their own student gets the money. There is big variances between what we put in the budget and out expenditures because money is coming at different times so at the end of the day when your annual reports are produced by Minister of Finance you find a big variation between expenditure and budgets because we do not know our actual source [inaudible].

[Inaudible] resource quickly there could be some contribution from funding initiative, but we also know that they are also attracting personnel from the public health systems, the officers and the ministers we train to go and work in these in projects especially [inaudible] so we have to look at what is the source of the complaint before we can give it an answer. Thank you.

RICHARD HORTON, M.B.: Thank you very much indeed [applause]. I am going to take just a few minutes over the time so that we can get these comments in because I think it is really important to get your voice here. Yes.

WONGA CAMALIA: My name is Wonga Camalia [misspelled?] I work for Oxnard International [misspelled?]. Two quick comments why Alma-Ata failed or it did not work I think because it was seen as a cheap option of providing health care. You trained volunteers they sit in the community they talk to women, forget about hospitals, forget about doctors and nurses,

and the world community, the international community so-called forgot that doctors and nurses do not grow on trees.

They have to go through guess what primary, secondary, and tertiary education. What you are considered tertiary education is considered [inaudible] so we do not have doctors and nurses, by the way, no pharmacists, nor [inaudible] nor other health workers so that is my first point. My second point as public health physician what really frustrates me about this debate of HIV health system is that how much it can actually happen on the ground that you can integrate HIV services with health system service.

The question for the global fund for PEPFA, for the World Bank, for us is just three quick examples of if the HIV money is going to be the primary care unit or a clinic I think we need to put the HIV sign on it or are you going to provide service for everybody because that is right HIV kids or HIV parents kids they do not need vaccination and by the way they do get pneumonia and they do need diagnosis and treatment just like everybody else.

So, unless this financing will finance HIV and other service at infrastructure level second thing we would have that debate if we did not do that. So, quickly if you train a health worker and give them money to provide only HIV service then you are pulling the workers from the maternity ward.

Now, if they get money for providing service then we will go from there to the HIV ward you will have everybody trained on HIV, maternity ward, and non-maternity ward, and everybody providing service with one example that it can happen on ground.

RICHARD HORTON, M.B.: I know, I am already in trouble with organizers. I am going to give 15 to 30 seconds for just two final responses from up here who have not spoken a second time. Rolake and from Gorik please.

GORIK OOMS, PH.D.: Will they be allowed to speak afterwards.

RICHARD HORTON, M.B.: I am being told we have got to finish the session so Rolake.

GORIK OOMS, PH.D.: Should I stand here or not that is what I am asking. No, no I am so sorry. You should at least tell us that.

ROLAKE ODETOYINBO: Thank you very much. I think really as we talk and we talk about strength in health systems it is a good thing we are having this talk now because like we all have said one thing HIV has thrown up is really exposed the weakness in our health care settings and it is asking us what then can we do and what should we do to strengthen this.

And, then even we go back and we talk about Alma-Ata, which is supposed to be public health for all reveal a single policy framework, but is that what we have.

Okay, public health, where is the public health, who are those really who will strengthen public health. Are they accessing their own health care from that same system? If not then what really do we have in place to support the majority of the people and is it really within one policy framework.

We are working from a million and one agenda and trying to see how we can merge everything together. I think these are the things that we really need to look at as we talk about HIV and the role it can do in changing health systems. Personally what has happened with HIV it has changed things and we should be looking for how then can we do more to foster this change and to make sure that we get more things done with what we have available for HIV.

RICHARD HORTON, M.B.: Thank you and Gorik you gave us a brilliant opening give us 30 seconds as a finish.

GORIK OOMS, PH.D.: Okay, I live in a country with a very high standard of health care it is so high that it is unaffordable and unsustainable for most of the people living in Belgium. It only is because we share the burden because there is permanent solidarity among the people.

Now, if we could extend that permanent solidarity to the rest of the world only 1 or 2-percent of what we are spending in Belgium then we could indeed increase the level of expenditure in Mozambique from \$9 to \$40 per person per year and then we could start paying decent wages to nurses in Malawi

et cetera, if we continue to look only national economies, sorry, some countries are simply too poor and that is why Alma-Ata failed.

RICHARD HORTON, M.B.: That is it. Thank you so much. Give a round of applause for our panel and thank you for being here [applause].

[END RECORDING]