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HIV and Millennium Development Goals
Kaiser Family Foundation
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DEBREWORK ZEWDIE: –and gentlemen. As soon as you take your seats, we will start this session. Please take your seats for us. Thank you. Good afternoon. My name is Debrework Zewdie, and I am the Deputy Executive Director of the Global Front. And I welcome you to what promises to be a very interesting session with a very interesting title.

We have distinguished speakers and panelists and the way we are going to conduct the session would be the speakers will be given about 15 minutes max each. And then I'll give them less than three to five minutes for each panelist and then we'll open it up for discussion so that we would get the most out of this session.

What does the session promise to do? There are a number of things which we have as an objective. The first one is the interaction between HIV and other health related millennium development goals. As we all know, there is a change in both the global health and global development architecture and with regard to– Eric, you're welcome. With regard to universal access and MDG, we want to see the impact of these changes in architecture, especially on HIV/AIDS.

The most important thing is how does all this translate at country level? And finally, we will look into the future direction to lead to the MDG Summit in September. More

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importantly, do we really have the resources to lead us to where we want to be?

The speakers that we have, Dr. Gottfried Herschel [misspelled?]. I am not going to abuse the names. If you don't know Gottfried is indeed, from this country, which we are being hosted. And Gottfried will be followed by Anne Starrs [misspelled?] for purposes of efficiency; I am going to introduce both of them together so that we go directly into the presentation.

Gottfried started his new position as Director of the HIV/AIDS Department of World Health Organization very recently. And before that he has played important roles in child health and also in the three by five initiative which has every impact that we are seeing today. More importantly, Gottfried is a team builder, a consensus builder and a coordinator between the different agencies and we are glad to have him in this session.

The next speaker is Anne Starrs. Many of you know Ann. Anne is the co-founder and the President of the Family Care International a governmental organization dedicated to making pregnancy and childbirth safer in the developing world.

They both have extensive CVs, but you would agree with me what we want to know is what they are going to say about us and I'll go directly into the presentations. The first speaker will be Gottfried, and he will be talking to us on HIV and

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MDG's critical interactions, policy evolution, and implications. Gottfried?

GOTTFRIED HIRNSCHALL: Thank you very much, Debrework Zewdie. Good afternoon ladies and gentlemen, colleagues, and friends. My task today is to situate the fight against HIV in the context of global efforts to which the millennium development goals in the run up to 2015. This slide shows all eight millennium development goals or MDGs. Goals four, five, and six are usually identified as the health MDGs. However, all the MDGs are health related in one way or another. Furthermore, it can be argued that action across all the MDGs is necessary to effectively combat HIV and AIDs.

And conversely, the strengthening response to the epidemic that MDG six can contribute to progress across the other MDGs. Lack of progress on MDG one, on poverty and hunger, MDG two on access to education, MDG three on gender equality and empowerment of women, and MDG seven on the environmental sustainability, all increase the vulnerability to HIV.

Conversely, a vigorous response to the HIV epidemic can help alleviate poverty and hunger, improve access to education, and promote gender equality and empower women. And a vigorous response the epidemic can support progress in child and maternal health and strengthen developing partnerships,

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including the MDG eight target in improving access to affordable essential drugs.

Who does not remember the debate on compulsory licensing? And more recently, the creation of the Unit Eight [inaudible] poll. So, recognizing that all the MDGs are linked to one another, what is the state of play? Globally, there is some encouraging signs of progress with improvements in the MDG indicators shown in green on this chart.

For example, MDG one. Fewer children are underweight. Prevalence is down. MDG five, more couples are able to plan their families. MDG six, tuberculosis treatment success rates are up. But there are also areas of progress that has been much too slow, as we can see from the indicators shown in red on this chart.

Globally, insufficient progress has been made towards MDG five on maternal health. Essential drugs including generics often remain unavailable or unaffordable. In yellow, we show the indicators where despite progress, there's a need for vigilance to ensure that improvements are sustained and hold out across all parts of the world.

This slide provides an overview of regional variations in progress towards the three health MDGs four, five, and six. Three WHO regions are making good progress towards MDG four on child mortalities; the Americas region, AMR, the European region, UR, and the Western Pacific Region, WPR. These same

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three regions are also doing well in relation to MDG five on maternal health. For MDG six, on HIV/AIDS, TB, and malaria, the WHO Eastern Mediterranean, Southeast Asian, and Western Pacific Regions are making good progress.

By contrast, the African region has made insufficient progress of MDG four. Three regions, Africa, Eastern Mediterranean, and Southeast Asian regions are facing challenges regarding MDG five. Four other indicators, where there has been some progress, it is often uneven and fragile.

And the pace of progress is different between different interventions and the scale-up in ART coverage in the past five years, with global mobilization around three by five. And improved financing opportunities has been truly impressive in all regions of the world, including the African region.

On the other hand, coverage of deliveries by a skilled-birth attendant are a critical requirement for reducing maternal mortality has hardly changed. This unequal progress has fueled, obviously, much discussion.

Let's face it, it's been said that the response to HIV/AIDS has been over funded to the detriment of other health priorities. This slide shows the evolution of ODA for health from 2002 to 2005. While funding for HIV has increased, funding for other infectious diseases and for health sector development also increased at about the same pace. Only funding for reproductive health and the population remained

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more or less stagnant. The problem is not that HIV/AIDS has diverted funding from other sources. Rather that the increases in funding in health and development overall have not been sufficient across all areas.

Indeed, funding for HIV/AIDS itself continues to be inadequate. And coverage for essential services is still insufficient. At the end of 2009, it was 50-percent for AIT and with the new guidelines that will be launched, it will be even less. At the end of 2008, only 42-percent for PMTCT and about only about 20-percent of PLWH [inaudible]. These coverage indicators are worse than for other essential health services such as TB control immunization coverage or antenatal care.

All the same, investments into HIV has continued to rise and HIV has risen from a small stakeholder within the development response to a major one. This positions the response to HIV as a significant game changer in global public health. The contributions have been many. Changes in government structure to strengthen the participation of civil society and the private sector. Changes in the priority given in the public health to addressing human rights and re-addressing inequities and increasing focus on people-centered services.

Combined with a re-growth of service delivery for HIV, the natural expectation is that the response to HIV should also

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benefit other health outcomes; most prominently, child health and maternal health. This is indeed possible, but it is only possible in as far as HIV is a driver of adverse health outcomes in those health fields. AIDS is associated with an estimated 2-percent of childhood deaths globally and 4-percent in Africa. The direct impact of HIV to child mortality is therefore relatively small.

However, the proportion that is HIV related can be large in countries with high HIV prevalence and lower levels of under five mortality due to non-AIDS related causes. This slide shows the impact of HIV on progress towards MDG four in child health in different parts of sub-Saharan Africa. In 2003, an estimated 17-percent of all deaths of all children less than five in southern African was HIV related.

However, none of these figures reflect indirect effects on child welfare due to the impact of AIDS in reducing household income, increasing orphanhood, and diverting resources from child education and healthcare. The good news is that the proportion of childhood deaths associated with AIDS is now decreasing.

In Southern African, there was a 20-percent decline to 14-percent between 2003 and 2007. This decline is due to family planning, successes in HIV prevention among adults, and PMTCT among other factors. This demonstrates the critical contributions that the HIV response can make in some settings.

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The strong link between HIV and sexual and reproductive health are well known. What has not been recognized until recently is that AIDS and complications of pregnancy are the two leading causes of death among women of reproductive age globally, with tuberculosis in third position. Recent estimates draw attention to the important adverse effects of the HIV epidemic on maternal mortality, especially in countries with large epidemics in Southern Africa.

This slide shows trends in maternal mortality ratios worldwide and in selected countries. While reductions in the worldwide trends are shown in the white line at the bottom, maternal mortality ratios actually increased in some countries, some years back together with rising prevalence of HIV among young women.

HIV has slowed progress in reducing maternal mortality in sub-Saharan Africa and therefore, globally, and is threatening progress towards MDG five, so there are hopeful science that some effective countries are now reversing this trend.

This slide shows graphically the strong relationship between HIV and TB. The rising incidence of TB worldwide has followed after a few years, the rise in new cases of HIV. TB however, can be overcome through aggressive action to reduce HIV and address HIV/TB co-infection. The MDGs have been

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instrumental in focusing the attention of the world on critical issues in health and development.

Despite the many achievements, there remains some daunting challenges. These are some recent estimates of infections and deaths that need to be tackled. Again, coverage gaps tend to increase, not decrease with population growths and changes in eligibility criteria for key interventions such as ART. This is not the time to flag in our efforts, with only five years left to the MDGs.

Health systems should be designed to deliver essential services across the life course before and during pregnancy, during childbirth, and the postnatal period, during childhood, and beyond. In relative, people are dipping in and out of the healthcare system and not accessing the full range of interventions in an integrated way.

The challenge is how to ensure a more integrated delivery of critical interventions. And how to learn from the successes in scaling up complex interventions such as ART to ensure that other services such as testing, family planning, and antibiotics to treat pneumonia accessible to all in need. And here we are not even talking about those who do not have access to services because they are too far, too poor, or too marginalized and discriminated against because of their sexual orientation, sex, or HIV status.

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There is need for integration, but this requires, however, that your work towards more comprehensive and really integrated approaches. This slide shows the levels that integration can take place, and I'm afraid you may not see all the details from the distance.

We need to start at the top. Clarifying our focus and improving health outcomes in ways that contribute to the MDGs with an eye to improving health equity, social inclusion, and participation, and strengthening accountability systems. This should lead to work to improve integration at the service delivery level seeking to improve universal access and to provide universal access to health services across the life course in ways that meets the needs of the people.

This also requires more efforts to strengthen the health system such as its workforce, its procurement and supply systems, its capacity collect, and use of strategic information. And then critically, it requires reforms in government structures so appropriate policies are set that commit all those concerned to mobilize the required funding and adopt appropriate policies to make a difference.

These are the challenges that I see ahead of us. We need to sustain and increase high-level commitments as we move to the MDG summit and the global fund replenishment meeting in September. We need to advocate for and ensure fully formed

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responses, including HIV and sexual and reproductive health and maternal and child health.

This is not an either or option. Efficiency gains are key. We need to strengthen systems to deliver integrative services. We need to ensure access for those most vulnerable and excluded. This conference needs to discuss real ways to work towards universal coverage with services to key populations such as drug users, and same-sex workers, prisoners, migrants.

Finally, we need to document what works. We need to invest in strategic information and operational research. The time is now. Yes, the financial crisis has taken its toll. All the same, there's unprecedented political commitment to accelerate action to the MDGs and recognition that this requires increased aide and improve aide effectiveness. Ensure it. Better results, more money, and more value for the money. Let us all work together now to deliver on those promises. Thank you. [Applause]

DEBREWORK ZEWDIE: Thank you, Gottfried. The next speaker will be Anne Starrs and she will be talking to us on HIV and MNCH MGD four and five. Can we do one without the other? Key issues and margin evidence. Ann.

ANNE STARRS: Thank you very much, Debrework Nowicka. And thanks to everybody for coming and joining us this

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afternoon for what I hope will be a very interesting and stimulating discussion.

So briefly, what I'm going to be talking about is a little bit of background on where we stand with progress, specifically towards MDGs 4, 5, and 6. Gottfried has already given us some statistics, so I'll show slightly different pictures, and then talk about some of the program and policy linkages that are embedded within these issues within MDGs four, five, and six, around target populations, common needs, and the need for comprehensive services, and then talk about some of the policy harmonization issues and end with a question and some observations about where we stand towards integration on the funding level.

So clearly, focusing in particular on the health MDGs, as Gottfried has shown, progress towards them is closely interlinked, it's not even across the three health MDGs, with MDG five being the furthest off track and sub-Saharan African regionally being the farthest off track with all the health related MDGs. As he noted, HIV is a significant factor in female mortality. It's the leading cause of death for women of reproductive age, followed closely as his slide indicated by the complications of pregnancy and child birth. And we know that HIV/malaria are also significant factors in child mortality as well, although we shouldn't lose the focus on the

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childhood diseases, diarrhea, pneumonia, and etcetera that are also significant pillars.

As he noted, the problem of lack of functionality in health systems is a significant contributing factor across the health MDGs to the lack of progress, and as he noted, funding is seriously inadequate. Per capita health expenditures in the poorest countries are somewhere in the range of $10 to $15. The needs are three to four times that level.

So, these pictures show where we stand in progress towards MDG five from a map perspective. The green on the top slide shows where we stand in terms of progress towards achieving the MDG four target of reduction in child mortality. The green is countries that are on track, yellow is where progress has been insufficient, red is where there has been no progress, or in fact, reversal of progress.

The bottom half map shows where we stood in 2005 in maternal mortality. Again, green is a low maternal death reaching out to red for a very high maternal mortality ratio. I should note that there are recent estimates that came out in April for maternal mortality in The Lancet, produced by the Institute for Health Metrics and Evaluation and then another set of estimates, revised estimates, new estimates on child mortality that were produced in The Lancet in May. They show different numbers, but the trends are very similar and The

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Lancet paper on maternal mortality found that there are 23 countries globally that are on-track to achieve MDG five.

Clearly, that is extremely inadequate. Here, with a different color scheme, we have the global HIV prevalence in 2007. And again, the dark red being the worst, yellow being the least worse off and again, you can see that sub-Saharan Africa is the hardest hit. There is some differences geographically with central and eastern Europe being also an area of significant need, which is not such the case for MDGs four and five, but still, there are strong commonalities.

So what are the implications of this? We have seen that geographically, HIV/AIDS and maternal and child mortality are often most severe in the same countries and regions. And we'll also see in a minute that there are significant overlaps in terms of the effected populations.

Problematically, there are many commonalities as well. Sexually active women are at risk of HIV infection, STI, unintended pregnancy. HIV positive pregnant women are at risk of HIV complications obviously, then are at serious risk of complications of pregnancy and child birth. And studies have found that HIV positive women have a maternal mortality rate, they have a risk of maternal mortality that is one and one half to two times higher HIV negative women.

HIV infection significantly exacerbates childhood issues, health challenges as well under nutrition, diarrhea,

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the other childhood disease. We know that the basic health services that are needed to provide and to address these various health challenges come through the same channels. Through health facilities from the local up to the referral hospital level, but also through community outreach mechanisms and through the important work of civil society organizations that address these issues from a range of perspective.

We also know that there are common health system needs that need to be in place if these services are to be provided effectively and in particular, if the needs of marginalized and vulnerable populations are to b met. And it's also critically important that we recognize that sexual and reproductive health, childhood health problems, and HIV problems are strongly grounded in these underlying gender, cultural, and social factors.

The issues of gender discrimination, of violence against women, of lack of equity in education, lack of equity in women's access to economic opportunities are tremendous contributing factors across the range and programs that address these issues need to be linked not only in terms of provision of health services, but in terms of their focus on these underlying factors and their integration of these issues into the way health services and health interventions are designed.

So this slide shows what I was talking about what I mentioned a minute ago in terms of the target populations.

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Where is the overlap? We have roughly 1.8 billion women of reproductive age in the world. We have roughly 210 million pregnancies per year, not all of those of course are carried to term. We have 640 million children under the age of five in need of a range of services. We have 130 to 140 million newborns whose health and well-being is largely dependent on the health and survival of that mother. And then we have a population of HIV positive people somewhere in the range of 30 to 35 to 40 million and then we have these high risk groups.

So we can see that while there isn't complete overlap in terms of the key target populations for sexual reproductive health and MCH services and HIV, there is a significant overlap. There's a lot of work that's being done to try to take advantage of those interlinkages of those opportunities, but a lot more needs to be done and I think that if we're able to do that and really scale up those integrated approaches, we'd be a lot closer to where we need to be.

So if we look particularly at these target populations of women of reproductive age and especially young women, pregnant women, and newborns, there's a significant overlap in the health problems they face from the SRH and MCH side and the HIV side and in terms of the health services that they need.

This chart is by no means complete, but it illustrates the opportunities that there are to link and integrate services. On the left hand side we have a range of SRH/MCH

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services, sexuality education, family planning, and then a range of maternal health services. On the right we have some core HIV services that can be provided in an integrated way with these SRH/MCH services.

And I should note that I should have done it by two directional arrows here, because of course, these HIV services that are listed on the right can and should integrate many of the SRH/MCH services that are there on the left.

Just a quick comment on PMTCT, just to remind us all that PMTCT is not just about the prevention of HIV transmission to the newborn, but as WHO and the UN agencies have defined it, PMTCT also includes a number of interventions that cut across this SRH and CH/HIV continuum including the prevention of HIV infection in women of reproduction age; the prevention of unintended pregnancy in HIV positive women, and of course, ongoing treatment for the mother and her family if she's HIV positive.

There's been a number of studies that have come out recently that show the critical importance of the survival and well-being of the mother to the survival and well-being of the newborn. That's not of course, the only rationale for investing in the survival of women, but it is an important one.

Very briefly, these are the key elements of health system strengthening that of course need to be as I said, in place both for SRH and MCH services as well as for HIV and AIDS

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related care. I'm not going to go into them in detail, I'm sure everybody in here could recite them in their sleep.

So, what are some of the benefits of program and policy integration in principle? There is a study that was recently conducted by IPPF, WHO, UNAIDS, UNFPA, and University of California at San Francisco that found a range of benefits from linking SRH, NCH, and HIV services. Increased access and utilization of HIV testing, condom use, and STI knowledge, provision of comprehensive services in a single location or setting means that there's less stigma for those who are seeking those services, greater satisfaction in many cases, among users, and often a stronger rights focus in the way that those services are provided.

We've seen greater program effectiveness, some cost savings from the integration of STI and HIV prevention into MCH services and vice-versa. And we've seen that health workers gain skills and were able to work more efficiently and more effectively. There's a number of country examples that are cited in the literature.

There is growing research that's being done in this area. We still don't have anywhere near enough data and we certainly need to look at these issues in terms of scaling up, but there is progress being made.

So turning to the global level. We've seen a growing trend also in a number of global mechanisms in efforts and

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initiative that have been launched in the last couple of years to focus on the health MDGs as an interconnected set of issues. The high level task force on innovative financing for health systems that was launched two years ago, and that shared its report at an event in New York last September analyzed the funding needs and mechanisms for MDGs four, five, and six together.

The Secretary General's joint action plan for women's and children's health which was announced in April and is gathering momentum in moving towards launching this September at the MDG Summit, actually initially began or was at one point conceptualized and proposed as a joint action plan for MDGs four and five. The recognition of the importance of those inter-linkages between MCH maternal and child survival and the issues of HIV/AIDS, TB, and malaria is the reason that the joint action plan is being focused on women's and children's health specifically, avoiding that terminology of MDGs four and five to recognize the important of HIV, TB, malaria, to the survival and well-being of women and children.

We've seen some interesting developments among the funding sources. The health systems platform, that GABI [misspelled?] the global fund, and the World Bank have recently launched with WHO's participation is looking at the health MDGs in an integrated fashion. We have at the end of April, the decision point that was adopted by the global fund to fight

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AIDS, TB, and malaria, which called for country coordinating mechanisms and partners to increase or strengthen the MCH components of their applications to the global fund and also task the Global Fund Secretary with developing a menu of options on whether and how the Global Fund could or should do more on MCH that will be presented to the board for decision in, we hope, December.

We've seen the U.S. government's global health initiative, Massive Good, the Muskoka Initiative Declaration, that was just announced a couple of weeks ago, a few weeks ago in Canada. That latter one focuses, did prioritize maternal and child health, but the Muskoka Declaration also clearly recognizes the importance of integration with HIV and AIDS and recommitted the G8 members to replenishment of the Global Fund and to universal access.

I'm not going to go over this slide in detail. This is a slide that's taken from the draft, UN Secretary General's joint action plan, and it shows that what are the estimated annual funding needs for the health MDGs for the years 2011 to 2015. The document is under revision and these numbers may be adjusted somewhat, so don't memorize them and don't write them down, but they are out there somewhat.

It clearly demonstrates the huge need in terms of the health system cost, that lower set of numbers, the red to pink. The blue shaded section is the program, the funding needs for

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programs directly related to women and children's health, maternal health, family planning, immunization, etcetera. And then the top, the yellow to brown indicates the funding needs, the funding shortfalls projective for TB, malaria, HIV/AIDS, essential drugs, water, and sanitation.

Just a quick comment. If we're looking towards effective funding mechanisms for an integrated approach to sexual reproductive health, MCH, and HIV, what are the key criteria for such a funding mechanism? It needs to be responsive to country needs and plans and fill gaps. It needs to reward performance results. I know there's a fair amount of debate out this issue, about performance based financing versus need based financing, but I think there's a clear trend towards acknowledging the importance of performance of achievements, as a basis for additional funding.

It needs to, and we hear this very loudly from, partners from the country, from the governments and civil society organization, funding mechanisms needs to minimize the administrative burdens, the governance structures for these funding mechanisms need to allow for multi-sectoral participation, take a rights based approach in their programming and prioritization. They need to promote and facilitate integrated approaches across these areas, these health MDGs, as well as the other particularly the gender

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related, the education related MDGs, and they need to strengthen those health related capacity related issues.

So I'm going to leave you with some possible discussion questions that I hope we'll be able to talk about. Do we have enough evidence on the programmatic benefits of integrated approaches across MDGs four, five, and six, and with the other MGDs as well? Where and when does integration not work? And what can we do about it? What is the role of funding mechanisms? Is integrated funding really necessary for integrated programming or can we achieve integrated funding with vertical funding? And can the SRH/MCH and the HIV communities come together effectively for advocacy and programming and delivery of the services?

I'm going to end with a little advertisement, I think there's somebody here who's going to be handing out announcements of a session that's just been put together in the last couple of days, for anybody that's interested in hearing more and talking about the UN Secretary General's joint action plan, there's going to be a breakfast panel on Wednesday at the somewhat ungodly hour of 7:30 in the morning, the information is here and there's fliers that will be handed out. Thank you. [Applause]

DEBREWORK ZEWDIE: Anne thank you very much. We're going to go to the panelists now. We have three distinguished

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panelists and for those of you who just saw the last slide from Anne, that's something which we are going to concentrate on.

But let me take a few minutes very shortly and introduce three of them. The first one is Morolake Ooletoyinbo. Morolake is known to many of you, but what I would like to see when I see Morolake is an activist, a fighter, a writer, a TV personality, and who brings a breath of fresh air to the fight against HIV/AIDS. Morolake you are welcome.

Next to her is ERIC GOOSBY. With no introduction required at all, Eric is a veteran who has joined this fight from day one. And now he is the leader of PEPFAR, which is one of the largest funding mechanisms for the issue that we are discussing.

And we're also very grateful to have Dr. Penna from Brazil. Dr. Penna is the Secretary of Health Surveillance and the Minister of Health and Chairman of Advisory Board of the National Agency for Sanitary Surveillance.

What we want to do is to the three panelists, you have seen the two presentations, this is also a debate which has been taking place in the last few months and which is at the center of both the MDGs and universal access and funding.

So, from where you sit, please take three to five minutes to look into what does it look like at the country level? And what does it mean providing the resources so that

we don't go in 10 different directions, but come together and make it happen. And what does it look like from the government level as well. So let me give the first chance to Morolake.

MOROLAKE OOLETOYINBO: Thank you very much. When I hear the word MDGs and somehow we have all of these various acronyms and words and clichés and it has a way of boxing us into corners and putting us and just dividing things up and we're all forced to take sides.

And when you really ask can we do one without the other, we've listed all the MDGs and wherever we look at it, whether we are talking about poverty or education or women empowerment or child health, maternal health, AIDS, malaria, and environmental susceptibility, global partnership for development.

In all our work, it's obvious that we are all drivers of whatever problem you have with one, somehow you can always link it back to the other. So, what we would like to see, which we haven't seen at country level is a link between everything.

Because even when we - I work primarily on HIV and AIDS and when I look at issues around HIV and women's rights and women's empowerment, you can always often trace it back to poverty and trace it back to access to basic education.

So if somewhere within that mix you still have to tell yourself, well, we had three to one, but the absence of the

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other, totally negates what we are doing, which means we have to go back to the drawing board and see where do we begin from. How do we get this back in?

So even though I started out working on HIV for example, I've realized that there's no way I can move HIV campaign if I'm not able to access services of [inaudible] empowerment and for the women that I serve. We're seeing women who access to the free pills, but our women have been forced to sell the drugs so that they have money on the table to take care of their children.

That's an unfair choice for any women, any mother, any human being to make, and which means we really must go back and see what benefits.

And whether we look at maternal health as a woman, I mean I have reproductive health services as a woman with HIV going through the so-called PMTCT [misspelled?] program you realize that at the end of the day if I do not have services and care concerning my reproductive or maternal health, which is what you’re looking at when you think of MTG5, then I really cannot have access to basic comprehensive services going further down the line at MTG6.

Which means, for me, what we really would like to see is a place where all of us can say this is the big picture, and then how can we distribute the jobs such that each person takes a piece of the job and ensure it’s done. So it’s not this is

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mine, it can go elsewhere, but we are all serving the big, it's a big picture, and we are all dealing with each piece of it and ensuring that that comes in and that's what we've not seen in country, but it's what we would like to encourage all our partners to do rather, than divide us up such that even right now you're thinking about HIV.

And the money is going away from HIV so where is it going? Do we chase health, children's health, do we chase maternal health, we are tired of chasing the money, let us sit down and address the issues knowing that it's all one big piece.

DEBREWORK ZEWDIE: Thank you Morolake. Eric, what Morolake says makes imminent sense. As a mother, as a woman, and as somebody who has paid with life through this epidemic. It makes imminent sense when she says we are tired of chasing the money. How do we make it happen?

ERIC GOOSBY: Well thank you. I think that realizing the relationship between four, five and six is, I think important. You cannot, as has been stated, and as the data shows, the relationship is linked. The same individuals who are having children, or are children, or women, the mortality associated with them, often are HIV infected, in many of the areas of the world as we saw from Gottfried's presentation it puts us in a position where they are linked. To respond to one without acknowledging and taking advantage of the delivery

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platforms being made available to respond to the other is a missed opportunity.

We believe that combining our HIV/AIDS platform, our HIV/AIDS/TB platforms, our maternal and child health platforms and our family planning platforms really are going to allow us to bring more people in Fund of care and treatment in all three MDG areas.

The United States, in an attempt to acknowledge these relationships has evolved our thinking in the United States with our vertical programs to really try to take every advantage of allowing the HIV/AIDS platform to begin to expand and respond to the needs of the patient in Fund of us who has a maternal and child health issue, an immunization issue, a problem with nutrition, with neglected tropical diseases. That same individual may have a relatively easily diagnosed chronic progressive disease such as diabetes, hypertension or coronary artery disease that off of these already existing platforms can be diagnosed and treated. To not take advantage of that would be to miss a big opportunity and, indeed to engage in the development of new platforms without taking advantage of those already existing would be a huge waste of resources.

We are trying to converge our ability to diagnose and treat diseases but increase the capability of each platform in which we already have invested time, energy and human resources to expand their capability to address the needs of another.

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It's not an issue of money moving from another disease to ignore it, to drop those resources going to HIV/AIDS it's so we can respond to the HIV/AIDS in Fund of us who has a non-HIV/AIDS disease. It's the logical maturation of these programs.

We will be able to help more people and, I think I also have to underline the fact that to fully address the totality of the unmet need presented by 4, 5 and 6 is going to require that we look at 1 in terms of the, I really have to acknowledge the underlying common denominator of poverty, gender and equity that permeates all of the MDGs and those must be acknowledged in all the work that we do. I believe that we will best realize our ability to make a difference for more people by opening up our medical delivery platforms to recognize and respond to the whole totality of the disease entities that impact our patient populations.

DEBREWORK ZEWDIE: Thank you. Dr. Penna, Brazil has been a leader in the fight against HIV/AIDS and the country has contributed a lot to our global knowledge. How do you see this as you see HIV/AIDS, MDG4, 5 and 6?

GERSON PENNA: Thank you. I speak from a very privileged point of view, as a Brazilian government elective reduction of the poverty as a priority. In translating it into practice, Programma Bosafamilia [misspelled?] is recognized as

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one of the most successful programs in the world to reduce the social inequalities, especially poverty and hunger.

Also Brazil has in its constitution access to health as a right, and the state it has the duty to provide it. The strength in the public health system is also the government’s priority. In the organizations of assistance and health and surveillance is an integrated network of service including HIV and the order of disease are the different levels of care is included in their right of health.

As Dr. Starrs pointed out as a discussion question, we think that there is a sufficient evidence that the program much integration has impact on health indicators. Malaria is a good example in Brazil. We had an important reduction in severe cases after introduction of hobity test [misspelled?] in primary healthcare. In order to achieve the MDG we also have to go beyond the health sector.

For example, Brazil’s plan to fight the AIDS epidemic among women is an initiative articulated by The Ministry of Health and women’s affair. It’s supported by other part in this, such as [inaudible] of sight in United Nation agencies. Women’s vulnerability to HIV goes beyond reproductive health, and one need is to consider the gender issues, including violence against women as right of feminization of AIDS.

We must recognize that all MDG are interrelated. When it’s important that we cannot do one without the others is the

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need to have integrated policies that address education and health in order to reduce in a more classical education in Fund mortality. Also the incidence of AIDS among young people. In Brazil, the health and prevention program in school is being carried out in almost 60,000 public schools involving sexual and reproductive health including condom distribution, and sex education.

I would like to refer Dr. Gottfried's presentation in regard to assess the administration of drugs. Unch health of veros in Brazil [misspelled?] are listed as essential drugs, and do you understand that scaling up access to anti-retrovirus, we require some changes in the global scenario to ensure sustainability as Dr. Morra [misspelled?] mentioned earlier today we need a cheaper, safer, and more patient-friendly drugs. That means, at the end of the day confronting sensitive issues such as impact to intellectual property on antiretroviral drug pricing.

Let us revisit history. Malaria, TB, Chagas disease and others, and now AIDS. All of them started as virtual independent problems, so I would like to stress that we need primary healthcare with high quality and integrated health services. Finally, I would like to ask you the panelists to give us their views on what would be potential benefits of south to south collaboration this context. Thank you.

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DEBREWORK ZEWDIE: Thank you very much, Dr. Penna. Let us open it up, we've about 60 minutes for discussion. There are 6 microphones in the room. Please go to the microphones, tell us who you're and, if possible direct your question to a specific panelist or speaker and the floor is open now. Microphone number three.

PATRICK NOAK: Good afternoon. My name is Patrick Noak, [misspelled?]; I'm partner at Scenario Developments. We are told that all the MDGs are interlinked but we've mainly heard about MDGs 4, 5 and 6. It strikes me that the one that is sort of being left out is number 7 which is environmental sustainability. I think it also goes very much with the fluctuating attention that HIV and AIDS get over the years, so we've years where it's seen as a medical issue and years where we see it's being more addressed as a developmental issue. I was wondering whether environmental sustainability is being glossed over to some extent because we've simply have very, very little information about HIV and climate change seem to interact with one another and what the relative and directional impacts are between the two. It's not a question to anyone in particular but addressed to the panel. Thank you.

DEBREWORK ZEWDIE: Okay. Microphone number four.

STEFAN GERMAN: Stefan German [misspelled?], World Vision International in Geneva.

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I would like to pick up on Ann's point related to integration and the effectiveness of integration and whether we've the evidence. I think we do have some elements of evidence and we just had a two-day children's preconference symposium where we looked at family-centered approaches and family first.

I think from the joint learning initiative on AIDS we actually have gathered a whole body of evidence and there is international AIDS society special journal edition which was launched last night focusing exactly on this integration issue of family-centered approach and World Vision just had a campaign on Child Health Now when the key sort of message and that is sort of borrowed from some others is more money for health and more health for the money.

We really have to think through how can we ensure that at the macro level and at the micro level we get this integration piece level at the macro level and that is the question I have to Eric is the global compact in our HB plus in terms of the country count compacts and sort of one national plan for health. I think this is a key of integration at the national macro level whereas at the micro level issues about community system strengthening, home visitation strategies, primary healthcare with community health worker is absolutely critical but it's not coming up enough in current sort of policy debates. I think we are quite concerned when we see

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examples like in Ethiopia where, you know the role out of community health workers at that local primary health care level seems to give such significant benefits that there is not more uptake on this. Thank you.

DEBREWORK ZEWDIE: Okay. One more question, microphone number four.

DAVID MASSUPA: Thank you very much, my name is Reverend David Massupa [misspelled?]. I'm here because of World AIDS campaign worker. I'm a campaigner, a Global campaigner, but at country level I'm also representing the Interfaith. Actually it's not a question, I want to make an appeal, especially to Global Fund representative seated there as well as to the Board of the Global Fund. We've seen in many years that, indeed your Global Fund has been funding vertically without regard of MCH as well as sexual reproductive health. I want to state that. The HIV and AIDS, that which you have been funding cannot come about without sexuality.

When a woman is pregnant, she is pregnant because she was involved in unprotected sex. That being the case, the entry point of reproductive health starts there. Having said that, may I now appeal strongly that as Global Fund you need to change or restructure the funding mechanism to make it an integrated approach. Otherwise, it's not going to help us, we are not going to achieve, we've seen in the devastating

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countries especially where I'm coming from, in sub Saharan Africa, that we are far from reaching MDG 4, 5 and 6.

DEBREWORK ZEWDIE: Thank you. Let us, for those of you who are by the microphones I will come back to you. We've three questions now, one is Environmental sustainability, are we forgetting it? How do we get it right, a Global Compact and examples were given, and the third one is for the Global Fund, probably the speaker may not know that there are also two board members here, Morolake and Eric, so between the three of us we will be able to respond to it. Please, go ahead. No, with the environment, who wants to take the Environmental Sustainability, did we forget it? Ann? Thank you.

ANNE STARRS: Sure, I can comment, I come primarily from the reproductive and maternal health angle, so we might have to turn to others to talk, address this question about the links between environmental issues and HIV in particular. From the reproductive and MCH side there has been some research that has been done that looks at both the impact of population pressures on environmental issues and then also looks at the health consequences and the health implications particularly for women and children of environmental degradation.

We are still, I think very much at the research phase, there has been some tentative efforts towards, in particular the reproductive health in population communities coming together with the climate change/environmental communities, but

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there is a little bit of a sensitive issue there in the history because we've, in the 1970s and to some extent the 1980s concerns about population growth were, in some countries and some entities were used as an excuse or as a rationale for what turned out to be sometimes fairly coercive approaches to provision of family planning and, sort of population, that population control approach. There is a lot of sensitivity in the reproductive health community, in particular that engaging around environmental issues might bring back some of those sensitivities.

I think that is dying, much of those sensitivities have passed, or are passing and that there really is a very clear awareness and the research clearly demonstrates the importance of bringing the environmental and the reproductive health population communities together. Can I just take one minute, or a couple of sentences to comment on the Reverend's issue?

DEBREWORK ZEWDIE: Please, go ahead.

ANNE STARRS: Again, coming at this primarily from a reproductive and maternal and child health angle, I would agree that I think the trend that we've seen to some extent in the Global Fund already towards embracing maternal and child health, we know that through its focus on HIV/AIDS, TB and Malaria, its already addressing many aspects of maternal and child health and we've also seen that, at least in some countries that countries are using Ethiopia as a prime example,

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are using Global Fund funding to address really primary healthcare more comprehensively.

I think the one comment I would like to make here, as an advocate is, and an advocate specifically for reproductive, maternal and child health is that what we do not want to see happening is that the existing level of resources, the existing funding for the Global Fund is, has to go to a much broader range of issues. If the Global Fund or other funding mechanisms right now that are focusing primarily or exclusively on HIV/AIDS, TB and Malaria are going to embrace or take on some of these broader MCH issues.

If we are going to take an integrated approach, an integrated approach is not an excuse for limiting funding, for certainly not for reducing the funding or even for keeping the funding at the level that it's now. The needs are tremendous and we've to push, as a community for greater funding for integrated approaches, because that scaled up is what is going to have the impact.

DEBREWORK ZEWDIE: Thank you Ann.

MOROLAKE OOLETOYINBO: Thank you very much. I dare not claim, or even pretend that I understand the full package when we talk about the environment. However, talking about respiratory diseases in children, aggravation of TB, PCP pneumonia, looking at the environment, I mean those are clear things that it's easy to say "Well, there always is a link"

and, just like Anne said for a lot of us we think of population control, somehow what we think of, we go back to when women with HIV had been forcefully sterilized because you're trying to, you know, I mean it just brings back so many bad memories that you attempted not to even go there. That is an apt question because the question is which is the best way to do it, how do we begin to educate ourselves and our communities on what these links are?

As I reach the Global Fund, I sit on the board of Global Fund, I represent communities, and one thing I keep saying about the Global Fund is, unfortunately there is little Geneva can do for us. In country is where we must handle the Global Fund.

In countries where we must challenge CCM, whatever we bring from the country is what we will get funded at the top. I understand that, in some countries it looks like it's a cause but it's a cause that can be broken and we cannot allow a few individuals to determine what happens to all of us and just sit back. There is very little Geneva can do for us, we've a clear strategy that talks about integration of SRH into HIV services which means, right now, Global Fund proposals have been written for Round 10. Please get in there and ensure that you see those things that have been laid out clearly.

Let us push in country, to ensure that these things do happen.

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DEBREWORK ZEWDIE: Eric, do you?

ERIC GOOSBY: Sure. I think the need to consider how our vertical programs, the programs that we are now funding by disease, a specific disease, how that can be dismantled to make resources available to address a broader portfolio of need for the person, patient in front of you, the client in front of you is the idea.

I think the challenge that we've in expanding one aspect of the medical delivery system such as community health workers, that expansion of service and the interface that the community health worker increases with the population that you're targeting is best realized in terms of an expansion of capability. When that community health worker is supported and part of a medical team that includes a nurse, a doctor, a referral capability, a backup, a laboratory that can help diagnose and treat, and that there be an opportunity for services other than their expertise to access maternal and child health, family planning, reproductive health services in a way that is seamless and efficient in its ability to refer.

Either expand the capability themselves or a real referral system. That opening up of how we deliver care, especially in a development sense is a seed change. We currently do it one disease at a time, and the need, though, in any given patient is not one disease at a time, it's the totality of their problems presented to a medical system that

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should be able to triage their need, their complaint, their problem into a knowledgeable and accountable response.

I think it's where we are going as a world in thinking about how healthcare should be delivered, it requires a thoughtful development of a matrix that allows us to still respond to the needs of those appropriators, those governments, those legislative bodies that have appropriated and given the money for a purpose to be accountable to them still, but at the same time open up an opportunity to respond to all of the needs of the populations that are using these services.

That orchestration, although simple to say is probably going to take three to five years to actually transform in Ethiopia, that system so that it's indeed responsive to all those components that it needs to be.

I think there is a growing commitment on part of the world development community to look at what is, and what is not the best way for us to deliver care, indeed the economic severity that we find ourselves in has precipitated a lot of out of the box thinking. A willingness to expand and look at using common medical delivery systems, common laboratories, common procurement distribution systems, and I think for the first time looking at common management systems that put a number of different service sites under one management system so as not to reproduce it over and over again. Save those human resources and save the financial resources that can be

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directed into developing and supporting a care package. I think the, in terms of the south-south question that you put out to us, I believe that it's also something that we need to aggressively look for and support.

The ability for expertise is now, in HIV, TB, Malaria, in many of the primary care services, growing in maternal and child health, family planning, those expertise areas, knowledgeable areas of kind of excellence, individuals and organizations that have developed those expertise are now much more plentiful in the sub-Saharan Africa region, our ability to use expertise in Brazil to speak to Angola and Mozambique, just makes a lot of sense now. Those types of opportunities should be identified, nurtured and taken advantage of.

DEBREWORK ZEWDIE: Thank you, Eric. I would like us to be a little bit more provocative and challenge ourselves, because this is something which concerns all of us. I'm going to plead with the people who are already by the microphone to please adhere to questions and we can wait for the statements later. The more challenging you're the better it is. Microphone number one.

MALE SPEAKER: Where I really want to be provocative.

DEBREWORK ZEWDIE: Good, go ahead.

MALE SPEAKER: I would be mainly addressing, respectfully Mr. Gottfried, I have an assurance to send former citizen of the Soviet Union and in the U.S., [inaudible] and

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international consultant of the World Bank. I was called last week by the only television station that is left that is clearly to our best judgment opposition in Venezuela, everything else is in the hands of the government, has all the power, the executive, the judicial and the remaining powers.

I was asked the question, is Venezuela really compliant with the millennium goals, because a month ago a person came representing the United Nations, he said he was representing the United Nations to congratulate the Venezuelan people because he said "I can congratulate Venezuelans because Venezuela can be used as a reference in the world for being the only country that has been over fulfilling the task, the Millennium Goals."

Of course, he was joking, because we know that, to be able to address this seriously, professionally, this is the result of the feedback from many subcommittees within the United Nations that includes the World Health Organization, the International Labor Organization, the World Bank and so on and so forth.

In 2003, Mr. Chavez, the current president of Venezuela went to the United Nations in New York and he said that Venezuela had already fulfilled first and Sweden and all

DEBREWORK ZEWDIE: The question, please.

MALE SPEAKER: Now, the recent reports of the Venezuelan health ministry regarding issues 3, 4 and 5 indicate

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that infant mortality has worsened, maternal mortality has worsened, and we know, even from official reports of the Venezuelan Ministry of Health that infectious diseases that were already issues of times past has emerged in Venezuela, even though this government have received in the period of 12 years both 950,000 Million dollars that has been squandered.

I say this issue because as I was preparing myself to respond to the television and now comes the issue, we that have been involved in research know that "garbage in, garbage out". What do you do, Mr. Gottfried to make sure that the data that is coming to the World Health Organization is data that you can trust on? Would it be able for you to also consider NGOs in the specific case of HIV, for instance, the government reports below 200,000 cases. We know that, real life tells us that, if you consider under reporting and people that have, are symptomatic and, you know, are infected, are indeed about 700,000 people.

The central questions, what do you do with a country that has an institution within the government dedicated to fabricating information that tells us many things in the different areas, agriculture, for instance in oil. If you see the OPEC web, you see that Venezuela, according to the government is producing 3,000,000.

DEBREWORK ZEWDIE: Excuse me, can you stick to the question please?

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MALE SPEAKER: Yes, the question is

DEBREWORK ZEWDIE: There are other people waiting.

MALE SPEAKER: My specific question is, what do you do

DEBREWORK ZEWDIE: Okay.

MALE SPEAKER: When the data that is coming, is being forced-

DEBREWORK ZEWDIE: Okay.

MALE SPEAKER: -under the World Health Organization that, as you know, is not reliable and it takes you 50 minutes to

DEBREWORK ZEWDIE: Okay, we got it.

MALE SPEAKER: come to our country, I know that.

DEBREWORK ZEWDIE: Thank you. Microphone number two.

ISHAT ACHAT AUDRY: Thank you, my name is Ishat Achat Audry [misspelled?], I work with a young people's organization in India called the YP foundation. My question is specifically to three people. To Anne Starrs because my question comes from your presentation, as well to Mr. Goosby, and to Mr. Gottfried as well.

Anne Starrs' presentation spoke about the fact that comprehensive sexuality education for young people, particularly as one of the strategies that reduces young people's risk to disease and empowers them to improve their health and well being.

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Personally, as somebody who has been working in communities in India for the last 10 years, I support the integrated response because it's a refreshing change when a health system looks at me as a young woman and not just as a series of diseases that need to be treated. Keeping that in mind, none of the Millennium Development goals stress on the need for comprehensive sexuality education or on young people as a general population.

And if we are actually to sustainably address maternal mortality, reproductive health right services and HIV and AIDS and to achieve the MDGs, and if comprehensive sexuality education is not considered to be a priority I'm wondering how we do that. This also comes with a genuine concern that the majority of the world's population today are young people. We are not mothers, we do not have children, what happens to us?

DEBREWORK ZEWDIE: Good. Microphone number three.

ERIC LUGEDA: I would like to thank the presenters. My name is Dr. Eric Lugeda [misspelled?] from Nigeria. The question that was asked by Anne, whether integration really does work, we know that as a whole world of evidence which supports integration, we've had childhood immunization, integrated with malaria and malaria distribution of bed nets, deworming. We've had the addressing of these rare diseases, forgotten diseases in Latin America, Onchocerciasis, Filariasis, all these have been integrated, and recently we've had

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integration of HIV counseling and testing, prevention of malaria and aerial diseases in Kenya, and it works.

The question is, those of us seated in this room, and particularly those of you seated up there, you're decision makers, you move the developmental world. Why don't we make the decision today, right now, as part of the theme of this conference, and move towards the direction of integration. Over the past two, three decades we've tried to be well meaning in addressing some of the key health issues in the developing world, but we've been verticalizing rather than integrating.

We've done well, but unfortunately there is a whole world of evidence which shows that we are failing. None of the programs we've supported with billions of dollars, the past 10, 20 years have, are sustainable.

The question is, why don't you, seated up there, whichever decision making bodies you sit in move to integration right now? Because there is a whole world of evidence which shows that it works, why do we continue to keep doing the rhetoric, and conferences and everywhere without moving into action.

The second thing, how can we get these governments, particularly governments from developing countries to commit themselves to their roles? I am not an economist, but I know that with their reforms, the financial reforms within the World Bank, governments have been forced to adopt health reforms.

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They don't get funds unless they do A, B, C, D. Why don't we now say we will not fund support health programs unless governments take responsibility and do A, B, C, D towards integration in order to improve the health of their people. I think we should stop talking and saying so much rhetoric but move on to act and act right now.

DEBREWORK ZEWDIE: Thank you. Thank you. Microphone number4.

STEF TOPP: Thanks, my name's Steff Topp [misspelled?], I work at the Center for Infectious Disease research in Zambia. My question also leads on from the previous questioners, and it also comes from Anne Starrs presentation. That was, is it possible to integrate our programming while we have vertical funding.

I think a lot of the speakers are in a luxurious position representing institutions like the Global Fund which is, by nature, multilateral and Global, but the reality is that, a significant percentage of our AIDS funding remains bilateral, coming from the U.S. government. With vertical funding there comes conditionalities, and as with all programming necessarily, a desire to show efficacy, numbers specifically.

I agree that there's a lot of evidence out that there that integration can work, and I work on one of these programs myself, so my question is, specifically to Mr. Goosby, and

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that is "What has to happen for vertical funding programs to enable integrated programming at the country level?" Not, we know it's a challenge, but what has to happen? Thanks.

DEBREWORK ZEWDIE: Thank you. Let's go through this round and then we will come back to the next round. Data, what do we do with data? Complaints of sexual education, why not? Why can't we integrate right now? Why don't you people do it, and how do we hold governments accountable? Go ahead Gottfried.

GOTTFRIED HIRNSCHALL: Thanks to the colleagues, to the colleague from Venezuela.

What WHO normally does, we depend really on data that we can get from the government. We normally engage in a dialogue with the government to validate the data as much as possible. In some countries this is an issue. In some countries this is not very easy, and we are aware that, at the end of the day, from some countries we may have data that are not reflecting reality.

As WHO, as the secretariat that we are to the member states, to the countries, unfortunately we do depend to a fairly large extent on what countries are telling us and we obviously are providing support in collecting information. I understand your frustration; I think I know the Venezuelan situation fairly well. I've been there a few times and we will, obviously need to work towards further improvement but it's not necessarily that easy.

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On the issue, since I have the mike, I would like to really comment on the issue "Why are we not integrating immediately, why do we wait?" What's holding us up? I believe there are a couple of things that are really holding us up.

One is, anxieties, anxieties that we see reflected in this conference, and that is okay, if we are putting it together, that means basically, it's less for everybody. Anxieties that I think are justified to say, well, if this is all about efficiency gains, basically you're saying let's integrate it, let's put it all in one part, it therefore costs less, and therefore we need less money.

I think we need to have in this conversation a rational approach to integrating and really also including some of those startup costs that integration might cost.

It might be something you have to invest. You have to retrain people, you have to rethink some of the processes, some of the system strengths and issues that you will have to also budget for. So I think that solves it up to some extent.

The second issue is that we often when we talk about integration, we only focus on the service delivery. That is where we would like to integrate, but we leave out all the other levels; the political level, the program planning level, the way the funds are channeled. What we do with those issues and I think that makes is sometimes difficult to move more quickly into integration.

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ANNE STARRS: Thank you, I couldn't agree more about the fact that it's a problem that the MDGs do not explicitly have a target or indicator that is related to the need for comprehensive sexuality education for young people.

In fact, for all people, that the needs the specific needs, and the prioritization of young people, is not an issue cutting across the MDGs. The MDGs were not a perfect framework, they were a product of the political situation at the time that they were developed and there are significant gaps. The sexual reproductive health side, rit large, there was not even a target for access to reproductive health for all. That target was not formally adopted until the year 2007.

That target does implicitly include some focus on the sexual reproductive health needs of young people because there is an indicator specifically on adolescent fertility, but it is fairly buried in there. I agree, and I think that the challenge to us is as we look to 2015 we need to focus right now, over the next five years on achieving the MDGs but there are at some point going to start being discussions about what is going to be the development framework post 2015. I think this is one of the issues that needs to be looked at in developing that framework.

I think just to comment quickly on this issue of what needs to happen for there to be integrated programming. I agree completely with what Gottfried has said, and I think one

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of the implicit answers also to this challenge is what gets measure is what gets done. We very often, we are lacking in mechanisms and indicators that really reflect the benefits of integrated approaches.

I think it is a challenge to us as we look at a shift towards greater integration to insure that integrated programming, that there are indicators that look at the impact of integrated programming in these specific health conditions, health challenges and diseases, but that also looks at ways to track whether integration helps to make progress on each of the individual issues, as well as how we measure how integration is really happening. There is still some things that needs to happen on that front.

DEBREWORK ZEWDIE: Thank you, before Morolake and Eric and Dr. Penna respond to this integration question, I want to provoke the speakers, the panelist, and the audience.

Number one, are vertical programs all bad? Number 2, isn't there a lesson we should be learning from some of the vertical programs where we have seen a sea of change, whether it is in the development of health systems or even bringing out the infant mortality and maternal mortality issues. Is there something to learn?

I would understand that where we are going is towards integration, but are we not doing a disservice to ourselves by saying all these vertical programs are bad, so let's move on.

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So when we have tremendous achievement, so I would like you to address these along with why don't you have a path to integrate today, and why don't you hold our governments accountable to integrate today?

FEMALE SPEAKER: But for AIDS, the history of diseases, I don't know where at any point in history that we have had patients had so much power as we have in HIV/AIDS. I don't know how we have had so much activism. I don't know where we have been able to push for access to services. I don't know where we have been able to look our care providers in the eye and demand services.

I come from a part of the world where a doctor is a demigod. You don't even ask questions. You get a pill, you swallow, full stop. Nothing is asked. All of that is changing, simply because we are at a point where we are talking about access and rights-based services. I think that that is one thing we can learn from the AIDS movement. Where we ask ourselves, all that power, how can we channel it and ensure that we are able to move together on what we have identified as our priories?

If we kill that movement, in a bid to say enough of this vertical things, and I agree with you, I am not vertical when I need services, I hate to run around like a headless chicken, running from clinic to clinic looking for different services, when I am only a human being. I really would like to

have integrated services, but I think really it is important that we ask ourselves, what is working? Why is it working? How can we ride on this tide to ensure that we are able to do things better?

When I was in university 20 years ago, I knew what contraceptive pill to take because all of what we were asked was hearing was family planning. We had this campaign of one woman four children. All the other places that's what we were hearing. I am talking about 20 years ago. Right now the average undergraduate knows next to nothing. Why? Because we had programs that killed such programs simply because there was a new flavor and that is the risk we run. We are going to lose all the benefits we have gained if we kill what's working because there is a new flavor and it is the new way.

Integration is the way, but then what do we integrate and how do we assure that the platforms that we have built, for example, it's unacceptable to be talking integration if we are not talking community system strengthening. We can't not take advantage of community systems or civil society and say how do we assure that all of this programs you want to integrate are sustainable by tapping on the power that civil society brings.

That is something that we should think about in all of this, in the big picture of integration.

ERIC GOOSBY: I think the vertical program has had significant impact in many diseases, HIV/AIDS is to be sure is

one of them. We've had variable times when tuberculosis was positively impacted, then ignored for a while, it comes back, and resources shift to respond to it. If they are sustained that benefit is sustained and I think the sine wave, kind of waxing and waning of funding, is a phenomena we need to eliminate and be vigilant in not allowing to present itself over and over again. Because the history of these programs is we try it for a few years, and get a new flavor as you say, and move on.

The truth of it is that there is really does need to be a more comprehensive description of the topography that we are dealing with. It requires leadership, some courage to stand up and say that indeed it is time for us to look at the totality of the unmet need, the burden of disease across all diseases and populations, and try to construct a rational, compassionate, ground-up-driven delivery system that responds to the needs of the population over time. To hone a respond, that is responsive to the population, requires that the population using the services is in an intimate dialog with the decision makers around allocation of resources so that feedback loop of this worked, this didn't, allows for a self-correcting mechanism to be inherent in your system.

I think the other issue is the confounder and ideological belief system frequently moves into the medical needs of population. We have allowed diseases and needs of

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patients, move in and out political discourse that takes it. That’s going to happen but we shouldn’t allow it to take it out of a medical context. We should always keep the science and the argument for why that need is present, why it benefits the individual, benefits the family, benefits the society as legitimate elements of why we need to continue the service. And not allow an ideological belief that dominates a scientific or medical need. Reproductive health, family planning, injection drug use, issues in and around sexually transmitted diseases are all examples of that type of issue.

The beauty of being in a medical context is you do not have to bring judgment into it. A doctor, a nurse, a medical delivery system indeed enhances its ability to remain in front of that population, that individual who needs the services if there is a concerted effort to keep the judgment out of it.

It is not our job to judge, it is our job to respond to the needs of the person in front of us, to give them the best advice that we can give them, framed in the science that we know and understand to be true, to translate that so they can make a decision either themselves, for those that can get to that point and are comfortable with it. But always in dialog with someone and hopefully knows more and who can guide them in areas that they don’t feel comfortable with.

That’s an optimal picture, but that’s what an integrated medical delivery system should try to create. What

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people need when they enter that decision to take a vertical program to an integrated program, it's not rocket science. It is issues around job care capacities, critical training protocols, task shifting, cross training, all of those things we know how to do. We have done it in many settings. We can do it for this.

I think Anne is correct in that we need to make sure that we don't diminish the impact that the vertical program delivered. We need to be very focused on quantitating where we were with vertical as we move into an integrated model and where we are going with the integrating model. Define both process and impact outcomes that allow us to say we indeed have moved linearly with this, but we have moved with these outcomes now still able to demonstrate.

I think that the global health initiative in the United States is just this thought process. It is looking at the natural maturation of a program that's vertically constructed to now ask itself can it now reconfigure itself to respond to the larger portfolio of needs that the same patient in front of you, in the that vertical context, now presents. We believe for the United States government we are moving in all our thinking to an integrated model. We won't get there in all arenas, but all arenas are thinking about it. We are now loosening up those lines between vertical programs to allow for

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that horizontal movement and service expansion on platforms that are already up and running in a vertical context.

The last piece of this, and this is prior to the integrated piece on all levels that was mentioned, we need, and this is our job, to explain to our appropriators, the people that give us the money to do this, that the number game that so characterized vertical program reporting, back to congressional interests appropriators, can still happen. We can still report back on a vertical, on a disease specific line but integrate above the level of the service site on the ground.

So that provider in the clinic can respond without impediment to the complaint that is in front of them. I think that it is iterative, but it is not so difficult that we can't move in that direction. The global health initiative is truly just that attempt to start that movement to have a more comprehensive delivery system.

DEBREWORK ZEWDIE: Thank you, Eric. Dr. Penna.

GERSON PENNA: Yes, I would like to stress that we have to recognize that all MDGs are interrelated. Integration, as someone has mentioned, in my micro-level or macro-level has clear benefits. When we receive some grants of money toward malaria, to TB or to any other disease, use it. You have to know how to improve the health system as a whole with this money and it will give benefits to these patients who have these diseases.

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As those Caribbean saying goes, when it is all said and done, let us have more done than said.

DEBREWORK ZEWDIE: Thank you. I have six people in front of the microphone. We have 15 minutes. I want to plead with both people who ask the question and the respondents to be precise so that we can address as many questions as possible. Microphone number 1.

JOSE ISASOLA: Thank you madam chair. My name is Jose Isasola [misspelling?] I work for the Mexican Government. I have one question regarding the integration of sexual reproductive health and HIV services. I believe there is no doubt, in some places, in some settings, it works. It is the right thing to do. There is that concern many of us who work and live in countries with concentrated epidemics have. There is a challenge about a stigma, discrimination, homophobia, but it needs to be addressed.

In the country where I live, I believe, more than 80-percent of the people living with HIV are men. Many of them are men who have sex with men and many of them do not receive proper treatment from available health clinics. What are the options that need to be taken? What are your recommendations to have full advantage of integration of reproductive health services but still address the needs of the people who usually do not have access to these systems? Thank you.

DEBREWORK ZEWDIE: Microphone number 3.

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MARY ODOKO: My name is Mary Odoko [misspelling?]. I come from Uganda. My question goes to any of the members of the panel Yes, we are talking about integration. There could be integration of medical program. We could have increased funding or reallocation of funding, but could you talk on the importance and the role of good governance in achieving the MDGs.

DEBREWORK ZEWDIE: Thank you. Microphone number four.

MATTHEW SOLOMON: My name is Matthew Solomon [misspelled?], I am a student at Oxford University. We have spoken a lot about the integration but it has been mainly from a perspective of care and treatment and we haven't spoken much about the integration from the perspective of transmission and prevention. This can apply to anyone but maybe Dr. Herschel is another important space to understand the biological interactions between the social ecology of the disease and preventative, behavioral, and structural interventions. There is still a lot we don't know about in rural areas, interactions between patristic infections and viral order transmission in urban areas, issues of urban poverty, and infectivity, and is this not a space that needs to be opened up. Thank you.

DEBREWORK ZEWDIE: Thank you. Microphone number two.

NORINE: Thank you. My name is Norine from Riads, Israel as well as Repse {misspelling?]. One of the statements I heard is that we are thinking about the outcomes and the

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indicators. I just want to say the thing is right here and right now. As we are thinking, people are dying. The evidence is there and we all know about integrated care and support. As global leaders, are you integrated in your thinking? And if not, why?

DEBREWORK ZEWDIE: Good. Microphone number three.

FRANCOIS: I am Francois [inaudible] from the Dutch Center of International Cooperation and Sustainable Development. Madam chair, you wanted us to be provocative, so. I would say vertical programs are not the problem. The problem is that in the last 30 to 40 years we have seen a massive failure on the part of government, multilateral organizations to build sustainable health systems. Don't throw away the baby. If there hadn't been vertical programs over the last 20 years, we wouldn't be having a discussion about global health care as we are having today.

What surprised me in the discussion is that, when we talk about horizontal systems, that we don't raise the issue of health insurance systems. Because having full resources is one of the most effective ways to provide not only a predicable patient stream but also a predicable money stream. I would like to ask the panel to react to that question.

DEBREWORK ZEWDIE: Okay. Microphone number 1.

ANNA MILLER: Thank you. My name is Anna Miller [misspelled?]. I work in public health in Zimbabwe. My

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question is firstly to Anne Starrs; I think this new report for children is very exciting and I am curious where you see this action plan in the hierarchy of all global plans.

Then my second question is to everyone, looking at the flyer there is seven logos on the flyer for this plan, and just in general, as integration gets deeper and collaboration wider, what do you think about branding and logos and how we all can help ourselves and manage that. Thanks.

DEBREWORK ZEWDIE: Thank you. What I would like to do is to give each of the panelists to respond to the question that you see fit and also have your one or two final thoughts as you do this so we can maximize the time. Let me start from Dr. Penna.

GERSON PENNA: I don't have additional comments. Thank you.

DEBREWORK ZEWDIE: Eric, please.

ERIC GOOSBY: I guess I will comment on— we are not integrated at the multinational level. The ability to look at our programming and allow it to truly be additive in its entry into one country, into one province, into one city is markedly impaired. It tends to run a separate line that reports back to Geneva or back to Washington or back to the bilateral capital.

It ignores or has a less than sincere connection to the country government, the country civil society in which the work is being done. The issue of governance that was brought up is

critical for us to understand where the locus of management, control, oversight, and accountability resides.

We have not been honest in our own discussions with each other around how that configures at any given country on the ground. There is an awareness of that within the community that is growing. We are beginning to talk like we have never talked around those areas because I think people in decision making positions are seeing, especially precipitated by this economic decline, that our best chance at sustaining services and expanding services to respond to the extraordinary, still in front of us, unmet need on any disease front will be best realized by a convergence of those resources; a convergence of those planning processes.

But it needs to be matched with a rigor of oversight and governance that sustains it. I think that the commitment to do that is also in a dialog with the grassroots people, the people who use these services or will benefit from the prevention interventions, or will benefit from the immunization strategies, or the family planning reproductive health strategies. In dialog with that governance body, at the country level, to keep that system whole.

I think that the piece of that governance that we have not fully engaged in dialog with, is country government, civil society. We have to think of and nurture new lines of communication that are honest, real, and transparent to allow

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that to continue to grow. Those systems that continue to be self-perpetuating are those that have that healthy relationship. It is a goal that I think we are becoming clearer on, and I hope, over the next few years, can move toward.

DEBREWORK ZEWDIE: Thank you. Morolake.

MOROLAKE OOLETOYINBO: Thank you very much. We started out taking about MDGs and can we do without the other and right now what we are really focusing on and what's upper most in our minds is how do we integrate. Are we talking about integration of HIV/SRH or even good governance of MDGs that has been asked? What I would like to say where we can talk about integration, I would like to see integration, not just in programs but what about the donor integration rather than defending donors coming into various countries with their various agendas. Can we have some donor integration? Can we have some integration with the bilaterals and all the various--there is too much happening everywhere--can we—. As we talk about this integration, rather than only look at the health care settings, can we really do integration?

Even in our civil society rather than stay in our different turf and hold on tightly to it, can we really do integration and ensure that our people are served, which at the end of the day is what matters mostly. It doesn't matter who you think you are, what logo you carry, if you are not service

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human beings, it is really a waste of our time really and a waste of those resources.

But even as I say that, I would like to say for integration, are we ready to integrate human rights-based services? Do we really want that integrated or are we just mouthing it. The kind of challenge that happens in the AIDS programs, are we ready and open to have rules in other programs so that it's- do we want the activists in SRH? Do we want the activists in our maternal health? Are we ready to accommodate the activist in child health programs?

Really? And if we are not ready for it, not just about that money because the money comes with all this baggage that people like me will bring to that table. Are we ready to integrate client-centered services that what matters most is the human being in front of you and not any other agenda that you have as a health care provider?

Finally, let me, this is the last chance that I have, I guess, so I am going to say as I close that we do not want to see a change in costs. We do not want to see a change in direction. We do not want success being punished and saying enough of this that's going to that. We don't want our donors and our partners to take the easy way out and kill everything we have accomplished in the past number years.

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What we want is to scale up services, scale up in what's going on in, what we have rather than to divert resources and deplete all the parts. Thank you.

ANNE STARRS: Let me address the question about the joint action plan and then make a couple of final points. Where does this joint action plan fit into the global development health architecture?

We will be talking about this a little bit more, quite a bit more on Wednesday, so I don't want to take too much time. But just to say that the basic principles of the joint action plan that the UN secretary general has set out is to build on the existing initiatives, structures, and efforts. It is not a new structure in any way. It's saying we need to accelerate progress on the health of women and children. There are a range of options out there, there are a range of activities being undertaken. There are a range of structures, partnerships, of fund, et cetera, that are already dealing with aspects of this issue. What the secretary general is doing is challenging key state holders across a range of sectors, donors of course, governments, civil society, private sector as well, to say what more can be done to accelerate the progress so that we have a better chance of achieving the MDG targets for 4, 5 and 6 by the year 2015.

Just a quick comment on the logos, the logos that are on this flyer, reflect the institutions and organizations that

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are going to be speaking at this event. The UN secretary general's joint plan will ultimately, probably embrace dozens, if not hundreds, of different partners, so we are not going to all have our logos on that final statement.

Just a couple of points on this issue around integration, I would agree very much with what Morolake has just said. I think the key area, the key challenge that we have in terms of moving towards integration is this issue of providing integrated services for people, for the ultimate user. That is really what we are talking about. When we look at the different structures and systems that are in place to provide those services, in some cases vertically, I think it is not, we want as much as possible and where it's logical to have integration at those other levels as well, but there is also collaboration and linkage. That if we can get the donors, that we are not going to have, and I don't think we would want, one donor to be funding everything in the health field. We certainly do not want one civil society group. What we want to be doing is advocacy. What we want for these different players, for these key actors to be able to get together towards that ultimate goal of integrated services that meet the needs of the individuals.

I think we had a question from Mexico that talked about how to ensure the needs of marginalized populations are met, in particular, for example, men who have sex with men who are not

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necessarily going to have their needs addressed in an integrated approach that combines sexual reproduction health and HIV.

Clearly part of this principle of providing integrated services needs to be that the rights, again as Morolake said, the human rights of all individuals and their needs for services are met. There are some thinkers from Mexico, Julio Frank [misspelling?] and other colleagues, who have been promoting what is being called the diagonal approach which is really looking at building on the strengths and advantages of vertical approaches, linking that with the advantages with more horizontal approaches and coming up with, what they call, this vertical model, where you assess the impact of vertical funding, as it maybe, but you access its value and its impact in terms of its impact on a range of key health indicators.

Whatever the approach is, we need to be looking at is what are we measuring, are we making progress in meeting the needs of those individuals, and what more can we do from the different perspectives. Not necessarily all becoming one entity, but by working together so we are addressing those needs at the community, at the household, at the individual level.

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MALE SPEAKER: Thanks. Let me just address a couple of questions and then a couple of closing remarks. Is it legitimate to ask the chair a question?

DEBREWORK ZEWDIE: Absolutely.

MALE SPEAKER: So then I will take advantage of that as well, particularly because Debrework you are obviously highly placed in the global fund. I wonder how useful see that from the global fund perspective yourself. This whole conversation should the global fund should remain focusing on what it is now? Should it become sort of the MDG health-related MDG fund or more? Where would you draw the boundaries and what do you think would be the logical conversations that need to take place in this regard? I really would like to hear a little bit about how you feel about that.

A couple of things, I think that the issue of key population, mostly with populations, is key for achieving our HIV-related outcomes but also more importantly the MDGs. There is a whole set of MDGs. I believe Jose we need to look at what is feasible to integrate into our routine systems.

I wouldn't just start giving up on the routine system from the beginning. I think we might to go this extra step and say well, we need to invest in our health workers so they can accommodate a broader range of situations, or individuals that may have different characteristics that they did also to take

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care of, including the moms that we know of. Only that is really feasible.

I do think, of course, we need to think of alternative ways of getting the services to the people through outreach, or through the NGO sector, whatever that would be.

I do think we need to examine this carefully before we make sort of a premature conclusion. In terms of whether you draw the line, and to come back to the colleague I am talking about sort of the structural determinants and the whole environment that ultimately influences what people do and influences their health. I think this is the real crux of the matter to say, what is really in the package and how broadly do we need to define what needs to happen and how further do we need to cost it ultimately influence patient behavior, care-seeking behavior and health outcomes.

I don’t really have an answer to it but we know that in HIV prevention if we do not go a little bit further, we are not going to achieve the prevention outcomes that we want and we will not see the transmission reduction that we would like to see happening.

On the issue of are we integrated in our minds, I can talk a little bit about sort of what’s happening in WHO at this moment. We are not yet necessarily all integrated in our minds but we have a great opportunity we have been asked by our member states to develop an HIV strategy for the next five

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year. I think what we are now going to do, we are not just looking at HIV as HIV in a classical, vertical sense, but really two important elements in this new strategies will be on how will we link to maternal and child health outcomes and also to the health system issues. We see that as an opportunity to really formulate a broader strategy that takes HIV as an entry point but really branches out very stronger, very quickly to those other issues that we have been talking about.

There is I think, quite some commitment at the various senior level at WHO at this point to really look and maintain certain levels of specificity that is obviously needed, but really when it comes to programmatic linkages to formulate them very, very clearly and to translate them into some in concrete ways, in our normative providers but also in our technical support that we provide to countries. I think we are going in this direction. We clearly will depend on a lot of our partners to support their thinking and to provide their input in a similar way.

I would just like to reassure those who think, okay are you giving up on HIV? No, we are not. We are going to be very clear on what the HIV specific outcomes will need, what will be required, but we will see those linkages not as a threat but rather as an opportunity for sustainable and for the future.

DEBREWORK ZEWDIE: Thank you. Let me take the last one and a half minutes to respond both to Gottfried and also to

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make a few points. The question is what is the global fund saying about MDG four and five. When we prepared the results for our replenishment meeting recently, we found out that most of our resources are going to protecting women and also children through our funding for HIV/AIDS, tuberculosis, and malaria.

That was significant when it was surprising to us and we shared it with the world. All we are saying is very simple, two things. Number one, already with TB, HIV/AIDS and malaria, we are addressing MDG four and five. If the world wants us to address MDG four and five, there are two conditions. One, the resources that are coming to HIV/AIDS, TB and malaria should be increased and not diluted because our mandate, I alluded to your global fund, it's actually your global fund and our global fund, and it was established for a specific purpose to fight HIV/AIDS, tuberculosis, and malaria.

But [inaudible] is a very good example and Rwanda is a very good example, because the global fund is demand driven, countries have resourceful ways of using the global fund resources. If your path has built its entire primary health care with the money they got from the global fund for tuberculosis, HIV/AIDS and malaria. If you look into health systems, the investment of the global fund into a health system is also tremendous, so is for MDG four and five.

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So the first thing is if we are given resources on top of what we are doing now for the mandate with which we were established, we will be happy to expand what we are already doing on MDG four and five. That's the first one.

The second one, when the question on MDG four and five came, the question for us was is this going to make life easy for the countries or is it something where if you for every problem that comes up, you fund another organization or you create another organization, what does that first country level.

So that is the thinking at the global fund. Now, four points to conclude this. The title was HIV/MDGs, can we do one without the other. I think it was inevitable that we went toward integration because we are talking about MDG four, five, and six and more. The first point we should learn from vertical programs.

Vertical programs happened because of the deficiency we had, and more importantly, because of the limited resources we have. Eric is a very good example where as recently as two or three years ago, we had, in some countries, a pharmacy with the drugs funded by the global fund, another one funded by PEPFAR [misspelling?]. That is integration should happen.

The second thing is if there are enough resources for addressing all these issues, we wouldn't even be talking about this. There are enough resources in the world to deal with

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these MDG four, MDG five, and MDG six. It's a no brainer if you protect somebody from HIV/AIDS and that same person dies from malaria or child birth, it defeats the purpose. So that is how we should look at it.

The second one is we should be efficient and effective with the resources that we have. The fear I have when we are debating about vertical versus horizontal is we shouldn't send the wrong signal to the people who are funding us as if we have done it or with HIV/AIDS or tuberculosis or malaria. We need to be very careful.

The last one is we are on the trajectory of scaling up in many of these vertical disease. We will reach the MDG for malaria for example. Where do we want to go as we take the other MDGs, which would undermine the achievements in HIV/AIDS. I think that is where we should be going and we should be coming closer together so that we learn from the vertical programs and we know vertical programs will never succeed if we don't build health systems and if we don't address the other MDGs.

That is what I got from this. I hope you got something out of it. Join me in thanking me these distinguished panelists and speakers and thanks to you. Thank you.

[Applause]

[END RECORDING]

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