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38th Union World Conference on Lung Health Ways Forward on Health System Strengthening and the Stop TB Strategy November 10, 2007

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PETER GONDRIE, M.D., M.P.H.: Good afternoon to all of you. We would like to get started with the symposium of this afternoon. It's called Ways Forward on Health System Strengthening and the Stop TB Strategy. And it's right. We are in the Union Conference of 2007 and not the Union Conference of 2008 where this will be the main theme, but last year when discussing about the symposium, a couple of people thought that it would be very worthwhile to bring this topic and this issues under your attention.

It's that with all the scaling up that's going on, with the increase in financial resources, it's becoming more and more apparent that the structure and the strength or the weakness of the health system is the key factor, a key factor, that we need to address if not only we want to achieve the infection control Millennium Development Goals but also the more general health development goals.

That's why we organized this symposium, and what we proposed that we're going to do this afternoon is we are going to have first two presentations on global initiatives and global experience. After that we'll make some ample time for discussion. And after that discussion, we'll have two presentations on experiences at the regional level and experiences at the country level.

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Unfortunately, Dr. Chuan [misspelled?] of India is not able to be here today, and so we won't be able to listen to his presentation, but that will enable us that we have a bit more time for discussions. So after the two presentations on experiences at regional and country level, we will have ample time for clarification and for discussion.

Enough for that and now I would like to invite our first speaker of this afternoon, Diana Weil of WHO Headquarters for her presentation.

DIANA WEIL: Thank you to all of you for coming this afternoon. I'm afraid that I may be less effective than Tony Harries [misspelled?] in preventing sleep after lunch, but let's see. This is the wrong session. Okay. Do we have an afternoon session? I should have checked this. Oh, there we go. Okay, very good.

My first presentation is to put in context what is the most critical issues we wanted to discuss today is how do we strengthen systems and TB outcomes at the country level. But given as many of you know that there is much energy at the global level right now in support of health more than there has been in the past, we wanted to discuss some of the global context and how it's changing and some of the initiatives that might be helpful for our work at the country level, at the regional level and across partners at the global level to advance what we're doing.

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I'm presenting on behalf of myself and Peter Gondrie from KNCB, and I've put on the cover what the ultimate aim here is: To serve patients and serve frontline health workers, those serving in the community. And what we believe systems are all about are the systems that support both the patient and their families and the systems that support the health providers at whatever level they may be.

So the aims of this talk is to provide a big of an overview of some of the health system strengthening principles that are relevant to TB control that are beginning to get a little bit clearer and, certainly, we've found are needed for the full success of the global plan to stop TB for the next ten years.

We'd like to talk a little bit about some of the justifications, precedents, aims and approaches of some new global health systems strengthening initiatives, partnerships, networks and discuss how the TB community can engage to help achieve both our TB care and control objectives as well as achieving other health MDGs and development in general.

So our premise today really is that our 2010 Universal Access Targets, whether it for TB, HIV or other health interventions, and our 2015 TB targets we do not believe will be reached without health systems strengthening happening at the same time as our concerted efforts on TB specifically.

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The Stop TB Strategy, as many of you may have heard from previous presentations this week, is the bedrock behind the global plan. It builds on the DOT Strategy, and it adds in some of the critical approaches we need and innovations we need to respond to both the threats today and the opportunities that are there for expanding care. And if you note, the third element of the Stop TB Strategy explicitly notes, and this is very purposeful, contribute to health systems strengthening.

Now, all of the elements of the Stop TB Strategy have an influence and potential impact on systems strengthening, but we wanted to state here very clearly that we have a mandate within our strategy to participate and a necessity to improve system-wise policies, such as related to human resources, financing and other core building blocks I'll describe shortly. We need to share innovations that strengthen systems, including the practical approach to lung health, the public/private mix model, community-based care models. And we need to adapt innovations where they've been driven from other fields that can contribute to TB control.

So what is a health system? Just this year, in fact this last month, WHO published—and I urge you to go to the website at WHO to get this document—a strategic document for the institution itself but also guiding, we hope, for others called "Everything's Business: Strengthening Health Systems to Improve Health Outcomes. And in it, it defines—and many of you

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have seen iterations of this before—what a health system is. It consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more health improving activities.

So the emphasis here is this is not a traditional sense of institutional providers as being the healthcare system, but rather a mother caring for a child, a community caring for its ill HIV-infected or TB patients. It involves environmental health. It involves inter-sectoral action for health. So it's a very broad approach to what a system is.

Now, this is my interpretation of where we are in terms of moving on the vertical/horizontal debate, and as many of you may have seen in press articles recently, we're continuing this debate between is it better to build horizontal health systems or to fund disease control?

But I think we all, Peter and all of our colleagues at the table today, I think, believe that we're moving toward the diagonal for health outcomes, meaning that we need to strengthen horizontal systems and build the vertical elements of those systems that support health outcomes.

So historically, if we look back to the 1980s, we had the primary healthcare movement, and we're coming back to an anniversary in that alma mater movement, so look for in 2008 many discussions around what is primary healthcare today and

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how we can support it in the 21st Century. Then we saw investments in child health, which could be perceived as a vertical investment, in the late 1980s and the perception of selective primary healthcare, some priority interventions.

In the 1990s some of the things that were important to global health policy dialog were essential health packages and investments in system reforms, which unfortunately, sometimes dominated in driving efficiency objectives without the added budgets for health systems and so in many cases had deleterious effects for disease control and even primary care even though that was not the intended affect.

In the year 2000 the UN Millennium Development Goals were set, as we all know. The Commission on Macro-Economics and Health made a plea for more health financing, given the importance of health to development. And we began a focus on epidemics and disease prevention and care, given the driving epidemics of HIV, TB and malaria and the initiation of some extremely important international mechanisms that now exist for financing and partnership.

Between 2005 and 2007, I think we've all seen in documentation and in dialogs across global health meetings some tensions with a push toward recognition that health systems desperately needed strengthening and that money seemed to be going only into disease control and that it might be driving distortions. But in fact at the same time we were seeing

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important outcomes and impact from these disease investments, and so there was a drive to continue those.

As we move, we believe now, in 2008 we're beginning to see this diagonal with ongoing strengthening of HIV, TB and malaria efforts. The replenishment of the Global Fund suggests that we're going in the right direction and support for other health MDG priorities as well as an overall push for Universal Access. And many of our HIV activists and TB activists are speaking health systems as well as the concerns of the populations they speak for exclusively.

WHO's strategy document includes a rather straightforward—many of us know these but it's good to be reminded—the building blocks for health systems. And they include the health workforce, probably the prominent concern of many of you in the room that face it on a daily basis, the struggles we're having with insufficient resources worldwide, information systems, medical products and technologies obviously including drugs and diagnostics so dear to our heart in TB, financing systems and sustainable approaches to financing, service delivery structures, the upfront delivery, and the overall leadership and governance or stewardship function that's required by government and other partners to drive all of these elements.

So some of the key ways that national TB programs and partners can contribute to health systems strengthening have

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been laid out in a document that we're finalizing now with WHO with a taskforce that we've been working with over the last two years called the Health Systems Strengthening and TB Control Taskforce. And we have a dos and don'ts section here where I've listed some of the dos on engagement and larger health systems efforts.

And one is to align TB control planning and budgeting within wider sector plans and service delivery frameworks; to optimize the use of shared resources, such as frontline staff. We don't want diversion from one task, robbing Peter to pay Paul. To reduce duplicative structures, we don't need to create new structures where good, strong structures exist. And to adapt innovations, as we've said before, both within and beyond TB.

Now, the non-negotiables is also something that many of us in the room, many of you in Africa know well from the mid-1990s and other countries, such as Bangladesh, where sometimes reforms in health changes ended up diverting systems into integrated systems prior to the development of strong systems to replace them. So in the interim, drug supply systems fell apart. In some cases training systems failed to be sustained.

So what our non-negotiable is, is whatever system reforms we make or innovations we make to increase equity or access or efficiency, we have to be sure that we can deliver the drugs and we don't have a break, we can provide the

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information we need, and we can supervise the staff and engage with the community.

Now, in the last few months you may have heard on September 5th in the UK, Gordon Brown the new Prime Minister, announced with partners, global partners, a new international health partnership. Many people had begun to get fatigued with individual partnerships, so now we have a new international health partnership. And now I've seen, and there's a new newsletter out, where it's called the International Health Partnership Plus. And I've got to tell you, I don't know what the Plus stands for, but I'll find out.

And there's a background document called Scaling Up for Better Health to support this initiative. It builds on the experiences of sector-wide approaches in health, aid effectiveness principles of the last few years to encourage the ownership of governments and coordination around government plans and many of the dialogs, which you can still find materials on the web, the high level forum and the health MDGs.

So this new partnership aims to build a compact between donors, between international agencies and partners and, most profoundly, to the low- and middle-income countries, particularly low-income countries that need support around a whole array of health MDGs with the aim to achieve the MDGs but also look forward to sustainable systems beyond 2015.

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So you can see that there are eight or more now donor countries committed, seven first-wave countries, and this is most critical. I want to have everyone look at this and hope you can access this presentation later to see seven countries plus Malawi and Nigeria are aiming to join. Now, there are countries where we hope that this International Health Partnership has impact, and we hope that those of you from those countries or partnering with those countries can find out immediately, either from the donor partners or agencies, what does this partnership mean for those countries and how can you engage.

And the aim again is to build on health sectors plans, but we need to make the most explicit and the best quality health sector plans with targets and benchmarks and partnerships to move them.

So some of the ways we think we can engage with this partnership most importantly is to push the divide between Venus and Mars. Many of us in this room, there's in some circles the discussion around health system people and disease control people. And frankly I think most of us feel that if we're working in public health, we're working on health systems. And I think most people working in health systems believe they're working for health outcomes. So in a way we're creating an artificial divide, so I would hope most people in the room feel that they're already halfway between those

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planets. But unfortunately I still think in many places, we talk about this divide too much.

Agency to agency, having agencies that in the past haven't talked as much together, now talking across different disciplines. And partnerships, what we can learn most importantly from a rather mature partnership that's shown success, the Global Partnership to Stop TB, how can this global international health partnership and health systems learn from the ways that we work with working groups and innovations and consensus building?

Now, the joint work most importantly in compact countries involves what you've probably heard a little bit from the presentation from Katherine Floyd was the preparation of budgeted and costed plans in countries in line with the global plan. And these costed plans incorporate all the elements of the Stop TB Strategy that need to push ahead and can, we hope, be very powerful tools to be embedded into stronger national health plans. So you're not funding a TB plan here and a maternal health plan here and a hospital plan here, but they're integrated, but they're actually carefully costed and aiming to reach the targets.

And also we want, as we've said before, to share information about innovations in health systems, and I think many of us, it's such a broad field. What are those innovations? And we need to hear a lot more in the

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documentation through work on health systems strengthening. What are the innovations that work best in what contexts?

So one of the other partnerships critical to us is the Global Fund, as you all know, so critical. Today they're meeting in Beijing—not in Beijing. They're meeting in Kunming and in China at their board meeting, and so in fact this slide is very provisional. It's just our interpretation of what we think is happening right now in those discussions.

You may know that Global Fund's stakeholders, board members, civil society, many others believe, and rightfully so, that health systems strengthening is critical to the success of the Global Fund's objectives. And while the Global Fund is investing heavily in health systems, as many have documented, through its investments today it's not going to be sufficient to achieve the outcomes on time, so we need to strengthen systems as well beyond the HTM interventions.

Round Five of the Global Fund included explicit call for applications around health systems. There were some difficulties in terms of the preparation and low response rate on that. Round Six and Seven also allowed health systems strengthening within the disease control components, but again, there was somewhat of a limited response and some confusion around the guidelines and not a lot of technical support available or funded to support good proposals.

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So the aim for the future, and the Board is quite concerned about it, is how do they contribute? And should they do it at a minimum—clearly they all agree on the Board and the Secretariat an all partners that any health systems strengthening efforts of the Global Fund should advance HIV, TB and malaria outcomes and try to be as explicit as possible and measure those. But also they hope to complement the larger array of issues now facing the Global Fund in funding programs and strategies rather than only sometimes limited projects and to harmonize better with partners.

So we think the potential approaches that might be considered, we don't know whether it to be a separate window or within disease-specific interventions, but like the GAVI HHS support, which you may know about, the fund could support strengthening health system assessments, increase collaboration among HTM partners in country and with health planners and policymakers and then aim to pilot or scale up interventions that may already be going on by others that they could contribute to or help stimulate innovation.

How we all think, we believe, in the TB community we can contribute is to provide assistance, as we have been in previous rounds. Some of our colleagues sitting in the room have been deeply involved in this, in providing assistance and developing proposal guidance frameworks for applicants, continuing to support consultants and partners in proposal

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development, documenting elements of previous TB-specific grants and better providing—we've provided consultations on health system strengthening financing this summer with the Global Fund to help prepare for their meeting today in China.

But what we think we can do in the future is to even further strengthen our framework. Help revise guidelines if the Global Fund Secretariat requests it and monitoring indicators and provide intensive support in our workshops for proposal preparation and implementation on health systems strengthening as one of the elements in those workshops and quite importantly to provide explicit examples.

A lot of people in health systems strengthening—it sounds so gross—but if you get down to talking about, well, there's an extension worker program in Ethiopia. It's been partially financed, but it doesn't have enough resources, and TB community care can only go on if we have that extension worker program. That's an example where maybe Global Fund financing could help expand TB success.

The Global Health Workforce Alliance—I'll speak quickly about a couple of others—is a partnership funded by a range of donors, including the Gates Foundation and bilateral donors with a base at the World Health Organization. It's based, as we all know, on the huge concerns around insufficient number, capacity and distribution of health workers and their pay around the world and documentation of particularly acutely

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affected country, low-income, middle-income countries, most of them in Africa and Asia, that face huge crises that need to be addressed.

So it aims to forge solutions and consensus around a very wide array of partners, and the approaches that it's taking is to address advocacy for overall financing for health workers, scaling up of education and training efforts and harmonization around those training efforts. Universal Access to HIV care and, as we know, we heard from Tony Harries [misspelled?] this morning, treat, train and retain and task shifting are all critical. And we hope that in the future, public health programs, others that share similar concerns and challenges like the HIV community, can join in and try to figure out how we as public health programs can contribute.

There's also critical work on migration policy to reduce the outflow of health workers that don't return to their homes, given the incentives to work abroad, and working groups on tools and guidelines.

So the Global Health Workforce Alliance, two quick things. They have these working groups. I think those of you that are most committed to health human resources should contact the Workforce Alliance, become a partner and seek whether you can contribute to those taskforces.

Many of us in TB have been using useful tools on task analysis. How do we use multipurpose workers that could

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contribute to many other fields that are behind us in terms of assessing how do we use best the limited health workers available? We can also very critically contribute in an important way to developing human resources plans for TB but then contribute those within larger plans on human resources development.

And lastly to alert you that they're having a Global Forum on Human Resources for Health in Kampala, Uganda, in March 2008. And it would be fantastic if—they were expecting 600 to 800 participants—but if many of you in the room can look ahead and submit abstracts or articles to the *Lancet* as noted here and contribute to bring the TB voice to that, that would be powerful.

The Stop TB Partnership is creating an MOU with the Workforce Alliance, so we hope to see some fruition across partnerships through that. The Health Metrics Network, another partnership that focuses on information systems and alignment around information systems and particularly around capacity building in developing countries. There are many institutions working on better data utilization and assessment at global level, but the Metrics Network, along with WHO and partners, wants to build that capacity at country level for local use and problem solving. And some of the approaches that it is using is to create a harmonized framework around standards, looking

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at vital registration systems, providing financial and technical support and building constituencies.

How we can contribute, I think, on the Health Metrics Network is documenting some of the best practice from years in TB control where we've used things like local cohort analysis where we all know in a local health center that has a cohort analysis going on of its patients. Nurses and doctors and auxiliaries know that cohort, know how to use that data for problem solving and program evaluation. And it may be one of the best practices in local use that others could learn from.

However, an impact measurement in TB control we have an urgent need to scale up our efforts in measuring impact, both given XDR, MDR, TB, HIV concerns, and that the Health Metrics Network is looking better at platforms of population-based and household-based survey platforms that might be helpful to us to build on so we don't always have to create a whole new survey in country.

This I think you can best look maybe at the printed version of this on the website later, but there are other initiatives. Just to let you know, the Health Eight, the major agencies involved, lead international agencies and the Gates Foundation have formed a group of leaders that meet now about quarterly to discuss health concerns. We are building our capacity, as we said, at WHO generally in our health systems workforce to be based in countries and regions. The Global

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Alliance, the GAVI Alliance in Immunizations is really one of the pathfinders in how disease control programs can contribute on health systems.

The Doris Duke Charitable Foundation has launched a campaign to fund efforts in certain countries in Africa on broad health systems' work as a complement to disease financing. And there's an array of analytic and research networks that you can look to working on policy research, which I really don't think we've infiltrated or collaborated enough with to date.

And lastly many capacity-building initiatives, including the Health Systems Action Network, which is a newly-formed, recently-formed group of members from all regions and local partners that are communicating via the Web and via meetings to build a cohort of partners working in this field that actually probably even compared to TB hasn't had a cohesive flow for many years.

So in conclusion, how do we move forward? The key is at the country level so building networks to scale up with communities and providers and initiatives across the array of concerns in the health MDGs that need to be addressed. We need to coordinate the planning and implementation support that we both internationally provide and people provide locally in country.

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There are many local initiatives, and we have to prioritize. You probably look through this whole presentation and wonder how do I choose, but I think we have many constituencies, many expertise areas to offer, and I think we can obviously offer a lot to many of these initiatives. We can document much more if we can on what we're doing on health systems, and next year and advocate more for funding for health overall as well as our individual areas.

So again to reiterate what Peter said at the beginning, next year's conference is focused on disease, global lung health threats and the implications for health services to respond. And I urge you all—today is the last day I think for submission to the TB section—if you have ideas for seminars and symposium to submit them now, but please attend in full force next year to address this theme. Thank you. [Applause]

PETER GONDRIE, M.D., M.P.H.: Thank you very much, Diana, for this clear and very comprehensive overview. You might be a bit overwhelmed by the information, but still, as I explained in the introduction, I would like you to wait a bit with questions and points of discussion that you have 'til we have heard the next presentation. Next presentation I would like to invite Knut Lonnroth, also of WHO Headquarters.

KNUT LONNROTH: Thank you, Peter. Good afternoon, everyone, friends, colleagues. In the previous presentation, Diana discussed why TB control need to be engaged in and

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concerned with health systems strengthening. She gave you a long list of broader health systems strengthening initiatives, and she talked about how TB control programs and technical partners can become more proactively engaged in those broader initiatives.

In this presentation I will discuss HHS from within TB control programs through day-to-day implementation of the normal DOTS and the new Stop TB Strategy basic element. I will claim that most TB control programs are already doing a great job in contributing to health systems strengthening, but then I will argue that they and the technical partners that are supporting them can do much more. And they can do much more by applying what we could label an HHS mindset into all aspects of planning and implementation of the normal TB control activities.

Now, there are some tools in the pipeline for support exactly that. Diana has listed some of them already. I will just briefly touch upon some of these tools, and then finally I will argue that we need to have more documentation and better research to support and to fine-tune these tools.

Now, if you ask TB program managers their view on health systems strengthening and TB control, and in fact we did this last year in a survey of some 15 program managers, many of them—if not most—will claim that they're already making a significant contribution to health systems strengthening simply

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by implementing DOTS. And the argument is that DOTS has a very strong focus on health systems strengthening and particularly health systems elements that are required for the implementation of TB diagnosis and TB treatment in an efficient way.

So for example political commitment. That is about increasing healthcare funding and improving governance. And next there are lots of emphasis on some health systems fundaments that are required to deliver TB services in an efficient way, including focus on human resources, on lab strengthening, on drug supply systems. And finally there is a lot of attention to monitoring, evaluation, surveillance and supervision.

Now, all these are health systems building blocks, and you can easily map them onto the general health systems building blocks that Diana was referring to, which is a part of the new WHO health systems strategy. So you have health systems building blocks. You have TB control programs that obviously are a part of the health system, so obviously, just be doing this obviously you are strengthening the health system.

And furthermore, and this is often not fully appreciated, most TB control programs are already fully integrated into the primary healthcare system and to the general health system at least on the service delivery level,

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so diagnosis and treatment of TB normally take place within the normal primary healthcare settings. So therefore again, if you strengthen human resources, labs, drug supply systems, then again you should automatically strengthen the health system.

But, and this is a big but, this kind of argument, it only holds true under certain conditions. And before we jump to the conclusion and say that just by doing DOTS and now implementing the new Stop TB Strategy we will in fact achieve a broader health systems strengthening, we need to consider a number of questions concerning how TB control is being planned and implemented.

So for example if we managed to increase financial resources for TB control, is this money coming as additional money to the health system or is it money that has been transferred from other parts of the health systems? And if that is the case, what is the opportunity cost or how could that money have been used elsewhere in the system?

Next, if we manage to improve lab capacity and if we manage to improve drug management system and health information, are we doing it by strengthening the basic health systems building blocks and thereby improving to general strengthening of these elements or are we creating parallel systems, perhaps because the general system is too weak even to be started on any strengthening activities on these particular components?

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And if that is the case, what is the additional transactional costs and how much of an additional burden is this additional transactional cost for the program?

Next, with relation to human resources, if we're able to improve the human resource capacity to take care of TB diagnosis and treatment, are we doing that by putting in place TB-specific incentives or by recruiting TB-specific staff from other parts of the health system? And if that is the case, are we disrupting the implementation of other important healthcare initiatives by doing so?

And finally on training, it is often assumed that any training activity automatically is something that strengthens the system because you're improving the capacity of the healthcare staff, but obviously it depends on how you're planning and implementing the training. And if you do it in an uncoordinated way or if you do too much of it in certain areas, you can certainly disrupt the implementation of certain clinical essential elements.

So if you're able to answer no to all of these questions in a TB control program, then I think that argument that I put forward to you, that DOTS implementation is synonymous with health systems strengthening, that is okay. But if not, there is room for improvement.

And this is the HHS mindset that I was mentioning about. This is what it's about. It's about asking these

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questions about the implication of TB control planning and implementation that goes beyond the TB indicators on process and TB outcomes. So for this we are developing some tools that should aid this process, and this is coming back to the dos and don'ts and the non-negotiables that Diana was talking about.

I'm not going to present in any detail what examples of dos and don'ts or non-negotiables we are putting forward. I'll just give you a few words about the basic principles about this.

So first of all the dos and don'ts for HHS. They're aimed to promote this health systems mindset, and that mindset again is mainly about thinking outside the TB box, thinking about the implications for the wider health systems, of all the small details of program implementation that the programs are doing. It is a lot about coordination and harmonization and alignment.

Is it also about integration? Well, it could be, in some situations may be a part of this could be further integration of certain elements of the TB control. But this is where we have to start to be really careful, and as Diana discussed, we have ample evidence from the last 10, 15 years where too much or too quick or mindless integration of various public health programs have been really damaging, not only for TB control but also for other public health programs.

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Therefore, we have to put forward also a balancing argument. When we say that we want people in the program and the technical partners that support them to think more outside the box, think about the health systems implications, we have to also remind all of us that we should not take it too far, and we have to really secure the fundaments of TB control that need to be there.

So this includes drug supply, functioning labs, qualified staff and quality diagnosis and treatment, the required monitoring and evaluation, supervision, et cetera, and all of these are the basic DOTS elements basically. So it's non-negotiable to have all these things in place, but what is negotiable is how you put it in place.

So further integration is negotiable, and when it is appropriate to integrate, that depends on the local situation. It depends on the strength of the health system. It depends on the strength of the program. It depends on the competing demands on the health system beyond TB control in a particular setting. So there's no one answer to what is an appropriate level of integration. It needs to be assessed in each specific setting.

Now, moving on to the new Stop TB Strategy. For the DOTS strategy the health systems strengthening element is implicit. In the new Stop TB Strategy, as Diana said, it is explicit. There is this component of health systems

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strengthening. Now, it is important to point out that that component, number four of the Stop TB Strategy, it is not an invention package per se. It's not something that should be translated into a budget line for programs to implement health systems strengthening as a side issue. It is again about this mindset and the mindset about how we plan and implement all the elements of this new Stop TB Strategy, so first of all, with regards to DOTS. And now with MDR-TB management and with TB-HIV management, this same mindset should apply also to these elements.

Same argument should be there for PPM, for community involvement and I guess also for the research agenda that there is a need to think also about the wider health systems implications, of all the things that we're doing on the new Stop TB Strategy.

Now, as Diana also listed, there are three dimensions to this, and the first one is to actively participate in broader efforts to improve health systems. And the first part of that is indeed what Diana was talking about, to get engaged with a broader health systems strengthening initiatives. And the second element or sub-element of this is what I've been talking about, to ensure that everything we do has an optimal impact on the wider system, the HHS mindset and the dos and the don'ts.

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Now, the second dimension is about adapting innovations from other fields, and this is really coming back to strengthening TB control but doing it by looking at innovations in other parts of the heath system. And finally it is to share innovations that strengthen systems, so some of the service delivery innovations that have been developed by programs and by technical partners to improve TB control, perhaps they can be adapted and shared in other parts of the health system and thereby contribute to broader improvement of the system.

It includes for example the practical approach to lung health or PAL, engaging all healthcare providers through public/private mix or PPM approaches and through using international standards for TB care. It includes also perhaps community DOTS and TB-HIV collaborative activities.

Now, I will take you through some arguments with regards to two of these, namely, PAL and PPM as a little exercise on what are the potentials for strengthening systems by doing this kind of TB service delivery innovations, and I will start with perhaps the most obvious example, which is PAL, and I will do it by mapping the potential for health systems strengthening onto again the general health service building block that Diana was talking about.

So first of all, looking at health services or service delivery, this is really the essential element of practical approach to lung health to standardize and to implement

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evidence-based and integrated management of respiratory illnesses, including TB, including acute respiratory infections, COPD, asthma and chronic bronchitis.

Now, TB is the entry point here, but then the whole package is about integrated and standardized across all respiratory illnesses. And since in all primary healthcare settings, respiratory illness is one of the dominant issues that the staff need to deal with, obviously if you do this you will strengthen a significant part of the primary healthcare system.

Second, with regards to health workforce, by training people and thereby increasing the competency among primary healthcare staff to apply these standardized and evidence-based management principles, that is, first of all, it's improving the competence to do exactly that for respiratory illnesses. But perhaps it can also have implications for their ability to implement also standardized and evidence-based guidelines beyond respiratory illnesses at least in theory.

Next, on leadership and governance, PAL is also about fostering integrated planning and thereby improve the efficiency and the use of healthcare resources, so that should in principle and in theory reduce the cost by having a standardized and integrated approach.

And finally looking at medical products, and here there is in fact quite a lot of evidence coming out that PAL can

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improve the rationality in the use of medicines, not only for TB drugs but also for antibiotics in general and, beyond that, also for treatment of asthma and COPD for example. And there's also data to show that this can reduce medicine costs, both for the health system and for patients.

Now all in all, this potential health system strengthening effects, we don't have all that much evidence to support that this, in fact, is the case, so you can regard them as hypotheses. However, there are some publications coming out and over the past year there have been three looking at PAL implementation in Bolivia, in Nepal and in South Africa. So that is a starting point, but certainly this evidence base for PAL needs to be strengthened before we claim further that PAL in and by itself has a health systems strengthening dimension to it.

Now, moving onto PPM, same exercise, mapping onto the general health systems building blocks and starting again with health services. And just as for PAL, the essence of public/private mix approaches is to foster evidence-based standardized procedures, not to cross different respiratory illnesses, at least not yet, but to cross different types of healthcare providers.

So the focus is on TB, and the focus is to make all providers implement evidence-based principles. In theory this could serve as an entry point and a template for these

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providers and particularly with regards to the private sector where there is often a huge gap with regards to standardized and evidence-based treatment. It could be an entry point for also implementing other public health interventions once this has been up and running for TB.

Next, health workforce. One was to look at PPM in fact is to see it is as a way to harness a part of the human resource for health, which has been often place very under-utilized for the implementation of public health strategies, and now I refer again primarily to the private sector. Once you have harnessed them for doing good TB control activities, it is a possible entry point again to harness this part of the health workforce to do other public health interventions.

Moving on to health information, here we have two quite concrete examples of how PPM can contribute to wider improvement of the health information system, and the first one is what needs to be element number one of any PPM initiative, namely, to map out who is out there and doing what in the health services.

So for example on district or sub-district level, map what are the public providers, who are the private providers. Look at the hospitals, these small clinics, the individual practitioners. Look at the formal sector as well as the informal sector. Often health authorities, of course, have a good overview of the public sector facilities, but very often,

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the private sector facilities are missed. You won't find them when you go to the local health authorities. It's not in their list of providers in my region. And certainly, of course, if you look at the informal health sector, it's usually not there at all. Yet, they can be important for the implementation of public health interventions as the PPM experience has shown.

Now, by doing this mapping we're setting the ground for PPM, but perhaps it can also set the ground for other health interventions by just showing to health authorities, well, first of all, this is the magnitude of the issue. This is how much of the other providers that are out there, and second, giving that information as a starting point for implementation of other initiatives.

The other element, which is also central in any PPM initiative, is to improve the referral mechanism and the information exchanged between public and private providers, between private practitioners and public health authorities. So establishing this kind of information exchange for TB control could, in theory again, create an avenue for better information sharing also on other public health issues on infection control and surveyance, et cetera.

Finally, on leadership and governance, what PPM is trying to do in one way is to give capacity to public sector healthcare planners and managers on how to effectively evolve and supervise, train and monitor a wide range of healthcare

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providers. And the capacity is often weak, again, with regards to the private sector, so having this experience, which is something that all public sector providers and health planners that we have been in contact with during the implementation of PPM projects have had to work really hard one because it's not something that is done overnight. And it takes quite a lot of effort to get people to reach out outside the normal domains of operations, which includes the private sector, which people often feel uncomfortable with trying to reach out, engage with an supervise.

So in theory that kind of experience would also be something that once it has been done—and that will take some time and effort—but once it is there, that kind of experience can also be used to reach out to more private providers, for example, or use the same private providers for implementation again of other public health interventions.

Similarly, on the receiving end of leadership and governance, the providers themselves, it's an equally long and sometimes tough journey for the providers to accept the leading and the governing role of public health authorities and public sector providers to come to them and supervise and demand them to send reports, et cetera.

Now once that trust, which is required for that, has been established, then maybe this is again opening up an avenue for better collaboration and in a wider respect a better

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possibility for the stewardship functions, which is required from the public sector.

Now, having said this, unfortunately most of this is just speculation because even though we have very good evidence now to show that PPM is good for TB control, we don't have any evidence to support that in fact it also has a wider health systems strengthening dimension to it. So while PAL has some evidence, some publications, for PPM it is simply not there.

So moving on now to the available tools and some of the weaknesses of the tools, which is indeed that the evidence base is not that strong, I'll just simply list some of the tools that are available and not go into the details of them.

The first one is a document from 2003, which is called Expanding DOTS in the Context of Changing Health Systems. This tool mainly deals with what Diane was talking about, how to get engaged with the broader health systems strengthening initiatives and mainly on country level. It also talks about the non-negotiables, though it doesn't label the non-negotiables in that way in the document, but it's about how to protect the essential TB functions when there is a health sector reform going on, when there are dramatic changes to the health system.

The second document is a draft. I wouldn't call it guidelines but some guiding principles on health systems strengthening for NTPs and for their partners. This is

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basically outlining that HHS mindset I was talking about and the dos and the don't's and the counterpart non-negotiables. A part of that document is a checklist on health systems strengthening issues that could be used during program reviews.

And this checklist has been tested in a number of country reviews over the past year. The guiding principles have been disseminated and discussed now for about a year, and we hope we'll be able to finalize that document by the end of this year.

And finally also something that Diana touched upon. We have developed a framework for how to integrate a health systems element into a TB component of the Global Fund proposal. It has been there for Round Six and Round Seven, and once the Global Fund has decided where to go with health systems strengthening in Round Eight, we will adapt and change this framework, and as with the other frameworks we developed, make it available on the WHO homepage.

Now, to conclude, what I have tried to convey in this presentation is, first of all, that TB programs are already doing a really good job to strengthen systems and also with the support of technical partners. But much more can be done to really fully apply this health systems strengthening mindset and think about the dos and the don'ts while, of course, then protecting the essentials to protect the non-negotiables.

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There are some tools in the pipeline that hopefully should be helpful for programs and technical partners to take this agenda forward, but we will need more research. We will need more documentation to develop further and to fine-tune these tools. And since this is a scientific symposium, I invite all health systems researchers in the audience to really help us strengthen this evidence base, which is badly needed for us to send these kind of messages with emphasis. Thank you. [Applause]

PETER GONDRIE, M.D., M.P.H.: Okay. Thank you very much, Knut. We've had now two presentations. Diana started with kind of a historic overview and an overview of current initiatives and also motivation, why we as the TB community should engage in that, not only to achieve the Millennium Development Goals related to infection control but also the more general health-related development goals.

And then Knut elaborated a bit more on that, especially in relation to the Stop TB Strategy, the different elements, and he compared it with the building blocks of the system but also with specifically the fourth component, had two examples of PAL and PPM and had as well a challenge, I think, to all of us that we are doing a lot, but a lot more needs to be done. And especially we need to document it and to turn it into evidence-based issues that we can present to others.

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I would now like to give the floor during the coming 10 to 15 minutes to you, to the audience, for any questions or comments on the first two presentations. I think microphones are being passed around. Yes? Please identify yourself if you have a question.

AMAD HASSAN: Yes. From Afghanistan Amad Hassan [misspelled?]. My question is that we know that if we applied DOTS strategy properly so the HHS will be established, but why TB should affect the leading rule? Why the other programs?

DIANA WEIL: Versus—we take a few more, yes. We take a few more or—

FRANCIS: Thank you, Chair. When I was listening to the two sermons, I started feeling like a Catholic was being asked to convert and become a Christian in the middle of Afghanistan. I'm actually echoing what you are saying. I feel the audience, we've just been addressed, is incomplete because we in the TB world have been fighting to get TB recognized and put high on the agendas of most national programs. You are asking us to battle and take the lead in battling it.

I'm not saying this is the negative because you have made extremely good presentations, so health planners, those who are fortunate to manage, those who define the work plans we do, are not here. So I want you to carry these discussions further than here because these Catholics are already Christians. [Laughter] [Applause]

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The second aspect in the presentation [inaudible] is the other side where in the medical world it's very honorable to be a doctor even if you do make a lot of mistakes. People say the patient only came late. That's why he died. So the people we serve, if we are going to do, strengthen health systems and make the health systems so strong that they will be used, then we must listen to the people we are going to serve.

So we are the voices of those who are served in the health systems strengthening. We need to do the same in that aspect. Thank you.

DIANA WEIL: On the first question, I don't think the health system people will ever let us take the lead, so I don't think we're ever going to be out there all by ourselves. I think the idea is that we, as TB community I think we have a lot to offer, and sometimes we're too shy. Sometimes we have such a sense of community among ourselves that it's hard to move outside.

And I think we're at a critical moment where often in the past hearing from program managers and colleagues that in many countries they haven't been invited to the health systems table. They haven't been invited to speak at sector-wide program meetings. They might be in the room but not really speaking.

And I think with the indicators and the progress that many countries are making as well as the challenges they're

facing in very critical terms we have a lot to offer at that table, and I think with the dialog across partnerships right now I think we have fodder. I think what we're finding in the health systems community is a new iteration is that outcomes do matter, and people do recognize that parliaments and congresses want to see outcomes. And the health systems community needs to show outcomes for its innovations.

But using those TB outcomes or those TB impediments or those HIV outcomes, we try at WHO to work across HIV, TB and malaria and talk with the child health community and talk with the community working on pharmaceuticals because I think a lot of people feel they don't have enough voice in this. But I think the notion that we talk across programs and talk about the priority programs and how do they speak about those outcomes and how these inter-processes sometimes in the systems can help, will make a difference. So I think we have to be in the running. I mean whether or not we have to be on the playing field you can say.

Secondly, for Francis' concern I think, yes, none of us want to be fundamentalists. All of us want to be part believers, and hopefully, nobody's an agnostic in the room or an atheist in terms of believing that systems matter and disease control matters. But I think we have a chance. I'm not saying we're convincing ministers of finance, but in some cases I think they recognize disease outcomes can show results

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in a period of time that's good for their political career and also good for economic benefits.

In December 10th at the World Bank there's going to be a discussion around the economic benefits of TB control with leadership at the World Bank at the level that we haven't had before or in several years, and that's a very good thing. So I think we have a moment to speak a common language and try to integrate more meetings. We have a wonderful meeting and we have some more of these forums that we need to get together.

The last thing I will say is that on the health systems frameworks, you do find that the civil society voice and the engagement in health planning is still not very strong in many of these documents. There is the notion of district authorities playing a role and report cards on health systems, but I think we have a real important role, given what we've learned in the HIV and TB communities of bringing that civil society voice strongly on what we demand in terms of quality care and the risks of bad system changes that might destroy supply of drugs or destroy laboratory capacity or further limit health human resources. So by all means let's find a way that these system frameworks include the civil society voice stronger.

KNUT LONNROTH: I just wanted to add a few thoughts on the first question about TB control programs should take the lead. I think part of my argument is that TB programs and

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technical partners are already taking part of the lead in strengthening systems.

Now, one thing that came out of the survey of program managers that we did last year was that many program actually feels that in their country they are regarded as the good program with good performance. They're actually doing quite a lot also to strengthen these fundamental building blocks of the health systems.

So maybe the take-home message is not that you need to come up with something completely new and a new agenda on how TB programs should take the lead to strengthen systems, but think about some things that could be done on the margin, and then think about how to document and how to package and how to send the message about what you're already doing with the implication for the wider system, not only mention your TB indicators.

And that could be important also to keeping the profile of TB control programs and ensuring that the political commitment is there to continue to support programs also because they can contribute to the wider health system.

PETER GONDRIE, M.D., M.P.H.: Okay, thank you. There is room for a couple of more questions. Yes, please?

IRENE AJAPONE: Thank you. My name is Irene Ajapone [misspelled?]. I'm from Ghana. I'm a regional director of health services. The first speaker talked about the fact that

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strengthening health systems and vertical programs are not independent, and we need to think slanted. I agree, but some of the lesser suggestions, even on health systems strengthening suggests to me that you are still thinking vertical because basically, the health systems is the base on which all the programs exist.

And if you have TB looking independently at how to strengthen the health system, vaccines GAVI looking, malaria looking and so on, you are still creating a kind of vertical health systems strengthening because if you strengthen labs, it helps TB, it helps malaria, it helps HIV/AIDS. If you strengthen the health workforce, it helps almost all programs.

So why do you have the programs trying to independently look at how to strengthen the health systems and talking of who is taking the lead and who is not? I think you are still thinking vertical, and perhaps you need to start moving towards a place where you look at all these programs, whatever funding you want to use to strengthen the health system, how do you coordinate that function and coordinate the health systems strengthening?

Because what sometimes happens to those of us who work within the health systems is TB comes to you. I want to strengthen the health system. What should I do? Then malaria comes to you. Then HIV/AIDS comes to you. Then the donors come to you, and the suggestions you have for all of them are

the same, but it's taking your time times five, six or seven and it's fragmenting the funding. [Applause]

KNUT LONNROTH: I think that's an excellent comment, and I think being a little bit optimistic, I think there might be an opportunity to look at the Global Fund Round Eight. Now, we have to wait and see what comes out of the board meeting, but one thing that we've been trying to push I would say that I guess the TB is taking the lead. We're taking the lead on better coordination within the Global Fund applications.

So one thing that I would like to see, and I can assure you we'll try to push for it, if in Global Fund Round Eight health systems elements are built into the proposals, they should be coordinated across HIV, malaria and TB in order to avoid what you were talking about and in order to make sure that we're addressing jointly the common health systems bottlenecks that are common for the three programs.

PETER GONDRIE, M.D., M.P.H.: Okay. We have time two more questions. I have Dr. Sater [misspelled?] in the back and then—

DR. SATER: Yes. Sater [misspelled?] from WHO doing TB control. I don't think we are fighting between the TB care and the health systems. I think we are in the same boat, and then I think it's very important to remember. I'd like to share two things.

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One is that I was in Afghanistan last week, and in Afghanistan what was really I was so excited that there is a clear health systems blueprint. There is a clear [inaudible 1:05:39]. You may not believe this, but this is true. There is a clear contracting out health systems development plant that was extremely clear. In such a case that the full TB how we can integrate, how we can join the health systems—not join but work together with the health system. The construction of health is very easy.

And then most of the previous speakers say that many donors say I go to the TB person goes to health system people, HIV personal assistance people and other person go to health systems people. The challenge we often face is that health systems people cannot tell us where we need to contribute. That is also we often see.

And the second thing is that they say but still we need to speak the health system's language, and I think probably we need to do is I'm looking at this WHO's report. There are six health systems block, right? The health services so probably what do we need to say how TB control is contribute in the health services, how we are contributing in the health workforces, how we are contribute in the health information, blah, blah, blah, so that in each six of the blocks, what our contribution of TB care is how we are contributing to this

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area. If we can tell this in evidence, I think we can—it's one way to show how we are contributing health systems.

PETER GONDRIE, M.D., M.P.H.: Okay, thank you, sir. I will take two questions more, and then I will ask our presenters to comment. Yes, please.

VANANAN TUTI: Thank you, Chair. Let me first confess my name is Vananan Tuti [misspelled?]. I was Senior Health Advisor to Global Fund for many years. I'm not there now, but let me tell you about the tribulations we have had when this issue of health systems strengthening.

We had applications initially where there was no health system pitted for. Then we said no, but you can't deliver. They said, okay, let's put in a component for health systems as a stand alone, and all the proposals that came, majority if not all of them, got rejected except much later on when one or two were approved.

And then one country went and actually did the right thing: Looked at the health sector strategy, said how do we want our health sector plan actually implemented, and we present it as a health systems project. It was turned down, and the countries have been struggling to get what exactly do you mean by health sectors, health systems strengthening proposal.

I argued at that time that really what we are talking about is delivery systems, whether it's for HIV or TB or

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malaria. But then it's not about one delivery system for TB, then another delivery system for malaria and another delivery system for HIV. It's not, it doesn't help the health sector strengthening.

So this issue is still a problem. I don't think we have defined it yet, but I think we start from the country. The country has its health sector strategy plan, and all countries are currently being helped by WHO to develop the health sector strategy plan. And what we need to be looking at is how can we actually support the health sector strategy plan to be implemented in which we decided those diseases?

And I think we are still continuing the debate. I don't know what the Global Fund will come out with, but I've tried both of these when I was there, and each time the working groups would reject the whole idea. And up to now we have not been able through the Global Fund to actually strengthen the health systems. That's what I want to share with you. Thank you.

PETER GONDRIE, M.D., M.P.H.: Okay, thank you. The last question Ya Brupance [misspelled?]?

YA BRUPANCE: Thank you very much. I would like to congratulate you with organizing this symposium, and I think each bullet could be a symposium in its own right because it's the first time really we discuss these items. And I hope next

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year the agenda will be full, and we'll work through many of these things.

Meanwhile, I think so I support the HHS mindset for our TB control community and to proactively engage with the wider health services community and to get away from opposing views there.

But meanwhile I think we have to do our homework. We are here. We are responsible for TB control, and we have to deliver results, and we are responsible for delivering results. And I strongly support the development of these don'ts and dos and especially the non-negotiables. And I would like to ask that this discussion on the non-negotiables takes place in a wider audience and is really fertilized by our insights and our salts but also by our consensus because understanding what is the essence of our dynamics against tuberculosis and formulating that crisp and clear, not in vague words like drug supply, monitoring and evaluation.

But for example if you would ask me, I would say don't take away cohort analysis. I don't accept that. Why? Because it gives me accountability on case finding and cure, and I can act and improve my program. I can go to politicians, et cetera, et cetera. The situation is unacceptable here.

Secondly, I would be very precise on delineated responsibility and leadership at national and regional and district levels. There has to be a person who is responsible

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for the whole TB service in a specific area who is accountable. So both issues deal with really the possibility as a TB controller to be accountable for your work. The buck stops here, and you can act and you can go to politicians again or to the press, et cetera, et cetera.

And these are important lessons. And I think that when we will discuss this true and formulate them crisp and clear and not vague in many words, we will discover at the end of the day those things you want to have enshrined in a legal framework of your country. Because when they appear in a legal framework, then in the development of the health service the country, of course, takes care of the legal framework. And then we study TB control and its success in the industrialized world, we will see that all key activities are enshrined in that legal framework.

PETER GONDRIE, M.D., M.P.H.: Thank you very much, Ya [misspelled?]. And still our congratulation with the Japanese award, and when you were talking about accountability, I remember that with whatever idea we came to Ya [misspelled?] about new things in the DOTS strategy, Ya always says, "I don't mind but there are two things. A case must make a case, and a cure must be a cure."

All right. Now, I would like to hand over to my Co-Chair, Chrissy Hanson [misspelled?] for the second part of the symposium. Christy.

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CHRISSY HANSON: Great. Thank you, Peter. So now we're going to move into a couple of country presentations that are going to bring the global overview that these two have so aptly laid out for us down to reality, really what this means at the field level. So first I would like to ask Felix Salaniponi, who is the National TB Program Manager in Malawi, to present. He's going to talk about Mainstreaming TB and TB-HIV within Decentralized Health Systems in Malawi. So, Felix, please?

FELIX SALANIPONI: Can I have some technical assistance here? Good afternoon and welcome to this presentation. As it has been alluded, it is a presentation that is focusing on some of the practical national issues that Malawi has been engaged in. Because I'm talking of a situation of a particular country, maybe it might be appropriate to also give the background that Malawi is one of the countries in Africa, and those are our neighbors on the North, Tanzania, and then Mozambique spreads on the West to the South, and then we have Zambia on the other side. Actually, the Tanzanians are supposed to be our cousins and then the Zambians our brother and sisters, and Mozambique are supposed to be our uncles. [Laughter]

The issue here is about mainstreaming TB and HIV intervention within decentralized health sector reform for the country of Malawi. Just a bit of the background in terms of

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our decentralization policy that Malawi did take nine years ago, and this policy was enforced through the Local Government Act of 1999 in Malawi. Health services [inaudible 1:16:06] were developed with district assemblies, but the Minister of Health still retains the stewardship and the policy formulation laws.

Coming to the sector-wide approach swap for health, which is our entry point, this is encompassing the joint program of WORK POW for health sector-wide approach, and this was launched in the year 2004. The swap was formulated in line with the National Decentralization Policy, as I've said before, and the swap is the main channel through which the Ministry of Health and its partners aim to delivery the Essential Health Package, EHP. The Essential Health Package is the prioritized package of health services, and this is focusing on the 11 major causes of morbidity and mortality, and this includes tuberculosis.

In the plan of WORK POW there are six pillars. One of them is human resource, infrastructure development, et cetera. This is a means. There is one WORK plan for the simple of operations and financial resources are pooled in one owned basket.

Each district has its own costed annual work plan, and this is called the District Implementation Plan, the DIP. This DIP ensures that the district has all the mandate to decide

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what activities to fund without the interference of the central level apart from giving it the guidance or the stewardship.

When we come to the role of the national TB control program in the era of sector-wide approach for health, the sector-wide approach has actually resulted—here I use the word decline—but quite often it gives it like a negative connotation. It's portraying, it has resulted in consolidating or making this more to the national TB control programs programmatic and financial management controls. So it moved from those previous roles to the following: policy and guidelines formulation, advocacy, strategy guidance, mentorship and the stewardship, monitoring and evaluation to tell us what's going on.

For mainstreaming HIV and TB at the central level, there are various officers to coordinate different components. In other words we have focal persons. I cite here a few that are involved in TB training, gender and poverty, TB and HIV, research, operations research, community care, TB advocacy and social mobilization, drug management and logistics, laboratory services including central reference laboratory. Otherwise, this is what it would look like as a very call services, the areas that are blues, we mustn't go below those ones.

Now, scaling up TB diagnosis services. Currently, in Malawi there are 96 TB microscopy centers country-wide. This means one TB laboratory for every 150,000 population. There's

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one laboratory in the public sector that performs culture and drug sensitivity testing, and this is with only laboratory technicians working at this central reference laboratory. And obviously this results in delays and processing sputum samples for CDST.

Because this is a major issue in terms of scaling up TB diagnosis as we have picked up a big challenge on Universal Access to TB diagnosis for this one of our major response to TB control, the plans are that the lower cut of health workers are being trained as TB microscopy. This is a shift. The issue of task shift has been alluded to previously.

And these TB microscopies are supposed to work in the rural health centers. This is far away from the urban setting and the district. We make sure there is regular supervision for visits by qualified laboratory technicians so that they are meant to perform quality and control checks of smears examined by this culture. As we know as we are aware, we have given them the responsibility that has been assigned to them as a task shift.

And meanwhile we're going ahead with establishing additional laboratory to perform TB culture and the DST. And always for a long time there have been a mention for about Malawi having only one DST culture at the central reference lab, and these are just the plans ahead, thinking ahead so that we were, this already on the ground.

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When we talk in terms of because I did cite that this is at the different levels, the central level, the zonal level, and the community level. At the community in terms of TB care improving access to TB diagnosis and treatment is one of the main business, core issues, and this includes their commitment to speed up collection points being established in most of the districts. In fact this is a new innovation having lessons learned or evidence from one of the studies that was carried that indeed we could do benefit or add value by establishing these collection points as a way of scaling up our access to TB diagnosis.

Sputum samples are transported to the nearest TB microscope sites, two to three times a week. This innovation has shown to make TB diagnosis and treatment accessible, both to urban and rural poor communities.

In the impact of community involvement in TB case detection, I here cite a case for a local urban area in Sedeza [misspelled?] Community, which is in Lilongwe the capital. And this area community has a population of 32,000 people. It's an actual poverty headcount of 24-percent. The area research I was talking about showed various forms of barriers [inaudible] to TB diagnosis, and these included increasing financial cost for the patients that they had to bear as they had to travel long distance to health facilities. If they managed to do that, then there was the fees for the diagnosis and of course

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the shopping around in different health facilities as they had to visit many more maybe for reasons that they were not convinced they were getting the treatment that they were looking for.

Prior to establishment of this community, the TB initiative I'm talking about in Sedeza [misspelled?], there was only 26 new positive cases estimated standardized by the population at 93 per 100,000. During the first year of the intervention, 40 new smear-positive cases were detected, and you can see there draws up to 125 per 100,000. And thus looking at the last 11 months, we saw that 305 suspects were registered in a chronic cough register, 35 were smear-positive from TB, 84 smear-negative only and 20 extrapulmonary.

Looking at the collaborative TB-HIV, as activities for the implementation, I want to share with you that the national TB-HIV coordination body was established sometime back and functions very well. To be in line for the sector-wide approach governance structures, the TB and HIV coordinated body is at the level of a sub-group. In other words, we have several directories, which are technical working groups and below that the sub-group will be below them.

This group reports to both TB and HIV and the AIDS technical working group. This is to take care of the many problems that we see and hear about in the region about ownership or who originates what. Why should technical sub-

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group maybe belong to one disease component, so this was the way of trying to sort out those unfortunately misgivings or impressions.

This group, as I said, report to both, the technical working group. The TB and HIV is coordinated by the heads of the TB and the HIV/AIDS control program, so that's again brings an issue to balance the way this can be defined.

Here I take you to look at some data in terms of HIV disease among TB patients, and this is for the year 2006. Looking at this graph, a total of 27,011 TB patients were notified in the country. Seventeen thousand, reflecting 64-percent, were tested for HIV. Twelve thousand, represented 70-percent, indeed tested HIV-positive. Eleven thousand, representing 93-percent, were offered CPT. Six thousand or close to 7,000 started on the allergy due to TB. This include TB patients who concluded TB treatment during the previous year.

Now, in making HIV testing accessible and acceptable to all the TB patients, certain things have to be put into context. Although the proportion of TB patients being tested for HIV has been increased from 18-percent in 2002 to 64-percent in 2006, this to us within the national TB control program target is below what was set at 90-percent.

One initiative to increase the HIV testing uptake by TB patients is to train all TB officers as HIV counselors provided

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because these are the first-line people in terms of TB control. Basically, these come from the public health background. By training these or giving these arrangement, the initiative allows to provide onsite HIV testing and counseling to all TB patients.

Coming to the issue for antiretroviral services by the end of June 2007. There were 146 initiation sites, so these sites so these sites will initiate the ART; 109 in the public sector, thus the government, and that's seven in the, private sector; 110,000 patients were started on the ART since 2004, and this is reflecting 76,000 or 69-percent alive on ART; 16,000 patients were started on ART due to TB alone, and this is representing 15-percent of the total patients that were started on the ART; 246 patients are on circuit line ARV drugs, and only 17 sites where they can have access CD-4 capacity for country-wide. But as a matter of progress, I'm aware that Malawi has just 21 more CD-4 machine that by the end of November make it possible to at least at the district hospital to have the capacity for CD-4 count.

We have challenges in order to make this plans or rather make this system as we look at it function. The issue that never dies away is the issue that keeps on coming time and again, human resource crisis, and this is at all levels of the sector. And perhaps that's why one of the issues of tackling this is the issue for task shift and, again, as we saw the

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issue for some incentives that are given in terms of for top-off of SARIS [misspelled?]. This is by the general health sector.

And again we also look at the provision for HIV policy at the workplace as one of the measures because by prioritizing health workers again to access ARVs and putting this policy is one of the initiatives that has been put in place to make sure that those who are affected are well managed.

Then there's the issue of community volunteers that are involved in the community care. Quite often, these are the people that volunteer themselves from the village, but certainly these are the people that also have to do their own cost issues, making it difficult for them maybe to sustain their own livelihood as it results in the challenge of what do we get out of this. And since it is not the policy for either the Ministry of Health or the country, we always don't run away from the challenges of high drop-off rate on this so the issue of train, retrain and retrain for the volunteers comes in.

And anyway for TB control program because of this we have more bias in terms of for encouraging the family membership contribution popularly known as the guardian days, so like the aspect of DOTS is actually supervised by family member, and this is the one that is working very well.

And we also have the problem with currently RTB and the ARTs. Clinics are not integrated firstly at the level for

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operation. TB services are up to the community level. In fact we do say we have been able to get DOTS up to the doorstep. ART still are highly centralized. You can go up to the district health centers, so that again creates a problem. So infected patients need to come to the hospital twice for TB treatment and they are ART. And if they have to receive both treatment on the same day, they have to come to queue twice at the time and for ART clinics.

There's also the problem of when to start the ART in TB patients. It remains unresolved. Not that we don't know when to start but because the regimens that we use are not very friendly, so there's a question if we're using the regimen maybe two months later. Thank you very much for your listening. [Applause] I was seeing [inaudible]. [Applause]

CHRISSY HANSON: Thank you very much, Felix. Glad I didn't have to give him that piece of paper. Thank you, Felix. In the interests of time, we're going to move right ahead to a presentation by Peter van Maaren. Peter is WHO's Regional Advisor for TB in the Western Pacific Regional Office, and he's going to talk about their experience with scaling up public/private mix approaches in TB control.

PIETER VAN MAAREN: Thank you very much, Chrissy. It's a pleasure to be here to talk to you about scaling up of public/private initiatives in the Western Pacific region as possibly an argument for TB's contribution to health systems

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strengthening. Let me tell you what I'm going to discuss in the next couple of minutes. I'll give you first the background of the Western Pacific region and an overview of our regional strategic plan, first planned up to the year 2005 and then the next plan, 2006-2010. And I'll provide you with a rationale for the initiative to work on PPM activities in the Western Pacific, and finally I will give you some examples of the public/private work that has been done in the region, followed by some concluding remark.

This is the Western Pacific region. For those of you who don't know, we have countries with a population of—one country with a population of more than one billion and countries with a population of less than 2,000 people spread all over the region. And that's, of course, gives you a whole range of different activities in different settings.

Four of the global high-burden countries of TB are in the Western Pacific region, and they are listed here: China, Philippines, Cambodia and Vietnam. In the Western Pacific region itself, we have groups countries into high, intermediate and Pacific Island countries. And the seven high-burden countries in the Western Pacific region are the four that I just mentioned with added Lao PDR, Mongolia and Papua New Guinea. These seven countries have more than 90-percent of the burden of TB in the region.

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The TB control targets in the Western Pacific regions were set in 2000, first with the publication of a regional strategic plan for the year 2000 to 2005, where we would be looking at the intermediate TB targets in the year 2005 of 70-percent case detection, 85-percent cure and 100-percent DOTS coverage. The ultimate targets for the Western Pacific region is an impact target to reduce the prevalence and mortality of TB by 50-percent by the year 2010 based on 2000 levels. So this is a different target than the Millennium Development Goal, which looks at the baseline of 1990, and we are trying to reach our target five years ahead of the Millennium Goal year of 2015. If we achieve these targets, we feel we make an important contribution to the achieving the Millennium Development Goals in 2015.

Just to take you back to the year 1999, that was the year that in the Western Pacific a TB crisis was declared by the regional committee, WHO’s governing body in the region. At that time the Western Pacific region was home to one third of the global TB cases with almost 1,000 deaths every day.

Seventy percent of the cases were in the most productive age group of 15 to 54, and we saw the emergence of TB-HIV and for the region more importantly the emerging of drug-resistant TB. At that point in time, only 40-percent of the estimated TB cases in the region were notified, and less

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than two third of them were actually enrolled in the DOTS programs.

What were some of the public/private issues or the public/public issues in the Western Pacific around that time? Across the region, we saw very largely vertical or very vertical programs of public TB service delivery with an uncontrolled TB service delivery through general hospitals in China and in several other countries in the region, a very strong, unregulated private sector in the Philippines and in some of the other countries, and poor collaboration between particularly urban private sector and the NTPs in Cambodia and Vietnam. At that time, we also had a very severe lack of linkages between the different public sectors, for example the prison sector.

In the regional strategic plan 2000 to 2005 PPM featured prominently, and I will explain to you a little later why. Across the region, the NTP has to link up with general hospitals and particularly in China, assess public/private mix trials that are taking place in Philippines and develop the strategy for scaling up and strengthening the PPM collaboration in that country.

We had planned to establish a regional policy framework for PPM by mid-2002, and we were intending to provide a lot of technical support for countries in the piloting and scaling up of PPM activities.

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Now, this slide may warrant a whole presentation in itself, but I would like to keep it short and explain why we would like to use this so-called onion model, which was developed by Chris Dye [misspelled?] and his group in headquarters, why we would like to use this for dealing with PPM.

As you can see in this onion, there are a total of five rings, and as you see, the Ring #2 is a lot bigger than the other rings. And while we ultimately would like to see all our TB cases located in the fifth ring where the diagnosed cases reported and managed by the DOTS facilities, we do have a major gap in missing cases, and this is the reason why the Ring #2, which consists of all the true TB cases, is so very big in the region.

When we did our analysis of the different rings and the different strategies or approaches that can be used to find these missing cases in the different areas, all the countries in our region agreed that we have to focus heavily on Ring #2. And the approach to be used was considered to improve the access to TB services with one major strategy as an important strategy for many countries defined as PPM.

In the Western Pacific region the missing cases are in the private sector, as we saw in Philippines and many other countries where private sector is predominantly in the urban settings through the private clinics but also the general

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hospitals. Many general hospitals do manage TB cases without following the DOTS strategy, without notifying and sometimes without properly diagnosing TB. But there are also other public sectors where TB cases can be found and are currently not adequately managed or treated, such as the prison sector.

An example from China: In the year 2000 during a national prevalence survey, it was found that quite a considerable proportion of the TB cases were not reaching the TB dispensaries and, therefore, did not enroll in the DOTS program but were found in general hospitals and township hospitals. As you can see, more than half of the cases were actually located, could be located in hospitals.

In the Philippines, also a prevalence survey showed that 30 to 50-percent of the TB patients first seek care in the private sector before moving on if at all they move on. And in the private sector it was known that management of TB was frequently very poor.

Now, over these first five years, the 2000 to 2005 periods, lots of activities have taken place. And certainly PPM has been a very critical area that contributed to the success and the progress that has been made in the Western Pacific region. As you probably know and those of you who were here last year, we reported on having achieved the global TB targets in 2005 by exceeding the treatment success target and

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the case detection target with a 100-percent coverage of DOTS across the region.

PPM has contributed significantly to that success, but it was not only PPM as you will probably imagine, and the national TB programs in our regions have made extremely big efforts to make this happen in 2005. So in 2005 we saw the progress as very strong, but for us that was not good enough because we saw that the involvement of the private sector was still very slowly increasing.

The collaboration with the general hospitals was not optimal and in many countries still very inadequate. Just referring cases from hospitals to TB dispensaries may not be enough. We may need to work more closely with the hospitals in managing cases. And at the same time, in 2005 both prisons and rehabilitation camps were inadequately covered by the DOTS strategy. That means in the year 2005 we were still faced with a considerable number of challenges to get us to the 2010 target, and I've highlighted here one of the main challenges that we were facing in the region: improving access to TB services and the need to scale up further PPM approaches.

But you can also see that the region was facing a lot of other challenges at that time, and actually one of the major challenges that we are still facing at the moment is the spread of MDR-TB.

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The 2006-2010 regional strategy, therefore, has PPM goals featuring very prominently in the regional strategy. By the year 2010, we would like to see that all countries will have a 90-percent public/private DOTS coverage in their country. That is translated as 90-percent of all facilities should be providing DOTS or referring to a DOTS facility.

What is the progress of PPM at the regional level? At the regional level, we have strongly worked on the development of training opportunities for people in the region for different countries to strengthen their PPM approaches. We have a regional advanced TB training course, which this year will run for the second year in succession, which will provide extensive coverage of the PPM component. The RIT training course in Japan has an extensive module included in their training course. At the regional level, we are promoting in all the countries the use and implementation of the international standards of TB care, and we have really stepped up our technical support to the countries for PPM.

But the majority of the work, obviously, takes place in countries, and I would like to give you an example of what has happened in a number of countries in our region in the area of PPM.

First about Philippines. The Philippines setting, as I mentioned earlier, has a strong private sector with initially fairly poor collaboration with the NTP. A number of models

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have been developed in the Philippines to implement PPM. The public/private mix, which looks at it from both sides, both from the private sector as well from the public sectors, requires referral and treatment by the private sector as well as in the public sector. But also models of public/public mixes are being developed and implemented. Non-NTP public hospitals so refer to public DOTS centers or provide DOTS services themselves.

And then one specific PPM model, which is unique for the Philippines and actually for the region is the PPM for MDR-TB, where the management of MDR-TB is started in a private facility but with the involvement of the national TB program. Ambulatory DOT is provided by community volunteers or public facility staff outside this hospital-based private facility.

Philippines has achieved a lot. In 2005 the existing PPM unit contributed up to 3-percent to the national case detection targets. At that time, the global front supported PPM program had been installed in 28 units covering a population of six million. In these areas, 9-percent additionality was seen to the case detection in the different programs' project sites, and the treatment success rate, whether the patient was treated at the public site or at the private site, reached 92-percent.

We see an increased case detection in the areas in public health areas where PPM has been implemented. The

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expectation is that in 2007, by the end of 2007, PPM efforts, PPM program will contribute up to 10-percent to the national case detection efforts, which is a considerable achievement if you look at where the Philippines came from.

This is an example of what happened when PPM approaches are being implemented in the public and private sector in certain areas. This is an example from the Global Fund supported program, which was evaluated in 2005. In all the units where we see that the public/private initiative was implemented, introduced and implemented, ultimately an additional 10-percent case detection was achieved.

What about PPM in China? As I mentioned, the biggest problem in China in terms of case detection and access to TB services was the hospital sector. At that time, before the PPM initiative was taken, poor collaboration existed between the NTP and the public hospitals. And this model of public/public mix resulted in quite an improvement in the situation.

Three aspects were very important here. Since the hospitals report to the national level through the Internet-based TB information system, hospitals refer TB cases or TB suspects to the TB dispensary for further action. And for those patients that still don't show up at the TB dispensary, the TB dispensary themselves will trace these patients and try to get them examined and put on treatment if necessary. At the moment, we have seen that the implementation of this system,

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particularly the Internet-based reporting system and the referral mechanisms, have been scaled up widely across the country down to the county level.

So what has that resulted to in China? In China the case-detection rate increased from 45-percent in 2003 to 79-percent in 2005, and obviously, that contributed to a major extent to the region reaching the global targets. This increased detection can, therefore, largely be attributed to the following: the Internet-based reporting by health facilities of TB suspects and TB cases, the referral of those cases by hospitals to TB dispensaries, and actually the rigid follow-up by TB dispensaries of patients that do not report in the TB dispensary after referral.

What about Cambodia and Vietnam? Particularly in the urban settings in these two countries, we see an unregulated TB services by pharmacies, private doctors and laboratories with very poor collaboration with the public sector. In Vietnam we have a problem of the prisons and the rehabilitation camps that initially had very poor linkages with the national TB program.

For the public/private initiative in both Cambodia and Vietnam, the referral mechanism has been very prominent. The national program in Vietnam took special action to link very closely with the sector that controls the prison and rehabilitation camps, and as a result, there is now a very strong collaboration between these sectors. And TB patients

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and TB suspects in prisons and rehabilitation camps in Vietnam have a good chance of being detected and adequately treated.

We are in the stage of the piloting being completed in Cambodia. Still, initiatives are being developed in Vietnam, but scaling up is really on the agenda right now. And in Vietnam we will see further expansion of the collaboration of the NTP and prisons, NTP and prison and rehabilitation camps.

The referral mechanism is working, but it is still at a very small scale. But the collaboration of the public sectors of the NTP and prisons and rehabilitation camps has resulted in an early diagnosis and effective treatment of TB cases in prisons and rehabilitation camps.

One other country where PPM activities have been initiated and are very firmly on the ground increasingly is Mongolia. It's a setting where there is a very rapidly-growing private sector in an urban setting, particularly in the capital Ulan Bator, and there are also substantial problems with TB in prisons.

The model chosen for Mongolia is to establish a referral and DOT mechanism by involving the family doctors mechanism that has now been established, particularly in the urban setting. As far as the TB problems in prison, we are using the public/public approach where there is very strong collaboration nowadays between the Ministry of Justice and the Ministry of Health.

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The public/private collaboration between family doctors and the NTP is still at an early stage, but it is very promising. The collaboration between Ministry of Justice and Ministry of Health has resulted in a very effective way of dealing with TB in prisons, and one particular aspect should be noted is that the level of MDR in prison settings in Mongolia is extremely high. And the fact that the MDR problem is very high and the collaboration has strengthened so much has allowed Mongolia to set up a very effective MDR-TB program supported by the Global Fund.

Let me get to my concluding slide. Does PPM strengthen health systems? You may notice that this is the first time that I use health system. It's not an easy question to answer, and maybe I should be letting you to be the judge of that, but I would like to make a couple of comments that I feel in our Western Pacific region are very important.

We have realized that a strong NTP is a prerequisite for any successful PPM initiatives, and there is growing evidence that PPM is often the starting point for an increased access to the TB services. By involving private and non-NTP public providers, the access to TB services increases with the chances of getting patients earlier diagnosed and therefore more effectively treated.

PPM has contributed substantially to the increased case detection in the region. And finally we feel that the Global

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Fund has been instrumental in many countries in our region in strengthening the collaboration between the different sectors.

I would like to acknowledge the work that has been done by the different national programs, and herein particularly I would like to mention Vietnam, Cambodia, China and Mongolia, also the Philippine Coalition against tuberculosis, which is a coalition of partners that has very much promoted the concept of PPM. And finally I would like to thank our colleagues of WHO Headquarters and WHO Philippines. Thank you very much. [Applause]

CHRISSY HANSON: Thank you, Peter. So we have about ten minutes for questions for either Felix or Peter or general comments from your own country perspective of what you're dealing with in trying to work in health services.

YOKO: Thank you very much for all presenters. My name is Yoko from Japan Jaica [misspelled?], currently working for Ministry of Health in Cambodia. My question is about the challenge of TB-HIV co-infection and health systems strengthening because it was not so much mentioned in the previous first presentations I think. And then I wonder if the challenge of TB-HIV co-infections for increasing cases is a good opportunity to enhance the coordination of two national programs and then strengthening health systems. Or if I put my question in that way how to utilize this momentum to move for a better coordination among national programs in turn it will

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make a great contribution to health systems strengthening. This is my question.

And then I have one comment about the presentation of Knut. I do agree that the concept of non-negotiable for TB programs. I think this is a good idea when we talk to the TB people to move forward to the HHS discussion, but I'm also afraid. I'm not a TB specialist or I'm not the TB people, sorry, not to phrase it that way, but when I talk to the TB people, they say that everything is non-negotiable [laughter], even that TB-specific incentives. This is very [inaudible 2:02:06] in Cambodia because they said the system is very weak. That's why we have accountability for our programs.

So then the systems people decides too much emphasis on vertical program is the cause of weak system, so where to start I wonder. I really need your advice. It's an issue of leadership and territory, so if we are successful in collaborate in TB-HIV co-infection among two national programs, it would be the starting point to go to the health systems strengthening or am I too [inaudible] I don't know. Thank you very much.

CHRISSY HANSON: Thank you. Okay, I'll take Bertie's [misspelled?] question over here and then get some responses. I saw his hand up. Thanks.

BERTIE SQUIRE: Thank you very much. Bertie Squire [misspelled?] from the School of Tropical Medicine in

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Liverpool. Felix, I have question for it, and I'm struck by trying to put my mind into Knut's health systems strengthening mindset and then hear you say that there are now I didn't quite catch how many CD-4 machines there are going to be in Malawi, CD-4 counting machines. Can I ask you to what extent you think there may be a danger that putting those CD-4 counting machines into the labs in Malawi may actually have a bad effect on the health system by exacerbating the human resource crisis that we face in the labs by taking staff away from quality-assured provision of basic smear microscopy, malaria microscopy and safe blood?

So I see there is a tension between the need to provide that level of health service in a health system that is struggling, and I'd just appreciate your response to that idea of the health systems mindset that has to take that into account.

CHRISSY HANSON: Okay, let's have some responses from Felix and Knut, and then we'll take more questions.

FELIX SALANIPONI: Thank you for the two questions, the first one on HIV and TB strengthening collaboration as to what extent is this working. From my presentation when I reflected on different levels of what I called governing structures, the central therefore, the zone and so on, I did come up with an issue for the sub-committee, which is comprising both the TB and the HIV people. So it is at that level, and this is almost

the entry point for strengthening the system and then the point of condition.

But this will not be any use if it didn't trickle down. That's where the implementation takes place at the district. At the district hospital or district setting I did the mission of the district implementation plan, which is a joint, so all have issues are packed and then they are planned and then costed from that.

From the TB and HIV side, the policy is that those patients that enter the system because they have HIV, they also are offered TB screening. Those patients that enter the system because they have TB, they also offered TB or the other way around. So we have both the TB-HIV co-infection, the patient at the entry point being looked at differently depending at what level. This is against maybe the previous [inaudible 2:06:56] whereby the two facilities rather have been working independently, and one shop there and one—this is where we are moving toward and it is seen as a type of centering the system on the HIV and TB co-infection.

On the CD-4 count, I hope I got your question correct, Bertie, but what I was saying, which you are so aware of I hope, is that four years since now six, five years around the corner? There's been a limitation of CD-4 counts in Malawi, and they are for the reasons that I based it on. One, it's because the public health approach that Malawi decided, but as

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of when the progress has been made, improvement's been made, people have been raising issues. To what extent will Malawi go ahead or remain and not use the CD-4 counts and rely on this?

So that again is a wonderful systems strengthening, so it's a way of—and it is often taking different people or it's from one hospital to another because the mechanism, as far as I hear, I was just two weeks ago at the place where these are being procured and purchased is that these people will train the already existing laboratory technicians. So there will be transfer of knowledge and skill to these people. They already have technical on board.

So it's not the taking away of stuff when elsewhere, but yes, it's a give and take situation whereby the same people, yes, would have to spread the capacity in terms of that. I think it's something that has to be accommodated because you never have to any point where you think you have enough capacity so that you can have this.

BERTIE SQUIRE: Thank you.

KNUT LONNROTH: In response to our colleague from Jaica [misspelled?], I think the answer that you got that nothing is negotiable, I think it indeed reflects a little bit of a lack perhaps of health systems strengthening mindset. But I do think also that that answer is also correct if you look at it from the TB control perspective. And I think this is also what—I don't know if Jack Brachmans [misspelled?] is still

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here, but I think that was his point, that there are some things that we should never negotiate about, and these are the basic elements of DOTS to start with.

We have to make sure that there is quality bacteriology and diagnosis, that the drug supply is secured, that the treatment regimen is evidence-based and that there is treatment support available and that the coordinanalysis is done. That's non-negotiable.

But what is negotiable, again, is how it's being done, and this is where I think the health systems people and need also to understand, that not everything is vertical because that is the health systems people's, if we still use the terminology, their mindset about how TB programs are being implemented. And their perceptions are often incorrect, and I think it's about letting these two camps meet and discuss while looking at the real examples on the ground, and I'm sure a lot of negotiations can then take place.

CHRISSY HANSON: We'll take one more round of questions. Yes, here and then Sater and then Frank.

ISAAC SKOZANA: Hi. My name is Isaac Skozana [misspelled?] from South Africa working for CHMT. The slides I was looking at, they are more forecast in the Western, and as a person living with HIV, I kind of worry what's happening here in South Africa. Probably you saw the much where we pour out

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our heart because that much it was not for fun. It was a cry for help and especially to WHO.

Yesterday we saw our Minister of Health here in South Africa came for opening ceremony. The MEC for Health also came for the opening ceremony, but the question is what's happening about TB-MDR, XTR in South Africa? Why don't we hear anything about them? What about the conditions in prisons? The households that we are living in and lastly, what will you do in terms of committing our government's to fully participate in these programs? Thank you.

CHRISSY HANSON: Thank you. Okay, I think Dr. Sater [misspelled?] is next.

DR. SATER: Sater again. I think, Knut, negotiable and non-negotiable just came to my mind. I think we need to be a bit flexible. If we say we would love to work with you, but we don't want to negotiate [laughter] that's not going to work, no? So that's what we really need to remember.

No, my question—thank you for the wonderful mobile phone [laughter] and the wonderful presentations. I have a question to Malawi. If I remember correctly that the Malawi—this is a very important question for the Round Eight of the Global Fund. If I remember correctly, Malawi has $100 million HHS grant from Round Five? Round Five. And then I'd really like to know how this $100 million are used in the context of

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HTM and for the health systems strengthening because this is very important for what's new for the Round Eight HHS.

My question is not for Pieter, but for you, for me and for everybody. I really think that Pieter's question we need to answer. Does PPM contribute to health systems? I think there's no question about this wonderful PPM and hopefully it will contribute in the achievement of the 80, sorry, 70 class present detection rate. I think there must be some reduction, if not contribution to health systems, and if we can't prove that the wonderful achievement of TB control, TB care, have no relationship for the health systems strengthening, probably we are left alone.

I'm sorry. I don't have answer, but for example, if we look into the six components of the health systems at WHO, which part do we contribute in? In which PPM part TB is controlled? I think it's very important for us to answer.

CHRISSY HANSON: We'll take Frank and then we'll have our panel respond.

FRANK BUNSU: Thank you very much. My name is Frank Bunsu [misspelled?]. I work mainly implementing disease control interventions, Scoot Away Dos [misspelled?] in particular. There's no doubt that [inaudible] in implementing disease control programs we need the health systems people if I should say that way and that we need the health systems to be strong, to nimble it has to be effective.

Diana said we shared common health outcomes. It’s true. We do, but our interest overlaps in 30-percent of cases. In the 30-percent there are probably intersecting financial interests in utilization of health services and a little bit of real disease-specific outcomes.

Now, everything can wait, but our patients can’t wait. [Inaudible] who implement the disease control interventions we are very passionate about, outcomes for our treatment. So my question is how do we work in this slow-responding health system?

Most of them, when we talk to health systems managers, they will tell you that less integrate. Nobody has defined the work integration, and what they really mean by integration is financial integration. If you give everything to me, then, yes, I’ll be more efficient. But then if you look at the outcomes, you will probably at the end of the day be looking at how much you’ve been able to spend. Thank you.

CHRISSY HANSON: Thank you, Frank. I’ll pass the microphone down the panel and just let people respond.

DIANA WEIL: A couple of points from the very important concerns raised from our South African colleague, I think the principle concern that we all have to have is that we are dealing worldwide with health systems, some that are very low-capacity and low-income health systems, some that are moderate-income health systems that have more capacity but more

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complexity, federal systems with inequalities. And we have a large range of countries worldwide that are big, complex federal systems where you see the best available and the worst available.

And I think one of the biggest concerns we have, WHO the Commission on Social Determinants and our colleagues in health systems strengthening, is dealing with that inequities and dealing with a whole host of needs of a population and figuring out how to maximize the capacity that's available.

And I think there are many countries, and I think South Africa's one of them, where you see tremendous capacity, local capacity to offer and many innovations. And I think the energy now that needs to be brought to bear in terms of the urgency that you're bringing with the march and the action and the response plan that's now been devised by the Department of Health is to keep those benchmarks of what are those measureable ways that you can say using TB is one indicator. How are we changing the picture of getting more capacity across the country?

So I think there is a strong will, both here for South Africa, but many, many countries, middle-income countries and low-income countries that can do more and use their health systems expertise internally to focus on questions of disease epidemics.

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Regarding the PPM question of Sater, I think one of the, to be honest with you, health systems people, I don't think we have to, I think we're probably stepping back a pace to try to say that we have to sit and document how we contribute around each of these elements. I think we have to move along and say what's the next challenge? What's the challenge as in PPM and HIV? How can we share that rather than having to look back and just say how do we document and justify.

I think when we talk in WHO and they talk about health systems strengthening, almost the first thing they always turn to is, oh, in disease control programs we have PPM. We have public/private mix because in the health systems community looking to the private sector is one of the big concerns, particularly in parts of the world where almost half or more of the population accesses the private sector first.

So I think you're actually in a strong position where PPM is operating just by saying we're interacting with the private sector, but to say, okay, well, what next? What more is the private sector taking on that is poor-quality care? How could we train them better like we have in TB? How can we open up their laboratories?

The big issue about laboratory capacity strengthening I think Pieter brought it up. How do we open up those labs as an option as we're dealing with MDR-TB? So we don't just think

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about public labs, but we think about accreditation. So I think actually PPM is one of the strongest mantras in the health systems community, and I think this is a practical example.

And last for Frank's point, I think that the biggest question I think we have now is the issue as you said is integration. I mean for many years many of us has heard integration, integration, but for what and how and how do you do it? And I think if you take it to the next level of discussion, sometimes you stop the conversation altogether because there isn't an answer. Or sometimes you can actually get into the interesting questions. What does integrated supervision mean? Does it mean that everybody touches every disease area for five minutes of their supervision visit? Or how do we get an integrated team in a vehicle that may have been purchased by PEPFAR but brings people out to do child health, maternal health and TB supervision at one time?

So I think we have some room to have those dialogs, and there's actually for the first time at WHO at headquarters level a group that's discussing service delivery lessons learned across programs. And I think that's at least a starting place at that level. It has to happen at many other levels, too.

FELIX SALANIPONI: Yes, thank you. I have only one question. This is what are we doing with the huge sums of

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money that we have received from the Global Fund and health systems strengthening. The money is being used for health systems strengthening [laughter], and mainly it is for recruiting and training of our staff, and this is the health service assistants. Health service assistants are one of the kind of stuff within the government service system.

The work at the district level is people that have finished their school, school of health, who didn't make it to the college, the investor, and they are trained for 16 weeks on public health. They take on the initiatives of most initiative, whether it is disease control, maternal health and child health.

And for the first time, Malawi has been able to recruit 6,000, and this is maybe the days time we haven't been able to do this. And by first October this is what we can do effect, and this number is supposed to be increasing up to 11,000, so it's the biggest in terms of health systems. In Malawi I think this is the biggest I think impetus that we've ever had.

And then besides that, then, there's also because it's an element of recruiting, training, some money is used in the College of Medicine training doctors like the output in terms of training doctors has increased. Nursing as well, colleges, has increased. And also I am aware of what some of what seem to be perceived incentives to health workers, and this was housing condition the rural because people are just running

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away and this I know. And there is a big project in terms of for making sure there's available accommodations for staff as part of incentive, so that's also part of assistance. Thank you.

PIETER VAN MAAREN: Very briefly maybe I can answer my own question to some extent. I think if we in the Western Pacific region have been able, for example, in Philippines to get 5,000 private doctors trained on the DOTS strategy and have them together with their public colleagues facing their noses in the same direction, I think we have contributed to a strengthening of the health systems.

If it is only that, then I think it is still worthwhile doing it, and we have plans that I learned from the national program in Philippines to train another 10,000 physicians over the next few years. Ultimately, that will result in a very strong health system where public and private physicians are working side by side in the same direction. So I think that's to some extent quite some health systems strengthening.

PETER GONDRIE, M.D., M.P.H.: Okay, thank you. We are coming to an end. I would like to thank all presenters for their very excellent presentation. I want to thank Chrissy as my Co-Chair. I want to give you one thought if you're going home. I always like to do that.

We started today with the primary health declaration of alma mater [misspelled?]. I would like to remind you that this

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declaration was defined as a strategy, a strategy to achieve a target, a target that we all committed ourselves to, and that was health for all by the year 2000.

Sometimes in the discussions I heard a kind of complacency. I think that if 25-percent of avoidable death is still due to tuberculosis, if we are still only able to detect 62-percent of TB patients who are positive at 55-percent of all TB patients, there is still enough to do for us. And let's do it all together because it's something that our community, that the world community deserves. Thank you, all. And I hope to see you back next year at Union Conference in 2008 about health systems strengthening. [Applause]

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